2019 NCSBN APRN Roundtable Some Global Perspectives: Sequence of Next Steps & Overview of Survey Results Video Transcript

Event
2019 NCSBN APRN Roundtable

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Presenter
David Benton, PhD, RN, FRCN, FAAN, CEO, NCSBN

- [David] Good morning everyone. My task was also to provide some provocative thought and when Maureen said that to me, I said, "Be careful what you ask for." So what I'm going to do is I'm going to talk a little bit about some of the global trends that we're seeing, some of which Barbara has already touched on. But I want to then give you a couple of [[00:00:30]] examples of what's going in two other countries, really just to try and trigger some further discussion in terms of, you know, where are we going? What do we need to do for the future? So I'm going to start with just talking a little bit about some of the changes that we know are already out there and I'm not going to spend a lot of time on this. But we know that we are in a period of transition and the reason that we're in a period of transition is that the demographics, the social demographics of [[00:01:00]] this country and many other countries is changing. We are unfortunately living in a era where some of our children will actually have a shorter life expectancy than parents because of issues around obesity and chronic diseases where they will be presenting with multiple problems at a much earlier stage. And therefore, what does that mean for the configuration of health services and who indeed is going to provide those? We're certainly moving [[00:01:30]] from a model with the use of technology from one which is very much hospital-centered to one where services are really embedded within the community. But what does that mean in terms of our ability to utilize technologies and to engage with those things? A model, and I would argue and this is a little bit controversial but I think with the audience we've got, it's probably not that risky, a model where we're moving from a doctor dependent model to one we're team-based, where the right [[00:02:00]] person to lead the care is in charge not just because you've got a particular name or you've got a particular history but actually tailoring the leadership of the team to the symptomatology and presenting conditions. We're seeing a move from episodic care to one of actually thinking about how we engage with people over the lifetime of their conditions and indeed from cradle to grave. [[00:02:30]] So these are some of the issues that are out there and my question to you is, is the current configuration of healthcare providers the right configuration to deal with all of these changes and are we really thinking ahead in terms of the mix of skills that we need? One of the problems we have in developed countries as opposed to developing countries is that we have history, we have baggage, and we often [[00:03:00]] hold on to that baggage dearly because we don't want to take risk. And what we're seeing in some other

countries where they are starting with almost like a clean slate is they are jumping generations of thought, jumping of generations of education as part of that. And part of my presentation would argue very strongly that we actually need to look to see what's out there, to see what we can learn from our colleagues in other parts of the [[00:03:30]] nation and other parts of the world so that we can actually equally take those shortcuts. So when we think about healthcare systems, we tend to think about it in that straight linear line in terms of the frequency of needs versus the complexity of those needs. And we think that the world is, you know, there's a nice linear path that we go up but when you actually look [[00:04:00]] at the data, it suggests that that's not the case. What in fact we've got is an exponential decay model. And the problem with that is that when we think that we're providing a service with nice linear stamps, it means that there are little gaps that occur. So you've got people where you've got situations in the top left-hand area where you've got these highly and increasingly complex cases and people are not adequately trained to [[00:04:30]] deal with those. But equally, you've got a whole raft of individuals that are presenting with conditions that actually we're over-educated for and then we've got some, they're actually the folks that are in the wrong location altogether. And if you think about the demographics of the United States at the moment, the youth of the United States, the average youth in terms of the percentage of the population, are on the coasts. And in the center, we're [[00:05:00]] actually seeing an aging population and the demographics of how that will need to play out in terms of who is available to provide care and who needs care is very different. So even within a country, we've actually got some differences that we need to think about. On the global stage and many of you have seen these graphics before, we are seeing a fundamental shift in terms of the shape of the population. We're seeing fewer [[00:05:30]] children being born and due to the success of our health systems, we're growing old which is a good thing. Sometimes first thing in the morning when it's a cold winter's morning in Chicago, I think maybe no, not such a good thing. But what that means of course is that the whole population structure is changing and the competencies we need to deal with are changing as well. But more importantly [[00:06:00]] is the issue of something called the population support ratio. So if I was