CLINICAL PRACTICE

Development of the nursing profession: From nursing angel to patient advocate

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ABSTRACT

This reflection article deals with the nursing profession and its skills. The discussion begins with the birth of nursing and how it has advanced from the angel of nursing to scientific technical nursing in some parts of the world. The aim of this paper is to present a new kind of nurse, the patient advocate and its relation with clinical economics. The work of the "Patient Advocate" is based in the best health care, observing lower costs of resources, particularly those which affect the patient's quality of life, and identifying and questioning the team's decisions which are not supported by the principles of clinical economics. As a result, "Patient Advocate" is a proposal that encourages social actors to invest in the academic training of nursing personnel as well as in improving nurses' clinical and methodological competency, proactivity, and leadership in relation to health care.

Key Words: Education, Nursing, Health economics, Patient care team

1. INITIAL CONSIDERATIONS

The role of nursing for the maintenance and recovery of health, and in different stages of life, is a focus of concern worldwide. The effectiveness of nursing assistance, the number of nurses, and the international migration of the workforce are aspects that have promoted discussion about international models of nursing education.[1]

Over the years, the World Health Organization has made recommendations for the development of international standards for basic nursing education. The guidelines indicate that educational criteria must consider the results of this care practice anchored in evidence, competence, progressive lifelong learning, and in the employability of competent nurses, targeting the quality of care provided to those under the responsibility of nurses.[2]

Another movement deals with harmonization of nursing education, involving national governments. The "Bologna Process", arguably the most prominent among such initiatives, proposes making academic curricula compatible and comparable, nursing included, not only in Europe but also in more than 46 countries.[3]

As the world population grows older the demand for nursing care has increased, comprising primary, secondary, and tertiary attention and involving health needs in distinct moments according to levels of dependence and severity, as well as life threatening events. In addition, nursing assistance requires the presence of the professional with the patient 24 hours a day. This is why the effectiveness of the attention provided assumes such importance in the health services system.

Thus, the current theoretical reflection recalls the origins of scientific nursing, highlighting the Nightingale System as a conceptual and theoretical landmark in the organization of

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curricula for nursing schools worldwide—and especially in areas under British influence—launching nursing as a science. In this context, we analyzed the development of nursing education in European countries, North America, Australia, and Brazil. In sequence, we present the professional education in its different levels (i.e., technical, undergraduate, and graduate level) in an attempt to comprehend the scientific and legal state of nursing practice regarding the assistance and managerial aspects as well as teaching and research, comparing nursing development through the ranking of document citations according to international indicators.[4,5]

This context provides elements for discussion of the theoretical proposal termed "Patient Advocacy", anchored in the "Clinical Economics" perspective.

2. The birth of scientific nursing

The Nightingale System, a process postulated by the Englishwoman Florence Nightingale in the mid-nineteenth century, was a landmark for transposing nursing as a secular practice, founded on knowledge and based in theoretical and observational grounding. This approach fundamentally established that the training of the nurse should be made up of methodical, theoretical–practical teaching, rigor in the selection of students, and the financial and pedagogical autonomy of the institution carrying out the training in health care.[6]

The systematized teaching of nursing, which had begun in Great Britain, spread to Scandinavia, France, the United States, and Canada, shaping the scientific, academic, and professional training of this strand of health sciences.

Nursing's evolution as a profession, over the last 200 years, has occurred in progressive stages, with professional improvements in management and in academic performance. The service provided by nursing is important, as it is intended to bring benefits for the population's health. It must therefore be subjected to certification, at the undergraduate, Master's degree, or doctoral level.[7]

3. Current status of nursing in Europe, Australia, and north and south America

The configuration of authority regarding the determination of health and illness, care practices, and professional meaning involves social, cultural, economic, and political organization and competencies. This premise may explain why teaching in nursing is heterogeneous. In some countries, nursing is not seen as a separate area of knowledge, and legal professional organizations have not been established.

In Germany, training occurs predominantly at a technical level and is offered by hospitals. In order to exercise the profession, it is necessary to have been trained in a specific course in one of the following four areas: general nursing, pediatric nursing, nursing of the older adult, or obstetric nursing/midwifery (organized independently), lasting three years and dependent upon passing an examination undertaken by the State.[8]

At different points, there have been attempts to integrate nursing into the list of higher education courses. Currently, in Germany, higher education is organized in two structures: in colleges, where training is directed towards more practical teaching; and in the universities, where the teaching seeks to develop more intellectualized aspects, articulating teaching, research, and practice.[9]

Thus, nursing in Germany can be asserted to be a health profession, as it aims to occupy political and institutional spaces, particularly motivated by the organization of the European Economic Community.[9]

