The culture of midwifery in the National Health Service in England

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INTRODUCTION

This study forms part of a research project which examines the supervision of midwives in England. Early in that project it became clear that an aspect of midwifery, such as statutory supervision in England, could only be understood in its context. That practice context is deeply influenced by the culture of midwifery in the National Health Service (NHS). This article seeks to examine the data on that culture. Efforts to change the culture and the supervision of midwives are addressed in the larger study (Stapleton et al. 1998).

The vast majority of English midwives practise within the NHS and all midwifery students in England gain their clinical experience there. This article therefore only examines the midwifery culture within the NHS.

HISTORICAL BACKGROUND

The regulations and the inspection of midwives, set up in the Midwives Act of 1902, had the explicit aim of ensuring medical and social control of midwives (Heagarty 1996) and thus achieving a trained and disciplined workforce. Much adjustment was required as a largely working class body of midwives were subject to the ‘occupational demarcation’ (Witz 1992 p. 109) stipulated by medicine and the requirement, by their leaders, that a midwife’s primary loyalty was to her ‘profession’ rather than to her own community of clients (Heagarty 1996, Marland & Rafferty 1997).

In 1937 it was laid down that inspectors of midwives should be called supervisors of midwives who ‘should be regarded as the counsellor and friend of the midwives, rather than a relentless critic’ (Jenkins 1995 p. 52). Nevertheless, supervisors’ disciplinary duties remained unchanged.

The number of midwives employed in hospitals grew rapidly and the foundation of the NHS in 1948 united their employing hospitals. In 1974 The National Health Service (Re-organization) Act united hospital and community midwifery services, and moved the organization of relatively autonomous community midwives
into the hierarchical structures of hospitals where midwives’ practice was already constantly visible and tightly controlled. From then on all NHS midwives experienced both statutory supervision and hierarchical management.

**Gendered institutions**

Cultural codes of gender deeply influence the structures of social institutions as well as individuals’ socialization and patterns of relationships (Davies 1995). Midwifery was traditionally the work of women, ‘with women’ in the privacy of the home. As such it fitted well the culturally coded female skills in ‘the maintenance of relationships and the sustenance of human life’ (Bologh 1990 p. 124). Organizational life, on the other hand, developed from social constructions that arise from a masculine vision of the world: socially coded as separating, controlling, competitive, masterful and hierarchy-orientated (Davies 1995). This analysis explains the terms on which midwives achieved in 1902 ‘the unenviable distinction of being the only profession controlled by a body on which its members must never be more than a minority’ (Donnison 1977 p. 179). Dilemmas inevitably followed from this. Earlier this century, different sets of gendered values underlay the actions of the midwives and their inspectors. These differences were experienced as tensions between caring for clients as individuals and professionalizing midwifery.

The gendering of institutions continues to this day. The very reasons for the existence of hospitals, the centralization of medical equipment and expertise for maximum efficiency, reflect the male-cultured values and create a ‘hierarchy of institutional expertise’ (Freidson 1970 p. 127). Midwives are low in the hierarchy and their position is often seen as that of ‘subcontractor’ (Schwartz 1990 p. 58) to ‘medicine as the engineer repairing faulty machinery’ (Littlewood & McHugh 1997 p. 109). Such a model separates birth from life and women from their wider social environment. The female-gendered skills of support, caring and being with women tend to be invisible within these gendered institutions.

Language too is gendered (Tannen 1991, 1995) and is therefore not developed to capture the subtleties of these female skills. Such a linguistic situation ensures that official documents, or even student curricula, scarcely acknowledge such skills. This is ironic as research now demonstrates the positive measurable outcomes of these skills, currently described in terms such as support and empowerment (MIDIRS 1996).

**Professionalization**

The aspiration to professional status changed midwives’ relationships with clients as the midwife’s primary allegiance was claimed by her profession rather than her immediate clients. This change was achieved in practice initially through the inspectors and later the supervisors of midwives (Heagarty 1996). Midwifery’s professionalization was by means of deference to the ‘dominant profession’ (Freidson 1970 p. 70) of medicine, relative to which are ‘subordinate professions’ or ‘semiprofessions’ (Etzioni 1969) suited to the role of ‘handmaiden to a male occupation which has authority over them’ (Simpson and Simpson 1969 p. 231). Whilst such an analysis can rightly be labelled the ‘machismo theory of professionalization’ (Parkin 1979 p. 124), it echoes our history.