to draw this image just for Japan because Japan is the most extreme example of this at the moment, although Korea is going to overtake them very quickly, the number of individuals that are available to work and the number of individuals that are in retirement is changing radically. So as you can see from this graph, in the next [[00:06:30]] several decades, we're actually going to have half the number of people available to provide care that we've had in the past. What does that mean for the way that we deliver services into the future? Now I know some of you, and this is a completely different presentation but the use of technology will help but there are some things that technology cannot deal with and what is our discussion about the rule of technology in relation to advanced [[00:07:00]] practice and how that will be delivered? There's an interesting paper the other day that appeared where surgeons are getting very, very worried about the fact that first assistant rules are actually disappearing because technology is actually replacing that. The surgeon, the first surgeon, is able to control all the retractors and various other things using foot controls rather than actually having someone in there. Now what does that do for the educational experience [[00:07:30]] for those individuals? What does that mean for the future? That's just one example. Back in the mid-'90s, at that point, I was still in in the UK and this quote came out. And I think it's a very important quote because one of the things that we're getting into at the moment is this kind of turf war between who does what. We need to think about it somewhat differently. We've got to think about [[00:08:00]] it is that we're not just simply substituting one intervention for another but we're actually coming at it from a very different concept and by sharing those thoughts with a publication…with a population, we're in a much better position to get them on side as part of their…of being champions for us. So on the back of this, the four countries of the United Kingdom [[00:08:30]] came together: Scotland, England, Ireland…sorry, Northern Ireland, and Wales and the Royal College

of Nursing which is a professional association worked with the Department of Health to really start to shift the mindset in terms of how advanced practice with the nursing was viewed. And they came up with this publication called "Freedom to Practice: Dispelling the Myths" and they just basically unpacked all the things that were being said by usually physicians [[00:09:00]] about how things were, you know, going to fall apart and people were going to die and all those sorts of those issues. Sounds familiar. It doesn't matter whether you're in Japan or whether you're in Ethiopia or whether you're here in the U.S., those kind of statements are being made. But what's important is that we are able to provide evidence to counter some of those points. So for the remainder of this presentation, I'm going to [[00:09:30]] focus on examples from two countries that have gone about moving forward the agenda of advance practice in somewhat different ways. So I'm licensed both in the United Kingdom and in Spain and I'm going to use those as two examples. Now, the first one is from Spain. So the Spanish decided that with their changing [[00:10:00]] demographics, and they actually got the second oldest life expectancy in the world, but like the United States, they're seeing this concentration of populations where there are large rural communities with a much higher average age. And they decided that they needed to think very differently about their whole education system. And this wasn't unique to Spain because within the [[00:10:30]] whole European Union, they wanted to become the most advanced innovative education framework in the world. So what they did was they said, "Okay, how do we do that? Well, first of all, we develop a framework and then secondly, we promote it." So some of you may have heard of something called the Lisbon agreement under Bologna system which basically said, "In the whole of Europe, we're actually going to have a common educational framework so that we all [[00:11:00]] know that what a bachelor's degree is, what credit it has, what level of study it entails and we're going to have the same for a masters and we're going to have the same for the doctorate." And they were very clever because they wanted to make their European Union a very strong educational environment. So they talked to somebody called a DG Development, the Director General for Development and they said, "Could you make some money available around the world so that we'll try [[00:11:30]] and promote this idea?" So the framework that's now being used within the European Union, the 27 members of the European Union, has now been adopted within 44 countries across wider Europe, 10 countries across North Africa, most of Asia and Oceania as well, and 19 countries in Central Latin America. That framework is de facto the global framework [[00:12:00]] for education. And what it does is it actually specifies across all degrees. So whether you're talking about a nursing degree or a theology degree or an engineering degree, what the level of study looks like and what the tariff associated with that will be. What does that mean? It means that because they are using that, it provides greater flexibility of learning for the student so they can actually, as part of this [[00:12:30]] framework, learn in different institutions as part of their program of learning. This is now being developed across the board. Spain