I Setting the Scene
1 The Principles, Practice and Evolution of Rheumatology Nursing

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The aim of this chapter is to provide an understanding of the important contribution that therapeutic nursing can make to a patient living with a chronic rheumatological condition. After reading this chapter the reader should be able to:

- describe the key elements of nursing and explain why they are important to a patient with a rheumatological condition;
- discuss the skills and qualities required for the nurse to enter into a therapeutic relationship;
- describe the difference between supportive and therapeutic nursing and provide examples to illustrate this;
- discuss the actual and potential barriers to therapeutic practice;
- outline the components of the nurse consultant role.

DEFINITIONS OF NURSING

The most widely known definition of nursing is that of Henderson (1966) who states that ‘the unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible’. Although this definition is not new, it contains the elements relevant to today’s health care with its emphasis on empowerment, rehabilitation, education and self-management.
Health and illness are not static but dynamic entities, fluctuating in response to many internal and external influences. The role that the nurse assumes will be governed by the patient’s perceived need at any particular time. Shaul (1995) in a qualitative study, identified four defined stages that patients encountered as they adjusted to living with rheumatoid arthritis (RA). These included:

- becoming aware (Symptoms became persistent and impacted work, the family and mood.);
- seeking medical help;
- learning to live with it (Through experience, the individual develops different coping strategies that equate with their context.);
- mastery (The individual adapts and lives with the symptoms.).

**CARING**

Caring is one of the most important values of the nursing profession. Although often referred to as a basic requirement, there is nothing basic about high quality nursing care. The term ‘basic care’ has been used and interpreted incorrectly to the detriment of the profession. Nursing requires a combination of:

- knowledge
- understanding
- expertise.

Identifying and meeting the needs of patients who are unable to care fully for themselves involves having regard for people as individuals and being concerned about what happens to them (Malin and Teasdale, 1991). The process of caring comprises elements of both action and emotion. However, in practice the action element frequently dominates, as the nurse concentrates on the patient’s physical needs (May, 1991; Henderson, 1994). This can result in a neglect of the emotional needs that have been shown to be the predominating factor influencing the experience of good or bad care as perceived by patients (Smith, 1992).

An overemphasis on the physical manifestation of rheumatoid arthritis (RA) such as synovitis of the small joints, without consideration of the effects the condition has on the individual’s lifestyle, will not provide comprehensive care and may well be harmful. RA can impact on the patient’s social activity with over 50% of patients experiencing social isolation (Yelin and Callahan, 1995). If no one has explored the emotional impact of chronic illness with the patient, they may find themselves bewildered, and unsure of where to turn.
for help and advice. It is common for patients with a chronic condition to experience a plethora of emotions including:

- shock
- anger
- grief
- depression.

It is essential that the nurse has the necessary support and education to provide the emotional elements of care; otherwise care will not be holistic, meaningful or relevant to the patient.

**THE ELEMENTS OF NURSING**

The key elements or functions of nursing can be seen in Table 1.1. The main link between the elements is the nature of the relationship between the nurse and the patient.

Once problems have been identified, a plan of care will be formulated which incorporates the patient’s identified needs. Chronic conditions have a global impact on the patient’s life; living with a rheumatological illness will affect not only the individual but also their family and significant others (Ryan, 1996a). The social implications of rheumatological illness are discussed in Chapter 7.

As well as a sound knowledge base, the nurse will require the ability to understand exactly what physical disability means to each individual (Powell, 1991). For instance, a mother with active inflammation in her hands may be prevented from lifting her child, causing feelings of guilt and anxiety. She must be allowed to express her feelings and be given support and advice about practical measures such as lying on the bed to cuddle her child. For others, inflammatory changes in the hands may affect their ability to work, causing depression and poor self-esteem. Counselling will be required to support the individual through this life crisis, but until the nurse is able to appreciate and understand the impact of illness from the patient’s perspective, they will not be able to offer care from a humanistic viewpoint.