The training of nurses in France is undertaken by the Institutes for Training in Nursing Care (Instituts de formation en soins infirmiers), and takes place over 37 months, including theoretical and practical studies with hospital placements. In order to achieve growth in his or her career, the professional can opt for complementary training as Cadre de Santé (health manager), aggregating competencies in administration and teaching; Cadre Supérieur de Santé (health manager, higher education), with functions of administrative responsibility; or Directeur de Soins (care director), with competence for general management of nursing in an institution. Based on the Cadre de Santé training, it is possible to apply for university training or a professionalizing Master's degree; or, if desired, it is possible to opt for a number of specializations.[10]

The European countries, aiming to standardize diplomas in higher education, sought support in the Bologna Process of 1999, for implementation of the License, Master's, Doctorate (LMD) system. The LMD System permits the nurse access to the university route and consequently to inclusion in training at the professional Master's degree or doctoral level, which would tend to propel professional practice and the development of research in this field.[10] In France, however, the nursing curriculum does not allow nurses to benefit from this system.

As a result of the Europe of Knowledge movement, Spain implemented its University System Reform in 2005, modifying the structure of the University diplomas and thereby benefitting nursing: previously, studies in this area were restricted to the graduate level, whereas after this date, postgraduate studies were implemented for nursing (Master's degree and

doctorate).[7]

The content of training programs for nursing education seems to be similar across Western European and Anglo-Saxon countries. These programs address clinical pharmacology, clinical decision-making skills and diagnosis, consultation management, issues concerning concordance and adherence to medical treatment, as well as legal, policy, and ethical considerations concerning nurse prescribing, professional accountability, and responsibility.[11]

Nursing in Australia consists of three categories: Enrolled Nurse (EN) short-term training; Registered Nurse (RN) with graduation, representing more than 80% of the professionals working in this country; and Midwives, with specialization in registered obstetrics. All of these professionals are registered in the Health Department Nursing and Midwifery Office.[12]

In countries such as the United Kingdom, the United States of America, and Canada, the characteristics of nursing are more advanced. In these countries, the nurse can care for various health problems in nurse treatment rooms, and can offer nursing care services, besides routine care and complementary examinations.[13] The provision of PhDs in nursing is a fundamental element for the undertaking of research and scientific evidence for health care.

As an indication of the advanced level of nursing in North America, it can be emphasized that in the United States, the undertaking of scientific research and the offering of doctorates in nursing has been in place since 1933.[14]

In Australia and the USA, there are different norms for the practice of health in each state; for some skills, it is not enough to be a nurse, it is necessary to have a Master's degree. In the UK, in addition to undergraduate nursing, there are specific courses for the nurse to obtain certain competencies.[15]

In Latin America, including Brazil, the nursing curriculum follows the hospital-centric model; however, in recent decades these have been adapted in accordance with the perspectives of Brazilian public health, with a focus on health promotion and actions for preventing health problems. This entire transformation has formed the basis for the changes in education in nursing, in order to meet the principles which guide the SUS (Unified Health System), which emphasizes the importance of the different types of professional training in health care.[16]

The Brazilian National Curricular Guidelines for Nursing (DCNEnf) propose that the structure of the undergraduate courses in nursing should ensure "the implementation of a methodology in the teaching-learning process which encourages the student to reflect on the social context, and to learn to learn."[16]

Through the National Curricular Guidelines, education policies indicate the organization of higher education towards forming health professionals' competencies and skills, including attention to health, decision-making, communication, leadership, administration/management, and continuing education,[17] thereby configuring the range recommended for training, and ultimately the theme of the nurse's professional practice.

The historical process of Brazilian nursing qualification through postgraduate courses (stricto sensu) began in 1972, with the aim of training nurse researchers for the practice of lecturing and for undertaking research,[18] aspects which indicate the care-related and academic focus desired for nursing in Brazil.

The great expansion of nursing in Brazil is proof of this. The expansion is characterized by greater autonomy in the exercise of the profession through the opening of nurse treatment rooms, although the characteristics of this activity are still being discussed.[13]

Worldwide, nursing is still grounded in a pragmatism which must now be superseded. Nurses were initially seen as angelic beings, who then transitioned from religious practice to secular professional practice in the 19th century. The emphasis on these angels of nursing obscures the fact that they were competent professionals with scientific and technical knowledge. Years of separation between nursing and medicine have resulted in a loss of biomedical knowledge through lack of interaction between these professionals—knowledge which could contribute to the improvement of the health services provided, and reduction of costs.[19]

Nursing broadly encompasses a variety of specialists and professionals of all educational levels, including those with no formal training that may or may not be recognized by the legislation in each country, those with minimum training and those who had complete formal training (university level).[1,20] This scenario illustrates the need to develop the nursing activity as a field of specific knowledge and social practice where individuals acquire scientific background through undergraduate and graduate courses.[1]

According to the World University Ranking (2016),[4] which uses two indicators related to the institution's reputation in teaching for nursing practice and two indicators in the evaluation of knowledge production (publication and impact factor of the research produced), we were able to verify that those countries influenced by the English nursing educational model, with a history of teaching focused on sci-

entific method for assistance, management/coordination of health services, and research/education (university training for nurses), had the highest frequency of universities with a better reputation in training and research production; whereas those countries that have more recently implemented higher education and access to Master's and PhD degrees, did not appear in the ranking.