**An oppressed group**

Another body of theory, developed in a very different context but useful for examining the historical dilemmas of midwifery, is that of oppressed groups. Modern midwifery in Britain, very much defined by the more powerful profession of medicine, fits the definition of an oppressed group as one ‘which is controlled by societal forces that have determined its leadership behaviour’ (Roberts 1983 p. 21). The analysis of Freire (1972) gives insight into how, in the process of internalizing the values of the more powerful group, the original characteristics of the oppressed group come to be negatively valued. Midwifery insights were muted or denied with damaging effects for those who thereby rejected value in their own traditions and identity. The resulting low self-esteem is highly self-destructive (Taylor 1996), especially as it is held in balance with subservience to the more powerful group (Kirkham 1996). The tension thus produced was seen by Fanon (1963 p. 4) as released in ‘horizontal violence’: conflict within the oppressed group especially towards those seen as slightly deviant; which, in turn, reinforces the status quo. In midwifery:

... scapegoating, back-stabbing and negative criticism. [T]he failure to respect privacy or keep confidences, nonverbal innuendo, undermining, lack of openness, unwillingness to help out, and lack of support have all been described as horizontal violence.

(Leap 1997 p. 689)

A further secondary process, resulting from the tensions of oppression is fear of change.

**Recent changes**

Women’s voices are now heard and can affect policy. There is no doubt that the views of women service users profoundly affected the Winterton Report (Her Majesty’s Stationery Office 1992) and *Changing Childbirth* (Department of Health 1993). The aim of woman-centred care became NHS policy but this aim had to be achieved within structures whose encoded values were very different.
In recent years, midwives have reclaimed some areas of traditional expertise and become more able to cope with medical power-holders (English National Board for Nursing, Midwifery and Health Visiting, ENB 1995). Midwifery gained in professional terms by the construction of its own managerial hierarchy (Harrison & Pollitt 1994), though this has suffered some recent reverses with the flattening of management structures and loss of many midwifery management posts. The climate of competition, as well as business management in health care, has brought changes in midwifery services. The emphasis upon a flexible workforce and issues of skill mix in maternity services have made many midwives feel insecure.

RESEARCH METHOD

An ethnographic approach was taken to gain insight into how midwives view their world. In 1996–1997 five sites were studied which were very different in their geographical and social settings, their clientele and the organization of their maternity services. In-depth, semi-structured interviews were conducted with 168 midwives drawn from all grades and practice settings on these sites. Midwives were asked to reflect upon the setting for their practice and, when assured of the confidentiality of the interview and the anonymity of the data, they did so with considerable insight. Ethics Committee approval was gained in all areas.

The style of the study appeared best suited to a grounded theory approach in its analysis (Glaser & Strauss 1967). Such an approach allows for the emergence and continual evolution of theoretical frameworks in synchrony with the actual research. The interview transcripts were selectively coded and categorized in accordance with the principles of grounded theory. The categories were constantly explored in the ongoing interviews and analysis and, whilst some categories collapsed or merged, others appeared. This process went on until no further ‘movement’ of categories was detected or the categories were constantly explored in the ongoing research. The interview transcripts were selectively coded and categorized in accordance with the principles of grounded theory. The categories were constantly explored in the ongoing interviews and analysis and, whilst some categories collapsed or merged, others appeared. This process went on until no further ‘movement’ of categories was detected and the researchers felt confident that the categories had reached the point of ‘saturation’ (Strauss & Corbin 1990).

FINDINGS

Service and sacrifice

When midwives were asked to reflect upon midwifery, in their experience, a distinct culture of midwifery emerged from their many, very similar, descriptions. This was seen as essentially a culture of women which emphasizes, and internalizes, the values of caring and commitment, irrespective of personal sacrifice. (There are male midwives, two were interviewed on site 5, but they are very few and do not appear to have influenced the culture within which they work.) ...most of us have families and we give them 120% and more. As women we do that anyway... So when we come to work, it is just more of the same thing. ... we don’t even think about it, we just get on and do it. And I think management realize that...