<table>
<thead>
<tr>
<th>Table 1.1 Nursing functions (Wilson-Barnett 1984)</th>
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<tr>
<td>- Understanding illness and treatment from the patient’s viewpoint</td>
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<td>- Providing continuous psychological care during illness and critical events</td>
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<tr>
<td>- Helping people cope with illness or potential health problems</td>
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<td>- Providing comfort</td>
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<td>- Coordinating treatment and other events affecting the patient</td>
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Essentially, nursing is a social activity. The nurse will need to possess good communication skills and a level of understanding and knowledge about the complex nature of rheumatological illness to be able to offer a complete care package.

**THE PHILOSOPHY OF NURSING**

A philosophy of practice is essential. It should provide a clear outline of what nurses perceive to be important and central to their practice. This ensures a continuity of approach and can unify the team and ensure that care is practised from a shared understanding with an identified purpose. If nurses working within a clinical area do not share a common purpose, disunity and fragmentation of care can occur. To be meaningful, the philosophy should be derived from those working in both primary and secondary care. Each clinical area will need to determine and develop the beliefs that shape present practice. A philosophy imposed by the wider organisation without the necessary consultation will probably fail in its objective. A rheumatology philosophy of care can be divided into four interlinked and complementary areas (Figure 1.1). Underpinning each area is the patient as the central focus of care delivery.

**BELIEFS RELATING TO HEALTH**

Health is the state in which the individual has adapted to physical, psychological and/or social imbalances and is able to cope with their arthritis in a positive and constructive manner. In the context of rheumatological conditions, health does not mean the removal of all symptoms, as this would be an unre-
alistic outcome and an unfair burden to place on patients. Health and illness are not static entities, many rheumatological conditions are characterised by flares and remissions and the patient will require advice, support, guidance, motivation and education to deal with problems presented by each new phase of their illness.

BELIEFS RELATING TO THE ENVIRONMENT

The hospital

The hospital environment is alien to most people and can cause anxiety and loss of confidence. To counter this, a person needs to believe that they can influence care management (Tones, 1991) even if the belief is illusory, and participate actively at all levels. Neglect of the patient’s individual concerns and perceptions can lead to isolation and the adoption of poor coping mechanisms. Nursing must create a positive atmosphere that will address both internal and external issues. If the orientation of the ward is committed to task delivery with little emphasis on interpersonal communication, the patient will be unable to explore their emotions to the detriment of their health and acceptance of their condition. Work by Edwards et al. (2001) has demonstrated that when patients are nursed on specialist rheumatology wards they report increased confidence in the nurses’ ability and knowledge, whilst patients nursed on non-specialist wards reported a lack of understanding regarding their arthritis.

The community

As resources are increasingly diverted to the community, a person with arthritis may have reduced access to the specialist multidisciplinary hospital team. It is therefore necessary that nursing expertise moves into the community. A community rheumatology nurse can act as the interface between primary and secondary care. The rheumatology nurse can liaise with practice nurses and other community workers to promote a greater understanding of the needs of the patients and to ensure continuity of care. Practice nurses are conducting assessment clinics (Dargie and Proctor, 1994) and monitoring second line disease-modifying drugs. It is important that primary care is supported by the secondary care service, and that community nursing staff have easy access to their hospital colleagues. In this way, the patient can be given ready access to whichever service best matches their need. Aspects of seamless care are discussed in Chapter 16.

BELIEFS RELATING TO THE INDIVIDUAL PATIENT

The beliefs that the rheumatology nurse holds toward the patient have important impact on the care provided. Viewing patients according to the following beliefs is essential to underpinning quality care provision.
The individual is a person with an ongoing health related problem. The individual should not be depowered, but encouraged to share their own valuable knowledge store, which is essential to their care.

The individual will bring their own lay beliefs and life experience to all situations. These are usually consistent over time and pertinent to the individual concerned (Donovan, 1991). They need to be shared with the nurse, as they will influence the success and acceptance of care management. For instance, if a patient believes that exercise damages the joints, this needs discussing so that the patient can incorporate new information into their existing knowledge. In this instance, advice will be required about the type and amount of exercise needed and the anticipated outcome, enabling the patient to make an informed choice and contribute to the decision-making process.

