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A STUDY OF PROFESSIONAL VALUES AND ATTITUDES AMONG REGISTERED NURSES: the implications for future nursing policy, education and practice

by

A. Lancaster

Thesis submitted for the degree of

M.Sc. (Social Sciences)

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INTRODUCTION.

The word "professional" is frequently used by nurses to describe various aspects of nursing practice and responsibility. But there seem to have been few attempts to examine the implications of the term in relation to nursing, and to consider the extent to which the criteria for professional status are compatible with the requirements of effective nursing service.

Nurses appear to be apathetic toward their professional organisations. But little attempt has been made to find out why nurses do not give them more active support, or how far the existing organ-:isations represent the principles which nurses feel are inherent in nursing practice.

Nurses are frequently criticised for being reluctant to express their personal opinions on matters of nursing policy or to exert their authority as professional specialists. It is not known why they do not, or why they appear so indifferent to criticisms provoked by their attitude.

Nurse /

Nurse teachers and administrators are planning new educational programmes. But the views of practis-:ing nurses on the subject of nurse education have received scanty attention compared with the influence which they exert over the attitudes of student nurses in the practical situation.

These issues - the organisation of the occupational group, the provision of an appropriate system of pro-:fessional training, the ability of nurses to assert their opinions on matters which concern their own field of experience - are closely related to each other and to the total concept of professional responsibility.

At a time when the concept of nursing is changing, it would appear to be of some advantage to those respons-:ible for the planning of future nursing policy to be aware of the attitudes of practising nurses on whom the effectiveness of a nursing service ultimately depends.

The present study is based on the results of an opinion survey carried out among a sample of registered nurses in two areas of Scotland. Its purpose was to find out the attitudes of the respondents toward aspects of /

of nursing which appear to be related to the values inherent in professional practice.

The term "nursing profession" has occasionally been used in this study as a matter of convenience; it is not intended to imply a particular occupational status.

Because the majority of nurses are women, nurses are referred to in the feminine gender except when the reference is specifically to male nurses.

SECTION 1 : DEFINITION

"Professional values and attitudes"

The concept of a profession, according to Millerson (1964.a), is "of all sociological ideas, one of the most difficult to analyse satisfactorily".

Some of the difficulty lies in its elusive circularity. A profession cannot be analysed until it can be identified; in order to be identified it must be seen to possess certain characteristics; but its characteristics can only be recognised by observing the behaviour of individuals who are engaged in the practice of a profession.

The problem seems to have three main aspects. First, there are the semantic difficulties which have arisen as a result of the appropriation of the term "profession" by a wide variety of occupational groups.

"It is important, historically, to distinguish narrower and wider usages as follows :

> i) In the narrower and older sense the term refers to the professions of divinity, law and medicine, the first occupations that gave to people not living on unearned income a chance to make a living which did not involve trade or manual work. It has been /

been extended to include the army and
the naval profession.

ii) In the wider and more recent sense it refers to all people with an academic training and degree or its equivalent, such as scientists, teachers, sociologists, civil servants, or architects.

iii) In accordance with a strong trend in the development of industrial societies the meaning of the term has been further extended to include occupations that require some scientific training and knowledge, though not necessarily of university standard, and a diploma or certificate, usually based on examinations, for the exercise of their specific occupational skills."

(Gould & Kolb, 1964)

Second, there is the question of the standards and the authority which determine an occupation's achievement of professional status, and of whether the practice or the practitioner exerts the greater authority: the values represented by the work, or the attitudes of the person who performs it. Lewis & Maude (1952.a) stated that "the vital issue to-day is how far professional people are staying professional". This seems to imply that the concept of professionalism could /

could continue to exist as a phenomenon of historical interest while "professional people" perpetuate it in a new form. But the question may be reversed: how many unprofessional practices are likely to stay un-:professional?

> "It was often argued that the possibility of threatening strike action distinguished a profession from a trade. This was un-:true. Strike action has been threatened by the medical profession on a number of occasions."
>
> (Abel-Smith, 1960.a)

If there were static criteria by which a practice were judged to be or not to be professional, then presumably professional people who fail to fulfil them would relinquish their claim to professional status. The threat of strike action by the medical profession would result in medicine ceasing to be a profession, not in the acceptance of strike action as respectable professional behaviour.

Third, therefore, it is necessary to appreciate the factor that Millerson (ibid.) calls the "dynamic process involved in professionalism", rather than to look for a "static model", and to recognise that analysis /

analysis of the concept of a profession is only possible in relation to a particular historical or social environ-:ment, described in terms which must be redefined when-:ever a fresh analysis is made.

It would seem that the idea of professionalism adapts itself to fill gaps in the status continuum occurring in a socio-economic occupational structure, and that a concept of professionalism which does not allow for mutation has little relationship to the realities of professional development.

The professions of divinity, law and medicine filled the gap in the social scale between people living on unearned income and those engaged in trade and manual work. At the present time, the desirability of professional status still appears to derive from its broad, middle-class associations. It provides an attractive goal for the socially lower, upwardly mobile, who have been able to take advantage of wider educational opportunities, and also provides a reasonably respectable landing place for the socially-upper, downwardly mobile, for whom the possibilities of living on unearned income are greatly reduced in an era of high taxation.

Owing /

Owing to this "fluid" characteristic, it would seem that to predict the connotations which the term profession is likely to have in even twenty or thirty years' time would require a pre-view of the whole social pattern. In 1915, Flexner enumerated six criteria which at that "moment" he considered to be the criteria of a profession:

"1) Professions involve essentially intellectual operations with large individual responsibility;

2) they derive their raw material from science and learning;

3) this material they work up to a practical and definite end;

4) they possess an educationally communicable technique;

5) they tend to self-organisation;

6) they are becoming increasingly altruistic in motivation."

Although Flexner recognised the increasing prestige conferred by "those magical combinations of letters that either are or look like an academic degree", it was to the last of his criteria, rather than to educational qualifications, that he attached the greatest significance in relation to possible future developments:

"... under /

> "... under the pressure of public opinion, professional groups have more and more tended to view them-:selves as organs contrived for the achievement of social ends rather than as bodies formed to stand together for assertion of rights or the protection of interests and principles ... Devotion to well-doing is thus more and more likely to become an accepted mark of professional activity; and as this development proceeds, the pecuniary interest of the individual practitioner of a given profession is apt to yield gradually before an increasing realization of responsib-:ility to a larger end."

Subsequent writers have usually been more wary about predicting the course of future events.

It is interesting to note which aspects of professionalism are most frequently mentioned by those who have attempted to analyse the traditional idea of a profession, to try to identify the characteristics which have been given special emphasis and which might, therefore, be said to constitute the "hard core" of professional practice. There seems to be little evidence that such a core, exclusive to professional practice, actually exists. Although the same aspects of responsibility are repeatedly discussed, and each individual /

individual writer expresses at some point, implicitly or explicitly, his personal views on the "essence" of professionalism, the emphasis varies from one writer to another, or is very diffuse.

Carr-Saunders & Wilson (1933.a) did not see professional men as philanthropists - they expect adequate remuneration for the services which they perform - but

> "The obligation of the professional man to give his services whenever called upon, and without exercising capricious dis-:crimination, for example, on personal or political grounds, is very generally recognised ... Alongside the obligation to render service whenever called upon, there is generally recognised an obligation to give only the best service and to subordinate all personal considerations to the interests of the client."

The present trend seems to be to interpret "whenever called upon" as a collective rather than an individual obligation - for instance, by the setting up of group medical practice. Also, since the establishment of a National Health Service, the increasing insistence of the client on his right to receive the "best service" because he is helping to pay for it has perhaps become in /

in some cases as effective a stimulant as the prods of a weary professional conscience.

Lewis & Maude (1952.b) saw the basis of professional practice as the responsibility of one individual for the welfare of another, a responsibility which involves a special kind of personal relationship. They question whether the present demand for technical experts will "devalue all that is most worthy" in professionalism, grounded as it is upon "the fiduciary relationship with individual clients or on the voluntary sacrifice of extra monetary gain in the interest of the community". They believe that this type of relationship, even when a socialised service has had to be introduced to look after the interests of the community, requires the recognition of a code of ethics:

> "Professional ethics arise from the codes of the most ancient professions: the Hippocratic oath, the inviolability of the confessional, the devotion of lawyer to his client's interest. The relationship of client and practitioner is the basis of professional morality. It is between individuals, and it is fiduciary."

The authors ask whether these things can be part of engineering and technology as well as of medicine and /

and law? It could be argued that relationships based on both individual and collective "morality" are as necessary in a technologically advanced society as in the times which saw the development of the "most ancient professions", for any high degree of specialization produces a priesthood and requires a high degree of trust on the part of its clients.

Any reasoning which attempts to discriminate between the value of different kinds of service must presumably be relative and subjective. On what basis, for example, can the qualifications required of surgeons be compared with the knowledge and skill required by those who build a computer capable of rendering a type of service formerly carried out, perhaps less efficiently, by a human machine? How does the "morality" expected of a house painter, who works alone and unsupervised in the home of a client, differ from that of the traditional professions? Are there values inherent in certain kinds of service, or are they dependent on /

on the attitudes of those who give the service? It seems difficult to defend professional exclusiveness on grounds of professional morality.

To give efficient service, the practitioner must have had the necessary education, training and experience. Jahoda (1961) considers that the most outstanding characteristic of the traditional professions of law, medicine and the church is their "specialised knowledge acquired through formal education beyond the schooling that is ... prescribed by the law of the land". Other skilled workers have this too, however, and the definition which she gives of a profession stresses its collective responsibility rather than its educational qualifications:

> "A profession is ... an organisation of an occupation group based on the application of special knowledge which establishes its own rules and standards for the protection of the public and the professionals. Its emphasis is on the quality of performance rather than on the self-interest of its members."

Educational qualifications (cf. the difference between "narrower and wider usage" as described by Gould & Kolb), and the tendency for professional groups to organise /

organise themselves, seem to be generally recognised characteristics. Marshall (1939.a) summarised the functions of a professional organisation:

> "In the first place the association guarantees the technical efficiency of its members, not by supervising their work, but by testing their ability before they are admitted to practice ...
>
> Secondly, it imposes a code of ethics which includes the duty to offer service whenever and wherever it is required, to give only the best, to abstain from competition, advertisement, and all commercial haggling, and to respect the confidence of the client.
>
> Thirdly, it does what it can to protect its field from invasion by the unqualified ... to keep up the standard of remuneration of its members, and in general to safeguard the conditions of their work."

Prandy (1965) and other writers point out, however, that almost any occupational group can form an association and its existence does not confer professional status.

It would seem that the exact form in which group standards are expressed - for example, in relation to education, remuneration, and the conditions under which licence /

licence to practise is granted - must always be decided in the context of time and circumstance which are responsible for shaping the process of professionalism. The fact that there is concerted agreement regarding what "should" be done at a particular time, implies the existence of an underlying and relatively constant set of values against which the group measure their responsibility.

Implicit in all professional practice is the recognition that the effective functioning of the group depends upon the integrity of the individual. A professional person is expected to make decisions on his own initiative regarding any action which he considers to be in the interest of a client, and at the same time to maintain, without supervision or directive from a higher authority, the standards laid down by his occupational group.

Marshall (1939.b), discussing the implications of professional individualism, suggested that:

> "the individual is the true unit of service, because service depends on individual /

> individual qualities and individual judgement supported by an individual responsibility which cannot be shifted onto the shoulders of others. That, I believe, is the essence of professionalism, and it is not concerned with self-interest, but with the welfare of the client."

The exercise of such "individual judgement" appears to be the only effective means of sustaining equilibrium when social changes produce conflict between intra- and inter-professional loyalties, conflict which requires readjustment between the intrinsic and extrinsic factors which are involved in the "dynamic process" of professionalism. Corwin (1961) illustrated this by describing the position of the American nurse as a salaried employee "currently engaged in a drive to professionalise"; Millerson (1964.b) drew attention to the "apparent conflict which exists between 'business' and professional practice"; Prandy (op. cit.) studied the class attitudes of scientists and engineers (employed professionals) in relation to professional associations and trade unions. Whenever such conflict arises between the way in which the professional values are interpreted /

interpreted and changing values in the society of which they form a part, established patterns of practice may have to be modified in order to preserve underlying principles, in the same way as new translations of old texts are necessary from time to time to preserve their original meaning. The decision that terms are no longer appropriate is made as a result of "individual judgement supported by an individual responsibility". One example of such a change has been mentioned: the formation of group medical practices which fulfil the obligation to provide continuous medical care within the context of a nationalised health service.

The fact that this type of situation can only be dealt with satisfactorily as it arises, by "individual judgement" rather than through adherence to set rules of behaviour, is perhaps itself the unique characteristic of professionalism. The freedom which is the responsibility of individual practitioners ensures that changes in professional practice keep professional values constant, such changes being essential for professional stability.

If attention is focused upon the values which seem to form the basis of professional practice and the a reas in which they operate, rather than upon the manner in which they are interpreted, it is possible to differentiate four kinds of professional responsibility.

First, the obligation to render a service to the community is very generally recognised as a requirement of professional practice.

Second, in order to provide efficient service, a professional person must have a relatively high standard of education and specialised training.

Third, the personal relationships which are involved in professional services, between practitioner and client and between professional colleagues, are based on the assumption that the people concerned will behave according to a recognised code of ethics.

Fourth, a professional group must be capable of organising its own affairs and maintaining controls /

controls which will protect its clients from inferior standards of service and its members from unsatisfactory conditions of practice.

Many occupations may have these character-:istics. Professional services depend on the ability of individual practitioners to act according to principles rather than to conform to rules. This quality seems to include all other professional criteria. It implies that each individual has the specialised training and personal integrity to allow him to practise independently, and that the professional group has the power, and sufficient confidence in its own standards and controls of practice, to be willing to accept the responsibility of giving its members professional freedom.

SECTION 2 : NURSING

2.1 : Nursing Service

Nursing service has developed in response to a variety of needs - biological, psychological, social, economic - until at the present time it is difficult to separate the concept of nursing from the structure within which it has evolved and from the pressures which have been responsible for its present form.

First, in primitive society or within a family group the needs of the nurse and the nursed may be too interdependent, emotionally and economically, to be easily distinguished. Even in a more complex society, nursing on its less technical level - a baby being cared for by its mother, old people being cared for by the younger members of the group - is frequently a non-specific jumble of domestic chores and good intent. The idea "that it requires nothing but a loving heart, the want of an object, a general disgust or incapacity for other things, to turn a woman into a good nurse" was one which Miss Nightingale fought vigorously to demolish. (Notes on Nursing, 1859)

Second, the idea that the care of the sick and indigent /

indigent was a religious duty, grew out of Christian teaching.

> "Between pre-Christian and post-Christian care of the sick there was this great difference - that love and service toward one's neighbour were regarded as Christian duties no less binding than love towards God ... Probably no part of the Gospels, by reason of its very novelty, had greater influence on the earliest Christian charity than the parables of the Good Samaritan ... the care of the sick was lifted on to a higher plane; what had formerly been a mere occupation of slaves or a service of necessity in any house-:hold became a sacred vocation based upon Christ's actual command. Thenceforward it was the avowed duty of all Christian men and women to go outside the narrow limits of their own homes and tend others in sickness and distress."
>
> (Seymer, 1957.a)

Christian influences seem to have been both the strength and the weakness of the nursing profession. In many parts of the world religious bodies remain in control of hospitals and nursing schools, and there are doubtless many people who still believe that nursing cannot be fully effective unless those who practise it have a "sense of vocation". But scriptural authority has been used selectively: it is sometimes forgotten that the Good Samaritan paid in /

in full for the services of those who nursed the sick traveller.

Third, socio-economic factors have played an important part in shaping the form of present-day nursing. Until the end of the 19th century, pauperism or a sense of vocation were possibly the only incentives strong enough to persuade women to take up nursing and during the early part of the 20th century it still provided a comparatively cheap means of getting a professional training. Its development as a respectable profession also coincided with a change in the attitude of women which, as Abel-Smith (1960.b) points out, was to a large extent responsible for its popularity:

> "First, it appealed to the romantic or dedicated sort of girl in an age which offered few occupations for women. Secondly, it was in line with the tenets of the High Church movement. Thirdly, nursing and teaching represented almost the only practicable forms of escape from the parental nest. Fourthly, private nursing or a post as matron offered considerable financial rewards when compared with the few alternatives open to the sex. Fifthly, some experience of nursing became recognized as one of the "accomplishments" which a young lady could profitably acquire /

> acquire. Sixthly, the development of the nursing profession represented an instalment of the emancipation of women. It gave power - power over men."

In the early days of formal training some system had to be devised to cope with the heterogeneous mass of recruits. Rigid discipline and the insistence upon a high standard of personal ethics were stressed in order to protect the patient from well-meaning but potentially dangerous enthusiasm and to prevent the infant profession from damaging its own fragile reput-:ation. The exigencies of the time, especially in the Crimea, required the services of women who could at least be trusted to carry out orders conscientiously so that the sick received the basic requirements for survival and, if possible, for their comfort. Pro-:ficiency in technical, physical skills and the ability to perform heavy and often unpleasant manual work was of primary importance in dealing with war-time casual-:ties under extremely difficult conditions.

This fourth influence - the military tradition - was one which, like that of religion, produced rapid progress towards virtuous but rigid ideals in nursing, and /

and thereafter tended to deform its own growth. The association of nursing with war was perhaps in part responsible for the reluctance of many people to accept the preventive and teaching aspects of health work as "real" nursing.

Finally, the close association of nursing with medical science, as well as with socio-economic problems at all stages of life, inevitably precludes the formation of a static concept of nursing function. Like profession-:alism, it is a "dynamic process".

> "Modern methods of medical treatment have affected the work of nurses in both the hospital and the public-health field. The introduction of chemotherapy and antibiotics is modifying the nursing care required and adding new demands. Early ambulation and early discharge from the hospital create the need for more instruction of the patient in self-care, more teaching of the family to prepare for the early return to the home, and a greater integration of the hospital and the public-health services in order that continuity of care between hospital and home may be provided. More radical surgery necessitates a more skilful nurse. Increased emphasis on rehabilitation requires the assistance of a nurse with an understanding of the principles and methods of rehabilitation, and the ability to teach. As psychiatry and psychosomatic medicine play a more active part in the care of all patients, the nurse is expected to include the /

the aspects of mental health, and especially the principles of mental hygiene, in her nursing care. As public health and medicine advance, a share of the responsibility for the prevention of disease and the promotion of health falls to the nurse."
(World Health Organisation, 1954)

Not only in the clinical and social fields is the role of the nurse changing. She is expected to serve on hospital planning committees, participate in work study and research programmes, administer independent nursing schools and university departments and to act as consultant to government departments. Yet in spite of its continually widening perspective, nursing must retain its personal and unique responsibility toward the patient:

"The nurse is the one functionary of the hospital who is at the patient care unit continuously. All others, including the physician, come and go. The nurse is the coordinator, the mediator and the observer for all the patient services. To participate in all these events, she must understand herself, her own involvement, her attitude toward disease, toward people and toward the work situation. The nurse must understand the principles of organisation and administration because, in reality, whether she likes it or not, she has become de facto administrator in the complexity of patient care."
(Mauksch, 1965)

Unless /

Unless there is a clear understanding of the responsibilities involved in nursing service, nurses cannot be prepared to fulfil them, nor can steps be taken to make sure that their time and energies are not wasted in non-nursing duties.

The first problem - the continuing controversy within the nursing profession over both basic nursing curricula, and over the methods by which nurses should be prepared for positionsin administration and teaching - suggests that there is still some confusion and dis-:agreement about the aims of nursing education.

(See Section 2.2)

The second problem - the need to distinguish between work which requires the skills of a trained nurse and work which can safely be carried out by other members of the health team - is particularly relevant in a society which apparently suffers from a chronic shortage of nurses. In 1946 a Working Party on the Recruitment and Training of Nurses was appointed under the auspices of the Ministry of Health, the Department of Health for Scotland and the Ministry of Labour /

Labour and National Service, "to review the position of the nursing profession" prior to the increase in the demand for nurses which was expected to result from the establishment of a National Health Service. It was asked "to assess, if possible, what nursing force, in terms of quantity and quality, is likely to be required ..." First on the list of questions which the Working Party was to examine was: "What is the proper task of the nurse".

In 1947, the Working Party published its Report. It contained a mass of valuable material but, as the Nuffield Provincial Hospitals Trust pointed out, failed to answer the first question or to provide data on which an answer could be based. Many of its conclusions seemed to indicate the need for one.

Dr. John Cohen was unable to agree with the findings of the Working Party and published a Minority Report (1948.a) in which he stated briefly that a nurse's function was "to reduce the incidence and duration of sickness /

sickness" - a definition which need not apply exclusively to nursing.

The Nuffield Provincial Hospitals Trust, having expressed its dissatisfaction with the findings of the Working Party, initiated "a complete job analysis of the work of the nurse and other members of the health team in order to obtain the necessary data so that an answer can be given to the fundamental question 'What is the proper task of a nurse?'" Its report, The Work of Nurses in Hospital Wards, appeared in 1953. The advisory panel recommended that basic and technical nursing should be done by trained nurses, stating that this was their "proper task" and should not merely be supervised by them. It also recommended that the work of student nurses should be planned in accordance with their training needs. These subjects are still being debated.

Studies based on the work which nurses are seen to be "doing" have limitations, and can obscure aspects of nursing care which are not so easily observed or analysed. Ouseley (1959) has said that "nursing is, at root, a specialised form of human relationship", and it is unlikely that /

that any one interpretation of nursing will satisfy all nurses, or all patients. But Virginia Henderson is the author of a passage which, of all the attempts to define nursing, is perhaps the most frequently quoted as a description of a nurse's function:

> "To assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. It is likewise her function to help the individual gain independence as rapidly as possible."
> (Harmer & Henderson, 1960)

It remains the responsibility and prerogative of each nurse to express her personal values in nursing practice. In Nursing for the Future Brown (1948) quotes from an unpublished annual report by the director of nursing in a large teaching hospital:

> "Quality of nursing service cannot be measured simply by whether or not separate therepeutic measures have been carried out as specifically ordered. A basic requirement for good nursing is that it must be individualised, that it must include sensitivity to, ability to respond to and deal with the mental and emotional reactions which accompany physical aspects of illness ... it is the nurse who is with the patient at all hours of the day and night and must meet situations and answer questions which cannot be escaped. These things are the essentials of nursing care."

2.2 : Nursing Education and Nursing Practice.

2.2.1 : Development and control of nursing education.

The development of nursing service and nurse training has been persistently influenced by the fact that the care of the sick in many ways resembles the care required by small children, and has therefore been seen simply as an extension of "motherly instinct". In a patriarchal society, this concept of nursing has been (and still is, to some extent) reflected in the opposition which members of the pre-:dominantly male medical profession have shown toward attempts to improve the education of nurses - an attitude which has a counterpart in the opposition of the nursing profession toward male nurses.

The development of medical science was associated with a type of education from which women were until recently excluded. In the twelfth century, it was male students who flocked to centres of learning in Bologna, Paris and Oxford where special instruction was already being given in medicine, law and theology. Whatever education was considered suitable for women was given in the home or in religious institutions. Four centuries later, Fénelon's treatise On the Education of Girls initiated what was, even then, a new approach.

"The /

> "The very fact that it discussed the education of girls at all was of great significance at a time when ... better class girls were either left uneducated or trained in a narrow illiterate piety in convents. Fénelon himself had no very high ideal of womanhood ... Women in his opinion have no need of much of the knowledge that men possess ... 'It is enough if one day they know how to rule their households and obey their husbands without arguing about it.'"
> (Boyd, 1952)

In 1857, when plans were being discussed for the establishment of a training school for nurses at St. Thomas's Hospital,

> "a strong party in the medical world thought that nurses did very well as they were, and that training would merely result in their trespassing on the province of the doctors ... Strong opposition came from within St. Thomas's itself, led by the Senior Consulting Surgeon, Mr. J.F. South ... He argued that the sisters learned by experience and could only learn by experience, that the nurses were subordinates 'in the position of housemaids' and needed only the simplest instruction, such as how to make a poultice."
> (Woodham-Smith, 1955.a)

The apprenticeship system of nurse training has persisted. Because many nursing skills are practical, students must be given experience in carrying out clinical procedures, and be able to take a certain amount of responsibility for doing so, before becoming fully qualified /

qualified. As a result of this, and also until recently for economic reasons, many hospital authorities have been dependent on student labour. The Nuffield Report on The Work of Nurses in Hospital Wards (1953) stated that 74% of time spent on nursing duties was contributed by nurses in training.

> "Ten years later, the familiar pattern of the service demands of the hospital taking precedence over the educational needs of the student remains the major obstacle in the path of progress. In practice the so-called student is more in the position of a junior employee in the hospital service than of a student being educated to become a qualified member of a profession."
> (Rcn, 1964.a)

"Reports", said Miss Nightingale, "are not self-executive".