wanted to take it a stage further. They said, "Okay, we've got really well-prepared Bachelor of Nursing," and they moved to a completely BSN program over 20 years ago now. And [[00:13:00]] what they said was, "We actually need to really take advantage of this. We need to look at what these qualifications look like and what it means." And one of the things that we did in Scotland, and I'm just going to jump to Scotland for a moment, was when I was the chief executive officer of the National Council there, there was apprehension at the time by the Department of Health to move to graduate education. [[00:13:30]] And their concern was we wouldn't have enough people going into the system. They wouldn't have the entry qualifications. So what I did was I commissioned a piece of research. I got some independent researchers, educational specialists, to analyze the medical degree, the nursing diploma, and a law degree. And I said, "Tell me what the quantity and the level of study looks like." Well, of course, the medical degree [[00:14:00]] was like that but the level was about here. The nursing degree wasn't quite as much in quantity but it was actually…in terms of intellectual content, it was

higher. Now just think about it, what we do as nurses. We have to manage teams. We've got to do all these different things that historically our physician colleagues haven't had to do. The law degree was actually quite narrow in terms of the weight [[00:14:30]] but it was actually quite high. And by actually presenting that information to the Department of Health, we were able to persuade the fact that the current diploma was being undervalued by institutions and that actually moving to bachelor's degree within this overall framework would not present a problem in terms of tailoring off. So using frameworks in a systematic way can help. You can go straight from a bachelor's degree into a masters degree [[00:15:00]] in Spain but they also decided that they wanted to have an alternative route because they wanted to have, in a structured way based through clinical rotational models, an opportunity to gain the same level of academic credit as someone going through the masters degree. It takes a bit longer as you can see from this but at the end of the day, you actually come out with the same level of credit which both routes give you access to the doctorate. [[00:15:30]] Why is this important? Because it's important in thinking about how we move forward for the future in terms of having different pathways that meets people's different needs. Not everyone will be able to spend four years plus two years plus another three years in a straight run. Some people will actually need to take some time into clinical settings and they should. I mean if I think about when I was working [[00:16:00]] clinically, we didn't have the range of programs available that we have these days. And basically, you spend a lot of time in the library learning yourself but you didn't get any credit for that. It was part of the process. So putting it within frameworks is important. In Spain, as in UK, prescriptive authority comes with your bachelor's degree. So as a registered nurse, I can prescribe anything a doctor can prescribe providing [[00:16:30]] I've completed the program of study. Now interesting thing the Spanish did because the doctors didn't like this thought at all was they said, "Okay, let's look at the nursing programs, let's look at the medical programs, and let's look at the pharmacy programs. How much pharmacology and all of that do you get?" Well, guess what? The nurses get more pharmacology than the doctors. Well, that argument can't be made because we're better educated, aren't we? So sometimes [[00:17:00]] we've actually got to step back and ask these questions and get independent researchers to look at it because the argument always is well, you nurses looked at it yourself, didn't you? So you're not going to tell the whole truth and nothing but the truth. So let's think about that. So how do we, as we move forward, engage with other communities to help us make the argument using the expertise of economists, using the expertise of educational [[00:17:30]] theorists as well as part of the process? So enough about Scotland…enough about Spain. Let's move to Scotland very quickly. So in Scotland, we have a system called the knowledge and skills framework. Whether you are a porter or whether you are a neurosurgeon, you actually have a number of competencies within this framework. They're different obviously and the level is different as well. But when we did this work in the UK and it was a UK-wide project, [[00:18:00]] we discovered that there are in fact 42 competencies that are needed to deliver healthcare. And if you think about it this way, if you think about basic ingredients, you've got some flour, you've got some eggs, you've got some milk, you've got some sugar, and you've got some butter. It's the way that you put them together that determines whether you end up with pancakes or whether you end up with a gateau. So if we think about how we can start to measure people within a common framework, [[00:18:30]] that then starts to ask the question about what skills? What are the competencies we need to deliver care rather than what is your job title as part of that. It's a radically different way of thinking but it actually gives you the flexibility and agility that we need to face some of the challenges ahead. Interesting little development in terms of the model in the UK and in Scotland, in Scotland, we're a small [[00:19:00]] nation. We're five and a half million people. We can get all the people we need to work something out in a single room. We can sit them down and we can shut the doors and we can say, "You know, you're not going to get coffee until you fix this. All right?" But what that means is that we are able to start to think