Patient autonomy should be the overriding principle that guides nursing practice. Paternalism is based on the principle of beneficence (i.e. the professional knows best) and is frequently used to justify actions such as forcing treatment on the individual for the individual’s supposed good. Use of the principle of autonomy to guide nursing decision-making will remove the passivity and dependency implicit in paternalism. A heavy reliance on professional beneficence can unintentionally remove the rights or abilities of patients to participate in their own care.

The individual has the right to be an active rather than passive recipient of care if they wish. However, to assume that all patients wish to be empowered is not adopting an individualized approach. Research by Waterworth and Luker (1990) showed that some patients were ‘reluctant collaborators in care’. They wished to leave decision-making to the nurse, regarding their own involvement as neglect of care. By carrying out an individual assessment, the nurse will recognise the patient’s perceived needs and plan care accordingly. Some patients may prefer a partial involvement rather than a full contributing and participating role. This should be respected and reflected in care management. It will take time for patients to learn about their condition, and reliance on the nurse at a time of crisis, may be necessary for adaptation. As the therapeutic relationship develops, the patient may feel more able to contribute to care decisions. Nevertheless, the emergence of a new stressor such as a reduction in mobility may return the patients to a heightened state of dependency.

The patient is not an isolated being but lives as part of a social network. Any decisions concerning their care should incorporate the needs, values and expectations of these significant others. The individual has many social and occupational roles and the effects of illness must be addressed in a holistic manner.

The individual’s values, perceptions and expectations will be central to care planning and the success of care interventions.
BELIEFS RELATING TO NURSING

Carr (2001) defined the following beliefs:

- Nursing enables the patient to manage their condition, lead as full a life as possible and make informed choices.
- Nursing makes a difference to the patient.
- Nursing supports, enables, cares for and educates the patient.
- Nursing provides a high quality service.

EMPOWERMENT

The concept of empowerment is central to the provision of patient-focused care. Tones (1991) defines empowerment as the ‘process whereby an individual or community of individuals acquires power’ (i.e., the capacity to control other people and resources). An empowerment approach to health recognises the rights of individuals and communities to identify their own health needs, to make their own health choices and to take action to achieve them (Wallerstein and Bernstein, 1988). This is a rather utopian viewpoint, as the ability to make health choices necessitates active participation in the nurse/patient relationship and equality of access to the possible intervention, which may not always be possible. For example, a young mother with rheumatoid arthritis may not be able to attend a pain management programme because of her inability to use public transport. However, there is some merit in Wallerstein’s contribution, as it challenges the traditional view of the passive patient, placing the patient (in this definition) in a more active role. Empowerment necessitates a relinquishing of the power held by the health care professional or a sharing of power on a more equal basis.

Empowerment is a complicated subject, so much so that some authors (Gibson, 1991) have found it easier to define it by the consequences of its absence, namely:

- powerlessness
- helplessness
- hopelessness
- alienation.

The combination of an internal locus of control and a belief in powerful others can be of benefit (Wallston, 1995). For instance, the patient may respect the information offered by the nurse, but will judge its relevance against what is meaningful to them. If the nurse recommends an increase in exercise, they will experiment and balance the perceived benefits against time that could be spent on other activities. A person who believes only in powerful others, will
preclude individual judgement and prevent an individual assessment of whether the situation is within their personal control.

Empowerment comprises three elements:

- responsibility
- accountability
- risk taking.

Responsibility can be allocated to a person, but unless the person accepts the responsibility they are powerless to act. It may also be the case that an individual is willing to take responsibility, but social and political constraints prevent this. Tones (1991) states that acceptance of responsibility will be determined by the extent to which an individual possesses competence, skills and/or the belief that they are capable of controlling central aspects of their lives and overcoming environmental barriers.

**THERAPEUTIC NURSING**

Therapeutic nursing has been defined as ‘that practice where the nurse has made a positive difference to a patient or client’s health state, and where he or she is aware of how and why this positive health difference has occurred’ (Powell, 1991). Four main areas (Table 1.2) in which nursing can be seen to be therapeutic have been highlighted by MacMahon and Pearson (1991).