At the present time, statutory control of nurses' training is maintained through the General Nursing Councils, one for England and Wales and one for Scotland, which were first set up under the two Nurses Registration Acts of 1919. In 1943, Enrolled Assistant Nurses were given statutory recognition, but the word "Assistant" was subsequently removed from their title. In 1951, the Nurses (Scotland) Act consolidated all previous "enactments relating to nurses for the sick in Scotland". With certain exceptions, only persons who are registered /

registered or enrolled according to the terms of the Act are permitted to use the title nurse. (Part 1, Section 12)

The statutory duties of the Council are:

"(1) to register nurses who qualify for registration;
(2) to enrol nurses who qualify for enrolment;
(3) to draw up rules;
(4) to undertake responsibility for setting examinations and maintain-:ing standards;
(5) to frame disciplinary rules;
(6) to deal with those who contravene the Act;
(7) to undertake responsibility for approving hospitals as training schools;
(8) to withdraw approval of training school status from a hospital;
(9) to inspect training schools." (1)

At the present time there are four parts to the register: a general part, and supplementary parts containing the names of nurses trained in the nursing of sick children, nurses trained in the nursing and care of persons suffering from mental diseases, and of those suffering from mental defect. Apart from the maintenance of these registers, the functions of the General Nursing Council may be summarised as being "concerned with the approval of hospitals for the training of nurses and the conduct of examinations to enable nurses to qualify". (1)

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(1) Extract from information supplied by the General Nursing Council for Scotland, 1965. The Constitution of the General Nursing Council for Scotland is given in Appendix 1.

There are now, therefore, two distinct types of course leading to a statutory qualification in basic general nursing: training for the register and training for the roll.

(a) Training for the register occupies a period of three years. Candidates must be over 17½ years of age before starting their training and have passed at least two subjects at Ordinary level in the Scottish Certificate of Education, one of which must be English. On completion of training students are required to take the examination of the appropriate General Nursing Council. If successful, they are admitted to the Register and permitted to use the title Registered General Nurse (R.G.N.) in Scotland and State Registered Nurse (S.R.N.) in England and Wales. There is reciprocity between the two councils.

The majority of nurses complete general training first, but at present training for the supplementary parts of the register may be taken either as initial courses or following general registration. A new syllabus /

syllabus has been approved by the General Nursing Councils (operative, in Scotland, since 1964) giving students in general training a wider basic experience, including maternity nursing, work with the mentally ill, and public health.

(b) Training for the roll occupies a period of 2 years At present, no minimal educational standard is required for entry. Training is predominantly practical and the General Nursing Council is responsible for the final assessment of the pupil. Although the need for a recognised second grade of nurse was stressed as long ago as 1938 in the report of the Inter-departmental (Athlone) Committee, the value of the enrolled nurse has not always been fully appreciated either by nursing or medical staff and "hospital authorities which have previously conducted a general training school and have had to change to enrolled nurse training have regarded this as a down-grading of the hospital" (Rcn, 1964.b). In spite of efforts by the General Nursing Council to stimulate interest in this type of training, recruitment has been slow - a fact which could have a delaying influence on plans to /

to raise the educational standard of the registered nurse and to give student nurses student status.

Information regarding the number of nurses in training in Scotland is given in Appendix 2.1.

The present study is mainly concerned with registered nurses engaged in general nursing, but in rural areas and small hospitals general work is frequently combined with midwifery. The "second oldest profession" has a history of its own and is structurally independent. The first Central Midwives Board was set up in England following the passing of the Midwives Act in 1902 and a similar Act was passed for Scotland in 1915. Registered General Nurses may qualify as State Certified Midwives by taking one year of training and passing the examinations of the appropriate Central Midwives Board.

2.2.2. The work of qualified nurses.

On completion of training, the enrolled nurse continues to carry out "bedside" nursing unless, owing to her special abilities, she is recommended to take further training to qualify for registration and so, ultimately, for greater administrative responsibility.

For /

For the newly registered nurse, there are several possible courses of action, the most popular being:

- to work as staff nurse in the same type of hospital as the one in which she has trained (i.e. general, sick children's or psychiatric);
- to undergo training in a different type of nursing;
- to get married.

Although marriage is the major cause of "wastage", other contributing factors have for a long time been a subject of speculation. In 1956, the Dan Mason Research Committee made a survey of the work undertaken by nurses within 2½ years of qualifying. The study was based on 866 postal questionnaires completed by nurses in England, Wales, Scotland and Northern Ireland. This represented a 76.6% response. It was found that 93.2% of these had worked for at least a short time as staff nurses, and, at the time of the survey:

- 44.4% were in hospital practice,
- 20.0% were married housewives,
- 10.6% were practising midwifery,
- 15.2% were engaged in other types of nursing, including 4% who were already overseas,
- 1.9% were engaged in other occupations.

For registered nurses who do not become part of the "wastage" figures /

figures, choice of work is varied. The present trend seems to be to gain some experience as a staff nurse, to take midwifery training, and perhaps to go overseas for a year or two before deciding to settle down in one part-:icular type of work.

(a) Nursing in hospital is becoming increasingly specialised but the vertical structure, except at the top, still follows a traditional pattern. After approx-:imately two years as a staff nurse, those who remain in hospital usually apply for, or are offered, a post as ward sister. In preparation for this, they may be given leave of absence to take a short course in ward administration. Many nurses find this position satisfying and remain in it indefinitely, or until persuaded to take up teaching or administration. Courses for nurse tutors, normally of two years' duration, are recognised by the General Nursing Council. One-year courses are available in hospital administration, but do not have statutory recognition.

Information regarding the number of qualified nurses employed in hospitals in Scotland is given in Appendix 2.2.

Apart from registered and enrolled nurses, student and pupil /

pupil nurses, there are two other recognised categories of worker in hospital: the unqualified auxiliary and the ward orderly. These are employed respectively in routine nursing and domestic type duties and form the greater part of the staff in those hospitals which do not have the advantage of student labour. Many auxiliaries and orderlies give valuable service, but the use which is made of them seems to vary from one hospital to another, and where there is a shortage of qualified staff they frequently are left to carry out nursing duties. This, together with the fact that their uniform is often difficult to distinguish from that of nurses, sometimes creates potentially dangerous confusion in the minds of both their patients and the general public.

(b) Nursing in the community is mainly the re-:sponsibility of district nurses and health visitors, the latter having been trained more specifically as social workers.

The historical origins of district nursing are difficult to separate from those of other forms of nursing /

nursing service, especially from maternity work:

> "The Hebrew midwives who, according to the Book of Exodus, sabotaged the first (if indeed it was the first) anti-Semitic pogrom, doubtless did a good deal of general district nursing among the tents of Israel. And from time immemorial members of religious orders, both male and female, have nursed the poor in their homes as occasion offered."
>
> (Stocks, 1960.a)

In Britain, district nursing has for a long time been associated with the name of "Queen's". In 1887, three million women contributed to a jubilee birthday present to Queen Victoria. Her Majesty received a personal gift of jewellery, a statue of Prince Albert was erected in Windsor Park, and the remainder of the fund was devoted to "starting district nurses all over England" (Stocks, 1960.b). Queen Victoria's Jubilee Institute of Nurses received its Charter in 1889 and has had considerable influence over the development of rural nursing services in various parts of the British Common-:wealth and in North America.

With the passing of the National Health Service Acts in 1946 and 1947, district nursing became the statutory responsibility of local health authorities and an Advisory Committee /

Committee was set up to approve training courses and examinations. Such schemes may be operated either by local health authorities themselves or by some training organisation. In 1959 a minimum of four months was established as the training period required of registered nurses. The Queen's Institute, which had fought strongly against the new proposals, eventually decided to conform to the regulations of the Advisory Committee, and still continues (1966) to provide courses of training. Some local health authorities have initiated their own train-:ing programmes, while others employ nurses in domiciliary work without requiring them to take special training.

> "It is certain that the pattern of district nurse training, in harmony with that of British local administration as a whole, will remain chaotic and wholly illogical; only explicable to bewildered foreigners in terms of historical accident. The one general principle applicable to it, will be the principle of allowing as many people as possible to go their own way ..."
> (Stocks, 1960.c).

The employment of enrolled nurses in a domiciliary capacity, working under the supervision of a registered nurse, has been found successful in some areas, although it /

it is argued that the responsibility of district nurses for total family care, particularly in rural communities, and her role as adviser and teacher rather than as a carrier-out of technical procedures, limits the extent to which the enrolled nurse is able to give effective service in this type of situation.

In 1964 only 10 enrolled nurses were employed in domiciliary work in Scotland. (See Appendix 2.4)

Health visitors are registered general nurses who have had at least six months' training in midwifery and possess the Health Visitors' Certificate. Late in the 19th century "female sanitary inspectors" were employed in Glasgow, and Dundee appointed two health visitors in 1903. But there was no organised training course until 1919 when the Scottish Board of Health issued "Conditions for the Certification and Registration of Health Visitors". Two types of training were at first provided, one for trained nurses and the other for persons who had no nursing experience. Since 1932 all health visitors have been registered nurses and there is now a variety of training schools, organised in a variety of different ways /

ways by local health authorities, technical colleges, universities and the Royal College of Nursing.

At present, only female nurses may qualify as health visitors but the following statement appeared in the Annual Report (Rcn, 1965.a) of the Royal College of Nursing and National Council of Nurses of the United Kingdom:

> "Following an invitation from the Secretary of State for Scotland to consider recommend-:ations on the question of employing men in health visiting ... the Scottish Board sub-:mitted the view that health visiting should be open to men with similar qualifications to women ... that they should have a specially designed obstetric course and generally take the same course as women with minor adjustments in practical work; that they should be eligible to receive the Council's certificate, and should not be channelled into very specialised fields."

The Council for the Training of Health Visitors was established under the Health Visiting and Social Work (Training) Act (1962). Its duties are mainly concerned with the approval of training courses and the conducting of examinations in accordance with the needs of health visiting. These are indicated in the report of An Inquiry into Health Visiting (Ministry of Health ... 1956):

"The /

> "The functions of Health Visitors should primarily be health education and social advice; they may usefully undertake other functions but these should arise from or be incidental to their primary functions. In carrying out all their functions, Health Visitors should have full regard to the needs of the family and the part played by other workers."

In some areas, mainly where there are large concentrations of population, the home nurse, domiciliary midwife and health visitor fulfil separate functions. In rural areas they are frequently combined in one person. The district nurse who is also a State Certified Midwife may be responsible for conducting home confinements and, in some cases, is expected to carry out the duties of health visitor even although she may not hold the Health Visitor's Certificate. This arrangement may be a device for overcoming shortage of staff, but the system has its advantages so long as the "combined duty" nurse is qualified to carry out all aspects of her work.

Information regarding the number of district nurses and health visitors employed by local health authorities in Scotland is given in Appendix 2.4.

2 /

2.2.3. Some problems of nurse education

Planning for nursing education presents complex problems. The only aspects discussed here are those about which respondents in the present study expressed an opinion, directly or indirectly, or which seem relevant to the general understanding of the survey.

The requirements of nursing education are inevitably related to those of nursing practice:

a) theoretical - the scientific knowledge which is also the basis of medical practice;

b) practical - the skills required to carry out technical procedures;

c) psychological - the understanding of the emotional needs of people, particularly sick people, and of those who care for them.

The first problem is how to co-ordinate these three aspects. The criterion of an effective nurse training programme is the ability of nurses to cope satisfactorily with all situations in which the three aspects impinge upon one another.

Second, there are conflicting views regarding the type of person who is best suited to nurse. One view is that a nurse must have a reasonably high degree of intelligence and a good standard of education, so that she /

she is capable of appreciating the total needs of the patient, of planning and organising nursing care, and of taking full responsibility for her decisions. The other view is that the personality of the nurse is more important than her mental ability; that she works under the direction of the doctor, and that intelligence and initiative are, if anything, a disadvantage. In Britain, the establishment of two statutory grades was a recognition of the fact that nursing requires different kinds of ability: "bedside" nurses, as well as administrators and teachers.

Third, having identified the requirements of nurses and nursing service, there is the question of how best they can be met. The problem mainly concerns the preparation of the registered nurse. The idea that her education should be the responsibility of an educational institution is gradually gaining acceptance and in several countries has already been implemented. There are two suggestions: that nursing schools should either become part of institutes of higher education (universities or technical colleges) or that they should be organised independently on a regional basis. In either case, there should /

should be collaboration with hospitals and local health authorities in the area, to provide practical experience for the students.

Although such experience should be planned according to the learning needs of each student and not according to the immediate service needs of the hospital, it seems desirable that students should take an increasing amount of responsibility and, in their final year, become fully participant members of the nursing team. In this respect, one of the major difficulties is to know who should take over the work now being performed by first and second year students. The number of State Enrolled Nurses now being trained is insufficient for the purpose. (Appendix 2.1.)

A pre-requisite of any attempt to improve the standard of nursing education would be a higher minimum standard of education for entry to the profession. Before World War II, educational opportunities and the choice of careers for girls were limited. Of those who were obliged to leave school at fourteen, for economic or domestic reasons, many obtained employment in local hospitals ("free"

board /

board and lodging gave the more adventurous ones a chance to leave home which they might otherwise not have had) and eventually completed nurse training. It may be assumed that at least some of these girls had the potential ability to make good use of further education. Nursing has benefited from their lack of opportunity. The profession at the present time includes many older women who, although lacking advanced formal education, have contributed large amounts of wisdom and common sense to all branches of nursing.

To-day, with its modest entrance requirements and its somewhat tattered halo, nursing is less likely to attract the teenager with a good school record who has the opportunity to continue her academic career at a university. A number of these do enter nurse training but, generally speaking, few hospital schools cater for them. More time is spent trying to push less able students toward the minimum requirement of the General Nursing Council than in helping the more intelligent students to reach their own maximum; there is still a tendency to believe that a kind heart and gentle hands are /

are rarely found in conjunction with a good head.

The wide range of mental ability represented by a class of student nurses is itself a problem to both teachers and students. But there are different kinds of intelligence, and thequalities required in nursing are not easy to define.

In 1961, a committee was set up by the Royal College of Nursing under the chairmanship of Sir Harry Platt to consider all aspects of nurse education and to make recommendations. Its first report, A Reform of Nursing Education (1964.c), suggests that schools of nursing should be financially and administratively independent of the hospitals which provide practical experience for the students and that "the minimum educational requirements for entry to the School of Nursing should be passes in the General Certificate of Education at ordinary level in not less than five subjects". It also states that :

> "Educational standards are not, however, the only criteria of importance in the selection of the student of nursing. Aptitude and personality are vital factors in determining suitability and should be taken into account, although they are not easy of exact assess-:ment. It would seem that there is a need for /

for further research with a view to establish-
:ing basic criteria of aptitudes and personality
to be used in the selection of nursing students."

This report has stimulated a good deal of discussion among nurses who would like to see some definite action being taken to improve standards of training. But an educationist has stated that:

"The report lacks the statistical and factual
data which we in the educational world look
for as a matter of course in a report on, say,
the supply and training of teachers. The
Committee seems to have made no real investig-
:ation into the present situation ... This
lack of factual backing is so fundamental a
weakness that in my view the report provides
topics for discussion but not a basis for
action." (Stephens, 1964)

The General Nursing Council for England and Wales had other reasons for not accepting the recommendations of the report; it sent a memorandum to the Ministry of Health drawing attention to measures taken over recent years to improve nurse training, and stating that:

"The Council do not consider that the need
for a reform as drastic as that envisaged
in the Report is either necessary or
desirable at the present time."

The full text of the Council's memorandum was published in the Nursing Times, 1.10.65.

University /

University education for nurses is an ambiguous term. Seymer (1957.b) described the American pattern:

> "The term 'affiliation' is apt to be loosely used to designate almost any kind of connection between university and training school; it may mean anything from a few lectures given by university professors in a nursing school attached to a university, to a completely independent school in a university ... or again it may mean that a university gives facilities for post-graduate work [i.e. after 'graduation' from a school of nursing], such as diploma in nursing, or courses in public health or administration. On the whole, connections between training schools and universities seem to be multiplying and their co-operation in the teaching of nurses will doubtless be of increasing value."

In Britain, the pattern seems to have been similar, but has developed more slowly. The University of London has been associated with courses for nurse tutors since 1918 and there have been "affiliations" with a number of other universities. The first to participate in a basic nursing course was the University of Southampton: a scheme was started in 1957 in conjunction with the Nightingale Training School at St. Thomas's Hospital, London, but the course did not lead to a degree. A special shortened course of nurse training is available at St. Thomas's to graduates of British Universities. Since 1959, the University /

University of Manchester has awarded a Diploma in Community Nursing (a combination of training for General State Registration, Health Visiting and District Nursing) in conjunction with Crumpsall Hospital.

A Nursing Studies Unit was established in the University of Edinburgh in 1956 and provided post-registration courses in education and administration. Four years later, Edinburgh became the first university to offer undergraduates the opportunity to work for a degree (M.A. or B.Sc.) and at the same time, within a period of five years, to complete a nursing course which would enable them to qualify as Registered General Nurses. Practical nursing experience is arranged with the co-operation of Edinburgh hospitals and the Edinburgh Corporation health authorities.

Facilities for nurses to study the physical and social sciences within a university department should ensure that their theoretical knowledge of these subjects is adequate. Planned practical experience in hospital and in the public health field should give them better understanding /

understanding, and increased skill in the carrying out, of technical procedures. But if "nursing is, at root, a specialised form of human relationship" (Ouseley, ibid.) then nursing itself is the most difficult "subject" to define and to teach. It requires continual re-evaluation of both the curriculum and its context, of the perform-:ance of those responsible for nurse education and of the service which patients receive.

2.3 : Nursing Ethics

Statutory regulations control standards of nurse training and nursing practice by specifying the theoretical knowledge, technical skill and practical experience which a nurse must acquire before she can be "registered". They also specify the remuneration to which she is entitled in return for her services. But the effectiveness of the contract depends on some-:what intangible criteria based on values which are presumably accepted, in some degree, by both clients and practitioners. It involves nurse teachers and their students as well as patients and nurses.

Personal involvement seems to be something which is "expected" of nurses. It is interesting to note that Miss Nightingale required a monthly report from the matron of St. Thomas's Hospital on the Personal Character and Acquirements of her probationers. "Strictness was necessary. The Nightingale nurse must establish her character in a profession proverbial for its immorality." (Woodham-Smith, 1955.b) The purpose was to raise the standard of

of/

of nursing and, as a result, to raise the status of the nursing profession.

Standards of behaviour required in nursing are presumably no different from those operating in other situations. In 1953 the International Council of Nurses adopted a "Code of Nursing Ethics"; in 1965 the Code was revised and the title changed to "Code of Ethics applied to Nursing". (Appendix 3.2.1.)

In its introduction the Code states the general obligations inherent in nursing service:

> "Nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery and stress the prevention of illness and promotion of health by teaching and example ...
>
> Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession ... Professional nursing service is based on human need and is therefore unrestricted by considerations of nationality, race, creed, colour, politics or social status."

The fourteen rules which follow this statement deal with the need for nurses to maintain high standards of practice; to respect personal confidences, religious beliefs /

beliefs and cultural patterns; to co-operate with "other citizens and health professions"; to accept only the remuneration which has been contracted for, and to refrain from personal advertisement.

The Code draws attention to some conflicting aspects of professional nursing responsibility which, although they do not take the same form in all countries, are likely to become more common in societies where educational opportunities are increasing, where welfare services become socialised and where social status founded on Western standards becomes an increasingly important goal.

In Britain, the ingredients of such conflict seem to exist in all types of professional nursing relationships: with patients, doctors, lay administrators, members of other "health professions" and with other nurses. Corwin (1961) has described the situation as he found it among American nurses:

> "It is apparent that there is not one but at least three dominant conceptions of nursing - an office, a profession, and a calling. These provide alternative identities for the nurse who is at the same time a hospital employee (or a bureaucrat), a responsible, independent professional, and a public servant (when in a religious or humanitarian context). Each identity provides /

> provides a different source of loyalty - to the local administration, to professional principles and associations that transcend the local place of employment, and to the patient. There is reason to believe that the three ideal conceptions of nursing involve incompatible demands."

However conscientiously nurses may try to obey the International Code, they will be faced with incompatible demands. Practical examples may be taken from a variety of situations.

First, a change in the relationship between nurses and patients may be the result of social changes. Specialists in various occupations allied to medicine have become part of the "health team" and have taken over responsibilities which were formerly those of a nurse or doctor. This could result in better service to the patient, providing him with more expert care and protecting him from the weaknesses and prejudices of the general practitioner. On the other hand, the extent to which nurses feel obliged to "hold in confidence all personal information entrusted to them" must inevitably be influenced by the need for such information to be shared by other members of the team, if the other members are better qualified /

qualified to assess its importance. There is conflict between the right of clients to receive "only the best service" and the obligation of nurses not to divulge "personal information".

Second, the professional relationship between nurses and doctors is difficult to define. It seems to vary a good deal in different countries, and even between different areas of the same country. But many nurses are aware (even if doctors are not) that "an obligation to carry out the physician's orders intelligently" may present them with the problem of having to decide whether to carry them out at all. This problem arises in many different circumstances but is possibly more common where doctors are practising in a cultural environment which is unfamiliar to them, or where rapid advances in medical techniques require nurses to make decisions for which there is no precedent, for example, with regard to the instigation of cardiac massage.

Third, the Code states that nurses should co-operate and maintain "harmonious relationships" with nursing /

nursing colleagues. Because nurses frequently appear reluctant to express views which are likely to be in opposition to those of senior staff, it would seem that they would perhaps fulfil their professional obligations more satisfactorily - and eventually achieve more genuinely concordant relationships - if they could be persuaded to discard a traditional and sometimes misleading appearance of harmony.

The opposite could be said of professional nursing associations. Rivalries between them have produced some of the most violent conflicts in the history of professional nursing. To refrain from action which threatens to destroy "harmonious relationships" could, in certain circumstances, be considered more unethical than attempts to preserve them.

There are obvious limitations to the guidance which can be given by a written code of behaviour, and Corwin (op. cit.) drew attention to "one of the curious /

curious puzzles of society - the fact that people do not always *do* what they believe they should". Group standards can only be maintained at a level consistent with the standards of the individuals who comprise the group.

As with other aspects of professional practice, the responsibility rests finally with the individual. The I.C.N. Code seeks to protect the personal rights of clients, but it also acknowledges the rights of the practitioner:

> "The profession recognise that an international code cannot cover in detail all the activities and relation-:ships of nurses, some of which are conditioned by personal philosophies and beliefs."

This involves the ethics of education, as well as of nursing: to what extent should teachers attempt to inculcate students with their own personal philosophies and beliefs? The question concerns those engaged in health teaching, whose job it is to "stress the prevention of illness and promotion of health by teaching and example", as well as nurses who are responsible for the education of nurses.

In /

In the first case, district nurses and health visitors are familiar with the difficulty of trying to persuade their clients to mend their ways in the interests of health while they (the nurses) are guests in their clients' homes to which they have no right of entry except by invitation.

In the second case, although a code of ethics cannot be described or demonstrated in the same way as a physical law or technical procedure, it is presumably the responsibility of nurse teachers to acquaint students with the obligations involved in professional practice. The way in which these are "put over", whether in the lecture room or in the practical situation, is likely to have as much as, possibly more influence on the students' attitudes than are the ideas as expressed in the written Code.

Failure to prepare nursing students adequately, in any branch of their education, appears to be just as "unethical" as the failure of practising nurses to fulfil the obligations of "professional" nursing service. This involves the whole subject of nurse education /

education. A study of its historical development suggests that authoritarian methods may actually have inhibited the germination of professional attitudes and values, by discouraging the exercise and expression of independent judgement and by confusing discipline with blind obedience.

But there is some reason to believe that the attitude is changing. The following is an extract from an editorial in the Nursing Times, (11.11.66) and seems to have a wider application than to "The Ethics of Abortion", the title under which it appeared:-

> "Time was when nursing ethics was a subject taught in the nurses' class-:room and was sometimes concerned with the wearing of uniform, professional behaviour and opening the door for the doctor. That time is past.
>
> Nurses now have to make ethical decisions which tax the wisdom of theologians and of physicians. 'Thou shalt not kill, but need'st not strive, officiously to keep alive' is a phrase which must have passed through many a nurse's mind when faced with many a patient. But the whole instinct of the doctor and the nurse must always be to preserve life ..."

2.4 : Nursing Organisations.

In the early days of nursing reform, during the latter part of the last century, solidarity among nurses was slow to develop. There were leaders of nursing but few leaders of nurses. Seymer (op. cit.) has pointed out several possible reasons. The amount of effort required to fulfil their arduous responsibilities left little time or energy for other activities; there was more rivalry than co-:operation between the newly formed nurse training schools, and their boards were almost entirely controlled by men. Also, the idea of professional and women's organisations was less familiar than it is to-day.

By the 1880's a variety of people were calling themselves "nurses". In the public interest, and also to protect their own position, a group of ex-lady-pupils (1) initiated a move to establish a register of qualified nurses. They were led by a former matron of St. Bartholomew's Hospital, Mrs. Bedford Fenwick, who believed that only daughters of the higher social classes /

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(1) trainees under Miss Nightingale's scheme for preparing "ladies" for responsible positions in nursing.

classes should be permitted to enter nursing and that legislation was necessary in order to maintain their control of it.

Miss Nightingale opposed registration, chiefly on the grounds that candidates would have to be assessed by examination and that nursing ability could not be evaluated in this way. It was also felt that to narrow the field of recruitment on educational grounds was unwise, and that some "domestic servants" possessed personal qualities which suited them very well to become nurses, if they had the training. The struggle for registration was long and bitter, "a battle for status conducted against a background of rampant snobbery and militant feminism". (Abel-Smith, 1960.c).

It was the first of many issues which were to divide the nursing profession, but it also produced the first professional organisation. The British Nurses' Association was established in 1887, with Mrs. Bedford Fenwick as president. A Royal Charter was granted five years later and the Royal British Nurses' Association/

Association became the first organisation for professional women to be so incorporated (Seymer, 1957.c). Its history during the next thirty years continued to be closely associated with issues related to the statutory control of nursing practice and nurse training. The Association continues to exist, but in an attenuated form.

A second attempt to achieve co-ordination of the nursing profession on a national scale was made during World War I, when confusion between the status of trained civilian nurses and V.A.D.s emphasised the urgent need for unity. The College of Nursing was founded in 1916, its main objects being to promote better education and training of nurses, to approve training schools, and to maintain a register of those to whom certificates were granted.