We then conducted another analysis ranking countries according to citation of nursing documents.[5] This method places the USA first, followed by the UK, Australia, France, Canada, Spain, and Germany. These European countries are relatively young in the training of Masters and PhDs in nursing, but do have a strong level of socioeconomic, cultural, and scientific development.

4. Patient advocate and clinical economics perspectives

The pre-scientific practice of nursing was centered on helping the homeless human being as an act of charity, fruit of the mission of religious women who had become angels and mothers of the dying. To the present day, nursing work remains to some extent bound by this societal imaginary. Over the years, through both practical observation and informal teachings shared among health professionals, the organization of practical nursing developed based on scientific knowledge obtained through short practical courses for continuing education. The pioneering work of Florence Nightingale served for the construction of the scientific corpus of nursing, postulated in nursing theories and other scientific knowledge and legal devices.

For quite some time now, nursing has been seeking space and recognition as a profession for health, although remaining a subordinate occupation with a medium level (technical) training, relying on the mechanized repetition of techniques learned in medium-term courses—which makes precarious the benefits and potential of nursing care in the protection, recovery, and optimization of patients' quality of life.

Currently, in countries on different continents, nursing is recognized not only as care practice undertaken by the bedside, which can be undertaken without in-depth, methodological knowledge, but as a science of care that requires academic training. This presupposes systematized learning through scientific methods (without ceasing to value subjectivity, culture, and popular knowledge) and with the guarantee of prerogatives conferred upon the nurse, such as care practice, teaching, research, and the study at the Master's and doctoral level, holding nursing to be essential for ensuring health care and viewing the nurse as a professional who is integral to the health sciences.

It is emphasized that such recognition does not entail assuring or safeguarding the nurse as an active actor, who promotes and articulates actions in health, even in countries where the nurse's training takes place exclusively in universities, with curricula programmed for the technical-scientific preparation and vocationalization for scientific training at the stricto sensu level.

In this regard, as one of the links for the application of clinical economics, or CLINECS, in the work practice of health professionals, Porzsolt (2010)[21] proposed the concept of the Y-nurse, conceptualized based on the observation that there are many situations in daily nursing work which need to be resolved differently, and where the focus of nursing contrasts with the medical perspective.

The letter "Y", in English, sounds like the word "why". The Y-nurse is the member of the team with the greatest technical and scientific qualification, who is always (and only) called when there are fundamental differences of opinion between physicians and the health team. The task of the Y-nurses is to question why and ask why or how: "Why do we need to do this?" The Y-nurse is a highly trained and experienced professional, designated by management but answering only to the executive director, who is recognized as a scientific authority for optimizing health care, and who is paid appropriately.[21,22]

The continuation of CLINECS studies resolved that the most appropriate terminology for what was initially designated as the Y-Nurse would be "Patient Advocate", in accordance with the nature and objectives of this new professional category. The "Patient Advocate", after evaluation of the health team's decisions, is the one who compares the efforts employed with the outcomes, identifying the best outcome for the patient under the CLINECS concept, and recommending changes aimed at excellence in health care delivery (see Table 1) based on Padilha et al. (2013)[23] and Planas-Campmany, Icart-Isern (2014).[24]

In order to respond as a "Patient Advocate" it is desirable to have solid undergraduate training in epidemiology, statistics, the management of health services, evidence-based decision-making, and experience and clinical knowledge in the specialty.[22]

The work of the "Patient Advocate" is aimed at producing the best health care possible, observing lower costs of resources, particularly those which affect the patient's quality of life, and identifying and questioning the team's decisions which are not supported by the principles of clinical economics.

It is understood that the scale of the proposal in question requires that a set of special skills is provided in Patient

Advocate training, as well as informing the theoretical-methodological framework of the course. The framework is grounded in learning in clinical economics, based on CLINECS, which includes assessment of the validity of scientific evidence for health care, of drugs and clinical procedures, evaluation of results of scientific investigations (in ideal study conditions), cure and care (in real conditions), and the ability to communicate with patients, relatives, fellow nurses and other health professionals, preparation for holding academic discussion, and the capacity to examine and analyze the scientific bases of clinical decisions.