Rheumatoid arthritis is an incurable condition but the goal of well-being remains realistic. Supportive nursing has a role to play as the aim of many of the interventions (both medical and nursing) is to limit the potential for further deformity and disability. One example is disease-modifying drug therapy such as methotrexate or gold injections. However, to adopt an exclusively supportive approach would be detrimental to the patient, as it does not allow the patient to participate in the control of their management. Control is retained by the nurse, stifling any attempt by the patient to take an active part in their care.

Some nurses do not wish to develop a therapeutic relationship with patients (Salvage, 1990) and others do not value working with patients whose conditions are not amenable to cure (Nolan and Nolan, 1995).

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<th>Table 1.2 Areas of therapeutic nursing</th>
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<td>Nurse/patient relationship</td>
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<td>Conventional nursing interventions, <em>e.g.</em>, pressure-area care</td>
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<td>Unconventional nursing interventions, <em>e.g.</em>, practices taken from therapies</td>
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<td>Patient teaching</td>
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In order to improve the patient’s well-being the nurse must play the roles of:

- educator
- guide
- motivator
- supporter.

The satisfaction obtained when the patient and the nurse grow together, will help to remove some of the negative perceptions that nurses sometimes acquire when caring for patients with long-term needs.

THE NURSE/PATIENT RELATIONSHIP

Salvage (1990) has questioned whether patients desire a close relationship if their immediate concern is relief from pain and discomfort. This may be relevant to patients experiencing acute illness, but in chronic conditions it takes time and close cooperation to cope with pain that cannot be alleviated. This is where individual patient assessment is so important. It should be remembered that some patients may not perceive benefits from developing a relationship, and so long as the patient is aware of how to renew or establish contact should a problem occur, this view must be respected.

PATIENT PERCEPTIONS

Some patients with rheumatoid arthritis have a negative concept of the future that persists even after their condition is in remission (Hewlett, 1994). The nurse should identify and address any problems perceived by the patient in the initial assessment. If the patient is convinced that the future means a wheelchair existence, it is not helpful to be told that only 5% of people with rheumatoid arthritis require a wheelchair. Patients require acknowledgement of their problems and explanations provided within their own context (Donovan and Blake, 2000).

The concept of shared care, where the patients take responsibility for their condition with support and guidance of a named nurse, offers the best way forward. Patients who believe they can influence their condition will report fewer physical problems and enhanced well-being (Newman, 1993).

Adopting a holistic humanistic approach to care requires a change from the supportive role of doing for the patient, to a therapeutic approach which necessitates enabling the patient to feel in control (Chapter 5). For instance, if the patient’s main problem is that of pain, the nurse can have a therapeutic input by establishing in conjunction with the patient, the pattern, type and severity of the discomfort, whether or not it is related to activity, and the apprehensions and anxieties associated with it. This is a two way process,
first achieving clarification of the problems from the patient’s perspective and then working in partnership to minimise the stressor. By the use of empathy, respect and trust nurses enable patients to believe in their decisions.

It is also essential to encourage those who have value in the patient’s life to participate in care management. For example, rest is an important part of the treatment for a patient with a systemic condition such as rheumatoid arthritis in which both physical and emotional fatigue can occur. If the family is unaware of this, pressure may be placed on the patient to abandon resting. This can be avoided if the family learns the role of rest in the management of the condition. If there is an absence of shared understanding within the family, the patient may try to disguise their limitations resulting in increased symptoms and a reduced quality of life.

BARRIERS TO THERAPEUTIC PRACTICE

THE VIEW OF NURSING

Some nursing activities, such as assisting a patient to bathe, are often considered to be basic or menial where in fact they are essential to a patient’s well-being. Technical skills are associated with greater status and are therefore deemed to be more important than basic care skills. Therapeutic nursing will include technical skills, but at its core is the realisation of the value of expressive skills (Wright, 1991) which include the ability to:

- be with the patient
- provide comfort
- provide education
- provide the emotional element of care.