The College had the support of the nurse training schools and its membership increased rapidly. Attempts to amalgamate with the Royal British Nurses' Assoc-:iation were unsuccessful, but a growing number of nurses in both groups favoured statutory registration and /

and in 1919 each organisation presented its own bill to Parliament. Their differences were mainly concerned with the membership of the proposed General Nursing Council. The Minister of Health eventually gave up his attempts to reconcile the two, introduced his own bill and, following its enactment, appointed the nurse members of the Council.

These early attempts at professional organisation among nurses seem to have contained all the conflicting elements of professionalisation: the desire of practitioners for status, power and responsibility, the need of the client for a high standard of service and for protection from exploit-:ation.

The College of Nursing was incorporated by Royal Charter in 1928 and was granted the title of "Royal" in 1940. It is now by far the largest and most powerful of the nurses' organisations with approximately 42,000 members (Rcn. Annual Report, 1965. b). It was established with three main objectives;

> "- the introduction of a uniform standard of training, the provision of means of professional development and the betterment of salaries and conditions of service. These three objectives were seen and have always been seen by the Rcn as the three constituent parts of a whole, the whole being described in the modern Royal Charter as 'the advancement of nursing as a profession in all or any of its branches'." (Rcn. Nursing Times, 9.7.65).

The College has developed an active Education Division and has 8 representatives on the Nurses and Midwives Whitley Council (see Appendix 1.2).

Another form of nurses' association is the nurses' "leagues": alumnae associations of individual training schools. As early as 1904 some of these had affiliated with the National Council of Nurses of Great Britain and Ireland, through which they were represented at international level (see p. 70).

As the Royal College of Nursing increased its influence, many of its activities duplicated those of the National Council. In 1963 the two organisations amalgamated under the title of the Royal College of Nursing /

Nursing and National Council of Nurses of the United Kingdom, with the officially approved form of abbreviation: Rcn.

The Scottish Health Visitors' Association was established in 1919 under the name of the Health Visitors' and Women Sanitary Inspectors' Association. It acquired its present title in 1945 and at that time had a membership of 140 out of a total of 288 health visitors employed in Scotland. There are at present (1966) 600 members, out of a total of nearly 1000 qualified health visitors employed in Scotland. (1) Membership is restricted to nurses holding the Health Visitors' Certificate or "such qualification as is acceptable to the members of the Association" (Clause 3 of the Constitution).

The objects of the Association, as stated in the revised constitution of 1959, are as follows:

(a) To promote and protect the interest of the members under Clause 3 of the Constitution.

(b) To advance professional education and the interchange of knowledge and information amongst members.

(c) To advise and help individual members.

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(1) According to the 1965 Annual Report of the Rcn (Scottish Board) there were 526 members of its Public Health Section. This includes district nurses and health visitors.

The Scottish Health Visitors' Association is represented by one member on the staff side of the Nurses and Midwives Whitley Council.

The English Health Visitors' Association is a separate organisation but a "friendly relationship" exists between the two bodies.

The International Council of Nurses is a federation of national nurses' organisations. It was founded in 1899, partly due to the efforts of Mrs. Bedford Fenwick, and is the oldest international organisation of professional women. It stated that:

> "The essential idea for which the International Council of Nurses stands is self-government of nurses in their associations, with the aim of raising ever higher the standards of education and professional ethics, public useful-;ness and civic spirit of their members."
>
> (Seymer, 1957.d)

It is interesting that the "essential idea" included the four factors which are frequently stressed as the "essence" of professionalism: service, ethics, education and organisation. To-day, when membership of the I.C.N. is much sought after for its prestige value /

value, especially by developing countries, the Council makes it clear that the primary aim of forming a national association must be to improve the nursing service of that country, and not simply to qualify for membership in an international federation.

In March 1966 sixty-three countries were in membership with the I.C.N. (Appendix 3.2). An International Congress is held every four years, each year in a different country. In 1965, the Frankfurt Congress was attended by five delegates from each member country and by 6500 observers.

The original office of the I.C.N. was in London, England. It remained there, except for temporary transfer to the U.S.A. during World War II, until August 1966, when it was transferred to Geneva.

The I.C.N. has been in official relationship with the World Health Organisation since 1948, and is regularly invited to send a representative to the W.H.O. Assembly, Executive Board and Regional Committees. It is also in relationship with the Red Cross, U.N.E.S.C.O., U.N.I.C.E.F., and various medical organisations.

(Information regarding other major British nursing organisations is given in Appendix 3.)

2.5 : Professional responsibilities.

Leaders of the nursing profession are frequently heard to deplore the fact that only a small percentage of nurses are members of their professional organis-:ations, and that few of those who do become members take an active part in "professional" activities. Exhortations to remedy the situation are all too familiar a feature of the nursing press:

> "By and large nurses are not alive to the need to be strongly organised. They tend to be indifferent to member-:ship of organisations or else dissipate the strength of the profession by joining different types of organis-:ations. No profession can afford to squander its strength in this way. Nor can it afford to hand over control of its affairs to those who are not members of the profession. To do so is professional suicide and the surest and most rapid means of losing its identity." (Rcn. Nursing Times, 14.1.66.)

It may be argued that nurses are no better or worse in this respect than members of any comparable group - but is there a comparable group? Barker (1965), writing in the Guardian, suggests that

"Nurses /

"nurses are not, by temperament, articulate ... Membership of the medley of nursing organis-:ations that represent their interests is in the region of 55% ... they are largely passive in relation to their professional position: a state of affairs which makes them good, giving and dedicated nurses."

Although there were no letters in the correspondence columns of the Guardian to contradict this statement, there is no reason to believe that nurse administrators and teachers have ever been unaware of the relationship between professional power and prestige, responsibility and privilege. It seems to be the nurses who are more directly concerned with patient care who show little interest in professional politics. They are the despair of those who, having accepted positions of authority, are often obliged to make decisions on behalf of their nursing colleagues without knowing whether they are carrying out the wishes of the majority. A recent example was the result of the referendum of the Royal College of Nursing, asking members to state whether they were in favour of nurses being paid for working overtime. Only 29.0% of the questionnaires were returned.

"As a class, nurses seem to have little interest /

> interest in politics and even less in trade union matters. They will often complain bitterly about a Whitley provision which in fact has been negotiated on their behalf by their own representatives." (Elliott, 1966)

The question of collective responsibility and self-organisation seems to be closely associated with that of professional awareness, yet Barker's comment implies that professional passivity is an indication of professional "dedication" and that this produces "good" nurses - a view which was by no means shared by all the nurses who took part in the present survey.

In 1905, Miss Adelaide Nutting, later to become the first Professor of Nursing Education at Teachers' College, Columbia University, New York, appeared to have few doubts about the professional status of nursing:

> "We claim, and I think justly, the status of a profession; we have schools and teachers, tuition fees and scholarships, systems of instruction from preparatory to post-graduate; we are allied to technical schools on the one hand, and here and there to a university on the other; we have libraries, literature, and fast growing numbers of periodicals owned, edited and published by nurses; we have societies and laws. If, there-
> :fore /

> therefore, we claim to receive the appurtenances, privileges and standing of a profession, we must recognise professional responsibilities and obligations which we are in honour bound to respect and uphold."

In 1963 Kurtz and Flaming, two sociologists working at the University of Nebraska, questioned 98 general duty nurses on various aspects of their work and their attitudes toward it. The nurses were a "representative sample" but the hospitals were not randomly selected. Their questions were based on a "model of professionalism" and were focused on four characteristics related to nursing: learning and science, unstandardised performance, a code of ethics and state recognition of licence to practise. The authors were mainly interested in nursing as "an occupation that is attempting to achieve professional status" and did not appear to be concerned with nursing itself. But their con-:clusions are interesting both as a comment on the nurses' attitudes and upon their own view of them:

"... it /

> "... it is suggested that nursing as an occupation fails to meet several crucial criteria. However, the responses also indicate that the basic framework of professionalisation of the occupation is already in existence; the implicit con-:clusion must be that further strides in this direction will be taken if serious attempts are made by nurses in the coming years."

It would appear that nurses - at least, those in Nebraska - have not been very active in consolidating the position which Miss Nutting claimed for them sixty years ago.

Along with lack of interest in their professional status and reluctance to support their professional organisations, nurses also seem to suffer from an in-:ability to communicate. Failure to express their views, even when given the opportunity to do so, must inevitably give rise to the assumption that they have none to express. The matter was considered to be of sufficient importance to be a subject of discussion at the International Congress of Nurses held at Frankfurt-am-Main in 1965:

> "Atutor from the U.K. suggested that there was nothing wrong with the power of the average student nurse to communicate on arrival /

> arrival in the training school, but that somehow the system we adopted in hospital deprived her of this power quite early in her training. There seemed to be international agreement upon this sad fact."
> (International Council of Nurses, 1965.a)

The Committee on Senior Nursing Staff Structure comments in its Report (Ministry of Health ... 1966.a) on "the incoherence of the nursing administration itself and a seeming inability on the part of nurses to assert the rights of their emergent profession" as an equal partner with medical and lay administration.

> "It seems to us that the assertion of the professional status of nurses could best be achieved by assuming the right of the profession to be heard ... on all matters concerning nursing that are controlled by governing bodies; to present to those governing bodies the profession's concept of nursing policy; and, so far as possible (that is, where co-ordination with the other administrat-:ions is not involved) to decide the policy." (op. cit.)

This attitude of nurses causes concern to those who see no obvious reason why nurses should not behave in the same way as members of other professional groups. Their concern seems to be based on three assumptions:

first /

first, that the existing professional nursing organ-:isations effectively represent the main objectives of the group and fulfil the needs of individual nurses; secondly, that the values and attitudes which form the basis of professional practice are the same as those which nurses feel to be inherent in nursing practice; thirdly, that the inability of nurses to "communicate" is the result of an educational and administrative system rather than a consequence of nursing itself.

These assumptions appear to have been accepted by the professional nursing organisations, by nurse teachers and administrators, and by many people who have at some time been disappointed and exasperated by what appears to be nurses' inability to put forward their views verbally and coherently on matters which concern their own profession. But the evidence on which these assumptions are based does not seem to have been investigated from the point of view of the nurses themselves.

Nurses do not support their professional organ-:isations enthusiasiically or with the discrimination which /

which the organisations feel they should; but it is not known why they do not, and they do not appear to have been asked. Nurses show little interest in their professional status; and it is not known why, at a time when so many occupational groups are jealous of their "professional" privileges, nurses appear to lack interest in their own position. They seem to have difficulty in expressing their views verbally, but there does not appear to be any record of their having been asked why they seem so reluctant to voice their opinions, even on matters with which they are familiar.

In this context the term "nurse" applies to registered nurses whose work, in normal daily practice, is closely associated with "clients": that is, with patients or potential patients, whether in their homes, in the community, or in hospital. It does not refer to those who are concerned mainly with the administration of nursing service and nursing education.

The purpose of this study is not to try to measure nursing practice or nurses' attitudes against the standards /

standards which a profession requires of its members, but to find out how nurses interpret their respon-:sibilities, as nurses, in areas where professional standards operate.

SECTION 3 : THE SURVEY.

3.1 : The population defined : professional nurses.

In 1934, the Committee on Education of the International Council of Nurses published a report, The Basic Education of the Professional Nurse, which began by drawing attention to the wide disagreement over the meaning of the word "nurse":

> "In some countries there is no word in the vocabulary for 'nurse' ... it is necessary to find a new term or to build a new meaning into an existing term. A good example is found in the old English word 'nursing', which meant originally the nurturing, protect-:ing care given by a mother to the young child. Later the meaning was extended to cover the care of people of all ages and conditions and the nurtúre of plants and animals as well as human beings ... the nursing impulse is universal and nursing cannot, there-:fore, be restricted to any one group nor can it be completely professionalised. In the trained professional nurse, however, the nurturing function is carried to a higher level and extended over a wide area by means of special preparation, knowledge and skill."

In the United Kingdom, there seems to have been reluctance to recognise a distinction. An Inter-departmental Committee on Nursing Services (the "Athlone" Committee) /

Committee) was set up in 1937 "To inquire into the arrangements at present in operation with regard to the recruitment, training and registration and terms and conditions of service of persons engaged in nursing the sick ..." (Ministry of Health, 1939.a) In its Report it stated that :

> "The term 'nursing profession' embraces all the avenues of employment which are open to those who earn their livelihood by the nursing of the sick, or by work allied to nursing in connection with the prevention of illness or disease."
> (op. cit. b)

Of the twenty-one members of this Committee, four were nurses.

At the present time there is controversy over the suggestion that State Enrolled Nurses should be admitted to full membership of the Royal College of Nursing. Although this is in the first place a domestic issue, its result could have far-reaching influence on the relationship between the British nursing profession and nursing organisations in other countries.

The Grand Council of the International Council of Nurses /

Nurses decided at its Quadrennial Congress in 1961

> "that the voting membership of a national nurses' association seeking membership with I.C.N. should be 'composed exclusively of professional nurses', and a professional nurse was defined, in part, as one who had 'completed a generalised nursing preparation'."

The Education Committee of the I.C.N. found subsequently that "the terms 'professional nurse' and 'generalised nursing education' were 'differently understood and used in different countries and were not suitable for use internationally'." The Committee put forward an amended definition which was discussed at the International Congress in 1965:

> "The nurse is a person who has completed a programme of basic nursing education and is qualified and authorised in her country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness and the care of the sick."

The United Kingdom "took exception to the words 'the most responsible' service, expressing its opinion that a definition laid down by an international organis-:ation should not rule out nurses considered qualified and registered in their own country". Finally, the new /

new definition was put to the vote and carried, with only the United Kingdom in opposition. (1) For the purpose of the present survey the I.C.N. definition is accepted. The "most responsible service of a nursing nature" in Britain is supplied by registered nurses, and it is with this group that the study is concerned.

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(1) A full account of the deliberations of the I.C.N. on the subject of the "professional" nurse was published in the International Nursing Review, August, 1965, from which all the above passages are quoted.

3.2 : The Sample : people and places.

The study was limited to four categories of registered nurses who were engaged in general nursing:

(1) staff nurses and (2) ward sisters -

nurses employed in hospitals approved as general nurse training schools by the General Nursing Council for Scotland;

(3) district nurses and (4) health visitors -

nurses employed by local health authorities.

The complex pattern of the British health service prevents tidy classification of either nursing service or nursing personnel and makes the selection of mutually exclusive groups for sampling purposes difficult. There are 2 main causes of confusion.

First, in hospital, although the categories of staff nurse and ward sister are defined by their positions in the staff hierarchy, the patients themselves are not easily divided into "general" and "special" categories according to their diagnoses or treatment. In order to reduce the number of possible variables, maternity, psychiatric and other hospitals catering for one particular type /

type of patient or disease, were deliberately excluded from the survey, but some of the wards in general hospitals are quite highly specialised according to medical interests and the facilities available for treatment. It is therefore recognised that the term "engaged in general nursing" is difficult to qualify in relation to nursing duties.

Secondly, under local health authorities, general, maternity, psychiatric and social services may be inextricably mixed in the person of the "combined duty" nurse. It is therefore impossible to differentiate, not only between different types of nursing, but between different types of nurse. In the present study, all certificated health visitors were treated as one category, regardless of the extent of their duties at the time of their interview.

Nursing staff above the level of ward sister were excluded because it seemed of more value to concentrate on those who are most frequently criticised as being "inarticulate", and because the small area selected for study would not have produced a sufficiently large sample of /

of higher grade staff.

Two types of area were required for the study, one rural, one urban. All information was to be collected by personal interview. As a matter of convenience, Edinburgh was the obvious choice for the urban area. Because resources were limited, it was necessary that the rural area should be reasonably accessible to Edinburgh, but that it should fulfil three requirements:

1) its geographical position must be sufficiently remote to ensure that nurses were not in the habit of travelling frequently into the city to attend professional functions;

2) there must be two or more nurse training schools within the area;

3) the population of nurses available in each category must be large enough to produce the required samples.

The areas eventually selected were:

Urban: City of Edinburgh -

staff nurses and ward sisters at the Royal Infirmary and the Western General Hospital;

district nurses from the Queen's Institute of District Nursing, and Health Visitors employed by the Public Health Department.

Rural /

Rural: the counties of Fife, Perth and Kinross -

staff nurses and ward sisters at the Victoria Hospital, Kirkcaldy, Perth Royal Infirmary and Bridge of Earn Hospital;

district nurses and health visitors employed by Fife County Council, and "combined duty" nurses employed by the Health and Welfare Depart-:ment serving the counties of Perth and Kinross.

Although the most southerly of the counties (Fife) is at its nearest point within 20 miles of Edinburgh, traffic between them was until recently limited by the fact that the railway, the ferry, and a roundabout road route via Kincardine Bridge provided the only means of transport. The rural area was consequently "further" from the capital than its geographical position suggests. Although the opening of the Forth Road Bridge in September 1964 considerably reduced the travelling time between the two areas, it seemed un-:likely that this would have had much effect on the thought and habits of the people by the time the survey was carried out. It was intended to take advantage of the fact that the three counties were within easy reach of Edinburgh, but were unlikely to have been influenced by /

by their newly acquired accessibility.

(a) The Urban Area.

The City of Edinburgh (pop. 473,270) delegates the provision of a home nursing service to the Queen's Institute of District Nursing, which also runs a training school for district nurses. Health visiting is a separate service administered by the Edinburgh Corporation Public Health Department.

The Royal Infirmary of Edinburgh (1,000 beds) was founded in the year 1729. Its nurse training school was modelled on that of the Nightingale School at St. Thomas's Hospital and already by the end of the 19th century had "secured a world wide reputation" (Burdett, 1893). At the present time the school provides training for both the register and the roll but does not accept male nurses.

The Western General Hospital, Edinburgh, (500 beds) is a rapidly developing medical centre having been originally a Poor Law and subsequently a Local Health Authority institution. Its nursing school, which has a very good reputation, trains male and female /

female students for the general register. There is as yet no programme for pupil nurses.

(b) The Rural Area.

Fife is a small county with a varied economy which includes manufacturing, coal mining, fishing, agriculture and tourism. In the west there is an area seriously affected by pit closures, in the east the university town of St. Andrews, in the south naval dockyards.

The county health services are administered from Cupar. The policy regarding the nursing service is to appoint two types of community nurse: the district nurse-midwife and the health visitor.

The Victoria Hospital is in Kirkcaldy, an industrial town with a population of 52,000. The old building has accommodation for about 230 patients, but the phase of the building programme now nearing completion will double the bed complement. It has a training school for registered and enrolled nurses, male and female.

The counties of Perth and Kinross are served by a joint Health and Welfare Department. Its headquarters are in Perth (pop. 41,500). This is the only town in the /

the two counties with a population over 6,000; much of the country to the west and north is sparsely inhabited.

The county nursing service is carried out by "triple duty" nurses. Each nurse combines the work of general home nurse, domiciliary midwife and health visitor, although only about one quarter of them hold the Health Visitor Certificate.

Perth Royal Infirmary (240 beds) is a training school for the register and the roll, but does not accept male students or pupils. In spite of its small size it seems to enjoy the kind of prestige, and to emanate the distinctive aura which are associated with "Royals", that is, institutions which were voluntary hospitals prior to the establish-:ment of the National Health Service.

Bridge of Earn Hospital (735 beds) is situated four miles south of Perth. It came into existence during World War II as part of the Emergency Medical Service, has continued to grow and develop, and now includes /

includes a "fitness centre" with rehabilitative facilities for 100 patients.

It is a training school for both register and roll, accepts male and female students and pupils.

3.3 : Method and Response.

The interviewing schedule in its original form was tested on ten students who had recently been ward sisters but who were at the time taking a course in nursing education in the Department of Nursing Studies in the University of Edinburgh. A small pilot study was then carried out in Fife.

The main part of the survey was carried out between April and December, 1965.

A minimum of fifty respondents in each professional category was desirable if the samples were to be adequate for simple statistical analysis. These numbers do not represent the proportion of nurses to be found in each category in the total nursing population.[1] They permit comparison to be made between the opinions of nurses in different categories, in different places of employment (hospital and community) and between the different age groups which occurred as a result of the stratified random sampling. But it is not intended that the results of the whole sample should be used as evidence on which to make generalisations, by inference, about the /

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(1) Cf. Appendices 2.3, 2.4.

the opinions of the whole nursing population.

Nine employing authorities agreed to co-operate: five hospitals, three local health authorities and a branch of the Queen's Institute of District Nursing. Matrons and nursing officers supplied complete lists of their nursing staff and provided information re:garding duty rosters, holiday dates, relief duties and sick leave, from which it was estimated how many nurses would be available. Except where all the available nurses were required for interview, every effort was made to obtain a random sample. Some nurses were not familiar with the principles on which this type of selection is based, and the method did not always meet with approval from senior administrative staff, whose offers to arrange "suitable" interviews had to be resisted.

In one case a nursing superintendent stipulated that interviews should only take place at stated times, and should be completed within one week. This part:icular /

particular incident accounts for the low urban response rate. It also limited the comparisons which could be made between the opinions of community nurses in rural and urban areas.

The complicated nature of nurses' duty rosters presented difficulties, for example, when a nurse administrator "forgot" a night duty change-over until after letters had been sent to the nurses required for interview. Nurses on night duty were not included in the survey.

In another hospital, nurses were unusually elusive. Their off-duty was changed at short notice, ward emergencies resulted in sudden postponement of inter-:views, messages went astray, and a room being used for interviewing was required for another purpose before all the interviews were completed.

But situations such as these are common in hospital and were to some extent expected. The fact that all the nurse administrators were either helpful or appeared to be well-intentioned, and that the respondents often went to considerable trouble to minimise administrative difficulties /

difficulties, prevented serious disruption of the programme. However, Kinsey's statement that "the investigator of human behavior faces sampling problems which are not sufficiently allowed for by pencil and paper statisticians" was adequately demonstrated.

In the rural area, problems were fewer than had been anticipated. The nurses themselves helped to arrange interviewing time tables and co-operated with each other to make best use of the interviewer's time. In two hospitals resident accommodation was provided in the nurses' quarters and respondents were permitted to come for interview during duty hours if they wished to do so.

A total of 206 interviews were completed. Of these, 103 were with nurses in hospital (50 staff nurses and 53 ward sisters); 103 were with nurses employed by local health authorities (55 district nurses and 48 health visitors). There were 131 respondents from the rural area and 75 from the urban area.

The overall response rate was 72.8%. There was a significant difference between the response rates from nurses /

nurses in the rural and urban areas (81.4% and 61.5% respectively) but there was no difference between the response rate from hospital and community nurses.

Full details of sample numbers and response rates are given in Appendix 6.3.

The initial contact with each respondent was in most cases made by letter (Appendix 6.2). In a few instances there was an opportunity to meet groups of nurses to explain the object of the study. It was made quite clear to them that their nursing superinten-:dent or matron, whichever the case might be, knew that the enquiry was taking place, and that nurses would not be expected to make any comment directly relating to their present position or employing authority. In only one hospital did nurses require reassurance that their replies would be considered as strictly confiden-:tial.

The earlier interviews were recorded on tape. This did not appear to disturb the respondents, it permitted the pattern of response to be detected more accurately, and provided a check on subsequent coding. But /

But it was very time consuming and had to be dis-:continued after it had served its main purpose.

The time factor was also to some extent responsible for the fact that no attempt was made to probe very deeply into the opinions which were expressed. But a study in greater depth did not seem to be justified until some information had been obtained with regard to factors which one would expect to bear some relation-:ship to nurses' attitudes: their age, place of employment and type of work, and geographical area. For this reason, the whole of the present survey may be regarded as a pilot study.

Each interview took about one hour (Interviewing Schedule, Appendix 6.1). As was to be expected, some respondents found it difficult to clarify their ideas in the time available, but there was little evidence to support the view that nurses "are not, by temperament, articulate". In a few cases, particularly in rural areas when the respondents' first meeting with the inter-:viewer was at the time of interview, they tended to be wary of answering questions until they had satisfied themselves /

themselves about her experience as a nurse and midwife, that she was not, as one openly feared, "just one of those university people".

> "Nursing is an intensely practical job and therefore appeals to practical people who inevitably tend to look down on others whose work involves either theoretical or intangible considerations ... they regard everyone other than doctors and nurses as people whose work gets into the way of medical and nursing work."
>
> (Elliott, 1966)

The fact that the interviewer was a nurse, and that the respondents knew this, had obvious disadvantages. But they were possibly out-weighed by the advantages, especially as the interviewer was not connected with any nursing organisation and had not for some time been an employee of the British National Health Service. In this particular type of survey it might have been more difficult for someone who was not a nurse to recognise the significance of some of the nurses' remarks, to sense possible ambiguities and to know how to follow up some of the more evasive comments.

> "Every profession lives in a world of its own. The language which is spoken by the inhabitants, the landmarks so familiar to them, their customs and conventions can only /

> only be thoroughly learnt by those who reside there."
>
> (Carr-Saunders & Wilson, 1933.b)

Apart from the fact that nurses have only recently begun to emerge from a social and vocational monasticism, there is another factor which tends to isolate them, not only from the community, but from other members of the health team, and that is the nature of nursing - not the nature of the work, but of nursing itself. Its emotional aspects are not easily discussed; most nurses have a horror of showing their "feelings" and may rarely talk about them, even to their colleagues.