about how we look for commonalities rather than differences. So the advanced practice model in the UK looks somewhat different from what we have [[00:19:30]] here but as a result of that, it is more agile in terms of where it can move. Because there's two ways you can control a profession. You can either control it through scope or you can control it through title and title gives you far greater flexibility in meeting population needs and being able to explain that to the population is important in actually winning some of the challenges that we currently face. I'm rapidly running out of time so I'm just going to give one more [[00:20:00]] example. And again, this is about prescribing. So the UK has just done really interesting thing. They've actually come up with a set of prescribing competencies. It doesn't matter whether you're a doctor, whether you're a nurse, whether you're a pharmacist, whether you're a physical therapist, if you prescribe, these are the competencies. Everyone has to do the same thing. There's no difference. So with competencies as you can see, focus with the patient at the heart of it. [[00:20:30]] Then things about the consultation process, gathering the information you need to reach a determination. But then, it actually looks at prescribing governance so everyone has to play by the same rules as part of this. There, as you can see, are 10 and this is just one example of, you know, this is the competency associated with assessment of the patient and this one relates to prescribing safely [[00:21:00]] and prescribing professionally. So everyone is held to the same level. If you're really interested in looking at how nurse prescribing works, I would encourage you to look at Scotland because one thing and I hope I don't offend anyone but in Scotland, we are what I would describe is anally retentive over data. We gather data, we curate it, and we've done it for decades. So when we introduce nurse prescribing in Scotland, everyone had a unique number [[00:21:30]] and everyone was then reviewed on a regular basis. So we can actually look at what individual practitioners are doing as part of this process. Guess what? Nurses are safer prescribers. They actually consider more of the interactions. They're better responding at some of the side effects as all of that and the data shows that year-on-year. And therefore in terms of getting some of the evidence for that, that's really important. How do you then use some examples [[00:22:00]] with that? Well, I'm going to hop back to Spain for a minute. So when the Spanish were trying to make the changes that had already been made, remember and this is not just in the UK, so prescribing at the RN level is now becoming the norm in many countries. It's the norm in the UK, it's the norm in Ireland, it's the norm in many of the African countries as well where they have graduate programs. So what we're seeing is [[00:22:30]] a reshaping of education to meet the changing needs of population rather than simply further and further, higher and higher academic drift as part of the process which then frees up space for different things at those other levels. In Spain, the Spanish Nursing Council decided that they wanted to move in the prescribing direction. So what they did was they reached out to key authors in [[00:23:00]] some of the kind of what we would call the broadsheets. So the likes of the "New York Times" and "The Washington Post," those type of newspapers. They brought people from the media. So the kind of different folks from Fox and from CNN and various other things. And they paid for them to go from Spain to the UK to see what was going on in the UK. And the cost of that was just [[00:23:30]] over a 140,000 pounds, so about just short of $200,000 I guess. The media coverage that they got for that, if they were going to have to pay for it was 7 million pounds. So the return on investment by actually supporting and, you know, they said, "You can write whatever you like. This is a deal. We'll pay for you to come. We just want you to make a commitment that you'll write something about it or [[00:24:00]] you'll do a show about it." Well, if the Spanish Nursing Council wanted to pay for it, they would have had to pay 7 million pounds, $10 million for a $200,000 investment. So think about creative ways of reaching out to different partners. So as I come to the end, I would just ask you to about not what's been in the past but what we are now [[00:24:30]] facing. I would ask us to think radically about the way that education and service on society or interface with one another and I would ask you to think about the fact that somewhere in the world, someone else has

actually been facing the problem that you are and they actually might have some solutions that [[00:25:00]] will give you some thoughts to ponder upon and ideas for you to take a radical risk-based approach to moving forward. Because as we look forward, we know that the challenges of delivering health is not going to get any easier as the demographics shift and therefore we're all in this together. So moving to really thinking about who needs to do what, when, [[00:25:30]] and how is really very important. So I'm just going to say thank you and Maureen, is there time for questions or?