Midwives take on far more than they should. We have this culture in midwifery where you always have to give 100% and more. It’s like the job lays a lot of emotional blackmail on us and I wouldn’t always say that it’s management who do the blackmailing. We tend to do it to ourselves...

I think a lot of it is because people that come into midwifery want to help other people, they want to care, etc., and I think they just probably take on more than they could cope with just because it is the done thing.

This ethic of service, seen as fundamental to midwifery as a caring profession largely composed of women, often appeared to put great pressure upon midwives. The very nature of this ethic, and the respect accorded those who upheld it, made it exceedingly hard to challenge.

Within such a culture, the client-centred approach of Changing Childbirth (Department of Health 1993) was seen by many midwives as simply increasing the already considerable pressures upon them.

... Things have become a lot worse since Changing Childbirth as now they just expect us to do it... they take it for granted now that we’ll stay on and not even thank you for it... and there’s a real fear amongst midwives that women’s requests are paramount, regardless... there’s nothing wrong with putting women’s needs first as long as they include all women — midwives as well.

Midwives as women

Many of the midwives in this study saw themselves and their colleagues as women — in the same sense that clients are women — and, as such, as similarly deserving of care and support. Midwives listed their support needs to the researchers. They also described the tendency, in practice, to discount the need for personal and professional support. In some cases it appeared that this tendency was reinforced by powerful role models, some of whom were supervisors.

Any model of women-centred care doesn’t help midwives to think about their own needs because in that culture midwives aren’t seen as women — they’re seen as the ‘lead professional’... It’s important to think about the women but we’re important too... And you’ve got to get that balance right because if you get midwives stressed out and burnt out then it affects the care for these women. That’s one criticism I would make of B (supervisor)... she sometimes puts us in a difficult position where we’re expected to be as self-sacrificing as she is...

Lack of mutual support

When midwives experienced a need for support, despite their internalized culture of self-sacrifice, they felt shamed...
by their colleagues back into compliance with an oppressive ethic of caring. This suggests that working within a culture of caring and self-sacrifice, may not equip midwives with the skills to support and care for each other.

We don't support each other... we don't ever stand up for each other.

I think we midwives are really bad at supporting ourselves and saying 'NO' loudly and clearly... we're such a pushover.

For some midwives therefore there was a painful contradiction between their need for support, and the fact that the culture of midwifery could not acknowledge, nor provide for, that need.

Lack of role models of support

Many senior midwives were seen as providing problematic role models with regard to support. It was often observed that supervisors were not good at looking after themselves and midwives frequently expressed sympathy and concern for them. The caring attitudes of the midwives often led them to feel that they could not 'burden' the stressed supervisor further by discussing their problems with her.

... although I think supervision has a lot of good points and the supervisors here are very good, they are very weak at looking after themselves.

Sometimes I go home really, really upset, but I've never gone to a supervisor... and they are the ones who are supposed to be there to protect us... but there's not a lot of point... they're as stressed out as we are and you'd end up just having to take care of them.

Similar views were expressed about midwife managers who were seen as under considerable pressure from general management. When such senior midwives showed their high levels of stress and lack of support and of techniques for dealing with this stress, their behaviour also demonstrated that they did not prioritize these issues for themselves or their staff.

This could also be seen as the acting out of a culture which saw awareness of a need for support as a guilt-inducing sign of weakness and a lack of dedication.

The contradictions of ‘selfish needs’

It is noteworthy that many respondents, reflecting on support needs and on ways of looking after themselves, used the word 'selfish'. Thus, the word chosen by midwives seeking to address their own needs was itself an indictment in the caring, self-sacrificing, client-centred culture.

So I think we really need to be thinking about ourselves and be selfish at times really. But that really goes against the grain in midwifery...

A few midwives, perhaps as a response to the lack of adequate support or protection within the workplace did, however, make private resolutions to protect their own health:

... I've seen too many colleagues end up getting really sick so I'm going to stop coping with too much because I don't want to end up really ill.