> "From the beginning of her career, often during her own late adolescence, the nurse is concerned with the intimate private functions of the human body, maybe in diseased forms. Nakedness, pain, tragedy and death, each at first a shock, become familiar. Her great emotional task now is to defend herself against her own anxieties and to retain sensitivity to those of her patients."
>
> (Barnes, 1961)

But any group, because it is a group, can claim to be "unique". The peculiar characteristics of nursing are not described here by way of excuse, but because it seems that they should be borne in mind when studying the material /

material obtained in the present survey. It is fully recognised that a nurse, however anxious to avoid the effects of bias, will be tempted to take the samples, ask the questions and emphasise the responses which will show her colleagues in the best light. It can only be hoped that an awareness of this has to some extent neutralised its effect.

SECTION 4 : ANALYSIS

Method of Presentation

The tables on pages 302-324 show an analysis of data according to the respondents' place of employment, professional category, age group, geo-:graphical area and, in some cases, socio-economic class. Significant differences between these sub-samples and results which seem to suggest the need for further enquiry are discussed in the text and illustrated by diagrams.

Percentage figures in tables and text are given to the first decimal place. Percentages represented in diagrammatic form are shown to the nearest whole number.

In diagrams, the number of interviews on which each percentage figure is based is given in brackets preceding the description of the sample, e.g. "(50) staff nurses".

Differences between the results obtained from different samples are described as "significant" when they are statistically significant at a 5% level and as "highly significant" when at a 1% level. Calculation of signif-:icance was based on the Chi-square test.

Opp. page 103.

DIAGRAM 1. AGE OF RESPONDENTS

(PER CENT)
21 - 29 YEARS
30 - 39 "
40 - 49 "
OVER 50 "

% 10 20 30 40 50 60 70 80 90 100

1.1 (206) WHOLE SAMPLE

1.2 CATEGORY

(50) STAFF NURSES

(53) WARD SISTERS

(55) DISTRICT NURSES

(48) HEALTH VISITORS

% 10 20 30 40 50 60 70 80 90 100

See TABLE 1.

4.1 : Age, marriage and men

4.1.1 : Age

The respondents' ages ranged from 21 to over 60 years. (Diagram 1.1). It was to be expected that the community sample would contain a higher percentage of respondents in the older age groups because district nurses and health visitors are normally required to take further training before being employed in domiciliary and public health work, while hospitals employ large numbers of newly qualified staff nurses.

There was, in fact, a highly significant difference between the percentage of respondents over and under 40 years of age in the two samples:

in the hospital sample, 78.6% were under, and
21.4% were over 40
years of age;

in the community sample 38.8% were under, and
61.2% were over 40
years of age.

Diagram 1.2 shows that the majority of staff nurses were under 30 years of age, ward sisters between 30 and 40 years, and district nurses over 50 years. The ages of the health visitors were more evenly distributed between 30 and 60 years, but with a higher proportion of respondents in the 40-49 year age group compared with the other three categories of nurse.

The extent to which these patterns vary in different parts of the country is not known. Although the results of the present study were based on too limited a sample to provide basis for generalisation, there are several reasons why hospital work may become less popular with nurses as they grow older. Early ambulation of patients and the demand for hospital beds has increased the turnover of the patient population, particularly in "acute" wards. A wider programme of nurse training means that student nurses remain for very short periods in one ward, and the more permanent trained staff must be continually coping with a changing team. Ancillary staff introduced to "help" the ward sister may complicate still further the management of the ward and increase the frustrations which, ward sisters complain, prevent their spending as much time with the patients as they would like to do. Being in charge of a ward can be an exhausting job, physically and emotionally. In spite of the decrease in working hours, ward sisters may still find that they have little energy or time for interests outside their work.

In the report on a study of anxiety among nurses in a general hospital, Menzies (1961) states:

> "The nursing service seems to provide unusually little in the way of direct satisfaction for staff and students. Although the dictum 'nursing should be a vocation' implies that nurses should not expect ordinary job satis-:faction, its absence adds to stress ...
>
> Sisters, too, are deprived of potential satisfactions in their roles. Many of them would like closer contact with patients and more opportunity to use their nursing skills directly. Much of their time is spent initiating and training student nurses who come to their wards. The excessive movement of students means that sisters are frequently deprived of the return on that training time and the reward of seeing the nurse develop under their supervision. The reward of their work, like the nurse's, is dissipated and impersonal."

In hospital, nurses have the opportunity to keep up with recent developments in medical and nursing care and this can be particularly stimulating for young nurses. The professional status, too, of a ward sister compares favour-:ably with that of a district nurse. But there is frequently little opportunity to nurse the "whole" patient, or to get to know patients as individuals.

In domiciliary and public health work, the attitude of the nurse toward people and an interest in social problems are of more importance than an understanding of medical and nursing technology.

opp. page 106.

DIAGRAM 2. AGE OF NURSES TRAINING FOR COMMUNITY WORK (EDINBURGH)

(PER CENT) 22-29 YRS. 30-39 40-49 YRS. OVER 50 "

2.1. DISTRICT NURSING.

YEAR: % 10 20 30 40 50 60 70 80 90 100

(65) 1950

(77) 1955

(64) 1960

(85) 1965

2.2 HEALTH VISITING.

YEAR: % 10 20 30 40 50 60 70 80 90 100

(28) 1955

(24) 1960

(28) 1965

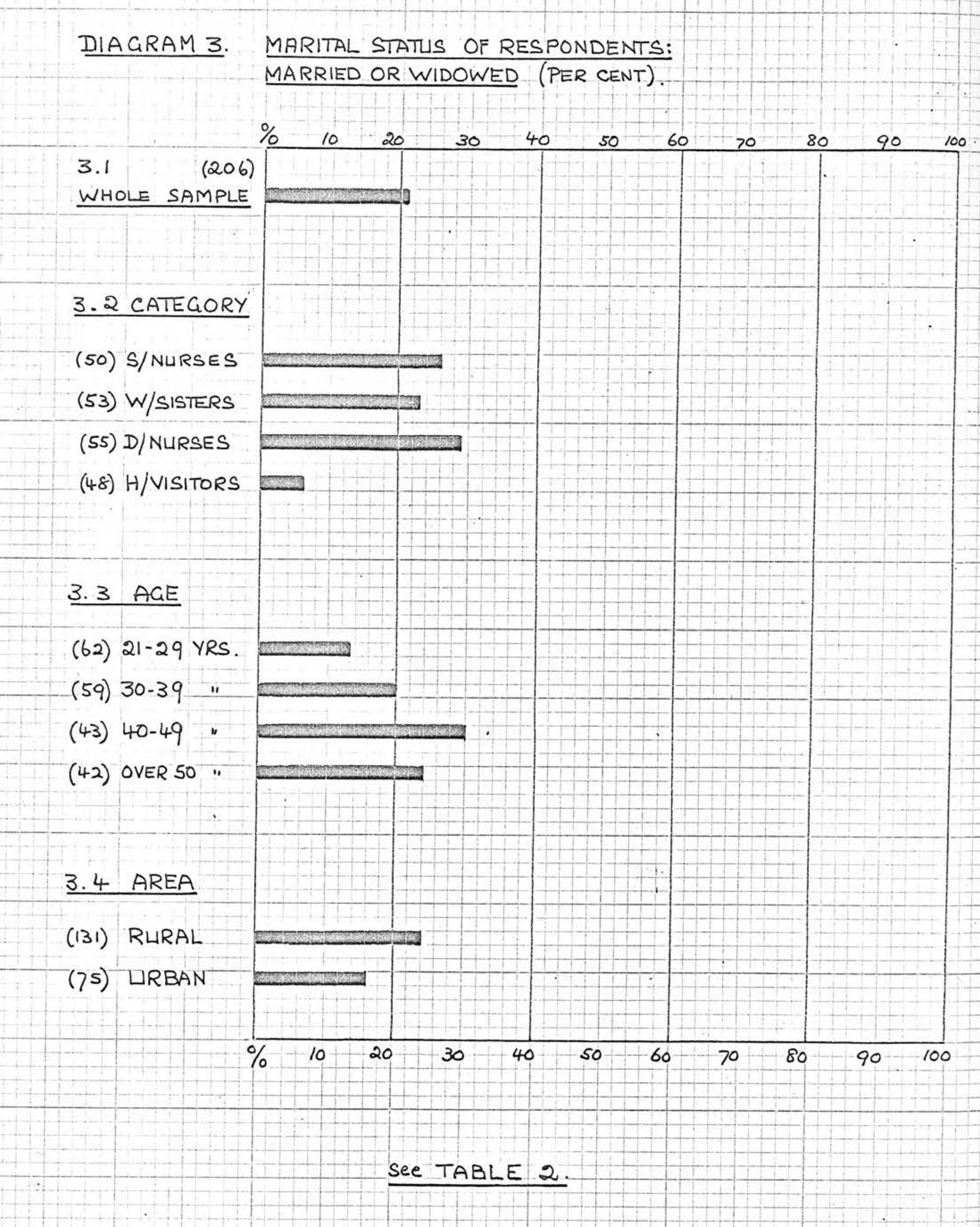
See APPENDIX 2.5

During the present study, concern was expressed by administrative staff that insufficient numbers of nurses in the younger age groups were coming forward to replace nurses in the community who were due to retire. Diagram 2.1 shows the percentage of nurses in each age group who commenced district nurse training at the Queen's Institute of District Nursing in Edinburgh in the years 1950, 1955, 1960 and 1965. There does not appear to be any significant change in the age of entry during that time, the majority of students being between 22 and 30 years of age.

A similar study of health visitor students at the Edinburgh Health Visitor Training Centre (Diagram 2.2) shows that during the past 10 years there has been an increase of students aged between 22 and 30 years, and a decrease of those over 50 years.

It would appear from these figures that the predominance of older nurses employed in community work is due to "wastage", rather than to the fact that such work does not appeal to young nurses.

opp. page 107.



See TABLE 2.

4.1.2 : Marriage.

Of the 206 nurses who were interviewed, 21.4% were married, widowed, or separated from their husbands. None stated that they were divorced.

Correspondence in the nursing press frequently suggests that hospital authorities are reluctant to employ married nurses. Shortage of staff has made it necessary for them to do so, but married women who wish to return to nursing cannot always find a suitable position in hospital. A twenty-four-hour service includes unpopular duty rotas which have to be shared by all staff, and nurses who have families to look after may not be able to do the hours required of them. Dom-:iciliary practice offers an opportunity to combine domestic and professional responsibilities with less strain on either, particularly in a rural area, where the nurse with a single district (i.e. where she is the only nurse) can to a large extent plan her own time-table.

Older married nurses who wish to return to work after their families have grown up may be attracted to district nursing for other reasons. The basic nursing skills will not have changed a great deal since their own training

days, whereas in hospital they would be required to learn new techniques and adapt themselves to new staff relationships.

Health visiting may involve a more rigid schedule, but it offers regular hours and no week-end duty. Many of the health visitors said they had elderly relatives or other dependents; one respondent said that all her health visitor friends had some kind of home commit-:ment: "No one would do this kind of job unless they had to". But only three of the health visitors were married, 6.3%, compared with 29.1% of the district nurses. The percentage of married or widowed health visitors was significantly smaller than the percentage of married or widowed respondents in any other category.

Diagram 3 shows the percentage of nurses who were married or widowed in each category, age group and geographical area; the differences were not significant between respondents in different age groups, or between respondents in different areas.

4.1.3 : Men.

Of the 206 respondents, 5.3% were men: 6 staff nurses, 3 charge nurses (equivalent to ward sister) and 2 district nurses.

The majority of registered male nurses are employed in hospital. In the psychiatric field they outnumber female nurses, but have so far failed to gain entry to the midwifery profession (Appendices 2.1 and 2.2). The role of the male nurse as a health visitor is under consideration (page 44).

Because nursing is still a predominantly female occupation, it is possible that in future there will be two main age groups of female nurses: young women who are either unmarried, or have recently married and have no children; and married women whose families are old enough to permit the mother to return to work. The higher marriage rate is also likely to cause a proportional increase in part-time nurses. These factors suggest that male nurses, for whom the chances of promotion in the general nursing field have hitherto been limited, will find the ranks of their female competitors

somewhat thinned in the 30-40 year age group, at a time when there is keen rivalry for posts likely to lead to higher management positions.

If the marriage rate for female nurses follows the trend of the national census figures, the ratio of male to female nurses could increase proportionately. There are, of course, other influences to be considered: opportunities in other services and in industry, opportunities for immigration and emigration, salary scales (particularly important to men who, unlike most of their female colleagues, have to support a family) and various other factors which are not the immediate concern of this study.

4.1.4 : Present trends and future professional development.

The demand for more nurses in the community health services is likely to increase as preventive, therapeutic and rehabilitative services continue to develop outside the hospital environment. On the whole, social trends appear to favour a continued, and possibly increasing, supply of recruits to domiciliary

and public health work.

The changing ratio of males to females may be expected to increase both the marriage rate and the birth rate. Although there will be more old people, there should still be a proportionate number of young people to care for them. But in future there are likely to be more wives and mothers, fewer spinsters. To married nurses, and to those with elderly relatives, work in the community seems to offer a number of advantages over work in hospital.

In the past, nurses who trained exclusively in hospital had little idea of what was involved in domic-:iliary or public health nursing. A wider basic training programme was introduced in 1962 and many student nurses now have the opportunity to work for a short period with district nurses and health visitors. Although this experience will not necessarily persuade them to take up community work, it will at least make them more aware of the opportunities which exist outside hospital.

Taking into account demographic changes, and the figures obtained in the present survey relating to the age,

place of work, sex and marriage ratio of nurses, three possible trends seem to be relevant to the present study:

(1) In future, there is likely to be an increase in the number of nurses who have domestic responsibilities; many of them will only be able to work part-time.

(2) The number of nurses working in the community, in proportion to those working in hospital, is likely to increase.

(3) There is likely to be an increase in the ratio of male to female nurses.

Three questions arise as to how these changes would be likely to affect the attitude of nurses to their work and to professional nursing as a whole:

(1) How do the attitudes of nurses working in hospital differ, if at all, from those in the public health service, toward nurse-patient relationships, nurse education, professional organisations?

(2) If more nurses were employed part-time, how would this affect the membership of nursing associations?

(3) Male nurses were excluded from the Royal College of Nursing until five years ago. Many of them are active trade unionists. This, together with the fact that they usually have a family to support,

> makes them very much concerned with matters about which female nurses seem to care comparatively little: hours of duty, conditions of work, salary, status and promotion. How would a larger male pressure group influence the policies of the nursing profession?

Owing to the small number of male nurses in the random samples, and the fact that the survey was not designed to find out specifically the views of male nurses, no attempt will be made to relate this last question to other parts of the survey. But in view of the possible proportional increase of male nurses, a study of their attitudes toward their professional obligations could be of considerable interest.

4.2 : Profession or Trade?

Respondents were asked to say what they thought was the difference between a trade and a profession.

The following points were those most frequently mentioned; the figures show the percentage of nurses making each comment.

34.5% - A profession deals with human beings, people's lives; a trade deals with inanimate material - "things", "machinery"; "it's a different kind of responsibility".

28.8% - A profession requires personal interest: "you give more of yourself", "there must be love of the work", "it's a vocation". A trade can be carried on effectively without personal involvement although "some tradesmen take a personal interest in the people they work for".

20.9% - The education is different. Preparation for a profession takes longer, is more theoretical, often requires a university degree. Training for a trade is an apprenticeship, more practical, "they learn on the job".

14.6% - A trade involves mainly manual skills, is "more mechanical". A profession requires "more scientific knowledge", "more theory".

13.6% - A trade is "a 9 to 5 job", "paid by the hour"; trades-:men "work to hours", "leave it behind at 5 o'clock". A profession "requires a bit extra", "doing the job is more important than the time it takes".

13.1% - A trade is carried on mainly for financial gain, as a means of earning one's living - "it's just a job". A profession renders a service; interest in the work is as important as the financial remuneration, perhaps more so.

8.7% - "Snob value".

9.2% - "Don't know".

7.8% - Felt that there was basically no difference: "the attitude to the work can be the same in both".

Although nurses were only asked to discuss professional responsibility in general, it was clear that to many of them the subject was inseparable from their own work.

District nurses were very much aware of the broader issues involved in nursing. Many of them suggested, directly or by implication, that technical procedures were the least important part of their work, and the least demanding. Their comments were not related

specifically to any question about "professional" responsibility but illustrated their concept of a district nurse's role:

> "It's going from one house to another, listening to all their troubles, switching your mind from one to another, being really interested in them all - often you don't do anything, but you're played out at the and of the day."

> "Giving a bed bath isn't nursing, it's the thing you nurse with."

> "You've got to stay and have tea, doesn't matter how late it makes you with your work. It's part of the job - they'd rather have a chat than a bath."

> "People let you into their homes, you see them at their worst, but that's all right, you're the nurse. It's rather surprising when you think about it. They seem to think nurses are different."

> "Nursing takes a lot out of you. Something must come from yourself to the patient - you have to give something to them. It's very exhausting but very satisfying."

> "You can't explain to people about nursing, can you? If you tried, it would make you sound as if you thought you were something wonderful and you're not - it's just nursing."

Deriving satisfaction from one's work was suggested by many nurses as being a characteristic of both professional and nursing service. Even those to whom nursing was simply a means of earning a living said that "no one could stick it if they didn't have an interest".

One health visitor, whose basic education qualified her for entrance to university, said that she had been doubtful whether to take up nursing or teaching. Asked whether she had any regrets about her choice, she said: "I don't think so. Perhaps I could have given more as a teacher but I have gained more as a nurse".

But there was also obvious appreciation of more tangible forms of remuneration. One staff nurse stated happily: "Nursing isn't a vocation to me. In a vocation you are supposed to work without payment and without thanks. I need both."

About 30 interviews with district nurses and health visitors in a rural area were carried out during the spring of 1965 when the general practitioners' dispute was receiving a good deal of publicity. A few of the nurses felt some sympathy with their medical colleagues but the majority were openly critical of their "unprofessional" bargaining methods. "Not much difference now between a trade and a profession. Look at the doctors".

The variety of comment in reply to the question on the distinction between profession and trade, and the small samples involved, limit the comparison which can be made between the views of respondents in different categories. But in two cases the difference is interesting.

First, of the 28 nurses who said that a tradesman "worked to hours", only one was a health visitor. Health visitors, as a group, were the only nurses who worked regular hours; they also had the longest pro-:fessional training.

Second, the statement that a trade involved more manual work than a profession was made by 20.4% of the

nurses employed by local health authorities (district nurses and health visitors), and by only 8.7% of the hospital nurses (staff nurses and ward sisters). The duties of the latter group involve as much, if not more manual work than do those of community nurses, yet in the minds of the general public it seems to be "the hospital nurse" who is accorded the greater respect. District nurses who had taken general and midwifery training and had, in many cases, worked as staff nurses and ward sisters, were sometimes asked whether they had ever thought of "going into hospital and learning to be a proper nurse". Asked by the interviewer whether they had made any attempt to explain this to their patients the answer was always the same: "Och, no".

Ward sisters in one hospital were concerned because the registered, enrolled and auxiliary grades were all "nurses" to the general public; they felt that their different types of training and the limitations of their responsibility were not sufficiently understood. Two sisters and one district nurse suggested that registered

nurses were the professionals, enrolled nurses were tradesmen and auxiliary nurses were labourers.

Although respondents were not asked to state whether they thought nursing was or was not a profession, fifteen volunteered the view that nursing is, or is becoming, a trade. Their reasons were not very clearly defined but there seemed to be a feeling that the "attitude" was changing, there was "more concern with finance", "less interest in the patients" and "it's getting to be just a job".

Some of the older nurses said that improved salaries attracted girls who were not really interested in nursing. It used to be different: "You had to like it or you wouldn't have stayed - at 27/6 a month".

Younger nurses also commented on what they felt to be a change of attitude. A 23-year-old staff nurse complained that "the girls coming in now are not interested in the patients; it's all this education, these O levels".

Some district nurses felt that there had been a change in the nurse-patient relationship since the establishment of the National Health Service. Patients and relatives sometimes took the view that since they were, in a sense,

the nurse's employer, she must take orders from them - a situation which seriously interfered with health teaching in the home. Relatives saw no reason why they should learn how to care for a sick person because "that's the nurse's job, that's what she's paid for".

4.3 : Attitude toward "official" nursing policy: Wages and Hours Bill, 1930.

This question was an attempt to find out the extent to which nurses "on the job" appreciated the issues involved in professional policy making.

When an occupational group involves itself in a dispute regarding its own remuneration and conditions of work, its practitioners are presumably claiming to be able to assess the value of the service which they provide. Their clients, on the other hand, could claim to be in a position to evaluate the service which they receive.

At the present time, when nurses frequently have to fight for autonomy in their own affairs, they give the impression that they "have little interest in politics" (Elliott, ibid.). It is difficult to know whether they appreciate the implications of negotiated settlements, in spite of the fact they may "complain bitterly" about the results.

To have asked respondents for their opinions on a topical incident would possibly have aroused varying degrees of emotional response and obscured their attitude

toward the underlying issues. It would also be likely to affect some categories more than others, introducing a variable which would make comparison between them of little value.

The nurses were therefore asked their opinions on a subject which is now mainly of historical interest. The issues were relatively clear: salaries and hours of work. But they involved a matter of "professional" principle which at the time caused a good deal of con-:troversy. It was described to the respondents as follows:

In 1930, a Member of Parliament drew up a Bill which proposed "to lay down minimum wages and maximum working hours for the nursing profession". At that time, nurses' salaries were not standardised, hours of work varied from one employing authority to another, and there was no Whitley Council which had the power to discuss the nurses' conditions of work. The "Wages and Hours Bill" proposed to make changes which would have been very much to the nurses' advantage. Unfortun-:ately, the Bill was drawn up without prior discussion

with any of the nursing organisations. The Nursing Times [(1)] opposed it on principle, stating that nurses should work out such things for themselves and not be controlled by legislation about which they had not been consulted. The Bill was withdrawn. (Abel-Smith, 1960.d)

Respondents were asked to state whether they agreed or disagreed with the attitude of the Nursing Times, taking into consideration the times and cir-:cumstances in which the events had taken place.

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(1) The Nursing Times "in 1926 became the official organ of the College of Nursing".
(Seymer, 1957.e)

opp. page 125.

DIAGRAM 4. WAGES AND HOURS BILL

(PER CENT) ACCEPT
REJECT
COMPROMISE

% 10 20 30 40 50 60 70 80 90 100

4.1. (205)
WHOLE SAMPLE

% 10 20 30 40 50 60 70 80 90 100

4.2. CATEGORY

(50) STAFF NURSES

(53) WARD SISTERS

(55) DISTRICT NURSES

(47) HEALTH VISITORS

% 10 20 30 40 50 60 70 80 90 100

See TABLE 4.

Diagram 4.1 shows that of the 205 nurses who were asked this question:

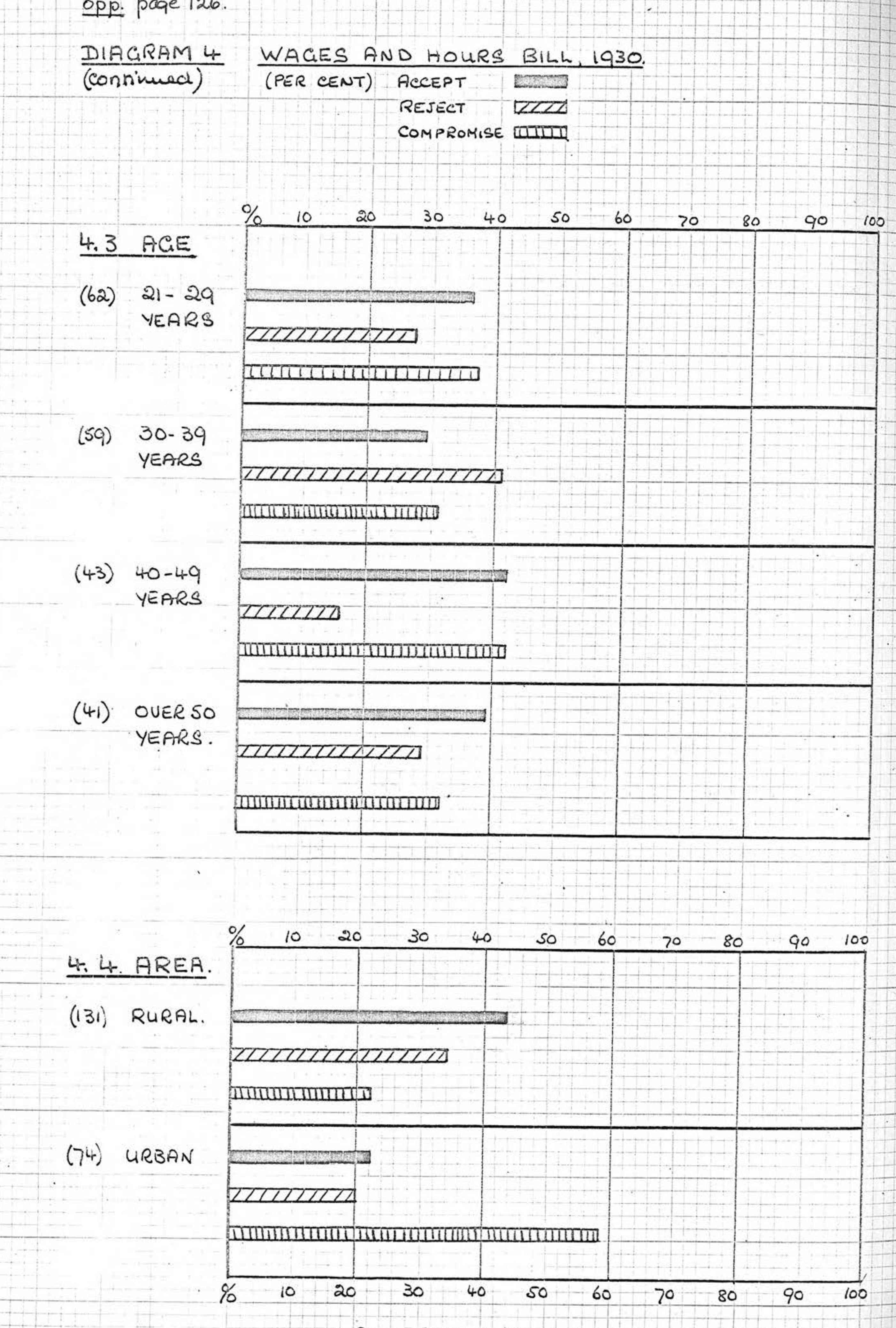
35.6% disagreed with the *Nursing Times* and said the Bill should have been accepted. They felt that conditions in 1930 were such that nurses should not have refused help when it was offered to them;

29.3% agreed with the attitude of the *Nursing Times*, that it was right to reject the Bill on principle, regardless of the advantages which it offered;

35.1% compromised, saying that the Bill should not have been rejected unconditionally, that nurses should have insisted on joint consultation before further action was taken.