- [Maureen] I have questions for both of you. To start with Dr. Todd, you gave the information about the diversity numbers in the graduate nurse education project and I was fascinated by that and you mentioned that, you know, the question always comes with the growth in graduates [[00:26:00]] and the growth in training have been there anyway because we see this spike in growth for APRN programs. What about the diversity number? Is that a surprising number compared to diversity and programs that were not part of the graduate?
- [Dr. Todd] Yeah. And the diversity I shared with you was the diversity from the survey that we did in the Philadelphia group. I don't have the diversity numbers yet from the…they pulled us down by the evaluators. It did surprise me [[00:26:30]] to be quite honest because when you look at the national demographics related to diversity in APRN education is much lower.
- Yeah. Yeah. So there may be something for you guys to kind of tease out of that information about why that worked. I'm fascinated by that. And David, for you, I know I'm really abusing the privilege here.
- You better retire. You better retire.
- For you, you know that I have a particular passion about increasing the effectiveness and [[00:27:00]] timeliness of diagnosis not only in the United States but across the world and what can nurses add to that. And so my question to you is I'm fascinated by the European projects that you described. We're trying to, here, trying to get people to think about increasing the registered nurse participation in diagnosis. Is there sort of a European counterpart to that? And then I'll let Kathy take the mic.
- So here is a [[00:27:30]] really kind of provocative issue. In Europe, when you do a degree in nursing or a degree in engineering or a degree in whatever, that's what you do. So the 4600 hours I did in my RN program was nursing. I didn't have a broad range of other things I had to do in prerequisites and all those. It was in nursing. So part of this [[00:28:00]] is actually about thinking about what do you use the time for and what do people need and how you move it forward. And by benchmarking across different disciplines, it then gives you the opportunity to ask some pretty fundamental questions about this. I think that's a big lift for the U.S. I think that's an enormous lift because it's a radical shift but my point is pretty blunt. Can you afford to continue the education system that you've currently got [[00:28:30]] or are you going to have to do something really radical to enable you to have the kind of skills available to you to meet the needs. I was recently in the United Arab Emirates where they are looking at what they called a Emiratization. So they have a population of 9 million, they have only 1 million Emiratis and they have a very low percentage of Emiratis in the nursing profession. And they came up with this idea that they wanted to have [[00:29:00]] more and I said, "Well, how many more do you want?" And they said, "Well, what do you mean? We're at 10% and we want 100%." And I said, "Well, if you think about just the basic numbers on this with 1 million Emiratis in the country, if you actually deduct those that are over 65 and the ones below 17, if you then think about the fact that you've also got lawyers and you've got computer scientists and you've got various other things, I'm assuming that you want [[00:29:30]] some Emiratis there as well." We then of course realized that actually, they're never going to get to the level of 100%. So I think some of these issues is actually about as much about workforce planning and what do you need as it is about education. But too often, workforce planning and education do not connect. It's only when, you know, when I was a director of nursing, an NHS Grampian, where I had a

whole [[00:30:00]] system responsibility and I brought the both of their universities that were in the patch plus the private sector and the long-term care sector all into the room together and we said, "Okay, so we're all nurses. So let's be honest. We've left our directors of finance at the door. Where are we going with workforce? What do we need in the future? How can education be part of that?" Because quite often, you know, as a director of nursing, I go along to my education provider and said, "Your students don't do [[00:30:30]] things that I want them to do." And the education provider said, "Well, you never told us what you wanted them to do in five years' time because that's how long it takes to produce someone." So that kind of dialogue is much as part of it as anything else. Kathy or…
- You're next.
- We're so kawaii.