Such resolutions were not voiced easily, nor without a sense of accompanying guilt; they were therefore unlikely to be implemented because of the strong resistance within the prevailing culture. Whilst the data contained a number of midwives’ observations on the need for ‘selfish’ behaviour in order for the individual to continue to provide a good service to clients, it seemed that these were private observations which were not usually discussed with colleagues. This inevitably reinforced the cycle of self-sacrifice and encouraged further self-neglect.

Guilt and blame

Themes of internalized guilt and self-blame recurred throughout the descriptions of midwifery culture. Several respondents volunteered accounts of incidents in which they appeared to be victims of circumstances quite beyond their control. Even when fully supported by a supervisor, they nonetheless appropriated the blame. This may have originated as a learned response which was entirely appropriate to a particular circumstance, but which had subsequently become fossilized as a generalized attitude. Even when exonerated, the pattern of self-blame remained.

... no matter how much I go through it, I know nobody can be blamed, but at the back of your mind you think it must have been your fault... it must have been something you did or something you didn’t do... My supervisor and everybody in the unit have all been there before and they know there is no blame to be put anywhere... but you still do don’t you?

Indeed, the habit of self-blame seemed to be so deeply ingrained in midwives’ attitudes, that it was not recognized as problematic and therefore not as something which a manager or supervisor might help a midwife to deal with in a more appropriate manner.

Policing caring: pressure to conform

Rather than supporting each other, midwives were occasionally perceived by their colleagues as monitoring each other’s self-sacrificing gestures in the name of caring.

... we don’t know much about how to be supportive to one another... I want to talk to my colleagues about how they seem to be policing me, but they will say they only want to support me. So I will continue to go round thinking they are policing me and they
will be saying I am ungrateful! I think the way midwifery is at the moment is that we are expected to be nice, kind people and the unmentionable parts of midwifery — how sad, anxious and uncertain you feel — are supposed to be put aside; not noted and not looked at. You have to deny all that to be a strong person in your colleagues’ eyes.

When such denial was present it cost midwives dearly, but the end result was neither visible nor quantifiable. The subject of personal needs was not one which was openly discussed by respondents, although when introduced within the interview setting, it did evoke some strong and articulate responses, as illustrated by the preceding quotation. In some circumstances, the enforcement of the prevailing ethic was particularly painful for midwives who were unable, or unwilling, to conform to local expectations. They were usually regarded by their colleagues as somewhat deviant and this behaviour was often linked with their ‘selfishness’ and a refusal to accept a self-sacrificing role. Examples which were frequently referred to by respondents included working days or nights off when requested, not taking allocated meal breaks, or regularly working overtime in the full knowledge that time-in-lieu could never be taken.

Many respondents felt greatly pressured, by themselves and by their colleagues, to conform to these behavioural norms. At times this pressure was so great that it was perceived as highly threatening. One community midwife used a telling metaphor to describe her feelings about routine updating:

But another problem here — or maybe it’s common in midwifery everywhere is the way we treat one another as midwives... as a community midwife I had to go and do my annual week of updating in the CDS [central delivery suite] and I can tell you I didn’t want to go back in... I was absolutely scared stiff... it felt like a lioness coming into a different pack... and they’re all just sitting waiting to attack... it felt like they were breathing down my back the whole time... there are such barriers and so little trust... I think we are very careless as midwives towards each other and for the profession...

If this is how respondents describe their experience of routine updating, it is scarcely surprising that midwives undertaking supervised practice following a critical incident, should find these scenarios threatening:

Then there was a complaint so she was brought in to be kept an eye on... We were all told she was in for observation... it was quite horrible for her... we were meant to report her if we saw anything wrong with her practice... I think she was brought in to be judged, not supported... and it was expected, as her colleagues, that we would sneak on her... which nobody did of course... It just wasn’t acceptable to us.

It is cheering that this midwife’s colleagues agreed not to ‘sneak’ on her, but the expectation that they should do so, was not challenged. In describing similar circumstances, the word scapegoating was occasionally used in interviews:

She was scapegoated rather than counselled or befriended... She has now left the profession. It was such a waste...

... it was identified that the midwife needed a 12-months refresher programme, but really she was carrying the can for everyone... There were a lot of things that were dodgy in the unit at the time... you were very aware that it really was a no-win situation...

**Doing good by stealth**

In a culture where there are such pressures to conform, and the tendency is for midwives to internalize the culture’s potential for blame and scapegoating, change can only be worked for in devious ways.