There was no significant difference of opinion between the hospital and community samples as a whole, but staff nurse and health visitor respondents appeared to be more in favour of consultation than were respondents in other categories. It is probable, however, that similar replies may have been given for different reasons (Diagram 4.2).

opp. page 126.



See TABLE 4.

Analysis of age groups shows that although there was no apparent difference of opinion between respondents under and over the age of 40 years, within each of the four age groups opinion was differently distributed (Diagram 4.3). For example, a high percentage of respondents aged between 30 and 39 years agreed with the "professional" policy that the Bill should have been rejected (40.7%), whereas a low percentage of respondents between 40 and 49 years held this view (16.3%). Both these age groups contained a relatively high percentage of respondents who were members of professional nursing organisations. (cf. Diagram 7.3)

There were significant differences between respondents in rural and urban areas (Diagram 4.4).

43.5% of the rural respondents;
21.6% of the urban respondents said that the Bill should have been supported;

22.1% of the rural respondents;
58.1% of the urban respondents suggested that there should have been consultation, rather than complete rejection.

There was little additional comment from those who agreed with the official view. They felt that it was "the right thing to do", that "nurses know more about nursing than people outside" and that "they were right to stick out about it". One district nurse said that "if we can't be energetic enough to do things for our-:selves we shouldn't expect help from other people".

From nurses who would have either supported the Bill or accepted it with reservations, comment was more lively:

> "The Nursing Times represented the upper hierarchy: it didn't affect them."
>
> "Junior nurses were afraid to act and the senior nurses were 'all right, Jack'."
>
> "Senior people didn't want a reduction of working hours; it would have needed more staff and cost more money."
>
> "Nurses have been their own worst enemies."
>
> "Nothing would ever get done if left to nurses."

"Nurses themselves are too conser-
:vative. Anyway, nursing is a
public service, so members of the
public should be permitted to have
their say about it."

"A male opinion is always useful.
There are too many women in nursing;
they tend to get catty and bigoted."

"Women didn't have much power in
those days. Male nurses might
have helped."

"We've been too long suppressed.
We need outsiders to clear up the
mess."

"They were cutting off their noses
to spite their face - very short
sighted."

"Outsiders would have some knowledge
of conditions in other professions."

"Nurses can be very narrow-minded;
we need outsiders to see a different
angle. But we shouldn't let other
people control us."

"We should be tolerant of other
people's ideas but we shouldn't
let them control us."

"Unbiassed opinions are useful,
but nurses should make their own
decisions."

"But a profession _can't_ choose
its hours ..."

31.7% of all respondents said that nurses should never refuse to accept help/advice/criticism; 15% said that "outsiders can sometimes see things more clearly". Statements to this effect were made by a similar proportion of respondents in each age group and each professional category.

In view of the idea that nurses "are largely passive in relation to their professional position", it may be noted that on this particular issue opinion was very divided. Only 29.3% of the respondents were prepared to support the "official" policy and none replied "don't know". It is possible that the statement that there should have been "consultation" provided a convenient compromise for respondents who found it difficult to make up their minds. But it also suggests that at least some respondents believed that violent opposition to the Bill served no useful purpose, however much nurses disagreed with the manner in which it had been presented, and that some, appreciating the advantages offered by the Bill, were nevertheless aware that nursing opinion had been ignored.

4.4 : Opportunity for expressing opinion.

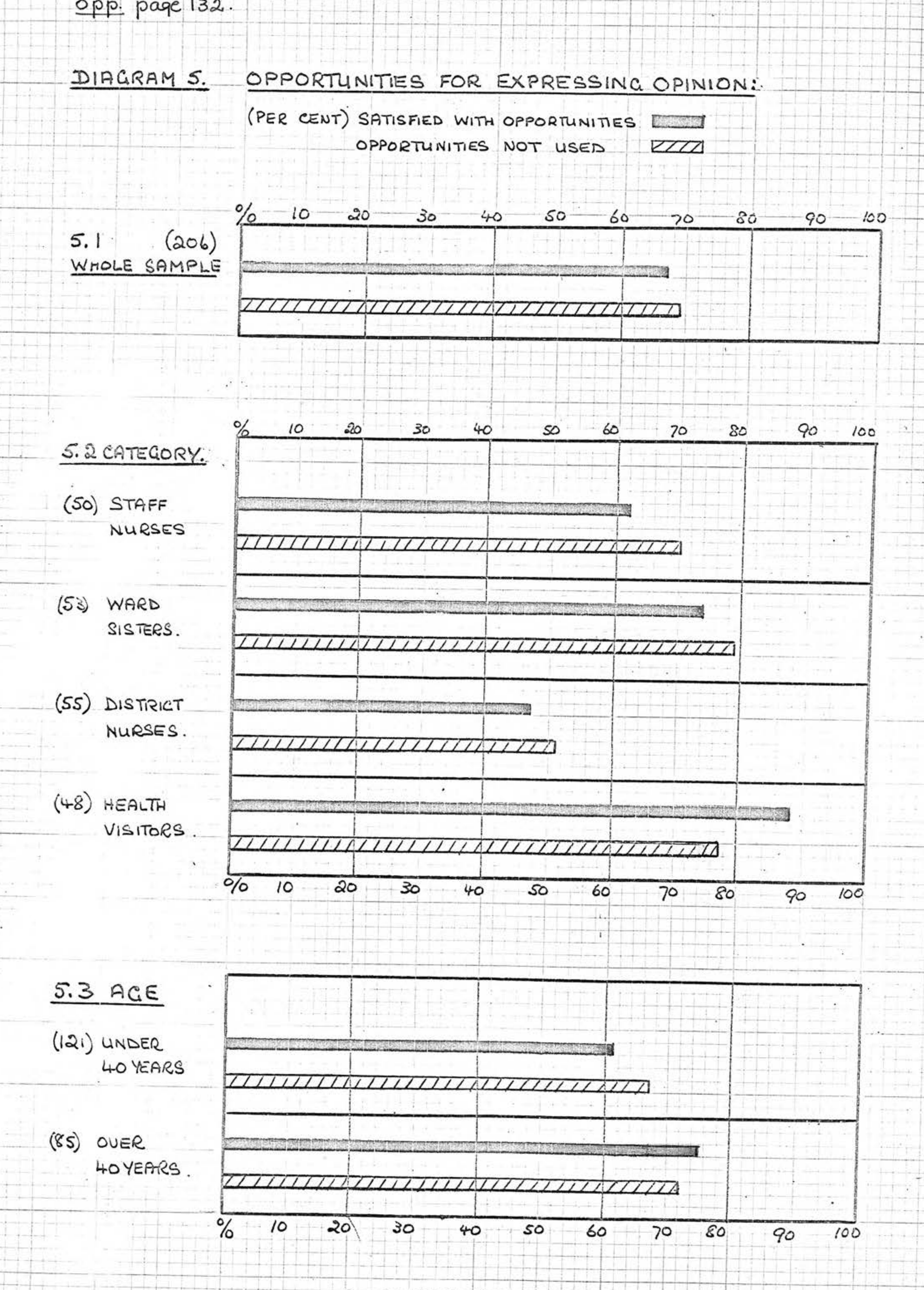
4.4.1 : Does the opportunity exist?

The question whether, at the present time, individual nurses have sufficient opportunity to express their views on matters relating to the profession as a whole was intended to find out how many nurses were aware of the existence and reputed functions of professional nursing organisations.

It was explained to all respondents that the question referred to such matters as nurse education and training, hours and salaries, annual leave - that is, to factors controlled by statutory bodies, and not to the internal policies of individual hospital or local health authorities.

In spite of this carefully prepared explanation, and in spite of the lead given by the previous question, some respondents could not see beyond the situation which existed in their own place of employment. They were anxious to discuss the availability or non-availability of "their" matron, or the frequency or infrequency of "their" staff meetings, and seemed to think that these

were the only means by which nurses could put forward their opinions. Those who were satisfied with the position (and under two employing authorities satis-:faction was very obvious) saw no reason to look for other opportunities.


opp. page 132.
DIAGRAM 5. OPPORTUNITIES FOR EXPRESSING OPINION:
(PER CENT) SATISFIED WITH OPPORTUNITIES
OPPORTUNITIES NOT USED
% 10 20 30 40 50 60 70 80 90 100
5.1 (206)
WHOLE SAMPLE
5.2 CATEGORY.
(50) STAFF NURSES
(53) WARD SISTERS.
(55) DISTRICT NURSES.
(48) HEALTH VISITORS.
5.3 AGE
(121) UNDER 40 YEARS
(85) OVER 40 YEARS.
See TABLE 5

Of the 206 respondents who were asked this question:

67.0% were satisfied that sufficient opportunity for expressing opinion existed (Diagram 5.1);

28.2% said that sufficient opportunity did not exist;

4.9% replied "don't know".

Differences between the views of nurses in different professional categories cut across the hospital/community boundary. A significantly higher percentage of health visitors were satisfied with their opportunities than were district nurses and staff nurses (Diagram 5.2).

None of the ward sisters or health visitors - categories which included the highest percentage of respondents who were satisfied with their opportunities - expressed ignorance as to whether opportunities existed.

There was a significant difference between the views of nurses under and over 40 years of age:

61.1% of respondents under 40 years were satisfied with the situation,
75.3% of those over 40 years were satisfied (Diagram 5.3).

This difference could be due to (a) ignorance on the part of the younger group regarding opportunities which exist; (b) greater demand for expression by younger nurses in relation to their opportunities; (c) fewer opportunities available to young nurses.

4.4.2 : Do nurses make use of opportunities to express their opinions?

Although 67.0% of all respondents said that they were satisfied with opportunities for expressing their opinion of these, 87.7% said that nurses did not make use of them. Of the 28.2% who thought that opportunities were insufficient, 36.2% said that nurses did not make use of those which were available.

Altogether, the statement that nurses failed to express their opinions, even when given the opportunity to do so, was made by 68.9% of all respondents.

Diagram 5.2 shows that the view that nurses do not make use of their opportunities was held by a signific:antly smaller percentage of district nurses, compared with the percentages of each of the other categories.

A relatively high percentage of respondents in the 40-49 year age group held this view,

compared with respondents in each of the other age groups. It is interesting to speculate on the possible reasons for these differences, but only 16.4% of the district nurses were in the 40-49 year age group (Diagram 1.2), and the sub-samples are too small to permit further analysis.

Opp. page 135.

DIAGRAM 6. OPPORTUNITIES FOR EXPRESSING OPINION: REASONS WHY NURSES DO NOT USE THEM.

See TABLE 6.

4.4.3 : Why do nurses fail to make use of opportunities for expressing their opinions?

Replies to this question were too diverse to permit tidy classification without risk of distorting their meaning. Only two comments were made by more than one quarter of all respondents (Diagram 6.1).

(1) 31.1% said that nurses were discouraged from expressing their ideas during training, also when they were "junior" registered nurses, and that the habit persisted:

> "In training they fed the lectures to you - you weren't supposed to contribute anything."

> "Nurses were never asked for their views."

> "We've been trained to accept things."

> "You're so regimented during training, it's difficult to change after being told what to do for so long."

The percentages of respondents giving this type of reply show significant differences according to professional category. It was given by:

41.7% of the health visitor sample,
24.0% of the staff nurse sample (Diagram 6.2).

These results do not seem to be closely related to the respondents' age. The percentage of district nurses who said that nurses were "discouraged" (27.3%) was very similar to the percentage of staff nurses who made this statement, yet 45.5% of the district nurses were over 50 years of age and 80% of the staff nurses were under 30 years. (cf. Table 1).

Their views can perhaps be accounted for by the comment made by 18.9% of all respondents (p.142) that "the attitude is changing". Staff nurses may have been subjected to less "discouragement during training"; the older nurses, brought up in a different social environ:ment, were perhaps less critical of restrictive attitudes which they were conditioned to accept as "necessary disipline" rather than as "discouragement". On the other hand, there was plenty of comment from older respondents to the effect that "things have changed a lot". There was in fact no significant difference between the percentage of nurses under and over 40 years of age who said that nurses were "discouraged" during training.

Diagram 6.3 shows that a significantly higher percentage of respondents in the urban area (41.3%) said that nurses were discouraged in training, compared with the percentage in the rural area (25.2%) who made this statement. The difference may partly be due to the higher proportion of health visitors in the urban sample compared with the rural sample: 34.7% and 16.8% respectively.

(2) 26.2% of the respondents said that nurses are reluctant to oppose senior staff. To do so could cause bad personal relationships and might jeopardise promotion prospects:

> "It could go against you when you put in for promotion or transfer, or if you wanted to apply for secondment."

> "I've a letter written to one of the nursing journals but I haven't got the courage to send it. I don't like anonymous letters, but if I sign my name it would be recognised and there might be repercussions."

> "If you wrote to a paper there'd be blue murder."

> "It's best not to draw attention to yourself."

Apart from comments which implied that nurses did not want to risk opposing senior staff because they feared the consequences, some respondents - it would be difficult to estimate exactly how many - seemed to feel that it was respect for their seniors, rather than fear, which made them hesitate to put forward opposing views. Nurses seem to have the idea that to disagree with a colleague on some professional matter is a personal insult. But the results of the present study suggest that junior nurses may have more con-:sideration for the feelings of their seniors than senior members of the nursing hierarchy have for those of their junior colleagues.

The statements that nurses are "discouraged during training" and are "reluctant to oppose seniors" are not mutually exclusive: junior nurses could be "discouraged" merely by observing the consequences of such "opposition". But there is no clear relationship between the two statements; when the replies of health visitors are compared with those of staff nurses, there actually seems to be a negative correlation.

Various other suggestions were made, each of them by less than one-tenth of the total number of respond-:ents; but since they seem to give some idea of how nurses view their own situation, representative comments are quoted here. The figures in brackets show the number of nurses who made comments in a similar vein.

Preservation of the "image" (15):

> "Nurses prefer to grumble and be martyrs, (but conditions have improved so much they have less to grumble about)."
>
> "We don't want to destroy the image of the 'poor nurse'."
>
> "We prefer to keep the image of the nurse as someone who doesn't care about material rewards."

Fear of being thought "agitators" (13):

> "It's not just what your seniors will think of you. It can make you unpopular with your own group."
>
> "Nurses discuss ideas among them-:selves, but if one of them gets up at a meeting and repeats what was said, they don't like it. I know, I've tried it."

"Nurses seem to think it's infra dig. to get up on their hihd legs. They've loads of ideas over cups of tea, but they peter out before meetings."

Ideas "blocked" at higher level (13):

"You get discouraged, and it doesn't do any good."

"You try, but you get fed up. It never gets you anywhere. We've tried so often, so many things."

Lack of ability in public speaking (12):

"We should be taught during our training. Nurses are great talkers - behind the scenes."

"Very few nurses are good public speakers."

Lack of information (11):

"There should be an adviser in hospitals; nurses don't know <u>how</u> to put forward their ideas."

"It's got to go through so many channels and there's no one to help you."

"We don't have enough information about the <u>means</u> of expressing opinion."

"Nurses are no 'worse' than other people" (6):

> "Women in general are reluctant to express their views in public."
>
> "It's a Scottish characteristic. Maybe it's got something to do with our education."
>
> "Lots of people don't like standing up and speaking in public."

Only two respondents suggested that nurses were that "sort" of person, otherwise they would not have become nurses:

> "Nurses tend to accept things, maybe that's the sort of person who becomes a nurse. Patients naturally have to come first and nurses tend to accept second place, in other things as well ... and just grumble!"

Approximately one-sixth of all respondents admitted that nurses were apathetic about "professional" matters, but were unable to suggest any specific reason for their attitude.

Twenty-one nurses (14.8%) of the 142 who said that nurses did not express their views even when given the opportunity to do so, replied "don't know" when asked to suggest reasons.

Thirty-nine respondents (18.9%) volunteered comments to the effect that "the attitude is changing". The following is a selection, from each of the professional categories:

Staff Nurses:

> "Junior nurses to-day are less afraid of authority - it's a good thing. It stems from the schools - the P.T.S. can't do anything with them. The change has occurred over the last three years."

> "The P.T.S. are more talkative, in the past three years. The same tutors are here so it must be coming from the schools."

> "The young ones are a different breed."

Ward Sisters:

"Nurses are more mature now. They express their views, and have more confidence."

"The older generation were discouraged. The younger ones are encouraged more."

"The attitude is changing dramatically. Nurses no longer accept things blindly."

District Nurses:

"We have respect for authority now, but not fear, as in the old days."

"Children are encouraged more now. It's partly a cultural change."

"The younger ones are better. To some extent it's an improvement ..."

Health Visitors:

"It's changing now, due both to changes in general education and to changes in nursing."

"Nurses were not asked their views. Now it's different."

"Not everyone could stand up to the way seniors treated them, when they were juniors. It's better now."

The replies to this question did not fulfil its intended purpose, which was to find out respondents' knowledge of, and attitude toward, professional nursing organisations and toward the reputed function of such organisations to "speak for" nurses. They do suggest, however, that the majority of nurses are aware of their own reluctance to express personal opinions on matters of professional interest.

The question was an open one and was put to all respondents. Two issues seem to be involved: first, the type of structured opportunity which they believed existed and, second, the opportunity to take advantage of the opportunity, which more than two-thirds of them believed did not. "Opportunity to express opinion" was interpreted, not simply as the machinery provided for the purpose, but as the ability and the freedom to use it.

The results seem to suggest that there is little purpose in professional nursing organisations trying to recruit members by advertising their business meet-:ings, conferences, educational programmes and Whitley Council representation, if nurses feel that within the

professional hierarchy, and particularly within their own employing authority, the traditional sanctions of "seniority" operate against individuals who "express opinions".

It may be that older nurses use their position, consciously or unconsciously, to counteract their own feelings of insecurity by criticising those who do not support their organisations and by intimidating those who do.

But the converse must also be considered: do "junior" nurses use the traditionally restrictive power of their "seniors" as an excuse for not support-:ing their organisations? If so, why should they need an excuse? Why do they not support them? Are they "free" to do so? Which age groups and which categories of nurse contribute the largest membership? What reasons do they give for belonging, or not belong-:ing, to professional organisations?

4.5 : Professional Nursing Organisations.

The attitudes of respondents toward professional organisations are studied, first, by analysing the percentage of membership in different categories, age groups and geographical areas, and according to the respondents' social class background (father's occupation). These figures are related to the attitudes of respondents toward the question of whether nurses have sufficient opportunity to express their personal opinions on matters of professional policy.

Second, an analysis is made of the reasons which respondents gave for membership or non-membership of a professional organisation.

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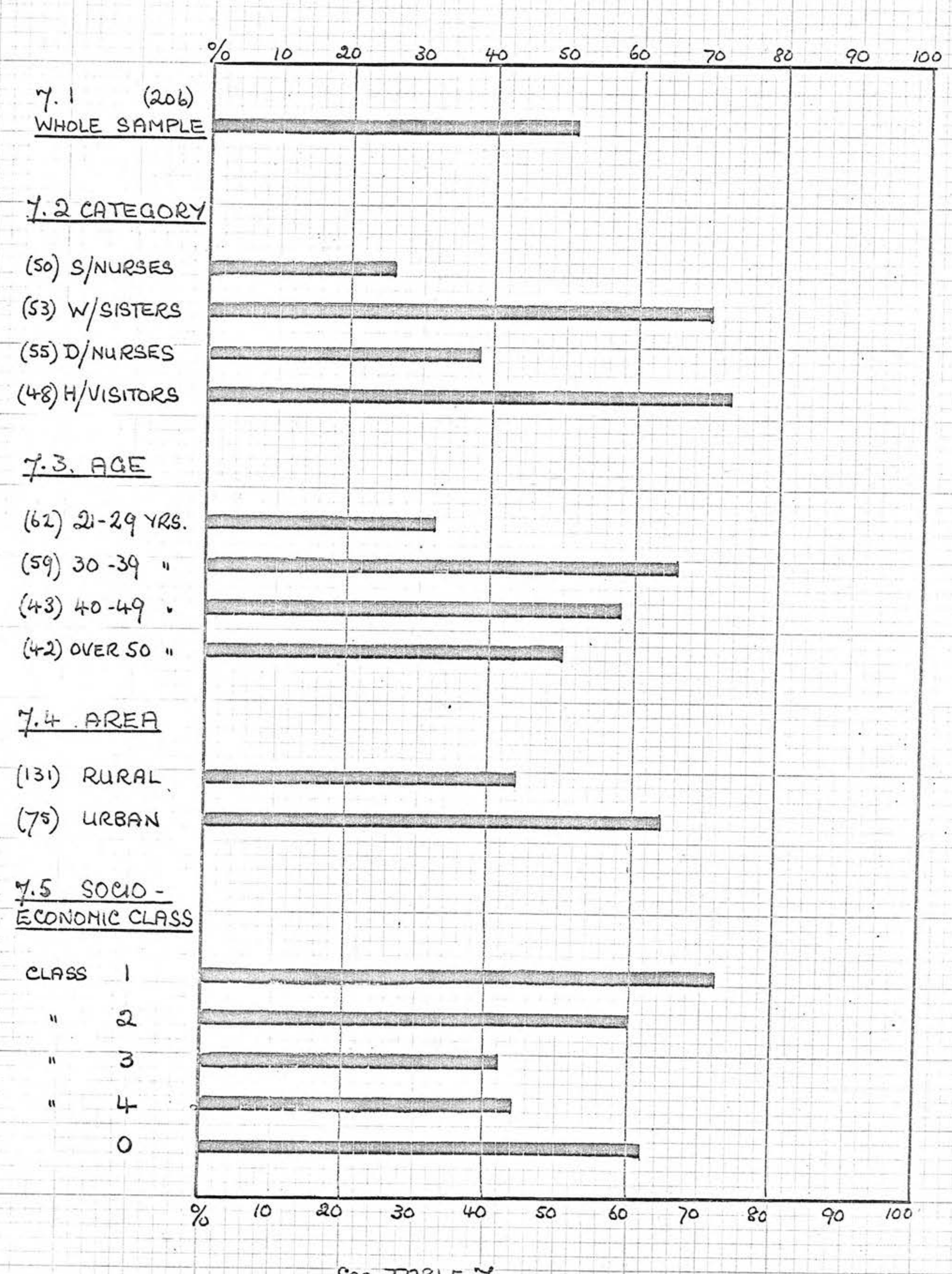

See TABLE 7.

4.5.1 : Membership of professional organisations.

Diagram 7.1 shows that of a total of 206 respondents 51.0% were members of at least one nursing organisation.

Place of employment : professional category. (Diagram 7.2).

Comparison between the percentage of membership in the hospital sample and the percentage in the community sample showed no significant difference. Once again, differences cut across the hospital/community boundary: membership was relatively high among ward sisters and health visitors, low among staff nurses and district nurses.

Age (Diagram 7.3).

The smallest membership percentage was among nurses between 21-29 years of age (32.3%) and the highest percentage among nurses in the 30-39 year group (66.1%). There was no significant difference between the percentage of membership among respondents under and over the age of 40 years (cf. Table 1).

Geographical area (Diagram 7.4).

The highly significant difference between the percentage of members in the urban area and the

percentage of members in the rural area (64.0% and 43.5% respectively) may perhaps be accounted for by the unequal distribution of health visitors and district nurses in the two samples.

Socio-economic class (Diagram 7.5).

There was a significantly higher percentage of membership among respondents from social Classes I and II, according to father's occupation, than among respondents from Classes III and IV (63.9% and 42.1% respectively), although only 35.0% of the nurses interviewed were from Classes I and II (cf. Table 3).

Marital status

31.8% of the married and widowed respondents were members, compared with 36.2% of those who were single. The difference is not significant.

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DIAGRAM 8. (COMPARISON: DIAGRAMS 5, 6, 7)

PROFESSIONAL NURSING ORGANISATIONS: ATTITUDE OF MEMBERS TOWARD NURSES' OPPORTUNITIES TO EXPRESS THEIR OPINIONS.

See TABLES 5, 6, 7.

There appears to be some relationship between membership of a nursing organisation and attitude toward opportunities for expressing opinion.

The health visitor category included the highest percentage of respondents who were members of an organisation, the highest percentage who were satisfied with opportunities for expressing their opinion, and the highest percentage who said that nurses were dis-:couraged from expressing their opinions during train-:ing. The replies from district nurses and ward sisters followed a similar pattern, but the percentages in each case were smaller. (Diagram 8.2).

