Do we really need *diabetes* degrees?

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Editor

The qualifications required by diabetes specialist nurses (DSNs) are currently being discussed and debated (see *The Lin*k page 80). In particular, there seems to be a feeling that DSNs need to have a degree specifically in diabetes. There are several strands to this debate, some of which are addressed below.

Current availability

It is apparent that 'diabetes' degrees are somewhat thin on the ground, as noted by Crowley (2000), making accessibility difficult for most nurses. There are likely to be several reasons for this. Perhaps the content of the degree can help explain the paucity of courses. Assuming that prospective course participants have already acquired sufficient academic credits to have a diploma in higher education, they will only need to study for one further academic year (approximately equivalent to 1200 hours work) to achieve a degree. Some would argue that the knowledge of 'pure' diabetes needed to enable practitioners to become experts in diabetes *nursing* would not require this amount of time.

Types of knowledge

Of course, this leads to the issue of what makes up 'pure' diabetes knowledge. It would probably include the physiology of diabetes and its complications; available treatments; psychosocial aspects unique to diabetes; and diabetes-related equipment. However, many other healthcare professionals need exactly the same knowledge to perform their role effectively. We are then left with the question of what constitutes diabetes *nursing* knowledge, and therefore what additional elements are required for a diabetes nursing degree.

In general, nursing knowledge is notoriously difficult to define because it is not discrete; it is eclectic by its very nature. We use information from the biomedical sciences, psychology, sociology and many other fields. Our artistry lies in the fact that we integrate elements of these knowledge bases into our work. In order to be effective practitioners, we need not only to have information, or knowledge, at our fingertips but also be able to understand and apply it to the specific work context. This, of course, necessitates practice, which makes clinical experience and practice an essential component of effective learning.

Acquiring intellectual skills

As individuals become more experienced, the use of higher order intellectual skills of analysis, synthesis and evaluation, often in the context of reflective practice, enables them to develop their repertoire of solutions to problems and to view situations more broadly. Undertaking degree-level academic work can help in acquiring these higher order skills more quickly and effectively; for instance, they are the very skills which are required to produce good academic essays.

Once these intellectual skills have been developed they can then be applied to any context, i.e. they are transferable. This consequently suggests that the degree subject is not as important as the intellectual development that it induces. Some would even argue that the subject is irrelevant. Outside the health arena, possession of a degree can place job candidates at an advantage, even if the subject is totally unrelated; employers consider the degree as evidence that the individual has critical thinking abilities and can learn independently.

Are diabetes degrees necessary?

It may be that we have to shift our attitude towards diabetes degrees. The purpose of degree level studies should be to improve our practice by developing critical thinking skills and broadening our perspectives; it is not just about learning more, but about learning better. This may be achieved by undertaking any health-related degree-level course, such as health promotion, psychology or health care studies, for example, and applying the content to diabetes nursing practice. There are clearly many more of these courses available and accessible, obviating the need to wait for a diabetes degree to be developed locally. Another potential advantage of taking a more general degree is that the individual is likely to be exposed to good ideas from other

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healthcare contexts which could be adapted to diabetes care.

Additionally, it must be remembered that factual knowledge of diabetes is not only acquired in classrooms; it can be learnt in many other ways, e.g. by reading, and questioning colleagues. I would suggest that knowing how this information is best used to provide effective nursing care to people with diabetes is what constitutes diabetes nursing knowledge, and this can only be gained through practice.

Conclusion

If the purpose of nurses doing a degree is to improve their nursing care, rather than merely acquiring a qualification, then they need to think carefully about the content of the degree under consideration, regardless of whether or not it is a 'diabetes' one. Will it make you a better nurse? ■

Crowley M (2000) Education for diabetes nurses: the challenge for the new millennium. *Journal of Diabetes Nursing.* **4**(2): 61–3

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Comment

Paediatric nurses should care for children with diabetes

I would never underestimate the excellent diabetes care given to children by DSNs who have no paediatric qualifications. The emphasis should be on the well child with a disorder who will grow and develop like any other child. However, I do find that there are other factors to consider in the provision of care to this group. There are other aspects of childhood illnesses that are relevant and, furthermore, children are not simply 'little adults'.