- [Natalie] Thank you. I'm Natalie Baker from Alabama Board of Nursing. David, I think I understood you to say that in the United [[00:31:00]] Kingdom, all healthcare professionals are all taught to the same competencies?
- No. So all degrees have the same level of tariff. So the quantity is the same and the level is the same but the composition of the competencies is different. So you have more of one…you know, an engineer has more systems [[00:31:30]] analytical skills but the level is the same. In terms of healthcare, we've now moved to a situation for prescribing. Everyone is taught exactly the same.
- So does that mean like a physical therapy because you use the example, nursing physical therapy physicians, so…
- Anyone that prescribes.
- So can a physical therapist then prescribe antibiotics?
- For certain things, yes.
- So how [[00:32:00]] does that help promote advanced practice nursing in this country if we're trying to have equal footing for all of the healthcare professionals? I'm confused with that.
- So the system is actually based on patient needs.
- But again, I'm not sure how that promotes nursing here. I'm just confused on that.
- Well, I think you've got to ask the question, what does the patient need in the future and who's the best [[00:32:30]] positioned to provide that and then you reconfigure around that. It's not just simply taking what we've now got and perpetuating it forward. It's actually about seeing. If you look at some of the demographics, we know that long term conditions are going to be very…the percentage of long term conditions is going to be very different which actually means, as nurses, we're going to have to respond to that. We're not just going to have the kind of same thing as we did 25, 30 years ago where childhood illness was much more of a dominant feature in [[00:33:00]] communities.
- So are we going to evolve from the National Council State Boards of Nursing maybe just to help professions? I mean I'm just confused because this is a nursing organization. That's my question.
- I wondered if I might give an example of that because I thought her analogy is a good one. If a patient is seeing a physical therapist and somebody needs to prescribe the TENS unit, does it make sense that that patient has to go see a physician or a nurse practitioner [[00:33:30]] to get a prescription for a TENS unit when that physical therapist could have done it? I think that's the point that the Europeans have made to us.
- But I mean to answer the question in terms of where are organizations going, if you look at…there is much greater dialogue now between the organizations. So if you think about what my predecessor was involved in under the then board of NCSBN in reaching out to [[00:34:00]] set up the try regulator collaborative, we're now seeing regulators actually working together on some of these issues. For example, the common set of competencies associated with those that prescribe in the UK would not have come about if we hadn't had the nurses, the doctors, the pharmacists all running the table together.

That doesn't mean to say that we all turn into a kind of homogenized group. We all bring our expertise to the table but we actually work in a very [[00:34:30]] collaborative and constructive way together to solve these patient challenges.
- [Kathy] So Kathy Chapel from ANCC. I was fascinated by your graph with the baccalaureate degree and then the masters degree on one side and the internship track on the other side. So my questions are two. Does the internship track have an academic partner? So at the end, is there a blended [[00:35:00]] model so that the individual graduates with a masters degree through this internship track and then is then eligible for the doctoral, entering into the doctoral degree program? So if you can expand that out a little bit for us.
- Yeah. They do actually have an academic partner as part of the process. The study modalities are different.
- The what is different?
- The study modalities.
- [Carol] Hi, I'm Carol Hartigan from American Association [[00:35:30]] of Critical Care Nurses and I have a question for Dr. Todd. I've been kind of frustrated at the demonstration of projects that just seem to focus on primary care because I'm more interested in acute care. So I noticed that you said that all specialties were included in the demonstration project and you mentioned acute care several times although this was for primary care. So I was wondering how you accomplish that because it seemed like you said, [[00:36:00]] you didn't include acute care NPs in the project.
- Yeah. Acute care were included…I think when I first came into the project, I know there was some dialogue about groups that were excluded but by the time we went to implementation, all the groups were included. So the acute care NPs on the adult side as well as the pediatric acute were included in the demonstration across all the sites where they had those programs.
- Well, we had a huge [[00:36:30]] population of the chronically critically ill which almost do fit a primary care need if you looked at matching patient needs to provider competencies and it would almost be primary care because you do establish a relationship with these patients. So it really could fit. Thank you.