I’m trying to make some changes here — just to the on call rota for instance, but I’m a bit worried that I’ll be seen as really bolshy, so I’m trying to do it very carefully... I’m not showing anyone that actually I’m really angry about it... I’m just making suggestions and trying to be fairly tactful about it.

This respondent clearly illustrates the complexity required in order to achieve objectives which cannot be voiced clearly and directly. This kind of surreptitious behaviour seemed to be common, permeating inter-professional, as well as intra-professional, activities. Such efforts were described by one highly experienced midwife as ‘doing good by stealth’. This activity, which may achieve its immediate aims in one situation, cannot achieve wider change because both the aims, and the activity itself, are concealed. Activities which fit the description of doing good by stealth were seen on all sites, though the degree of concealment varied from site to site.

This concealment makes concerted action impossible, as each midwife is isolated with her own personal, and unspoken, ‘selfish’ thoughts and plans. One reason given for such concealment was because the prevailing ethic and the available role models generated guilt in midwives. The midwife quoted above goes on to justify both her ‘tact’ and her secrecy:

... because although I do get angry about it, I also feel guilty about it and inadequate that I’m not coping as well as the others seem to be... and exposing yourself like that in midwifery means that you’re seen as a weakling or pathetic...

Thus the way midwives treat each other is fundamental in defining, and maintaining, the culture of midwifery:

Midwives tend to tread very carefully and from what I’ve seen they go out of their way to avoid conflicts or difficult issues; they are very human people and maybe that’s why they don’t create more fuss about the downside of supervision.
Whilst such a response may be indeed be ‘very human’, and certainly very female, it is also a response from a position of oppression and, as such, it severely limits midwives’ ability to improve their situation.

**Learned helplessness and muting**

Midwives’ reflections on the culture of midwifery raised a rich diversity of subject matter in which the familiar and recurring themes of guilt, loss, blame and a resigned acceptance of ‘women’s lot’ featured strongly. What was so striking about the general tone of these comments was the overwhelming sense of helplessness; of the low expectations and of the constant allusion to blame. On some occasions this appeared to be directed inwardly at the midwife herself; on other occasions it was directed outwardly towards a supervisor, or, as seemed to be the case on some sites, it was the women on the receiving end of care who suffered. A prevailing sense of powerlessness is evident as respondents are forced into acceptance of the status quo, or to engineer changes by a process of subtle manipulation.

Midwives, in the privacy of the research interview, were eloquent in their descriptions of the culture within which they worked. Within the professional setting, however, their voices were muted and change was achieved by stealth. If they did wish to be heard, they had few options but to find ways of expressing themselves through the existing structures.

Throughout the research, conversations with midwives circled around the subject of blame and guilt. They spoke of expectations of guilt and punishment irrespective of wrong doing and regardless of evidence. It seemed as if respondents spoke from a world which they perceived as constantly threatened, or at least distorted, by the likelihood of blame which provoked an array of defensive reactions. Furthermore, the strategies they employed for their protection seemed to require constant fine tuning in order to accommodate the nuances of daily professional life.

This is not to suggest that outward signs of disapproval such as blaming are inherently wrong, but what is lacking in these commentaries — indeed, what was largely absent in the data — was the counter-balancing influence of praise.

**The market, management and the culture of midwifery**

The pressures of market forces can be seen as reinforcing the more oppressive aspects of the culture of midwifery. Midwives described general management as oppressive on two sites.

... the women are seen as customers and if the demand wasn’t there it might close. There is a real fear that if we don’t provide good care, and look after them really well, they won’t come back and that the unit will close... but I think we go a bit overboard really...

In the course of the final analysis of this data, presentations were made on the culture of midwifery to several groups of NHS midwives. Each group found the concept of an oppressed group relevant to midwifery and identified the main contemporary source of oppression as general NHS management rather than medicine.

**DISCUSSION**

The culture of midwifery which emerges from this study is one where the traditional midwifery activities of support and care continue but within organizations with very different values. It is a major part of the midwife’s clinical role to treat childbearing women in ways which increase their confidence and ability to cope. Yet loyalty to their organizational culture prevents them from acknowledging themselves as deserving of similar support and care or seeing the potential for developing their professional confidence and coping skills.

