

What is a career anyway?

This is the second in a series of articles to encourage discussion about nursing and midwifery career structures in South Australia. Each article looks at different issues affecting professional career structures. It is hoped that these articles will stimulate workplace discussions, challenge nurses and midwives to ask further questions, and become a way of collecting feedback from as many people as possible. Your views are not only welcome, they are crucial.

Your career path:

Your career path is really your work life journey: the result of your decision making, the pursuit of what you value, or perhaps a meander while you decide what you value and what decisions to make.

Your career path is also linked to other life decisions – where you have chosen to live; how you manage your money; marrying; having children; taking care of elderly parents – these and numerous other factors influence your career path. And your career path can be influenced by the options that organisations make available in their employment structure.

This Career Structure Project addresses only one area of the many factors that make up your career path choices – the options available in the South Australian public sector. As illustrated in Figure 1, nurses and midwives have a wide range of choices in terms of the type of organisation they wish to belong to, and the type of work they wish to do.

Careers are now variously described as boundaryless, portfolio, protean (taking on many forms) and as multi-careers – all recognising the demise of the once accepted traditional ladder. The key to progression or even work survival “is employability rather than just employment” (Dexter).

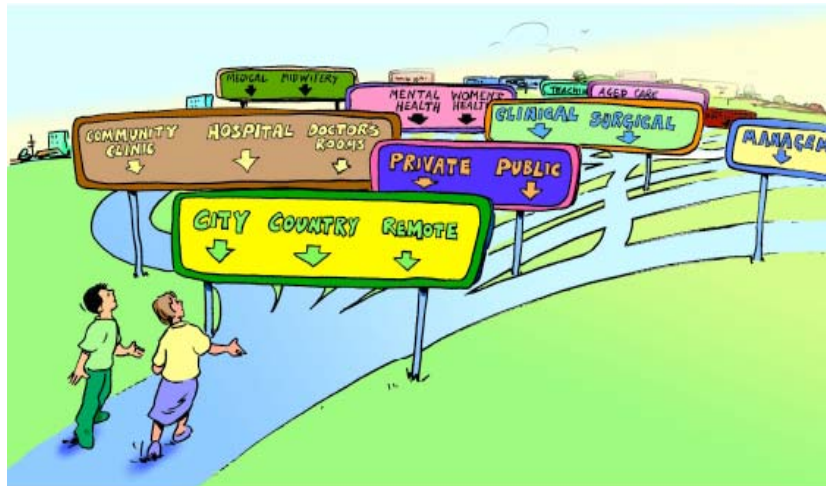


Figure 1: Career Paths involve choices

Within two generations, the view of having one job for life has moved to having multiple jobs in one career area, and is moving towards having multiple careers.

What is the start of a nursing or midwifery career?

What do you remember about entering nursing or midwifery? If you were a female leaving school in the 1970s your main choices were nursing, teaching and clerical positions.

More recent school leavers – both male and female – have a wide range of further education options in VET (Vocational Education and Training) and University or the option to move straight into the workforce in a range of industries.

Generally, people choosing nursing and/or midwifery hold some form of wish to help people through life events and/or illness. After all, if people aren't ‘your thing’ you would probably be reading now about career opportunities in accountancy, computer programming or selling insurance.

The entry points to enrolment and registration in Australian nursing and midwifery are becoming more consistent.

Entry points into Diploma of Nursing (SA qualification) include:

- Completion of Year 11/12;
- Certificate 3/other certificate 4/diploma/advanced diploma/Bachelor degrees; and
- Special entry categories (eg. Mature aged entry).

Entry points into a Bachelor of Nursing (or however titled) include:

- Required tertiary entry score or however titled;
- Enrolled nursing;
- Certificate 4/diploma/advanced diploma/other Bachelor degrees (including Bachelor of Midwifery);
- Certificate 4 Aboriginal Health Worker; and
- Special entry categories (eg. Mature aged entry) (Price 2001).

