

# Desperately Seeking New Graduates with Specialized Expertise

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Over the last few months, in the course of attending meetings and talking with colleagues across the country, I have noticed an issue that has surfaced repeatedly: new graduates are not sufficiently practice-ready to take on the highly specialized job requirements in the healthcare system of 2007. This year's version of the complaint – for it is a complaint that surfaces periodically, particularly during a nursing shortage – comes mainly from acute care hospitals. This healthcare sector is under severe pressure across the country, fiscally and from a performance perspective. The stance of nursing executives is that they have insufficient resources to orient and mentor new graduates over the extended period required for them to become confident and safe practitioners in the highly specialized environments that constitute many acute care hospitals today.

One proposed solution is to reconfigure undergraduate nursing education so that students graduate as specialists in some area of nursing. Nursing

education in the United Kingdom offers one model of specialization at the undergraduate level. There are four specialty areas: adult (medical/surgical), children, mental health and learning disabled. Students can enter one of these programs at the diploma or degree level, and preparation includes hospital and community care. The first year is common across specialties, and then students move into their chosen area. Because different registries are maintained for each group, being registered as a children's nurse means one is not licensed to practise with an adult population.

Clearly, one of the advantages of the British system is the additional knowledge and experience that nurses – for example, children's nurses – bring to their entry-level position relative to Canadian-trained graduates who begin their careers in paediatrics. This is true of each of these population-focused graduates. However, a downside is the lack of flexibility in recruiting new graduates, as it is not possible to recruit a children's nurse to fill an adult nurse's position or an adult nurse to a mental health nursing position. When nurses are in short supply, maximum flexibility in being able to move graduates into areas where shortages exist is an advantage. This lack of flexibility in the British model may explain why most of the countries that previously followed it have switched to the North American approach to nursing education, which produces generalists who are prepared to move into entry-level positions in the care of adults and children with physical and mental health problems, both in hospitals and at home.

Another proposed strategy is to extend the current nursing education programs so that new graduates can become specialists in a clinical area prior to graduation, and thus meet the expectations of the system without requiring extensive orientation and supervision. In this case, specialization would build upon the generalist foundation. Extending programs seems like a simple, straightforward solution, but it is one with its own set of complications.

In the short run, fewer students would graduate, as they would stay in their programs longer. These longer programs would require more clinical practice opportunities in a system that is already stretched to provide sufficient practice for the current programs. These students would require clinical preceptors, just as new graduates need clinical mentors. Longer

programs would increase the cost of nursing education, both for the students and for the educational system. If programs were increased by a year, then students would pay an additional year's tuition at a time when more and more of them are graduating with considerable debt. It's interesting that when some medical specialty programs were extended a few years ago, family medicine was lengthened from a one- to a two-year residency, and some internal medicine subspecialties went from four to five years. In that situation, the residents did not pay tuition, and they received a salary for the entire residency program.

Extending programs has an additional, less obvious cost to graduates, because it reduces the number of years of paid employment available to them; in the case of nurses, they lose the opportunity of an additional year of salary and contributions to pensions. If an additional year of training, largely in terms of more practice, were treated as an internship paid for by government, the solution might be more palatable to students, but it would not solve the limited practice opportunities or the shortage of preceptors.

Another challenge in determining how students might be prepared with more specialized knowledge prior to graduation is defining what constitutes nursing specialization. The Canadian Nurses Association certification programs probably are the best approximation we have. These 17 certification programs include 10 clinical specialties (cardiovascular, gastroenterology, gerontology, nephrology, neuroscience, oncology, orthopaedic, perinatal, psychiatric/mental health and rehabilitation) and five practice-area specialties (emergency, critical care, community health, hospice and occupational health). If we were to undertake preparing specialists in many, let alone all, of these areas, educational programs would have to be created, instructors found and a significant infrastructure developed to support it all. Such an initiative would literally be years in the making. Areas such as emergency and critical care nursing offer particular challenges because of the number of specialty areas of knowledge that they subsume. One provincial chief nursing officer told me that she hears most about the need for new graduates to be better prepared in these two areas in particular. We agreed that not many years ago, emergency and critical care units were extremely reluctant to accept undergraduate students for clinical experience. That situation has

changed, but the judgment required to manage many of these patients is based on experience as much as a strong knowledge base.

A major reorganization of nursing education may not be the best or only solution. There may be more promise in finding smaller-scale and innovative ways to provide more specialized experience for students prior to their graduation without increasing the length of their programs or resolving the thorny issue of what constitutes nursing specialization.

For several years in the early 1990s, when Canada was experiencing a shortage of nurses, teaching hospitals expressed many of the same concerns as we are hearing today: schools of nursing were graduating generalists into a specialized environment with insufficient skills to practise without several months of intense support. At the University of Toronto, in collaboration with our clinical partners (many of them teaching hospitals), we developed a program in which these partners identified practice areas where students could be employed during a 10-week summer period between their third and fourth years. Students were matched to these positions based on their interests; they were assigned a preceptor and were paid. The best of them (who constituted a significant proportion of the class) were retained to work on a part-time basis during their fourth year and then recruited to work on the units where they had already spent a year. By that time, the staff knew them and they were part of the team. Some students elected to spend their consolidation period on these same units because they wanted to become as skilled and experienced as possible in the specialty before graduation.

This program was not financially neutral for the participating organizations, but several were of the view that the salary they paid to the students was offset by their increased productivity if and when they returned as staff. Even if the students were not hired following graduation, the practice environments had the benefit of a mostly enthusiastic and dedicated group of novice practitioners during the summer period.

This program is only one possible approach to the issue, an issue that is real and urgently requires attention. *CJNL* has published, and will continue to publish, reports and evaluations of programs designed to increase the

skill level of students prior to graduation. In all the solutions of which I am aware, collaboration between the educational and practice organizations was key, and in all of them, practice environments played a major role in supervising students.

If healthcare organizations believe that a more comprehensive solution is required – because specialization will only increase, and expectations of new graduates continue to escalate – perhaps it is time for a national task force to examine potential strategies. It is clear, however, that no simple strategy exists, and whatever solution is developed, it cannot be one that involves only students or the educational sector. Practice environments will continue to be called on to provide the support and mentorship required by new members of the profession.