Staff nurses did not produce the same response; although only 26% were in membership with a profess-:ional organisation, 62% said they were satisfied with opportunities for expressing their opinions. The fact that less than one quarter of the staff nurses said that nurses were discouraged during training could suggest that, although attitudes may be changing, there is as yet little indication that the change has induced large numbers of staff nurses to support their profess-

professional organisations. From the replies of respondents in other categories it would seem that discouragement during training has been to the advantage of organisation membership.

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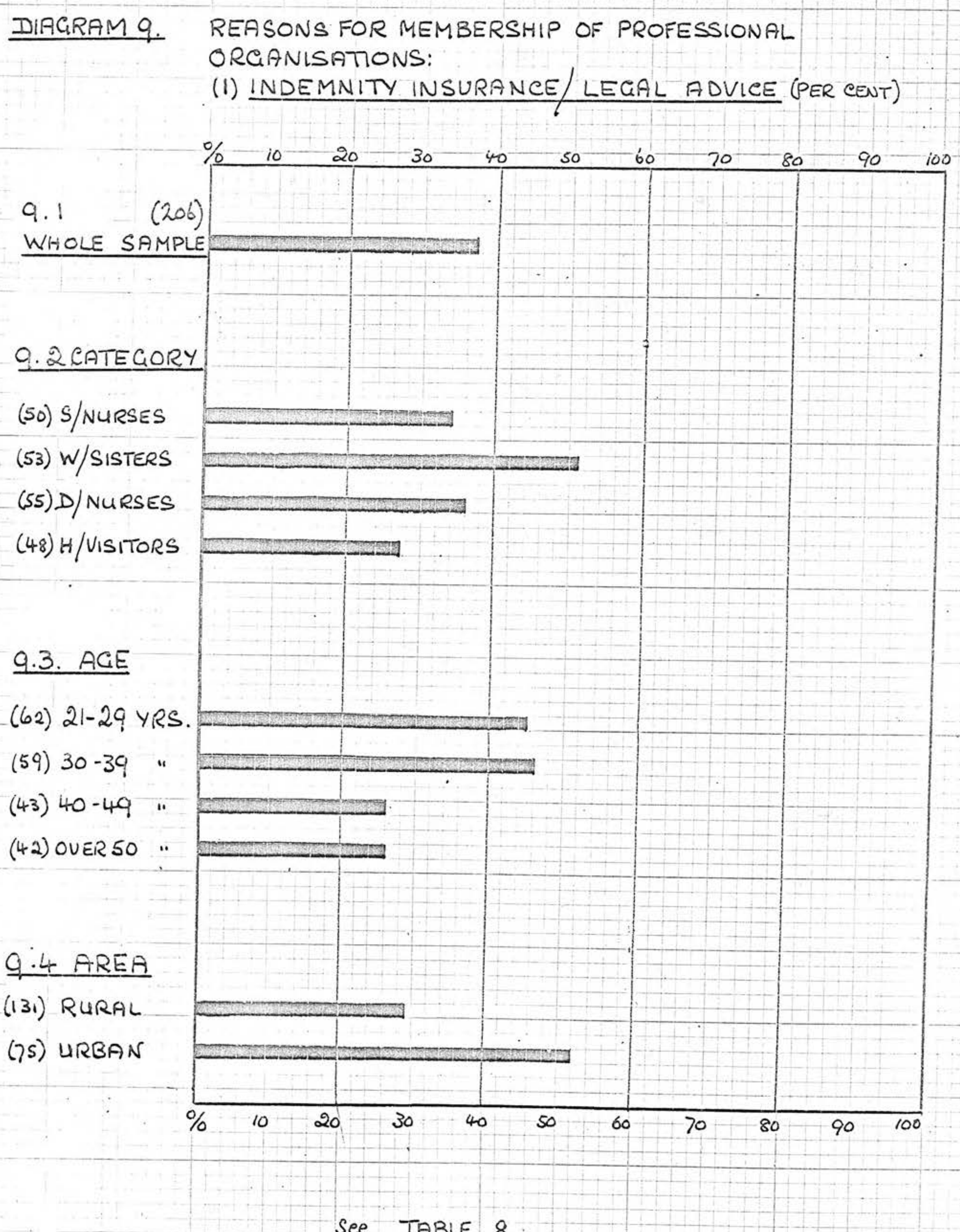
DIAGRAM 9. REASONS FOR MEMBERSHIP OF PROFESSIONAL ORGANISATIONS:
(1) INDEMNITY INSURANCE/LEGAL ADVICE (PER CENT)



See TABLE 8.

4.5.2 : Reasons for membership.

The five most frequently mentioned "reasons for membership" were:

(1) Indemnity insurance/legal advice: 37.4%.

(2) "It is our duty to support them": 22.8%.

(3) Representation: 15.5%.

(4) Educational facilities: 15.0%.

(5) Opportunity to meet colleagues, "to keep up with what's going on", "to discuss similar problems: 12.6%.

(1) Indemnity insurance/legal protection.

The advantage of being covered by indemnity insurance and of being able to obtain free legal advice was the reason for membership given most frequently by all categories of nurse except health visitors, and by nurses of all ages except those in the 40-49 year group, which contained a relatively high percentage of health visitors (cf. Table 1).

It was mentioned by:

45.5% of respondents under 40 years of age,
25.9% of respondents over 40 years of age (Diagram 9.3).

52.0% of respondents in the urban area,
29.0% of respondents in the rural area
(Diagram 9.4).

The difference of opinion between the two age groups and between the two areas is in each case highly significant; the two variables do not appear to be related, and the high percentage of health visitors in the urban sample certainly did not contribute to the above result.

Diagram 9.2 shows that there is a significant difference between the attitudes of the two categories which contained the highest percentage of members; insurance and legal protection was mentioned by:

50.9% of ward sisters,

27.1% of health visitors.

The health visitors seemed to feel that the nature of their work made the risk of legal action rather remote, whereas the ward sisters were aware of their own vulnerable position.

Although 34.0% of the staff nurses said that insurance was "a good thing to have", only 26.0% of them were members of an organisation.

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DIAGRAM 10. REASONS FOR MEMBERSHIP OF PROFESSIONAL ORGANISATIONS:
(2) SENSE OF "DUTY." (PER CENT)

% 10 20 30 40 50 60 70 80 90 100

10.1 (206)
WHOLE SAMPLE

10.2 CATEGORY

(50) S/NURSES
(53) W/SISTERS
(55) D/NURSES
(48) H/VISITORS

10.3 AGE

(62) 21-29 YRS.
(59) 30-39 "
(43) 40-49 "
(42) OVER 50 "

10.4 AREA

(131) RURAL
(75) URBAN.

% 10 20 30 40 50 60 70 80 90 100

See TABLE 8.

(2) Sense of duty: "one ought to belong to a professional organisation" was a statement difficult to interpret because it was made in many different tones of voice. It could imply that:

(1) professional organisations do a great deal to help nurses, therefore they deserve the nurses' support;

(2) membership is a wise precautionary measure, because a nurse never knows when she might require assistance;

(3) the respondent could think of no particular reason, but remembered being told that it was "her duty" by the person who, long ago, persuaded her to fill up an application form.

Staff nurses and district nurses seemed to be less imbued with a sense of duty than were ward sisters and health visitors (Diagram 10.2).

A sense of duty appeared to increase with age up to 50 years and then to decline (Diagram 10.3).

The difference between the results from the rural area and the results from the urban area could be related to the higher percentage of health visitors in the urban area and the higher percentage of district nurses in the rural area (Diagram 10.4).

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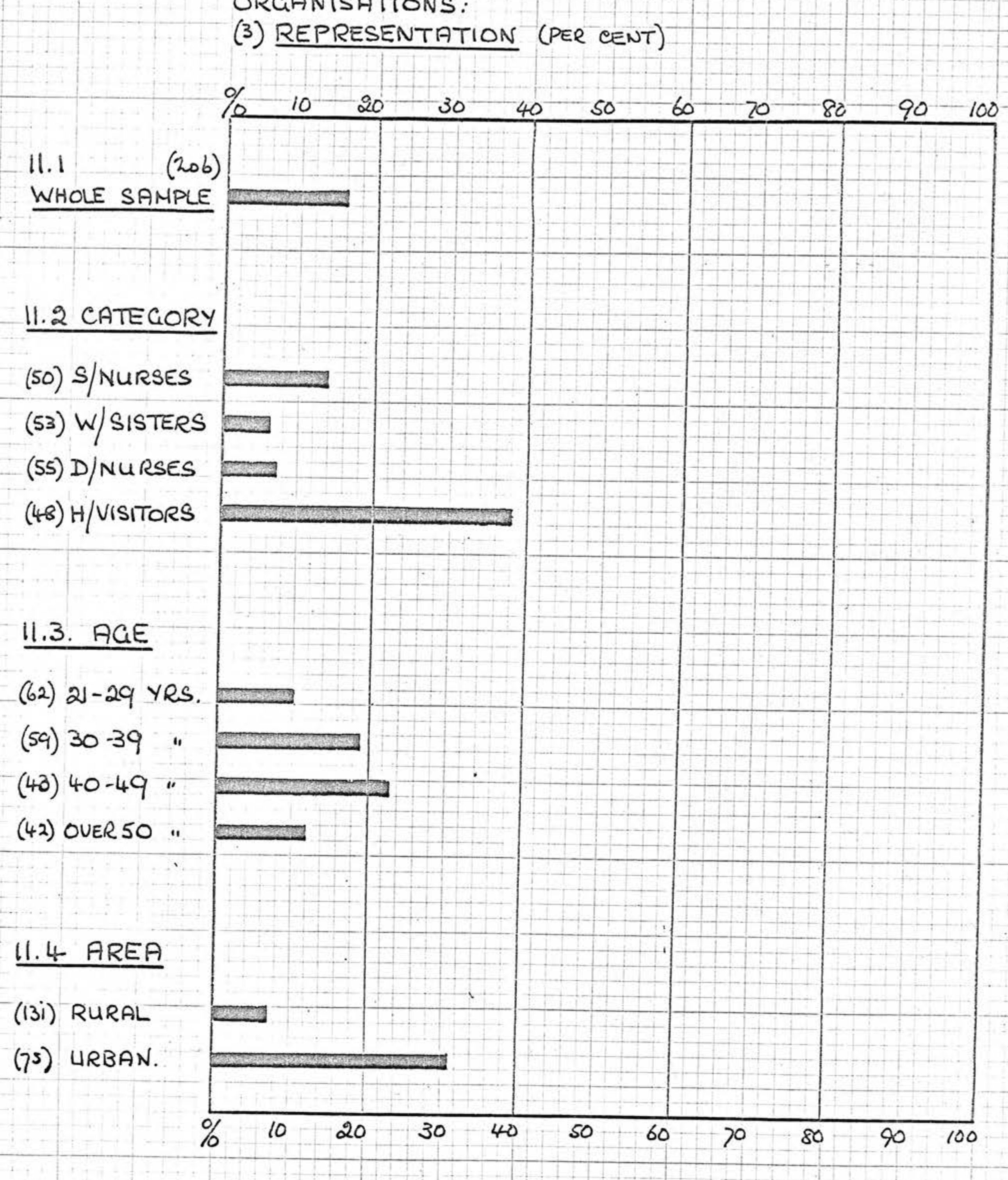
DIAGRAM 11. REASONS FOR MEMBERSHIP OF PROFESSIONAL ORGANISATIONS: (3) REPRESENTATION (PER CENT)



See TABLE 8.

(3) Representation: "opportunity to put forward ideas", was mentioned by:

37.5% of the health visitors,

7.3% of the district nurses (Diagram 11.2).

The difference between these two groups is easily obscured by the total percentage of community nurses (21.4%), which is itself significantly higher than the percentage of hospital nurses (9.7%), who considered representation to be a reason for membership - a further example of how generalisations regarding the opinions of nurses in different areas may conceal differences between large component groups.

Differences between the nurses in different age groups are not significant (Diagram 11.3).

The difference between the percentage of nurses in different geographical areas who mentioned "representation":

30.7% in the urban area,

6.7% in the rural area (Diagram 11.4),

could be accounted for by the different sample composition.

The percentages of respondents who mentioned "educational facilities" and "opportunities to meet

colleagues" show no difference according to category, age or area. Relatively few nurses seemed to consider that the educational programmes arranged by professional organisations provided an incentive to join. Respond- :ents presumably either did not consider them to be a function of a nursing organisation, did not have a very high opinion of those which were provided, or did not think of them at all.

It would seem that a study of "reasons for member- :ship" among nurses in different professional categories and different geographical areas could be of some use to those responsible for recruitment to nursing organ- :isations.

4.5.3 : Reasons for non-membership.

Altogether there were 228 comments in favour of organisation membership, of which 22.8% were made by non-members. There were 163 unfavourable comments, of which 38.7% were made by members.

The five most frequently mentioned reasons for non-membership were:

(1) Lack of interest: "Just haven't bothered", "There isn't time for everything", "I've been meaning to join ...": 28.6%.

(2) No encouragement: "Never been asked": 11.2%.

(3) Annual fees too high: 9.2%.

(4) Unable to attend meetings: 8.7%.

(5) Dislike of meetings: 7.3%.

Table 9 shows how these comments were distributed among the different samples, but they can only give a very general idea of the attitudes of respondents. Reasons for not joining an organisation appeared to be inter-related in a way which precludes statistical analysis. A nurse who said that she had not been encouraged to put forward her views at meetings could have "disliked meetings" as much as the one who said

so directly; nurses who were "unable to attend" might feel that the "fees were too high" for what they were able to "get out of it".

Although the statement "unable to attend" could have been an excuse for non-participation, this seems unlikely. It was given by 13 district nurses who were on call for midwifery cases and who lived at some distance from the town in which meet-:ings were held, by three health visitors who had home commitments, by one ward sister and by no staff nurses. If it was used as an excuse, it is also possible that nurses who gave other reasons were also making excuses - but excuses for what? If all the non-members had replied that they were not interested they would perhaps have been honest, but this would not have answered the question of why they were not interested.

Sixteen respondents said that they "disliked" meetings and many others implied dislike:

> "It's the same old faces, the same hats".
>
> "It's just cups of tea. They never <u>do</u> anything".

"You want to get away from nurses ."

"They're always telling us we should have outside interests. I have. I prefer them ."

Both members and non-members said that there was often little encouragement to join. Organisations seemed "remote and impersonal" and there was particul-;arly little encouragement for young people to take an active part: "And that", said one district nurse in her middle thirties, "means that you must be at least over 30. I'm only just beginning to speak at meetings without feeling I shouldn't".

Ten respondents said that nursing associations did not publicise their work sufficiently. There were presumably a number of others who knew so little about them that they did not know there was anything to publicise.

Much of the unsolicited comment on the activities of nursing organisations appears to be destructive criticism , but nurses who were members tended to state their reasons without further explanation.

The following are some miscellaneous comments on the subject of professional nursing organisations, by

respondents from each professional category.

Staff Nurses:

> "No notice is taken of you when you do go to meetings."
>
> "I'd never heard about the College until I came to this hospital."
>
> "I've never been approached by any organisation."
>
> "It doesn't appeal to younger people."
>
> "The Rcn is too impersonal. You think of them as a group of fuddy-duddies."
>
> "It doesn't fulfil its function - it's the same senior people all the time."
>
> "People should belong - but then they should have the freedom to discuss their views."
>
> "I used to be the only staff nurse who was a member. There was an idea that only older people joined."
>
> "If more people joined (the College) it would have more say in things."
>
> "They don't do anything - I don't get anything out of it."

Ward Sisters:

"Meetings are too formal."

"There isn't enough publicity. One doesn't know who the people are - they expect you to know what's going on."

"I don't put much into it so I don't get much out ... The news in the Nursing Times is always very detached."

"You are 'saturated' by the time you go off duty - but I know that's a defeat-:ist attitude. Some one has got to do the work."

"Living out makes it very difficult to get a good attendance at meetings."

"It does give you a broader view of nursing."

"You want to get away from work after duty. I hate being organised. We had enough of it in training."

District Nurses:

"I belong to the R.C.M.,[1] but I dislike meetings. I want to get away from nursing."

"The College is all right, but the young ones are not encouraged. Individ-:uals don't carry much weight."

"The Rcn., is not a welcoming body ..."

"The Rcn., the old guard, closed shop ..."

"Never did any good that I know."

"The Rcn., seems a remote body. It's not well known enough."

"Not worth the money - and I can't get to meetings."

"I was a member of the Rcn until last year. It was just 'the right thing to do' - never thought about it. It's just a negotiating body, about salaries. I don't approve of that."

"The College isn't as good as a trade union for bargaining."

"The College could do more if it had more members."

---

(1) Royal College of Midwives

"Reasons for membership?
None."

"I'm really very vague in
my mind why I didn't
continue ..."

Health Visitors:

"I used to belong to the
Rcn but lapsed."

"It's a large organisation,
too impersonal. You don't
get much out of it."

"It's too tied up in a small
nucleus."

"There's less need for
insurance in public health.
You don't tell people what
to do, you only advise."

"It's too remote ..."

"We can't take benefits we
haven't worked for."

"They don't do anything for
you. Whitley Council is
n.b.g. - they never do any-
:thing ..."

Differences of opinion between members and non-members of organisations are discussed in Section 5.1.4.

4.6 : Readership of nursing journals.

"Do you read any nursing journals: regularly, sometimes, or hardly ever?"

Out of a total 204 respondents who were asked this question:

56.4% said they read nursing journals regularly;

31.9% said they read them "sometimes";

11.8% said they never, or "hardly ever" looked at them.

Of the 134 nurses who said they read them regularly or sometimes, 74.4% mentioned the Nursing Mirror (an independent periodical with an editor who is not a nurse) and 47.7% mentioned the Nursing Times, which describes itself as the "journal of the Royal College of Nursing and National Council of Nurses of the United Kingdom".

Other journals mentioned were District Nurse, read by 9 out of 55 district nurses interviewed; Midwives' Chronicle (the journal of the Royal College of Midwives); and Family Doctor which district nurses and health visitors found useful for its "teaching" articles. Some of the district nurses said they sometimes "got hold of the G.P.s'

B.M.J. and Lancet".

There was no significant difference between the number of nurses who were members of nursing organis:ations and read nursing journals, and those who were not members, and read them. But a higher percentage of non-members read the Nursing Mirror.

Some of the respondents who rarely looked at a nursing journal said that they preferred reading "other things". In the words of one nurse:

> "One shouldn't read the nursing press too much. If you don't have much time for reading, you should read other things, otherwise you get very narrow-minded."

4.7 : Payment for Overtime.

In the pilot study, respondents had been asked whether they thought nurses should be paid for work-:ing overtime. When those who said "no" were asked to give their reasons, it was found that some nurses disagreed with the idea on principle and others, although they had no objection to the idea in theory, did not think it would work satisfactorily in practice. It was felt that some nurses would "go slow" or volunteer for extra duty merely for financial reasons. Respondents who made these points did not necessarily "disapprove" of overtime payment, but they did not want to see its widespread use in nursing.

On the other hand, some respondents who felt that overtime payment was "unprofessional", suggested that it might effectively reduce extra working hours simply because the National Health Service could not afford to pay for them:

> "The hospitals would get poor and we'd get rich."

> "It would make 'em realise how much extra we do work."

To make it clear why some respondents said they did not want payment for overtime, the question was rephrased. The nurses were asked to state, first, whether they had any objection to overtime payment on principle and, secondly, whether they thought it would work satisfactorily in practice.

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DIAGRAM 12 PAYMENT FOR WORKING OVERTIME:
PER CENTAGE OF RESPONDENTS
AGAINST PAYMENT "ON PRINCIPLE".

See TABLE 10.

Of the total 204 respondents who were asked whether they had anything "on principle" against nurses being paid for working overtime:

43.6% had no objection,

53.9% disapproved,

2.5 % could not make up their minds whether they approved or not.

Asked whether they thought it would work, "in practice":

18.1% saw no reason why it should not work satisfactorily,

54.9% did not think it would work,

27.0% said that it was not possible to know whether it would work until it had been tried; some said that they had "never given it a thought".

On the whole, the percentage of respondents who disapproved of overtime payment was higher than the percent-:age who approved.

There was no difference "on principle", between the views of nurses employed in hospital and those employed by local authorities, but it will be seen from Diagram 12.2 that more ward sisters and health visitors in the samples studied were against the idea of overtime payment than were the staff nurses and district nurses.

The attitudes of nurses in different age groups (Diagram 12.3) show a similarity between those of respondents under 30 years of age and those over 50 years, the age groups to which, respectively, the majority of staff nurses and district nurses belong.

Differences between the opinions of respondents in different geographical areas (Diagram 12.4) and in different socio-economic classes were not significant.

opp. page 169.

DIAGRAM 13. PAYMENT FOR WORKING OVERTIME: PER CENTAGE OF RESPONDENTS WHO AGREED/DISAGREED –

ON PRINCIPLE
IN PRACTICE

% 10 20 30 40 50 60 70 80 90 100

13.1 (204) WHOLE SAMPLE

AGREED

DISAGREED

DON'T KNOW

13.2. "WOULD PAYMENT WORK IN PRACTICE?" REPLIES OF RESPONDENTS WHO

(1) AGREED WITH PAYMENT, ON PRINCIPLE (89)

% 10 20 30 40 50 60 70 80 90 100

YES

NO

DON'T KNOW

(2) DISAGREED WITH PAYMENT, ON PRINCIPLE: (110)

% 10 20 30 40 50 60 70 80 90 100

YES

NO

DON'T KNOW

Since the purpose of the survey as a whole was to study "values and attitudes", practical consider-:ations were only of interest in relation to attitudes which they appeared to reflect or influence. But Diagram 13.1 suggests that in the case of overtime payment ideas founded "on principle" were not easy to differentiate from those based on "practical" consid-:erations; disagreement on one aspect appeared to be related to disagreement on the other.

Of the 89 respondents who had no objection to overtime payment "on principle", 34.8% saw no reason why it should not work satisfactorily in practice (Diagram 13.2(1)). But of the 110 respondents who objected to payment "on principle", only 5.5% thought that it would work satisfactorily in practice (Diagram 13.2(2)).

The distinction between principle and practice seemed to be quite clear in the minds of the respond-:ents who had previously given the matter some thought. But when nurses who began by saying that they were in favour of overtime payment were asked to consider its practical implications, some of them began to wonder

what the effect would be on nurse-patient relation-:ships and what would happen if nurses were expected to go off duty punctually:

> "You couldn't just walk off in the middle of an enema, could you? Well, you could, I suppose ... but the patient would think you didn't care, and he'd be dead right."

This type of half-statement was common , presumably because respondents knew the interviewer was a nurse and felt that she ought to be able to understand the situation without further explanation.

Nurses who had no objection to the idea of over-:time payment on principle did not necessarily ignore the nurse-patient aspect, but felt that some kind of remuneration was necessary to compensate the staff of operating theatres, for instance, who were on call at night, and also to prevent the same "willing horses" being taken advantage of in hospitals where, owing to staff shortage, nurses frequently gave up their off duty. Some thought that in general hospitals very little overtime was now being worked, but opinion on this varied. Some respondents pointed out that even

where a system of overtime payment was instituted, there was still nothing to prevent nurses doing "a bit extra" if they wanted to. One ward sister said that the nurses in her ward took great interest in their patients and sometimes came back in the evening to wash and set their hair; they certainly would not expect payment for it.

Of the whole sample (204 respondents), 12.7% volunteered the statement that cash payment should only be made where the extra time worked could not be made up at some later date. Nurses should not be encouraged to work overtime:

> "If you do it regularly you get tired, whether you are paid for it or not."

> "We've continually fought for a reduction in hours. Being paid for it isn't really the point."

Several respondents expressed the view that nurses undertook to provide a service, not to work for a stated number of hours.

> "The salary should be sufficient to cover whatever the service entails."

Although the respondents in each category were particularly interested in how overtime payment would affect their own group, there was a good deal of discussion about the different ways in which it might affect hospital and domiciliary work. Res-:pondents tended to assume that circumstances were "different" in work situations with which they were not familiar.

District nurses said that it would be difficult on district to differentiate between "work" and "time spent".

> "You don't *have* to sit around in people's houses after you've finished the work, but if it's some old body who's alone all day you can't just rush off."

One district nurse gave an account of an episode which took place while she was showing a visitor around her district. The visitor, who was a nursing superintendent in her own country, accompanied the nurse on her morning round and expressed displeasure that the should "waste time"

drinking cups of tea in patients' houses. She was corrected by the nurse:

> "I told her. I said: You're wrong. Nursing isn't just giving an injection or giving a bath. There's a lot more to it than that. You've got to drink those cups of tea whether you like it or not."

The superintendent did.

4.8 : Strike action.

The question of strike action provoked relatively little interest. Many respondents gave the impression that they considered it to be so incompatible with nursing that they had never given it serious consideration.

Asked whether they thought there were any circumstances in which nurses should strike:

> 90.8% replied "No";
>
> 8.7% replied "Yes" conditionally; one nurse said she was in favour of hunger strike.

Many of those who said "no" recognised the fact that nurses could be exploited because they could not do so:

> "We can't strike, but we are taken advantage of because of our position."

It was not always clear whether respondents objected to strike action because they felt that a profession should not strike or because nurses could not strike. As with the replies to the earlier question regarding the difference between

a profession and a trade, the two concepts were difficult to distinguish. Questioning the nurses whether their comments referred to all professions or only to nursing, one usually got a reply to the effect that there were many professions but some were more professional than others.

> "Strikes are unprofessional. That's what a trade does."

> "I'd like to, but a nurse has no right to withdraw her labour."

> "People have a right to protest but have no right to withhold their services when to do so would be harmful to people."

> "There are other ways in which one can make oneself unpleasant."

It was suggested by several district nurses and health visitors that to stop doing some "paper work" would do no harm. They seemed to find the idea quite attractive.