Entry points into a Bachelor. Of Midwifery include:

- Required tertiary entry score or however titled;
- Enrolled nursing;
- Certificate 4/diploma/advanced diploma/other Bachelor degrees (including Bachelor of Nursing);
- Certificate 4 Aboriginal Health Worker;
- Special entry categories (eg. Mature aged entry); and
- Registration as a midwife.

Entry into enrolment and registration may also occur through mutual recognition across Australian States and Territories and through registration processes for internationally educated nurses and midwives. Re-entry also occurs.

Thus “beginning” in the nursing and midwifery **professions** in South Australia occurs through both local education courses and registration/enrolment processes.

‘Beginning’ nursing/midwifery **work** is a far broader issue. Individual activities undertaken by nurses and midwives – such as personal hygiene care for those unable to assist themselves, obtaining blood and other specimens, ECGs, assisting in administering medication, emergency trauma care, providing health teaching, pregnancy counselling, etc. – are undertaken in a range of job titles outside nursing and midwifery.

Does this mean that nursing/midwifery career structures should provide a wider range of options or links than the current educational pathways provide?

Where does the ability to undertake a shortened undergraduate course in nursing (because of previous qualifications in music, forestry, etc) fit into this discussion?

Is credit for previous experience in university education equivalent to credit for experience in work that overlaps with nursing?

Finally, when thinking about entering nursing/midwifery, it is worth recognising the high level of mature aged entrants to the professions. For many of these men and women, the decision to enter nursing/midwifery signals a career change or transition. These entrants come with valuable life and employment competencies – are these attributes able to be applied in the present hierarchical career structure that tends to treat all beginners as young novices?

What are the ‘sides’ of nursing and midwifery?

The topic of overlap of work activities often creates debate as to the appropriate relationships between nursing work and ambulance work, personal carers and residential support work, technicians, clerical work in doctors’ rooms and aboriginal health work. Indeed, the defining of midwifery as a separate profession to nursing has its own debates about overlap of knowledge, skills and work activities.

The transferability of skills and knowledge gained through nursing education and experience is often referred to (Price, 2001) when promoting nursing as a good profession from which to potentially move to other fields. Do we recognise as easily the potential transferability of skills and knowledge from other fields into nursing or midwifery?

In a world of increasing multi-skilling, deregulation, use of market forces in public activities and focus on consumer outcomes, work will no longer be neatly defined and marked by clear lines between groups. Perhaps nurses and midwives in clinical, management and academic roles have some adjusting to do.

What is the ‘top’ of nursing and midwifery?

Historical career structures in nursing/midwifery have consistently linked the highest role classifications to management and policy functions. In general, in a five level classification structure for RNs/RMs only the first two levels allow for clinical functions without some form of management, education or policy role. Why is the accepted promotional progression in nursing/midwifery into management? How can we better clarify clinical responsibility in comparison to managing people, budgets and programs?

Accountability for clinical decision making, assessment, and interventions is a moral and legal obligation in both nursing and midwifery. Registered nurses and midwives are not passive implementers of medical practitioners’ orders, and do not work under medical supervision. All registered nurses and midwives hold direct legal accountability for their clinical practices and that of their colleagues. Nurses and midwives may be accountable for implementing and evaluating many medical treatment plans in addition to nursing or midwifery plans. They are also accountable for questioning planned medical interventions or treatment where these are likely to harm a health care consumer or where errors in prescriptions or treatment orders appear to have been made.

On one hand, nursing and midwifery have largely been placed in bureaucratic management structures in terms of promotional classification. On the other hand, when recognition for clinical nursing roles is claimed, sections of the medical profession and the print media start talking about nurses wanting to become medical doctors. While there are certainly some nurses who choose to change careers and become medicos, this is



not common. How can we make clear the desire of nurses to progress to expert knowledge and skill in clinical nursing and midwifery? **Nursing, not medicine! Midwifery, not obstetrics!**

And indeed how can we best assist nurses in management positions to see clinical nursing expertise as equivalent in accountability and responsibility to human resource and budget management?

Not all the answers to development of promotional positions for nurse clinicians lie in the nurse practitioner role. "A nurse practitioner is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations" (ANMC 2004).