Within the framework of therapeutic practice, no act of care having relevance to the patient can be described as menial. Indeed high technology skills without the addition of high touch skills have little meaning for the patient concerned (Wright, 1991). The importance of these expressive skills must be emphasised and should therefore be taught at both basic and post-basic level. A nurse engaged in therapeutic practice will relate to the patient as an individual, adopting a combination of skills that are perceived to be beneficial and to solve the patient’s problems. Nursing should not be embarrassed by this caring element, but should strongly endorse it as the component which the patient directly relates to the success of their nursing care (Smith, 1992). The challenge to nurses is to combine both technical and comprehensive skills into a healing whole which serves the patient (Wright, 1991).
EMOTIONAL INVOLVEMENT

It has been suggested that nurses do not want to develop the relationship required to nurse patients with a chronic, or indeed an acute, illness. A study of communication between nurses and patients on a surgical ward found that nurses in close relationships concentrated on medical treatment rather than emotional need (Macleod Clarke, 1983). To some nurses, working with patients who have ongoing needs offers little job satisfaction because they are unable to sustain a sense of therapeutic optimism (Evers, 1991; Reed and Bond, 1991; Reed and Watson, 1994). It is possible that rather than working in partnership with the patient to establish shared objectives, nurses set themselves unrealistic care objectives from their own frame of reference. Establishing and being committed to a relationship is demanding as it is necessary to give of one’s self to develop the trust needed for partnerships to grow. To encourage this depth of involvement or emotional labour (Smith, 1992), a nurse needs to work within a supportive framework with an assigned supervisor to assist with personal and professional development. Wright (1986) has stated that all nurses need the opportunity to:

- share feelings
- express views
- raise questions relating to practice in a structured fashion.

WORK ENVIRONMENT

The culture in which nurses work does not encourage them to spend time talking to patients, but time is essential if a relationship is to develop. There is still emphasis on achieving tasks rather than engaging in therapeutic interventions, and emphasis on a growth of support workers at the expense of qualified nurses. If these trends continue, it is questionable whether it will remain possible for a relationship to develop on anything but a superficial level.

In some hospitals, the outpatient department may be the only environment where the patient with a chronic disease is cared for, and so all newly diagnosed patients should be referred to a rheumatology nurse to begin the process of therapeutic care. A realistic personal profile of care should be established which could be used by other key workers, such as the physiotherapist or practice nurse, so maintaining the continuity of care between the secondary and primary health care sections. Care profiling and planning needs to be dynamic, otherwise it will raise expectations and then cause dissatisfaction if identified needs are not met.

Therapeutic nursing requires a nonhierarchical method of care delivery that enables nurses to be involved in the decision-making process and places them in a position where they can develop a partnership with the patient. The
philosophy of the work environment is of vital importance because if the nursing team is not committed to developing a relationship, a relationship will not occur. The belief that therapeutic practice is of mutual benefit will only become reality if it is actively fostered and reinforced by the organisation that delivers care. A routinised and ritualistic approach will not serve the needs of the patients.

THE DEVELOPING ROLE OF THE RHEUMATOLOGY NURSE

Rheumatology nursing has been evolving over many years, but due to the absence of a formal group or network through which nurses working with rheumatology patients could share and increase their knowledge and skills, its progress remained unappreciated until the early 1980s. This situation was resolved when, after many months of negotiation, the Royal College of Nursing (RCN) agreed to the establishment of the Rheumatology Forum (RF). The inaugural meeting of the RCN RF was held in Manchester in 1981. It was a significant event because it finally conferred acknowledgement that rheumatology nursing was a speciality in its own right, and this paved the way to future development.

The driving force behind the founding of the RCN RF was a rheumatology nurse called Vickie Stephenson. However, her vision did not stop there. She knew that nurses contributed unique care to rheumatology patients, but also acknowledged that they work as part of a multidisciplinary team, not in isolation. Although rheumatologists had their own association, the British Society of Rheumatology (BSR), nonmedical health professionals did not. Ms. Stephenson envisaged a new organisation, British Health Professionals in Rheumatology (BHPR), and played a significant role in its establishment in 1985.

Both the RCN RF and BHPR have gone from strength to strength, and it is largely due to them that roles are evolving rapidly and the work of nonmedical health professionals is acknowledged as being central to successful outcomes for rheumatology patients.