- Yeah. So all the groups were included.
- [Louise] My name is Louise Kaplan. I'm from Washington State University and my question is for [[00:37:00]] Dr. Benton. I spent a year as a Peace Corps global health volunteer in Eswatini which was at that time, Swaziland. And the models that you gave are much more analogous to what we have here in the United States but having helped start a family nurse practitioner program in Eswatini at the masters level, I'm acutely aware from international work that many of the countries that are [[00:37:30]] under-resourced can't achieve that model. And when you talk about nurse prescribing, that is happening in many, many countries through standardized treatment guidelines and essential medicines list, excuse me. And in many countries, nurses are not adequately prepared at the same level as the models that you gave in the UK and Spain. So I'm wondering how we help when people [[00:38:00]] look to the United States for advanced practice models, how we help countries that don't even have baccalaureate as the entry into nursing. How do we help them achieve the needs in their under-resourced countries where nurses really are the frontline workers and do far more as we talk about scope of practice that Maureen addressed? They're doing far more than many nurses in this country are doing. So how do we help them with advance practice and how [[00:38:30]] do we provide them with the types of resources?
- I think the first thing that we do is that we do just as you identified, recognize that there are some differences and that we do not try and transplant our model into their model without thinking about how it needs to change for those purposes. Quite often, [[00:39:00]] we go and we offer our expertise in a way that is not context sensitive. And I think part of having worked for ICN for 10 years, if you go there

and you listen, you learn a lot more than if you talk. That's part of our process. And some of these countries have got a lot to teach us. [[00:39:30]] So at one point, Johnston and Johnston were looking to develop their presence in in the BRICS countries, so Brazil and China. And they came to my office in Geneva and said, "Oh, well, we've got this wonderful idea about how we're going to teach all these Chinese and Brazilian nurses and this is what we're going to do." And I said, "Well, please don't do that." Because actually, they are further ahead than you are thinking. Because they were talking about using e-learning technologies [[00:40:00]] and they're not tied to uninterrupted power supplies and desktop computers and all of that. They'll show you how to use smart phones in a way that we've never even thought. This is going back several years ago. And if you've been in Swaziland, you know the rule that mobile phones has played in the treatment of conditions like multi drug-resistant tuberculosis and various others. And these are not smartphones. These are just basic rudimentary technologies but the role that they can [[00:40:30]] be and reimagined how some of these can be used. So I think what we've got to do is bring our expertise but offer it in a very deconstructed way so they could put it together in a way that actually meets their needs. There are other examples where…and the regulatory body in Swaziland know that…the chief executive of that body is somebody called Glory Msibi and she [[00:41:00]] is a great example of someone who did not take a traditional route. She's doctorally prepared but she actually skipped through bachelor straight to doctorate and quite often, institutions don't like that. When I was in Aberdeen, one of the more ancient universities, 1473, it was formed. They said, "Yeah, if you want to do any of our masters programs, you've got to have a bachelors first." And I said, "No, that's not how it's going to work. You're going to offer your modules and if some of the nurses [[00:41:30]] I have in my institution want to pursue those, they could pursue them and they can then build that credits tree into their masters." What they were worried about was that they were actually going to have drop out and attrition and that was actually going to reflect badly on them. But by actually demonstrating that many individuals in the world at the moment, about 90% of nurses are female and they have perhaps not had the opportunity [[00:42:00]] to pursue bachelors degrees as their first nursing qualification because they weren't out there. Personally, my initial nursing qualification is a certificate program. It just was not available in my locality to do a bachelors. There was only two programs in the country and I wasn't going to go to Manchester for one of them and I wasn't going to go to Edinburgh for the other. So we've got to really start to actually break the mold and think about how we come at these issues and not just [[00:42:30]] simply say, "Well, it's different but let's just do it the way that we do it," because we've made so many mistakes.

- Well, I appreciate that because I think that cultural and local context is what should really drive us. So I just want people to understand, we can't just transfer what we have. We have to start where the country is. So thank you.