The nurse practitioner role, like most innovations, challenges many assumptions and has been portrayed as everything from a scourge (source of devastation) (of medicine) to a holy grail (of nursing). Working autonomously does not mean working independently. Working beyond the common activities of nursing does not mean being a medical practitioner. Nurse practitioners work in this extended manner only in the area of their education and expertise – this does not equate to the role of GPs. Not all clinical nurses wish to be nurse practitioners. Expert, accountable, high quality nursing care can be the goal of any registered nurse/midwife and should not be limited to those accredited as nurse practitioners.

What variety of promotional positions might best ensure high levels of nursing and midwifery clinical expertise and skill are available across all hours of the day and across different practice areas?

The idea of dual career ladders in which career structures for professionals are separated from those for managers or administrators is seen in many areas such as the chemical engineering and pharmaceutical industries.

The dual approach says that you can move up the scientific track and be paid at an equivalent level to a supervisor or a manager by being a really excellent scientist and bringing value through innovation, ideas and scientific leadership...Although the precise details vary from company to company, career ladders have some common features. The first is the opportunity for employees to be in salary grades or on "rungs" equivalent to their colleagues on another ladder.

Companies also offer similar reward possibilities...and employees usually have the chance to move between ladders (ACS 1998). Of course, this dual approach is not as easy in practice as in theory.

Careers that go 'up'

What is your career goal? Do you have one? Have you thought about it? What plans do you have in place to achieve it? Some nurses/midwives have clear goals about the role they want to achieve and work steadily towards that goal.

For some nurses/midwives, working life is not part of their core goals and as long as they belong to a reasonable team, they will take the position that best fits the hours or location they want. Many nurses/midwives want to combine both work and life goals.

Some people want challenges at work. Some don't. Some people love to move areas and learn new skills. Some are afraid to move or do new types of work. Some people want to do as little work as possible. Some work for the sheer enjoyment of it.

For many years the writing about what motivates people (including in their career path choices) has described intrinsic and extrinsic motivators – that is factors from within a person's make up and factors from outside the person that stimulate or decrease motivation.

Steven Reiss's research (2004) indicates that there are sixteen basic desires that guide our behaviour, including the type of work tasks and work circumstances we prefer. The desires are power, independence, curiosity, acceptance, order, saving, honour, idealism, social contact, family, status, vengeance, romance, eating, physical exercise, and tranquillity.

These desires are what drive our everyday actions and make us who we are says Reiss. What makes individuals unique is the combination and ranking of these desires.

For example, a nurse with strong desires for social contact (having friends) and acceptance (having people's approval) is more likely to choose, enjoy and feel confident in work contexts that have high social interaction with team members and patients. A nurse with strong curiosity (desire to think) and idealism (desire for social justice and fairness) may choose the same work context as the first nurse but for entirely different reasons. These nurses may then seek a promotional position for different reasons and with different ideas as to what the role means and what it might mean to be successful in the role.

It cannot be assumed that all people who aspire to higher work classifications want power and extra money nor that people who do not want to move up traditional hierarchical career ladders are lacking ambition or commitment to work. Such broad assumptions take no account of the complexity of individuals and their motivations. This issue will be further explored in the



article considering the links between job satisfaction and career structures.

A key issue with 'upward' careers concerns the criteria for moving up. 'Advancement' may be related to:

- demonstrating increased competence;
- different or more complex levels of work;
- obtaining more knowledge or skills;
- obtaining qualifications; and
- specific performance outcomes.

Careers that go 'across'

Flatter organisational structures (the current trend) of course offer fewer levels for vertical promotion: going up. However lateral promotion offers possibilities in such structures.

This might occur through job enlargement where additional activities are put into a role. So a clinician may take up a formal education role, or manage a one to two year quality evaluation project and so on.

Historically professional career advances have been associated with increasing specialisation. The logical outcome of specialisation is that more people have more knowledge about narrower fields. Often this means they also lose knowledge currency in other parts of their own profession.