The intervening years since the inception of these two organisations have seen many innovations in care. The most significant events in nursing have been the establishment and growth of:

- nurse-led clinics
- consultant nurse role
- academic rheumatology posts for nonmedical health professionals.

THE EVOLUTION OF RHEUMATOLOGY NURSING ROLES

Although nurse-led clinics existed in a number of areas of chronic disease in the United Kingdom, it was not until the 1980’s that they began to emerge
in rheumatology. The first clinics began when nurses working on clinical drugs trials in Leeds began taking on responsibility for more patient-centred care (Bird et al., 1980). They monitored disease progress and provided education and support to the patients and their families. Once the clinical trial was completed, normal practice was for the nurse to return the patient to the medical clinics. However, many of these patients began to request referrals for nursing consultations because they appreciated the supportive, educational approach provided by these nurses. By 1981, the first publications about nurse-led rheumatology clinics in the United Kingdom began to appear (Bird et al., 1981; Bird, 1983; Hill, 1985), followed by the first descriptive research on patients’ evaluations of the care they received from the nurse (Hill, 1986). During the following two decades nurse-led care in all specialities, including rheumatology, has grown exponentially. There are a number of reasons for this and they include:

- an ever-increasing outpatient workload;
- reduction in the working hours of junior hospital doctors;
- pressure from government;
- willingness of nurses to innovate and advance their practice.

Over the years a number of descriptive papers have been published which outline the care that rheumatology nurses provide (Ryan and Oliver, 2002; Oliver and Mooney, 2002; Sutcliffe, 1999; Ryan, 1996b; Arthur, 1994). Research has also begun to emerge demonstrating the efficacy of care from nurse-led clinics (Hill et al., 2003a; Hill et al., 1994) and some of these results have been replicated in mainland Europe (Tijhuis et al., 2002; Temmink et al., 2001). As roles evolve, research is slowly progressing, although much work remains to be done. For instance the efficacy of the consultant nurse in rheumatology has yet to be evaluated, as has the role of the biologics nurse specialist.

NURSE-LED CLINICS

Nurse-led clinics are usually the domain of clinical nurse specialists and these nurses normally practise from rheumatology outpatient clinics alongside their medical colleagues. The setting up of such clinics and the care they provide is explained in detail by Hill and Pollard (2004).

The nursing role is essentially expressive in nature (Hill, 1992), consisting of a combination of skills including:

- caring
- helping
- supporting
- teaching
comforting  
guiding.

Nurse-led clinics provide nurses with the opportunity to use the knowledge and communication skills that they possess, and to take a holistic approach to care utilising the standards advocated by the RCN RF (2001). These standards incorporate the physical, psychological, social, spiritual and sexual needs of the patient. A survey of practice in nurse-led rheumatoid arthritis clinics (Ryan and Hill, 2004) demonstrated that nurses are engaged in:

- monitoring of disease status  
- emotional support  
- patient education  
- management of stable disease  
- management of patients on biologic therapies.

Approximately 20% of nurse specialists engage in extended clinical roles such as recommending treatment changes to the rheumatologist and general practitioner, and the administration of joint injections. Many also undertake research and teaching (Carr, 2001).

It is essential that the role of the nurse working within this sphere remains firmly rooted in patient need and that all role expansion focuses on the patients’ care. Unless this happens, there is a danger that the nurse could be viewed as a medical assistant instead of being at the forefront of developing their own profession in the interests of their patient group. Nursing requires strong leadership. It would be a tragedy if nursing were to be subsumed and lose its identity in a medically orientated alliance. The nursing profession needs to be clear as to what constitutes nursing and the necessity for both a physical and emotional element in nursing practice.