The nurses who felt that strike action could be useful qualified their statements:

> "Yes, so long as it didn't affect the patients."

> "Yes, if it's the only way. It shouldn't be necessary if we have trade unions and organisations. Anyway, why should the patients suffer?"

> "It may be necessary if conditions became so bad that the patients were suffering."

> "Yes, we should strike even if it's only to convince the lay public that they should give up the idea that nurses are angels."

Two of the respondents had been involved in short strikes in hospital about twenty years ago as a protest against lack of off-duty. "It worked." Another recalled an occasion on which doctors looked after the wards for five hours, to get permission for nurses to be allowed to stay out until 11 p.m. - perhaps not an altogether disinterested act on the part of the medical staff.

4.9 : The making of a nurse

Nursing must always, to some extent, be learned "on the job". The present system of nurse training in this country inevitably produces conflict between the demands of nursing service and the demands of nursing education. But the people responsible for service to patients must, also inevitably, become involved in teaching nurses. Staff nurses and ward sisters have always been teachers, consciously or unconsciously, positively or negatively, and in future, following the implementation of a wider syllabus, district nurses and health visitors will be required to take a larger part in training students at basic level.

Yet nurses in these categories are rarely heard to express their views on nursing education. It is doubtful whether they are often asked for them, and the attitude of hospital teaching staff does not always encourage co-operation. To them, staff nurses have ceased to be of interest as students and have not earned authority as teachers; ward sisters are frequently criticised for not being interested in teaching; district nurses /

nurses are considered to be "out on a limb", and health visitors are suspect because they have given up "real" nursing. Yet all these people have some responsibility for the attitudes and values which students develop as part of their professional equipment; each professional category sees nursing from a slightly different viewpoint, and can con-:tribute to the development of different qualities in students with different kinds of ability.

There are two questions to be decided: (a) whether the present standard of education required of candidates for training for the Register provides a sufficiently strong base on which to build a new and more effective system of nursing education, and (b) the extent to which it is necessary or desirable for nurses to have a higher education, at university level.

Discussion of these matters is usually confined to nurse tutors and administrators and, more recently, to educationists in the general field of education. But if specialists in education have something to contribute /

contribute to the training of the nurse in the clinical situation, then it seems desirable that specialists in clinical and public health nursing, who are in a good position to see the results, should also be invited to express their opinion on the education of the nurse..

4.9.1: Educational entrance requirements.

A Reform of Nursing Education, popularly known as the "Platt" Report, was being widely discussed at the time when the present survey was being carried out and was used as an introduction to the subject of nursing education. It was unlikely that any of the respondents would not have heard of it, although it was not assumed that they would all be familiar with the details.

Respondents were asked whether they thought the present qualifications for entry to training for registration were satisfactory (two subjects at ordinary level, one of which must be English, or an intelligence test issued by the General Nursing Council), or whether they agreed with the "Platt" Report that the standard should be raised to five subjects at ordinary level.

41.7%/

Opp. page 180.

DIAGRAM 14. EDUCATIONAL ENTRY REQUIREMENTS FOR NURSING: "STANDARD SHOULD BE RAISED".
(PER CENT)

% 10 20 30 40 50 60 70 80 90 100

14.1 (206)
WHOLE SAMPLE

14.2 CATEGORY

(50) S/NURSES
(53) W/SISTERS
(55) D/NURSES
(48) H/VISITORS

14.3 AGE

(62) 21-29 YRS.
(59) 30-39 "
(43) 40-49 "
(42) OVER 50 "

14.4. AREA

(131) RURAL
(75) URBAN.

% 10 20 30 40 50 60 70 80 90 100

See TABLE 11.

41.7% of all the respondents said that educational entrance requirements should be raised. Respondents who thought that this might cause a fall in recruitment figures suggested that a change to five subjects at ordinary level should be made gradually, to allow time to build up the establishment of other nursing personnel. Nine respondents said that nurses should have passed at least one subject at higher level.

The percentage of respondents who were in favour of raising the minimum entrance standard differed significantly according to their place of work, their age, and the area in which they were working. Statements to this effect were made by:

35.0% of respondents working in hospital,
48.5% of those in the community (Diagram 14.2);

35.5% of respondents under 40 years,
50.6% of those over 40 years of age (Diagram 14.3);

35.1% of respondents in the rural area,
53.3% of those in the urban area (Diagram 14.4).

It /

It can also be seen from Diagram 14.2 that a relatively high percentage of health visitors were in favour of raising the educational standard, compared with the percentage of respondents in other categories who held this view.

31.1% of the respondents were in favour of the requirements at present in force and saw no reason why they should be changed.

10.2% said that no scholastic standard should be required, that there should be "some kind of test", or simply an interview with the matron of the training school. Apart from one health visitor, who suggested that there should be "personality and aptitude tests like they have for the Army", respondents were unable to specify the "kind of test" which would be suitable.

Two respondents said that girls who wanted to be nurses should stay on at school until they were 18 years of age and continue studying "to whatever level they are capable of".

Two respondents said that scholastic achievement and personality and aptitude tests should all be taken into /

into account when selecting candidates for training. Poor performance in any one of these could be compen-:sated by good results in the others.

It was expected that a fairly large number of respondents would find a question on education difficult to answer, either because they were not directly con-:cerned with student nurses or because they were not interested in the subject. In fact, only six respond-:ents (2.4%) failed to state some kind of opinion.

Respondents who were in favour of raising the educational standard for entry gave the following reasons:

(a) Education is always an advantage, "the more of it the better", regardless of the occupation of the individual.

(b) Other occupations were raising their standards:

"Education means a lot these days. Other professions and trades wouldn't tolerate nurses' regulations for entry. If we don't ask a higher standard we won't get it."

(c) Nursing is becoming more technical; nurses need a better general education in order to be able to carry out their work intelligently.

(d) Nursing is being "diluted" by auxiliary workers/

workers. The standard for registered nurses should be raised to counteract the effects of this.

(e) Nurses must have a good standard of education in order to "hold their own" with other professions, both in status and in responsibility.

(f) Higher entrance requirements would aid recruitment: "We need a higher level to attract people".

<u>Respondents who were not in favour of raising the educational standard for entry</u> said that:

(a) Raising the standard would make recruit-:ment more difficult. "We would lose good nurses".

(b) Ability to pass school examinations is no evidence of ability to pass nursing examinations or to be a good nurse. Conversely, girls who have little academic ability frequently make excellent nurses. Having a very strong desire to nurse often provides the necessary incentive to pass nursing examinations.

(c) There is no valid reason for raising the entrance standard of education while the examinations of the General Nursing Council can be passed quite easily by students who have no school certificates. This point of view was expressed by a number of respondents who had themselves left school at the age of 14 or 15:

> "I managed all right myself. I'm not saying I'm a wonderful nurse /

> nurse, but I didn't fail an exam. all through my training."[1]

One nurse suggested that:

> "If we get girls with better education we shall have to change our methods of training, or we shan't keep them."

(d) Academic ability can be a disadvantage to a nurse:

> "Really clever people don't make good nurses. They need to be a bit unclever."

> "There are good human nurses without exams. The others couldn't 'come down' to Leith people."

> "You don't need brains to be a nurse, just common sense - not so common."

> "The best brains don't make the best nurses. The others, it's their whole interest."

> "It's an exceptional person who can work on two levels, intellectual and practical. It's not their fault, they're just like that."

> "More intelligence may mean more ability to take responsibility - but we don't want the academic type who can't 'come down'."

Approximately /

---

(1) See p.201: Oxford Area Nurse Training Committee (1966).

Approximately 30 respondents made comments to this effect.

23.3% of all respondents said that whatever educational level was decided upon should be rigidly adhered to; there should be no concessions, even for older women starting nurse training. Those who did not have the required qualifications should train as enrolled nurses. Some suggested that those who did exceptionally well might be allowed to proceed to registered training, or they could be encouraged to study and to acquire the necessary subjects at "O" level while training for enrolment. The number of respondents who said "no concessions", and the strength with which they stated their case, was somewhat unexpected.

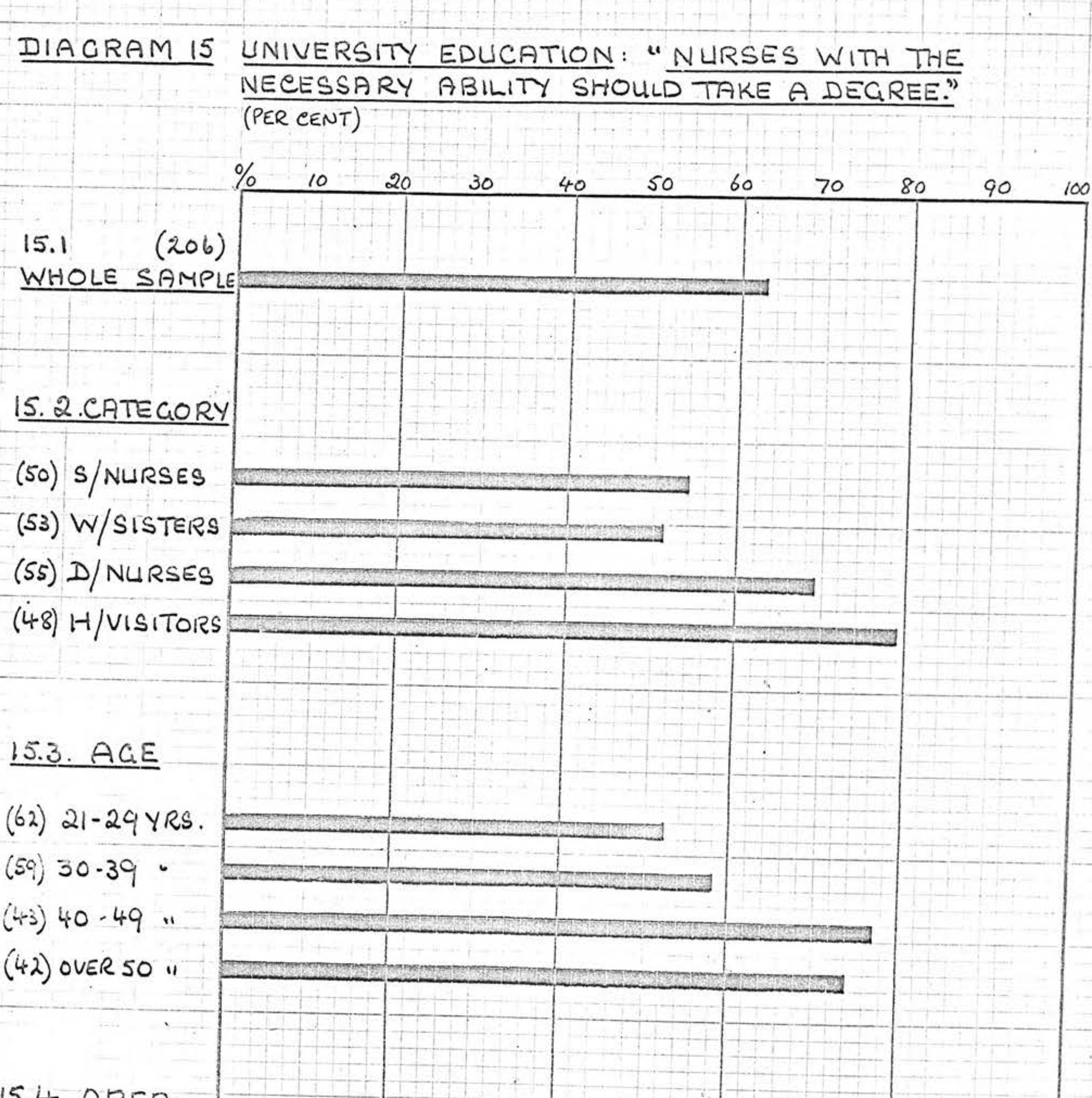
4.9.2: University education.

Statements to the effect that "nurses should have a university education" have been the cause of much misunder-:standing, and there is frequently opposition toward anyone suspected of trying to make nursing an "academic subject".

The term "university education" in relation to nursing is ambiguous (cf. Section 2.2.3.) It can refer either to education prior to the commencement of nurse training, or to courses in basic or post-basic nursing organised in con-:junction /

opp. page 186.

DIAGRAM 15 UNIVERSITY EDUCATION: "NURSES WITH THE NECESSARY ABILITY SHOULD TAKE A DEGREE."
(PER CENT)



See TABLE 12.

conjunction with a university department. The whole subject has caused a good deal of controversy among nurse administrators and educators, and it was expected that nurses actively engaged in the practical situation would be even less tolerant of any suggestion that a more academic preparation was relevant or desirable.

Respondents were asked whether they thought that a university education would be of any value to a girl who wanted to be a nurse, but who had the ability and the opportunity to take a university degree; should she be encouraged to go to university first? (Diagram 15)

63.1% said "Yes";
20.4% said "No";
11.2% thought that she should take nurse training first and "then see what she wants to do". They did not rule out the possibility that a post-registration course at a university might be of use to nurse teachers and administrators, but did not consider that it would be of any value to "an ordinary nurse".

Other reasons given for taking nurse training first were that many girls would have changed their minds while they were at the university, and that it would, in any case, be harder for them to "get down" to nursing at a later /

later date. "They'd be better to learn how to roll up their sleeves and work first."

There was a highly significant difference between the percentage of nurses in the hospital and in the community samples, and between the percentage in younger and older age groups, who were in favour of university education.

52.4% of the hospital sample,
73.8% of the community sample,

54.5% of respondents under 40 years of age,
75.3% of respondents over 40 years of age,

said that a girl who had the necessary ability should be encouraged to take a degree before starting nurse training, or as part of a combined course.

Diagram 15.2 and 15.3 show the way in which opinion was distributed, respectively, between the categories and age groups.

Many of the respondents who were in favour of university education gave the impression, by the tone in which their replies were made, that they thought the question rather a foolish one: "of course it would be of value ..." When asked to give reasons:

46.5% /

46.5% (of the 129 who were in favour) said that it would be good preparation for teaching or administration;

22.5% said that it would give the nurse a "broader" outlook: "Nurse training is so narrow." "Nurses can't talk about anything except nursing."

16.3% said that "nursing needs educated people". One respondent remembered graduate teachers coming into nursing during the 1930's when there were no jobs for them in the schools. "Many of them are at the top now. It was a very good thing for nursing."

12.4% said that better education would give nurses more confidence to express their views in public, to meet members of other professions on an equal basis and "to do something for nursing".

Although all these comments seem to express the same idea, respondents making the first one (that a degree would qualify a nurse for higher positions in nursing) implied that a university education would have little value apart from its utilitarian function.

The suggestion that nurses would benefit from university education at post-registration level also indicated that respondents did not think it would be "useful" to them in the practical situation.

Two /

Two respondents who had been at a university had left without completing a degree. Neither of them felt that a university education would be of any value to a nurse, although one, a health visitor, said that it might be of some use if it included a study of the social sciences.

The 41 respondents who said that a university education was of no value to a nurse seemed to feel that it would not only be a "waste" but could have the same disadvantages as those of a higher minimum standard of entry. It was suggested that "a university breeds snobbishness" and would prevent good nurse-patient relationships. Respondents who had worked with nurses who were graduates or undergraduates recounted their experiences:

> "... she had no idea how to treat people - her manner to the patients and to their relatives was terrible."

> "She'd been a French teacher ... You know what she did? Collected all the patients' false teeth in one big basin and spent the next week sorting 'em out."

> "He'd been accepted for Cambridge so I suppose he must have had brains of some sort /

> sort. He put all the thermometers into the sterilizer to boil ... a very nice chap, but no common sense."

The fact that such incidents had been remembered, and were considered to be worth recounting, suggests that nurses do in fact expect "academic" people to make good nurses, and are surprised when they make the same mistakes as other students. None of the respondents mentioned that nurses frequently criticise their own colleagues for having a "bad manner" toward patients, and that generations of student nurses without university degrees have mixed up dentures and boiled thermometers.

opp. page 191.

DIAGRAM 16 EDUCATION

(COMPARISON: DIAGRAMS 14, 15.)

(PER CENT) IN FAVOUR OF RAISING ENTRY STANDARD

IN FAVOUR OF UNIVERSITY EDUCATION

LEFT SCHOOL AT 16 YEARS OR OVER

16.1 PLACE OF EMPLOYMENT

% 10 20 30 40 50 60 70 80 90 100

(103) HOSPITAL

(103) COMMUNITY

16.2 AGE

% 10 20 30 40 50 60 70 80 90 100

(121) UNDER 40 YEARS

(85) OVER 40 YEARS.

16.3 AREA

% 10 20 30 40 50 60 70 80 90 100

(131) RURAL

(75) URBAN

See TABLES 11, 12, 13.

The statements that:

(1) the educational entrance level for nurse training should be raised, and

(2) university education is of value to any nurse who has the necessary ability,

were both made by a higher percentage of respondents in local health authority employment, in the over-40 year age groups and in the urban area than they were, respect-:ively, by respondents in hospital employment, in the under-40 year age groups, and in the rural area (Diagram 16). These opinions appear to bear no relation to the age at which the respondents them-:selves left school. The percentage of those who left at the age of 16 years or over (that is, above the present minimum leaving age) was significantly higher in the urban than in the rural sample, but the difference between other samples is not significant.

In the analysis of all samples and sub-samples, a larger percentage of respondents were in favour of university education for some nurses than of a higher minimum standard for all nurses. This attitude is clearly /

clearly seen in Opinion Summary Tables, 19 to 23. The nurses seemed to be aware that a very wide range of ability was compatible with nursing require-:ments, that the student capable of more academic work should have the opportunity to use her abilities, but that those with less academic interests should not be excluded from nursing without being given a trial.

Since the desire to nurse often gives the less able student the incentive to pass nursing examin-:ations, it was also pointed out by some respondents that, if the entrance requirements were raised, such girls would also make an effort to pass the necessary school examinations.

4.9.3 : Respondents' occupations on leaving school:

of the total sample of 206 respondents:

90 (43.7%) took some form of further education or training; of these:

48.9% started nurse training,
20.0% attended pre-nursing schools,
16.7% took (or started) secretarial training.

116 (56.3%) took paid employment; of these:

30.2% did some kind of work in hospital (frequently in the local cottage hospital), or nannying,
20.7% were at home, either looking after the rest of the family, working on a farm or in some kind of business,
19.0% were employed in "office work",
11.2% worked in shops.

Asked whether there was any kind of work which they would have preferred to nursing, respondents replied as follows:

No: 65.0%;
Yes: 30.6%;
"Maybe": 4.4%

Occupations most frequently mentioned were:

Medicine: 25.4% of those who said "yes";
Teaching: 31.8% (gym teacher or physical education mentioned 8 times);

Seven /

Seven nurses said they would prefer to be vets. A variety of other occupations were mentioned.

Asked why they were unable to do the work which they wanted to do, 42.9% said "financial reasons" and 27.0% said that they lacked the necessary ability or education.

Of those who said they would have preferred some other work, 25.4% said that they now liked nursing and would not wish to change; 54.0% still regretted that they could not do the work which many of them felt they would have found more satisfying and possibly would have "done better" than nursing.

4.9.4 : "Qualities" required by a nurse.

When asked to give their views on the standard of general education required by nurses, many respondents commented that scholastic achievement should not be the only criterion by which candidates were selected for training.

In some cases the purpose of this comment may have been to correct suspected bias on the part of the inter:viewer ("one of those university people"). But the importance of personality factors was also stressed by respondents /

respondents who said that nurses should have "as much education as possible".

Because it seemed advisable that the interviewer should be seen to acknowledge the importance of these factors before mention was made of university education, respondents were asked to state the qualities which they thought were most important in nursing. The question was only put to 177 respondents and the replies are not easy to interpret, but they seem to be of some interest in comparison with other attempts to define the characteristics of a good nurse. The results are therefore presented here without attempt at detailed analysis.

When directly questioned, some respondents found it difficult to be specific about the qualities required;

> "You need so many things - so many different types of people make good nurses."

Three respondents found the question "too difficult to answer".

The percentage of respondents making each type of comment was as follows:

57.0% /

57.0% : interest in people, desire to help people, kindness, compassion, a "vocational" attitude; "humanity";

34.5% : stability, sense of humour, able to take criticism, happy disposition;

27.1% : understanding, sympathy, tolerance, sensitivity toward people's feelings, "able to put yourself in the other person's place", gentleness;

26.0% : intelligence [1], an enquiring mind, able to think (some respondents stipulated that intelligence should be "enough" but not necessarily present in large quantities);

18.1% : patience, ability to listen;

16.4% : adaptability, be able to "turn one's hand to anything", "not too rigid";

15.3% : reliable, conscientious; must have sense of responsibility, integrity, sincerity;

14.7% : tact, capable of good personal relationships, able to "handle" people, "not cold and aloof", must have a "good approach";

9.6% : initiative, courage, "able to take knocks", not too sensitive, "mentally (as well as physically) tough"; "Ability to take criticism <u>when you have already done your best</u>";

9.1% : "practical common sense" [1];

9.1% : hard worker, must be "physically tough".

---

(1) Respondents appeared to distinguish clearly between "intelligence", by which they seemed to mean ability to reason, and "common sense", meaning a kind of intuitive judgement interpreted into action without conscious reasoning.

Other qualities which were mentioned were:

> loyalty, humility, impartiality, good powers of observation, neat appearance ("it helps the patient"), ability to give confidence, self control, an interest in teaching and an "awareness that one must always be learning".

Other comments were:

> "You must be willing to do things you don't like doing and look as if you did."
>
> "You need sympathy - but you must keep it behind the mask you grow."
>
> "You must be able to understand people without getting emotionally involved."
>
> "You mustn't be too scared of things but you mustn't get hard."
>
> "Kindness plus intelligence = registered nurse; kindness minus intelligence = en-:rolled nurse."
>
> "You need a dash good sense of humour to survive; and you need to be needed, want to do something essential."
>
> "A nurse must always be very tolerant without letting her own ideas go."
>
> "Sympathy, sensitivity toward people, ability to look beyond superficial, technical needs; gentle and courteous - and a gift of knowing what people need; interest plus efficiency."

and (unfortunately):

> "A nurse must have the ability to get under people's skin."

Many /

Many people have tried to describe the qualities desirable in a nurse. Those who have at some time been the object of nursing care have noted the things which they believed contributed to their comfort and recovery. Nurse teachers and administrators have specified the characteristics on which student nurses should be assessed. Medical practitioners have stated the qualities which they considered to be most important in nursing. For a long time the concept of a good nurse has changed very little.

Seymer (1957.f) quotes from one of the Indian Samhitas dating approximately from the fourth century B.C:

> "... knowledge of the manner in which drugs should be prepared or compounded for administration, cleverness, devotedness to the patient waited upon, and purity (both of mind and body) are the four qualifications of the attending nurse";

and from "Exanthematologia, or a Rational Account of Eruptive Fevers" by Thomas Fuller, published in 1730:

> "Tho it is impossible to meet with a nurse every way so qualified for the business, as to have no Faults or Failings, yet the more she cometh up to the following Particulars, the more she is to be liked. It is there-:fore desirable that she be:

1. /

1. Of a middle age, fit and able to go through the necessary Fatigue of her undertaking ...

5. Quiet and still, so as to talk low, and but little, and tread softly ...

7. Handy to do every Thing the best way, without Blundering and Noise.

8. Nimble and Quick a going, coming and doing every Thing ...

10. Well-tempered, to humour and please the Sick as much as she can.

11. Chearful and Pleasant, to make the best of every Thing, without being at any time Cross, Melancholy or Timorous ...

13. Sober and Temperate not given to Gluttony, Drinking, or Smoaking.

14. Observant to follow the Physician's orders duly; and not to be so conceited of her own skill, as to give her own Medicines privately.

15. To have no children, or others to come much after her."

Some of the above points still appear relevant.

The ability of nurses "to talk low, and but little" seems to have persisted into the 20th Century - at the expense, some would maintain, of professional independ-:ence. The view that nurses should have no children is /

is one which many hospital boards of management, in their reluctance to employ married women, would possibly endorse.

A more recent opinion, that of a psychologist, appears in the Minority Report of the Working Party on the Recruitment and Training of Nurses (Cohen, 1948.b):

> "Although intellectual ability within certain limits is an important asset in almost any occupation, I do not wish to imply that it is necessarily a factor of paramount significance in nursing. On the contrary, it would seem that a kind and cheerful disposition combined with a deep interest in the work count even more. This problem of the relative importance for success as a nurse of different qualities of personality and other such factors requires fresh investigation in the light of the criterion proposed for the measurement of nursing effectivemess. It seems to me that only by employing a criterion of this kind can we make any headway towards a scientific method of nursing selection."

The problem of finding a satisfactory method for selecting candidates for nurse training has still not been solved. The statement that "it all depends on how much they want to nurse" is frequently heard in nurse training schools, but the factor which is responsible for an apparently unpromising /

unpromising student becoming a good nurse has not been identified, still less have satisfactory tests been devised for finding out whether or not the factor is present; the only reliable tests are situations which are encountered in nursing.

One fact which does seem to be emerging is that educational qualifications have little relation-:ship to success or failure in nurse training.