Current and future health service professionals will have a need for broader knowledge, or organised networks of people with different pieces of knowledge and the time and processes to pool that combination of knowledge for better client outcomes. In the future, generalists – people with the capacity to work across a range of areas – are likely to be more valued than they are at present.

Thus a rewarding career path may be built across different areas of clinical

work, or in new roles that require more generalised knowledge and skills.

Careers that go 'out'

Clinical work will probably always employ the highest number of nurses and midwives – whether in institutional or home settings. However sectors other than health often seek nurses or midwives.

Organisations such as pharmaceutical companies, insurance firms, computer software companies, law firms and medical equipment and surgical supplies firms employ nurses/midwives in a range of roles.

Growing fields and new definitions of health care offer other opportunities for career paths that go in and out of nursing. Complementary therapy modalities, lifestyle improvement programs, corporate wellness programs and personal coaches and trainers are some of these areas.

Many cross professional career paths are taken by nurses: nursing and management, nursing and education, nursing and business, nursing and law, nursing and information technology and nursing and politics.

As midwifery separates from nursing, a cross career of nursing and midwifery may also be separately identified.

Cross career roles may have the individual employed in one or more organisations or sectors, such as health and education.

Internal growth in a role

Career development is still possible even if you don't move up, move around, move across, etc. The process of increasing competence, knowledge, skills and achieving better outcomes can occur when you spend time in one role. Or the role may itself change and develop in depth.

How could such development – personal and role – be assessed and recognised in career structures models? It is possible to find criteria that can demonstrate such development?

One of the current mechanisms for increasing remuneration at some career levels is time in a role: for example Years 1 to 9 in a Registered Nurse Level One role.

However being in one role for more time is **not the same** as becoming more competent, nor the same as developing yourself and the role. How could criteria be developed that separate those who have developed, and those who haven't, across the same time period?

Remuneration for care work

Nursing and midwifery work sits within an area known as 'care work'. That is, "jobs involving giving a face to face service to clients or customers of organisations for which one works" (England 2005).

Some researchers argue that care workers receive relatively low pay despite high skill requirements because of the cultural bias that has equated care work with women's work.

Others identify the indirect benefits of care work to the wider public, but claim that these are not calculated into wage structures.

Some put the view that the altruistic motivations of care workers and the emotional bonds they form with their clients make care workers more vulnerable to accepting low pay, especially if seeking higher pay is likely to have adverse effects on client services. Others say that you cannot assume that care and being well paid are mutually exclusive (England 2005).

It may be that the increasing emphasis in Australian society on economics as an indicator of human well being has had an impact on nursing and midwifery.

The science or technical concepts of nursing receive more emphasis in calculating nursing/midwifery costs and allocation of nurse/midwife hours. Perhaps this emphasis also serves to improve remuneration, rather than an emphasis on the care aspects of the professions.

This may be a reason that nursing/midwifery appear to have less of an economic penalty for doing care work. However, an imbalance of science and care may have implications for career choices.

Assumptions about the motivations of nurses and midwives can lead organisations to assumptions about what constitutes desirable career path and incentives.

Using incentives and disincentives to direct individuals' energies and behaviour is common practice in all work settings. The tendency by nurses to disregard, and in many cases, deny a direct impact of economic incentives/disincentives on their motivation and professional conduct is interesting.

Kingma (2003) recently set out to discover more about economic incentives/disincentives in community nursing. Kingma (2003) found that the community nurses she studied generally rejected an economic frame of reference as relevant in employment decisions, professional development, clinical activity and self-image.

"The profession's past and present do not encourage nurses to accept a definition of their self worth or self image using financial terms of reference. They are nonetheless sensitive to, and may be influenced by, a certain range of economic incentives/ disincentives. This knowledge facilitates the creation and introduction of more admissible and strategically powerful motivating factors in the area of nursing".

Understanding the value systems of nurses and midwives, how they respond to economic incentives/disincentives, and what they perceive as attractive career options is relevant to ensuring that remuneration and career structures are more strategic and effective.

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Published by the Nursing Office
Department of Health
South Australia

February 2006

Also published on www.nursingsa.com

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