The idea that children should be nursed by nurses trained in paediatrics, such as Registered Sick Children's Nurses (RSCNs) or Child Branch, is not new. The Platt Committee Report (Ministry of Health, 1959) recommended that children should enjoy the care of appropriately trained staff, fully aware of the physical and emotional needs of each age group. The Court Committee Report (Ministry of Health, 1976) emphasised the need for children to be nursed by RSCNs whether at home or in hospital, and recommended that community services for all children should be expanded.

Why specialist care?

The physical, psychological and physiological needs of children differ widely from those of adults; hence, nurses who care for them require different knowledge, skills and attitudes. As well as the knowledge of different techniques, children's nurses need an understanding of child development and of the importance of the family in a child's life. It is essential that children's nurses have the ability and temperament to work alongside parents, sharing care with them as equal partners (BPA/NAWCH/NAHA/RCN, 1987). Involving parents in care also requires special skills in teaching and support. There must also be an awareness of the purpose of, and need for, play. All of the above are essential components of RSCN training (Audit Commission, 1993).

Children are unique developing individuals who have the right to receive care from appropriately qualified nurses. Nurses on other parts of the register will not necessarily have the appropriate attributes (DoH, 1991).

The challenge

There are concerns about the lack of children's nurses outside designated units and the lack of commitment to employ RSCNs, increasing concerns about child protection issues, support for parents, increased unnecessary admissions and lack of facilities for adolescents (RCN PCN Forum, 1994).

Some sections of the child population are thought to receive a particularly inadequate service, e.g. adolescents, minority groups and children with special needs in mainstream schools (DoH/King's College Hospital, 1996).

In order to deliver a seamless service for children, an integrated model, incorporating primary, secondary and tertiary care services, should be adopted wherever possible for the provision of children's nursing services. Quality adolescent services should

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be commissioned. Nurses must collaborate with other healthcare professionals to provide nursing care for children that recognises the particular needs of the child (Yorkshire Regional Health Authority, 1992).

The Patient's Charter (NHS/DoH, 1996) states that whether children are nursed at home, on an adult ward or on a children's ward, they should have a named qualified children's nurse; children with a major chronic condition should be under the care of a paediatrician and a children's nurse. It is now the norm for children in hospital to be nursed by qualified children's nurses but this standard has still not been fully accepted in the community (RCN PCN Forum, 1994).

Tide of opinion

Specialist nurses can improve how children with diabetes understand and cope with their illness. Parents surveyed in 1988 indicated increased satisfaction with support if a paediatric, rather than an adult, diabetes service was provided (RCN PCN Forum, 1994).

The St Vincent Declaration states that the care of children with diabetes should be provided by individuals and teams specialised in the management of diabetes and of children (WHO, 1989). To achieve this, it has been suggested that each health district should have a paediatric diabetes nurse specialist (BDA/BPA, 1996). Later documents state that they are required (BDA, 1999).

Role and Qualifications of the Nurse Specialising in Paediatric Diabetes (RCN PDSIG, 1998) is based on the philosophy that the needs of the child with diabetes can only be met by a paediatric nurse who:

- Has extended skills in diabetes care, as an educator, counsellor, manager, researcher, communicator and innovator
- Is held responsible for his/her own actions
- Is registered on part 8 or part 15 of the Register of Nurses (RCN PDSIG, 1998).

Personal experience

On my caseload, there are children who have paediatric life-limiting conditions or mild-to-moderate learning difficulties; others are school refusers and/or suffer bullying at school. There are also a number of minor paediatric surgery cases. I am also faced with child protection issues (I have to attend regular updates on child protection). All these require a knowledge of diabetes and paediatrics.

As I stated initially, I know that many DSNs who are not qualified paediatric nurses give excellent diabetes care to children. I am also aware that, because of DoH recommendations, several of these nurses have been encouraged by their managers to undergo RSCN training in order to keep their paediatric caseloads. They do not qualify for the shortened course and have to undergo 14 months training. Perhaps this needs to be addressed by educationalists.

Conclusion

In conclusion, qualified children's nurses are trained in child protection, child development, the use of play, and holistic care for the whole family. Diabetes nurses caring for children should ideally be paediatric nurses with extended skills in diabetes care. ■

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