Table 1. Stages, forms, and functions in the development of professional nursing. The increasing significance of evidence-based decisions and of clinical economics is expressed by different shades of gray

Stage	Form	Function	Example
I	Nursing angel	Providing empathy, consolation, and basic support.	Start of a new profession
II	Nursing practitioner	Fixing real life requirements.	Formal education and specialization
III	Academic nurse	Developing theoretical concepts and evidence-based solutions.	Scientific development of the profession
IV	Economic nurse	Comparing costs* and consequences* for well-balanced decisions.	Adaptation to the require-ments of modern medicine
V	Patient Attorney (previous Y-nurse).	Scrutinizing the team's decisions. Comparing efforts and outcomes. Identification of low quality servi-ces. Striving for economy and excellence.	A new category of health care professional responsible for the quality of health out-comes.

Note. Based in Padilha et al. (2013) [23] and Planas-Campmany, Icart-Isern (2014) [24]. *Costs are what the patient has to accept such as hospitalization, risks and side effects of treatment. Consequences are what the patient will get back such as relief from pain, restoration of lost functions (including any aspect of health-related quality), and prevention of early death.

In this perspective, the training of nurses differs from that required for other biomedical professions, since the intellectual evolution of teaching in nursing—in addition to the concern for developing new theories, practices, and health care technologies—is directed at critical-reflexive training, without losing the holistic and humanized model.

The nurse's vision is centered not only on the treatment or technology used, but on evaluation of the process, adherence, and the effectiveness and safety of the clinical measures used, for the client's benefit. The solution may well be found in clinical management rather than in the substitution of one treatment for another that is more expensive and poses higher risk, based on observation and evaluation of the care offered. Integral attention given to empathy, holistic vision, and humanized thinking, in face of the health–disease process, is at the core of the practice of nursing, unlike other actors of the health team exclusively educated under the aegis of the biomedical model.

Thus, the hypothesis is that nurses are the most appropriate professionals to be responsible for balancing the costs and consequences of different strategies and treatment. This means that nurses constitute the health care profession that urgently needs to specialize in clinical economics (comparative costing in the CLINECS perspective versus benefits of different treatment strategies), a work that should preferably be within the scope of nurses' practice.

The main challenge of the work of the "Patient Advocate" is, through communication, to optimize the decisions of the medical and nursing team. The return on investment for the "Patient Advocate" concept is to increase the transparency and efficiency of health care, and this actor becomes essential in the health institutions' structure to the extent that the positive responses justify the annual expenditure.

As a result, "Patient Advocate" is a proposal that encourages social actors to invest in the academic training of nursing personnel (in countries where teaching is only at mid-level) as well as in improving nurses' clinical and methodological competency, proactivity, and leadership in relation to health care. It urges a review of thinking regarding the difference of valorization among the professions in the area of health, the social recognition of nursing, reduction of potential years of life lost, reduction of financial costs to the health systems, and, most importantly, decision-making power and comfort for the patients. In this way, this strategy finds space for reflecting on nursing practices globally—both within countries where it enjoys the status of a science, as well as in those where its role is exclusively manual and technical.

The studies which gave rise to "Clinical Economics" (CLINECS) were motivated by the perception that the costs and side effects of treatments that patients must accept are

not always well balanced with the benefits achieved through the treatments offered. There was no method in health care to balance all the costs (not only monetary) and the consequences (values), just as were neither alternatives for action on the part of the patient nor of the perspective of society.[25]

CLINECS bridges the objectives of the quality of the Donabedian triad (structure, process, and result) and the clinical-economic perspectives of other disciplines. In this scope, the patient's perspective is considered, which is a fundamental requirement of the concept; CLINECS means applying economic principles to the health services—with the caveat that the meaning of the word "economic" is not employed in the sense of gaining profit.[22]

For example, a complete economic analysis includes three parts: 1) "costs", that is, what is necessary to accept, such as hospitalization, side effects, a treatment's risks, or monetary costs; 2) "consequences", that is, the return, the solution to one's health problem; and 3) "alternative forms of actions", which means that the patient always has to compare the costs and the consequences of at least two or more possible actions.

Clinical-economic decisions, therefore, are a useful tool for finding the best among various possible solutions for the patient. In contrast, a commercial decision means making profit, generally monetary profit for one's own pocket or for a company.[22]

Based on CLINECS, it has been discussed that health care is the responsibility of a team of professionals, including politicians, physicians, and nurses among others, with it not being appropriate to indicate a scale of hierarchical importance.

The perspectives for the configuration of this proposal in the scientific structure of nursing are encouraging, given that the Institute of Clinical Economics (ICE) in Germany, in cooperation with nursing and public health researchers from Brazilian universities, is organizing a curricular matrix for the training of the "Patient Advocate", to begin in Brazil, with the intention to identify individuals with managerial ability to lead a team, to meet the international demands around this issue.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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