The value of a clinic run on true nursing principles was demonstrated by Hill et al. (1994). This study was an evaluation of the effectiveness, safety and acceptability of a nurse practitioner in a rheumatology outpatient clinic. It consisted of a single blind parallel group study, in which 70 patients with rheumatoid arthritis were randomly allocated to the care of either the nurse practitioner or consultant rheumatologist. One of the most noticeable aspects of the research was the marked difference in the referral patterns of the two practitioners, with the rheumatology nurse practitioner making greater use of the other members of the multidisciplinary team, such as the occupational therapist and physiotherapist. This study also reinforced the view that one of the primary roles of the nurse working with patients with rheumatological conditions is that of educator. Education is required to increase the patient’s cognitive understanding and to impart knowledge of self-management techniques such as exercise regimes. The knowledge shared with patients was well-received and there was a greater improvement in
knowledge and satisfaction with care than in the rheumatologist’s group. Education is time consuming and this was reflected in the fact that over the study period the nurse practitioner saw fewer patients than the consultant. However, the patients in the nursing cohort showed greater reductions in pain and depression compared to those patients in the consultant’s group. The nurse was shown to be a safe practitioner who was able to initiate and interpret clinical and laboratory data. These results were encouraging and demonstrated the effective and safe contribution the nurse can make to the care of rheumatology patients with a diversity of needs. Subsequently, this work has been replicated in the United Kingdom with similarly excellent results (Hill et al., 2003a).

NURSE CONSULTANT

1998 saw the introduction of nurse consultant posts across England (DoH, 1999a) providing the opportunity to define and expand the career pathway, whilst allowing experienced nurses to remain in clinical care. Prior to the introduction of this new role the pinnacle of clinical progression was reached at nurse specialist level and nurses seeking further career advancement had to consider entering education or management. Unlike clinical nurse specialist roles, nurse consultant posts have defined criteria regarding role function. These include:

- expert practice
- professional leadership and consultancy
- education, training and development
- research.

These criteria provide a clear framework by which to structure role development. The only component that has a stated time allocation is that of expert practice, where it is specified that 50% of time must involve clinical care. This clear emphasis on clinical care is important as it conveys to the wider community that providing effective care for patients is at the heart of nursing practice. The distribution of time spent on the other role functions is determined by the needs of the local population, the knowledge and skills of the individual nurses and the environment in which the post is placed.

One of the entry criteria for these posts is a master’s level qualification; the first time a nursing role has been equated with an academic level. The Nursing and Midwifery Council is currently working towards ensuring that all nurses practising at specialist level have a recognised academic qualification.

Although many clinical nurses will welcome the opportunity to retain their clinical skills and develop their education and research roles, the creation of consultant nurse posts has not been without problems. They were introduced
with no specific funding, which has led to many positions being filled by the existing nurse specialist without the nurse specialist being replaced. The creation of these new posts should not be at the expense of other essential senior clinical roles.

Early evaluation of the first 451 posts (Guest, 2001) highlighted the lack of organisational support and role ambiguity that many nurse consultants were experiencing. These roles clearly require strategic influence and support from appropriate mentors. It was also found that the role component with the lowest level of involvement was that of research, which is not surprising as many senior clinical nurses have little preparation in research skills.

**ACADEMIC RHEUMATOLOGY POSTS FOR NONMEDICAL HEALTH PROFESSIONALS**

Although some research has been carried out within the speciality of rheumatology nursing, a great deal more is required. The reasons for this omission are numerous and include:

- The complexity and multifaceted nature of nursing make it difficult to define and research (Ryan, 1998).
- Nurses working in clinical practice have little time for research.
- Few nurses are trained to undertake major research projects.
- Although there are a number of academic nursing departments in the United Kingdom, unless the department includes an academic with a special interest in rheumatology, there is little expert support for those who wish to undertake research in this area of nursing.

**THE ARTHRITIS RESEARCH CAMPAIGN (ARC) INITIATIVE**

These problems were recognised by the charity the Arthritis Research Campaign (arc), which funds a number of educational and research projects. In 1999, arc made the decision to establish a small number of academic posts at the level of senior lecturer/lecturer for nonmedical health professionals. The posts were targeted at rheumatology health professionals with a commitment to research, but arc was not prescriptive and it was left open to the applicants to put forward their own ideas. Successful applicants were to be funded for five years and it was expected that the host institution would secure the posts after this time. arc stipulated that applicants:

- must be working in a department of rheumatology actively involved in academic clinical research;
- would collaborate with a second academic department that was involved in nonmedical research such as nursing or physiotherapy.
Two calls for applications were made over two years. From these five grants were awarded; three went to nurses, one to a physiotherapist and one to a podiatrist. One of the successful bids came from Leeds. This application outlined a programme of research and educational activities, but more importantly it provided a clear vision of how academic rheumatology nursing could develop in the future. The long-term strategy was to develop an academic nursing department, which would ultimately justify the inauguration of a Professor of Musculoskeletal Nursing; a world first. It was envisaged that the new nursing department would build on the existing national and international reputation of the nurses working for the Academic Unit of Musculoskeletal and Rehabilitation Medicine in Leeds, to develop both nursing practice and research. The inauguration of an academic nursing unit would provide the stability required to develop a long-term research strategy. It would also allow longer-term projects to be planned and undertaken and provide the environment in which to nurture future nurse researchers and practitioners. This was the birth of the Academic and Clinical Unit for Musculoskeletal Nursing (ACUMeN).

ACUMeN

ACUMeN is a tripartite collaboration between two departments of Leeds University; the Academic Unit of Musculoskeletal and Rehabilitation Medicine and the Department of Healthcare, and Leeds Teaching Hospitals Trust (Hill et al., 2003b). The combined approach undertaken in developing ACUMeN was and remains timely. The need for collaborations and partnerships between practice settings and universities in all healthcare disciplines has been a consistent theme of a number of recent government documents such as ‘Making a Difference’ (DoH, 1999b), the ‘NHS Plan’ (DoH, 2000) and ‘Shifting the Balance of Power in the NHS’ (DoH, 2001). In nursing, these collaborations are predicated on the view that ideas are most easily and frequently generated at the intersection of practice, education and research. On a broader front, collaboration is central to clinical effectiveness and consequently addresses the Clinical Governance agenda (DoH, 1999c) in that it enhances:

- leadership development
- patient care
- promotion, maintenance and evaluation of best practice
- professional development
- the culture of the organization.

The structure of ACUMeN

The organisational structure of ACUMeN is shown in Figure 1.2. The three directors are responsible for the day-to-day operation of the unit. Although
the overall responsibility is shared, each director has a principal responsibility for one of the three domains that are encompassed by ACUMeN:

- research
- education
- practice.

The directors are accountable to and sit on a steering committee comprised of a representative from each of the collaborating departments. This group determines the overall direction of ACUMeN policy.

The project group meets four times a year to discuss new projects, progress and problems that arise. It comprises co-directors, nurses, rheumatologists, representatives from therapy services, educationalists and patients. Input from these individuals is seen as paramount to the successful implementation of ACUMeNs programme.

The objectives of ACUMeN

ACUMeN aims to:

- produce a long-term programme to demonstrate the contribution of nursing to health care and patient well-being;
- derive a programme of clinical research which will address local as well as national and international needs;
- provide a focus for clinical teaching;
- integrate research, practice and education and so develop a model for an integrated clinical and academic nursing career structure;
- foster multidisciplinary collaboration and working practices;
- develop a model for the integration of research, education and practice in nursing between the University of Leeds and the Leeds Teaching Hospitals Trust;
- develop a model for the involvement of users in the development of research, education and practice programmes.

ACUMeN was launched in March 2003 and within two years academic secretaries, two PhD nursing students and two research assistants had come into post. A 20 credit, level 3 rheumatology course had been successfully developed and run, and ACUMeN had become a designated teaching centre for a new arc masters course. A Practice Development Unit was also being established on the rheumatology ward at Chapel Allerton Hospital, and the nurses within the rheumatology unit had become much more research-aware than previously. It remains to be seen whether the aim of the inauguration of a Professor of Musculoskeletal Nursing materialises, but the foundation stones for such a post are clearly being laid.
ACTION POINTS FOR PRACTICE

- Review the philosophy of care in your clinical area. Does it encourage therapeutic practice?
- Conduct a patient-focus group in your clinical area to identify the beliefs of patients regarding their nursing service.
- Identify the skills needed for nurses to engage in therapeutic practice.
- Conduct a literature review of nurse-led clinics and identify areas for future research.

REFERENCES


Department of Health (1999b) *Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London, Department of Health.