**Parallel processes**

The culture of midwifery may usefully be examined in the light of parallel processes, as identified by Eckstein & Wallenstein (1958), or as conveyed in the truism ‘as midwives are cared for so do they care’. Such parallel processes would have worked smoothly in an era when inspectors and senior midwives deliberately modelled how midwives, in turn, were expected to behave with their ‘patients’ (Heagarty 1996).

Midwives are now required to facilitate their clients in exercising choice and control in their maternity care through relationships of trusts with a known midwife (Department of Health 1993). Yet midwives who are expected to facilitate choice and control for clients often lack professional experience of such facilitation, exercise little choice and control in their work and mistrust management. The oft repeated words ‘midwives are women too’ form a particularly poignant statement of midwives’ experience of exclusion from the rights they must offer to women.

The culture of midwifery in the NHS has equipped midwives to accept many changes, especially medical changes. It provides the comfort of accustomed response and a sense of belonging to a group which censors deviants. As such, it provides some sense of security in a rapidly changing world. By its nature, this culture cannot equip midwives for changes which call for more than acceptance and implementation within existing power structures. The empowerment of midwives in order to empower childbearing women is a fundamental change in professional relationships.
Trust and support are key issues in recent debates around improvements in maternity care and around the supervision of midwives. Taylor (1996 p. 215) sees the trust of colleagues as essential if midwives are to develop ‘a repertoire of flexible responses’ which form the basis of good clinical judgement. Yet the culture fosters distrust and rigid responses as each midwife is left in isolated and guilty awareness of her ‘selﬁsh’ needs, lacking the conﬁdence which underpins ﬂexibility. A culture which so fragments midwives’ awareness of their common problems prevents their working together for common solutions. Doing good by stealth cannot, by its nature, mobilize individual insight and empathy towards collective change.

This raises important issues around coping with professional stress. Such stress can lead to the creation of the rigid defence mechanisms (Oakley & Houd 1990) that were the mark of former oppression and rigid practice and from which midwives now seek to be free. Yet midwives are in a new era with new tensions, insecurities and pressures to control their practice which need to be faced with more ﬂexibility and skill than in the past. Such situations call for responses and alliances beyond those of the present culture.

There are close parallels between the experience of midwives and that of childbearing women. Yet professional and employer pressures have prevented midwives from identifying closely with their clients. The childbearing woman is a clear subject of scrutiny and screening. Such surveillance brings beneﬁts as well as anxieties. The midwives interviewed expressed similar reactions to pressures to conform and limitations on their practice. Such a logical and potentially powerful alliance would require cultural change.

The possibility of change

The culture outlined above explains much resistance to change in midwifery. Yet there were examples of successful change, which were recognized as inspiring by the respondents.

Where change was achieved in the face of the existing culture, this was done by senior midwives who were aware of the magnitude of their task. They consciously worked to equip midwives to resist cultural pressures and themselves modelled other patterns of behaviour. They helped midwives gain conﬁdence in new ways. Their most consistent strategies in achieving this were gently and privately challenging midwives, equipping them to use evidence in clinical debate and deliberately and appropriately using praise to counteract the corrosive effects of guilt and blame (Stapleton et al. 1998). Less sensitively planned approaches invoked negative responses from midwives.

CONCLUSION

The midwifery culture here described is built on a contradiction. It allows individuals, in isolation, to practice midwifery skills of care and support but cannot acknowledge the empowering potential of those skills for midwives and mothers. Thus the voice of midwifery is muted and midwives experience a professional state of learned helplessness and guilt.

Parallels can be drawn between the experience of midwives and that of childbearing women where research links mutedness with postnatal distress and depression (Brown et al. 1994). The present study suggests that, at a professional level, mutedness can be linked with low morale and the expectation of oppression.

If midwifery practice is to empower women then midwives must experience empowerment themselves. This is hindered by a disempowering culture. Change is possible but efforts to bring about fundamental change in maternity care must acknowledge and develop strategies to deal with the culture of midwifery. Such strategies must include support and respect for those who at present gain security from the existing culture. Without such strategies, change is likely to be resisted.

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References


Experience before and throughout the nursing career