A survey of 300 student nurses in five training schools was carried out by the Oxford Area Nurse Training Committee between 1961 and 1964. Inform-:ation was collected regarding the students' educational levels, performance during training, attitude toward nursing and, where appropriate, reasons for withdrawal. The following are extracts from the report (1966):

> "The students could be divided into three groups in respect of their attainment in the G.C.E. 'O' level examination, those who had no passes, those who passed in less than five subjects and those who passed in five or more subjects ... There was no evidence to suggest either that those with certificates were more likely to be successful nor that those with more passes were /

> were likely to be more successful than those with a few passes. (a)
>
> Students without qualifications were just as likely to stay as others and were just as likely to be successful in the final professional examinations ... (b)
>
> A more academic S.R.N. course might well alienate those who choose nursing because it is both practical and patient-centred. The really academic candidate could be catered for by extending the facilities provided by universities for joint degree and nursing courses and developing new post-S.R.N. courses in nursing administration and technical nursing. The training for all nurses does not have to be upgraded at the basic qualification stage in order to provide a technical and administrative élite." (c)

These conclusions follow fairly closely the views expressed by many nurses in the present study. Respondents seemed generally to agree that the first concern of nurses is to provide as effective a nursing service as resources permit, recognising the fact that the abilities which can be put to good use in nursing are as varied as the needs of the people who require nursing care. Those who believe that a higher standard of general education is necessary as a basic requirement /

requirement, regardless of personal qualities, find it hard to provide convincing evidence for their argument.

> "In 1939 the G.N.C. had consented to waive any educational standard for entry to all fields of nursing 'for the duration of the National Emergency'. As far as the Ministry of Health is concerned the war is still on ... the Ministry's case is 'If you have an educational minimum you won't get enough nurses', against the Council's 'You won't keep them unless you do'." (Cullinan, 1965)

The opinion of the G.N.C. is difficult to justify in view of facts such as those quoted above from the report of the Oxford Area Nurse Training Committee. The need for two grades of nurse has been recognised, but the educational dividing line remains controversial.

More time seems to have been spent trying to prove that a higher standard of education is or is not of value to a nurse than in trying to discover why nurse training is so successful in conditioning intelligent people to accept a system which frequently gives the impression of having been devised by people who are not.

With regard to higher education, there was no evidence to suggest that the respondents regarded a university degree as a status symbol; the fear that it might put an educational and social barrier between the nurses and the majority of their patients made some of them doubt its educational value. This identification with the patient was characteristic of the respondents' attitudes and is perhaps responsible for the reluctance of many nurses to interest themselves in "professional" problems of policy making and administration.

4.10 : Nurse-Doctor Relationships.

4.10.1: Who is best qualified to judge the quality of nursing care?

In the study by Kurtz and Flaming (op. cit.) American general duty nurses "were asked to indicate who in the hospital was best qualified to judge the quality of nursing. Approximately two-thirds of the respondents ranked nurses second or lower, with physicians mentioned most frequently and patients and administrators also mentioned. This attitude must certainly by inter:preted as a non-professional orientation among these nurses."

In the present study, 169 respondents were asked who they thought were best qualified to judge the quality of nursing care: nurses, doctors, or the patients themselves. The respondents consisted of 49 staff nurses, 44 ward sisters, 42 district nurses and 34 health visitors. Their replies (percentage of 169) were as follows:

39.1% : patients;

36.1% : nurses;

9/

9.5% : patients and nurses equally;

7.1% : doctors;

6.5% : don't know ("it would depend on the intelligence and state of consciousness of the patient", "it would depend on what kind of nursing you mean").

Two nurses said "nurses and doctors" and one nurse said "patients and doctors".

Most of the nurses gave this question a good deal of thought before making their final answer. They recognised that patients were frequently not in a position to assess the efficiency of a nurse, for example, they could not know whether they were being given the correct dose of medicine, or whether a surgical dressing was being performed with sterile technique. But the remark of one nurse seemed to sum up what many were trying to say:

> "A nurse can be technically efficient without necessarily being a good nurse - she's got to be interested in her patients, and the patients are the only people who know whether she is or not. They can always tell."

Of the 12 respondents who said that doctors were /

were the best judges, 6 were under 30 and 4 were over 50.

Although only 4 district nurses put doctors first, many of them spoke highly of medical opinion:

> "If you get a good g.p. who's really interested in his patients he can tell pretty well how they are being nursed. I know of some like that."

A more frequent comment, from all categories of nurse, was very decided:

> "Not the doctors. They don't know a thing about it."

The respondents' replies to this question make interesting comparison with their attitude toward the Wages and Hours Bill, discussed on pp. 127-129. They show a similar tendency to see both sides of the question, to believe that although nurses know more about their own job than anyone else does, the people who are on the receiving end should also be permitted to "have their say". Whether this attitude is, as Kurtz and Flaming suggest, a "non-professional orientation", seems to be a matter of opinion. It is very unlikely that any of the respondents would have been in the least interested in whether it was or not. 4/

opp. page 208.

DIAGRAM 17. "ARE THERE CIRCUMSTANCES IN WHICH A NURSE SHOULD NOT OBEY A DOCTOR'S INSTRUCTIONS?"

(PER CENT) YES
NO
NO EXPERIENCE - DON'T KNOW

% 10 20 30 40 50 60 70 80 90 100

17.1 (206)
WHOLE SAMPLE

% 10 20 30 40 50 60 70 80 90 100

17.2 CATEGORY

(50) STAFF NURSES

(53) WARD SISTERS

(55) DISTRICT NURSES

(48) HEALTH VISITORS

% 10 20 30 40 50 60 70 80 90 100

See TABLE 14.

4.10.2: Are there any circumstances in which a nurse should not obey the instructions of a doctor?

Kurtz and Flaming refer to an unpublished master's thesis by Wessen (1949) in which the writer indicates "that nurses' reluctance to assert themselves vis-à-vis physicians is the despair of those trying to help them improve their status".

Since the respondents in the present study believed that patients were better able to assess the quality of nursing care than doctors could (unless the doctor happened to be a patient), it is perhaps not surprising that 47.1% of the whole sample said that a nurse should not carry out a doctor's instructions if she considered them to be detrimental to the patient:

> "We're not obliged to obey a doctor just because he's a doctor. Our first duty is to the patient."
>
> "A nurse must continually exercise judgement in her work."
>
> "A doctor doesn't always realise the implications of the treatment he orders."
>
> "A doctor shouldn't ask a nurse to do something which he wouldn't do himself."

Examples /

Examples were given of doctors who were inexperienced, over-tired, in a hurry, or had been drinking. (A district nurse, describing her experiences with one of these last, said that he never caused her any trouble because he could never remember afterwards what he had told her to do.)

Mention was also made of doctors who had recently come to Britain and were not familiar with British behaviour, British drugs and other forms of treatment; they could cause nurses a good deal of worry, especially if they considered it "beneath them" to listen to the advice of nursing staff.

10.7% of the respondents said that a doctor's orders should always be obeyed. Some of the older district nurses said that they could not imagine the question ever arising; they had always co-operated fully with the local general practitioners and had given them complete loyalty. One nurse, however, seemed to detect a flaw in this statement, and qualified it by adding:

> "He knows me very well, of course. He would never ask me to do anything which he knows I wouldn't."

42.2/

42.2% of the respondents said that they could not answer because they themselves had never been faced with such a decision in practice, and did not know how they would act. None of these nurses gave the impression that they were in doubt as to whether the idea of disobeying a doctor was "wrong" in principle. Their doubts were about the way they themselves would act in a hypothetical situation.

> "You would have to be very sure - it would depend on so many things."
>
> "It would take a lot of courage to refuse to obey a doctor and I don't know whether I would have enough."
>
> "I agree in principle that a nurse is not obliged to obey a doctor's instructions, but I wonder what it would have been like to be a nurse in Belsen? I've often wondered about that."

The opinions of the hospital nurses did not differ significantly, as a whole, from those of the community nurses, although a noticeably small proportion of the staff nurses (2.0%) were prepared to say that they would never disobey a doctor (Diagram 17.2).

Diagram /

DIAGRAM 17 (continued) "ARE THERE CIRCUMSTANCES IN WHICH A NURSE SHOULD NOT OBEY A DOCTOR'S INSTRUCTIONS?"

(PER CENT) YES / NO / NO EXPERIENCE - DON'T KNOW

17.3 AGE

(62) 21 - 29 YEARS

(59) 30-39 YEARS.

(43) 40-49 YEARS.

(42) OVER 50 YEARS.

% 10 20 30 40 50 60 70 80 90 100

See TABLE 14

Diagram 17.3 shows that a significantly smaller percentage of respondents under 40 years of age (5.8%) seemed to feel that a doctor's instructions should always be obeyed, compared with those over 40 years who held this view (17.6%). If this is a true indication of their attitudes it would be interesting to know the reason for the difference. It could be that as a nurse grows older doctors are more willing to accept her advice, or it may be that she becomes more wary of involving herself in disputes with the medical profession, having learned from experience that they can have unpleasant consequences. A third possibility is that the younger nurses are more willing to "assert themselves" - a further demonstration, perhaps, of the opinion expressed by some respondents that "the attitude is changing".

There was an awareness, implicit in the comments of nearly all respondents, that a nurse is in a weak position, legally, if she opposes the wishes of a member of the medical profession. Most of the nurses who said that they would never refuse to obey an order were /

were prepared to question instructions which they thought had been made in error - it was a nurse's duty to do so - but beyond this they were not prepared to go: "You can't. It would be professional suicide."

The importance of never carrying out instructions unless they were given in writing was stressed by many respondents. Several suggested that this was a useful test when they were in doubt: if a doctor refused to sign a written order, a nurse was quite justified in refusing to carry it out.

Several nurses said that where personal relation-:ships were good, conflict did not occur; it was not a case of never disagreeing with a doctor: (this is an everyday occurrence) but of how to "get around it". A district nurse gave an example of a general practitioner who insisted that his incontinent patients should be nursed lying on newspapers:

> "Newspapers! Did you ever hear of anything so silly! What did I do? I just put them in before he came and took them out when he'd gone."

A staff nurse said that one could "lose the bottle..."

Most /

Most of the respondents interpreted the question as referring to orders prescribing drugs or other "medical" treatment. Asked what they would do if a doctor gave orders regarding "nursing" treatment, respondents tended to look at the interviewer suspiciously, as if doubting whether she were indeed a nurse.

On the whole, the respondents gave the impression that most doctors were "pretty good" about respecting a nurse's views. One example, which was frequently mentioned by staff nurses, was the giving of large doses of sedation to patients who were in the terminal stages of illness. Although nurses knew that in most cases this was done in the interests of the patient, they could not always bring themselves to give the injection. In such cases, the doctors usually gave it themselves.

A similar situation, but involving much deeper issues, arises when a cadaver transplant is needed quickly - a problem which was mentioned by two respond-:ents, and which an increasingly large number of nurses will have to face.

Analysis /

Analysis of the replies to this question present three difficulties:

First, it seems fairly clear that the replies "yes", and "no" and "don't know" over-simplify the attitudes which were involved. But they do, at least, reflect the ways in which the nurses viewed their own attitudes: for instance, the district nurse who said that the doctor would never ask her to do something of which she disapproved was apparently convinced that she "would never disobey instructions".

Second, although the replies appeared in many cases to be based on the assumption that nurses have a role to play which is distinct from that of doctors, the dividing line between medical and nursing responsibility is not clearly defined. A decision, in any particular case, must depend on the experience and personalities of both doctor and nurse, and upon the "general situation".

Third, respondents seemed to assume that the interviewer, as a nurse, would be familiar with the circumstances /

circumstances in which problems involving nurse-doctor relationships arise. Some of the incidents which the respondents described would, as they recounted them, possibly seem insignificant or unrealistic to anyone who was not. For this reason, it is inevitable that their replies should have been interpreted more sub-:jectively than those given in reply to other questions, where nurses were required to express their individual views, based on their own experiences.

For the above reasons, detailed statistical analysis does not appear to be justified. Respondents frequently conveyed their feeling by expressions and gestures for which, unfortunately, no objective and adequate recording device is available.

However, respondents' attitudes toward this question do seem to suggest that, although nurses in management positions may be apprehensive about the undermining of their powers by medical and lay administrat-:ion, nurses are not in imminent danger of losing ground in the practical situation.

Burling et al. (1956) note that in American hospitals "nurses /

"nurses have informal techniques of controlling the doctor even though he overtly holds sway". Nurse-doctor relationships in America may be different from those in Britain, but informal techniques appear to have a wide geographical distribution and to be closely related to the sex roles which are the basis of division of labour in the health field.

Mauksch (1966.b), in a study of the context of American nursing practice, has considered "some of the implications of the fact that nurses, with few exceptions, are female, while physicians, with almost as few exceptions, are male". He suggests that the physician can be compared to "the traditional male, the master of the home", and that the functions of the nurse are "compatible with the traditional female function of homemaker and with other aspects of the mother role which are managerial in nature".

The apparent reluctance of nurses to assert their professional independence vis-à-vis the medical profession suggests that they are perhaps unwilling to acquire professional status at the expense of this traditional relationship /

relationship. Evidence to support this seems to be traceable, not only in nurses' attitudes to doctors, but also, more indirectly, in their attitudes on relatively minor issues; for example, the refusal of many nurses to discard a form of 19th century dress which was considered becoming to females in an era before male superiority was overtly challenged.

The fact that nurse-doctor relationships in most cases involve a male-female relationship is one of which nurses have been aware for a very long time, not necessarily because of its interest as a sociological study.

4.11 : Nursing - a "vocation"?

At the beginning of each interview, respondents had been asked to state what they thought was the difference between a profession and a trade. Through-:out the interview, they were asked to comment on specific aspects of a nurse's responsibility. But it was felt that they should finally be given an opportunity to express their personal attitude toward nursing, if they wished to do so, and also to clarify the term "vocation" which about half the respondents had used, in various contexts:

> We sometimes hear discussion about whether nursing is or it not a vocation. The word seems to mean different things to different people. What do you think it means? How do you think it applies to nursing: Is it a good thing or a bad thing for a nurse to have?

Classification of respondents' replies according to whether they stated that nursing was or was not a vocation was of little value because the nurses did not all use the term in the same sense. Some inter:preted it as meaning "dedicated - like a nun", while others defined it simply as "an interest", "something you want to do". Many nurses gave the impression that they disliked the term ("... makes me shrivel up inside") but that, as one health visitor suggested, "we need another word for it, then it would be all right".

Some respondents appeared very anxious not to give the impression that they were "the martyr kind". They began by stating emphatically that nursing was not a vocation to <u>them</u> (they had not been asked this) and then went on to say "but you must want to do it", or the work would be intolerable. Others seemed to be expressing the same idea in different terms: "Must have a sense of vocation, otherwise it would be ghastly".

The semantic difficulty is in some ways similar to that of trying to define a profession, but vocation (except /

(except when used as a synonym of occupation) seems to involve a personal attitude, whereas profession can be studied as a sociological concept.

The two terms are sometimes used as if they were mutually exclusive. Marsh & Willcocks (1965), in their study, Focus on Nurse Recruitment, asked their respondents whether they considered nursing to be a vocation, a career or a job. None of the respondents are recorded as stating that it could be both, whereas in the present survey many of the respondents implied that there was nothing incompat- :ible about the idea of nursing as a means of earning one's living and nursing as a vocation: "Nursing is a job and a vocation"; "Depends on the individual. Any job could be a vocation". Others shifted the blame, as it were, on to nursing itself: "It is a vocation, whether you like it or not" - "it" referring to the idea of a vocation. "Nursing needs all you've got because you have nothing left of you afterwards".

Respondents who said that nursing was "just a job" frequently talked at length about their dislike of /

of "the vocational kind".

> "Vocation is a word which is often used by people who haven't got any. It can also be used as an excuse for taking advantage of people and stifling attempts to be critical."

> "Vocation is a word which is used as a means of making you feel you haven't got one when you ask for the evening off."

Some of the respondents who said that nursing was a vocation gave the impression that they were rather embarrassed by the question and felt that the interviewer, as a nurse, had committed a professional solecism by introducing the subject.

Respondents' comments are quoted here verbatim. There has been no attempt at selection, except that where a comment was repeated in similar terms, it has only been included once.

(1) Staff Nurses

"Nursing isn't a vocation at all. Don't know how the word got into it. I wouldn't be satisfied doing anything else, but I never heard a voice telling me to go and pick up my lamp."

"The vocational attitude should exist in nursing; it must - if you don't like helping people you shouldn't be a nurse. You've got to be able to clear up sluices and things."

"You've got to like nursing, but I object to people saying that one nurses for other reasons than money."

"You try to convince yourself nursing isn't a vocation. I started that way and got a bit twisted. It is a vocation - you take the job with you."

"I never heard the call that people talk about. It's rare, but some do have it. They're not necessarily the best nurses."

"Dedication to the job enables you to cope with difficulties; you need this in nursing."

"The best nurses are vocational nurses. It means those who wouldn't be happy doing any-:thing else."

"Nursing /

"Nursing isn't really a vocation; you don't need to be completely dedicated."

"A vocational attitude is necessary to nursing; you have to be devoted - there are no half measures."

"Unless you want to nurse you couldn't stand it."

"Nursing is a vocation. You must like people, be prepared to put up with all types."

"A vocation is a kind of urge to do a certain kind of work. It's not essential at the beginning, but it's a good thing to develop."

"Vocation is a thing in which you give yourself, unconsciously."

"Vocation is important - it means a sense of duty to one's fellow men, irrespective of airy-fairy views ..."

"Vocation means you are 'meant' to be a nurse. It's not just a job, you get satisfaction out of it."

"It's non-existent in nursing - never met a nurse with a vocation. It means single-mindedness. To me it's purely and simply a job."

"Vocation is possibly the same as profession: you need to be interested."

"Vocation means dedication. Nursing is a labour of love. I don't think about it as work. Those going in for it now treat it as a 'job'."

"There's /

"There's no dedication now; nursing is just a 'job' - the girls coming in with two "O" levels are just not interested in their patients. People with a lot of education are 'above' nursing." (aged about 23 years, left school at 16)."

"Vocation means absolutely dedicated. Not necessarily true of nursing. If you're super-dedicated you never know what's going on outside - it's not good for the patients."

"Vocation applies to religion or to God - out of date now. Nurses don't have it. People come into it for different reasons - but you've got to be willing to do extra work and that sort of thing."

"You've got to like it to stick it, but you must have outside interests."

"You either want to do it or you don't. Some don't. They leave."

"A vocation is something you put before other things. Nursing is a vocation - it needs a sense of responsibility, you don't go 'off on the dot'."

"Vocation is a niche you fit into. Nursing isn't the vocation - it's the person who has it - you make it yourself."

"Nursing is a vocation to me but not to all. It means you really want to do it. Some do it to please their parents, or because they can't think of anything else. It's quite a "good job" now."

"Long /

"Long ago people had vocations. Nowadays the pay is similar to other jobs. Used to be sheer drudgery. Must have been something to make 'em do it."

"Vocation is a calling. Nursing isn't a calling ... it's something in somebody."

"Vocation doesn't apply to nursing to-day - it's often a second-best choice; often girls come into it because they can't teach. They want something out but are not prepared to put in anything. A vocation is something you want to do; it can't be forced."

"Vocation is a religious attitude. Nurses deep down are religious. You're so deep down to tragedy, you tend to think ... we all have feelings too ... you never really get hard, underneath you still feel it; you have to put a face on things."

"Vocation? Never thought about it ..."

(2) Ward Sisters

"Vocation means a calling. Lot of rot. Nursing isn't. When you're young you don't know why you want to nurse - but then, you find fulfilment in it ..."

"Attitude is changing. People want to be 'off on the dot'. Can be the other extreme, which is not good."

"Don't know. Don't like the word."

"Something inside myself made me be a nurse; I couldn't help it. The glamour attracts some, but with most it is a vocation."

"It's /

"It's more than <u>just</u> a vocation. It's a means of earning a living."

"You must like it <u>deep down</u> or you couldn't do it."

"Vocation is quite a good thing - a feeling that you want to do something to help humanity."

"Nowadays it's more of a 'job'. People aren't so 'dedicated' - good thing they aren't."

"Vocation is a good thing; not enough people with it. When it ran out the trouble started."

"The word 'vocation' should be scrapped. I dislike the 'vocational' kind - usually leave other people to do the work. But I'd always come back to nursing even if I was left a million ... "

"Vocation is an old-fashioned word. It has snob appeal. It's not the same as dedication."

"You must be <u>interested</u> in nursing, or you can't make a good job of it. That's a vocational attitude."

"Don't like the martyr attitude. Can't call it a vocation if you're being well paid for it."

"Vocation means not just working for pay - it means trying to help people."

"Vocation means something chosen, done to the best of your ability."

"Nursing is just a job. People go into it for the glamour."

"Vocation /

"Vocation is a good thing. It's something inside yourself, you want to do something, and to do it better ..."

"Vocation is an emotional term. You have to be interested in nursing, it isn't just a job."

"A nurse needs a sense of vocation; not necessarily completely dedicated - you need outside interests to be able to understand patients. It isn't just a job - it's something you have to do. If you don't feel like that you might as well give up."

"Nursing is a vocation - people can't be happy if they don't like it, because it's not easy at times. That's a vocation."

"Vocation as a word is old-fashioned. But you have to be very fond of nursing - some of it can be so ghastly."

"Don't know ... I drifted into nursing ... no vocation ... "

"Vocation means complete dedication. I always wanted to nurse and wouldn't do any-:thing else, but it's not a vocation."

"Vocation is not complete dedication. Those with very little outside interests make poor nurses - they bring you closer to your patients."

"Vocation means giving up everything for one's job. We shouldn't nurse unless we wanted to and we should be prepared to give up some things, from time to time."

(3) /

(3) District Nurses

"Younger girls just think it's a nice profession. In the Highlands you teach if you have brains. If you haven't, you nurse."

"It has always depended on the individual. Still does."

"Vocation has been an excuse to exploit nurses. It means a 'wish to do a job'. Nowadays the public image of nursing is changing - less angelic."

"A vocation is a good thing in nursing - the young ones go in for the glory."

"We must bring God's work into nursing."

"Vocation means dedicated - like a nun. Nurses are often less dedicated than people in other jobs. They used not to go into it for the money but it's different now that the pay is better."

"Vocation means making yourself a martyr in the cause. Nursing isn't like that. Still, one does choose to nurse ..."

"A vocation is something you want to do and are very interested in - to help fellow creatures."

"A vocation is something you feel you have to do, even although there are difficulties in the way."

"Nursing is not a vocation. In a vocation you give up something, like a nun. If I didn't get paid I wouldn't do it - we are as well paid as anyone else and the hours are good. Nursing is a 'job' - other jobs are not vocations."

"Those /

"Those who are not interested in nursing get weeded out early; those who are left must be interested. There's too much said about poor overworked nurses. It's bad for recruitment and it isn't true.

"Attitude to work is changing - why not in nursing? A vocation means very keen on the job."

"Everyone doesn't have a vocation - a few do. It means dedication. We need some, but it's not good in its extreme sense."

"Sometimes nursing isn't very attractive, but you do your best because it helps the patient - and it's rewarding in the end."

"The N.H.S. has taken something from nursing - the lamp is growing dim. We get too much paperwork - ugh! I don't really object - as long as I think it's necessary!"

"Vocation means doing things without material reward - I need it!"

"Vocation you do for the pure love of it. All nurses, as far as my friends are concerned, feel that nursing is 'just a job'. I'd leave to-morrow if I could. But you can't separate the humane aspect, you've got to have some interest in it."

"In nursing you have to be prepared to put nursing first - other things go."

"Call it what you like, but you must want to give something, something in yourself, which makes it a vocation."

"Vocare /

"Vocare - calling ... Nursing is to some people. It needs all you've got because you have nothing left of you afterwards. It's a vocation, whether you like it or not."

"Must have a sense of vocation, otherwise it would be ghastly ..."

"Vocation is something to do with religion. That's not true of nursing, but you've got to be interested in it."

(4) Health Visitors

"Nursing is now just a way of earning a living. It's not the nurses' fault; it's part of the climate of the time."

"Nursing _is_ a vocation - if it wasn't, you couldn't stick it."

"Vocation is a word which is often used by people who haven't got any. It can also be used as an excuse for taking advantage of people and stifling attempts to be critical."

"There's less 'vocation' now. Nursing used to be done by 'monied' people - bargaining about salaries has changed things."

"A "dedicated" nurse is not always a good one - good motives gone wrong. But you must _like_ nursing - you're dealing with people."

"Vocation means liking for the job. Those who haven't got it are weeded out in the first 6 months."

"Depends /

"Depends on the individual. Any job could be a vocation. One must want to nurse ..."

"Nursing is a job and a vocation ..."

"Vocation is tending to die out. It's an urge to help people in a certain way, and the satisfaction you get out of it. We need another word for it, then it would be all right!"

"Vocation is the aim to do something, wanting to do it more than anything else, something special."

"Nursing need not be one hundred per cent dedication. It needs all-round people who can talk about other things. Other people do just as good a job as nurses, grocers, for instance."

"If it's in your inner heart, it's a vocation; you wouldn't stay in nursing if it wasn't."

"Vocation is nuns and religious orders, giving all one's time and energy and life to it - most unhealthy for a nurse."

"Nursing used to be a vocation - not now. Vocation is wanting to do something regardless of the conditions, like entering a convent."

"Vocation is something you do for the love of it - nurses don't even know what their gross salary is! I'm dependent on it, but I nurse because I enjoy it, not so much for the salary."

"Vocation - the word makes me shrivel up inside! It's not true that nurses are born and not made. Girls choose nursing, but they don't need to be saints."

"Vocation /

"Vocation goes back to the days of Florence - being a lady of means and being able to do things without financial reward. Nursing need not be a vocation. It's something you want to do more than anything else."

"Most nurses have an aptitude, but it's just a job. So is the ministry these days."

"Vocation is a word which is used as a means of making you feel you haven't got one when you ask for an evening off!"

"I was educated in a convent and the word vocation does not embarrass me. It means more than just giving a service, it's genuinely wanting to help people. Why else do people nurse? I love nursing. You wouldn't stay in it otherwise - it's not glamorous and rose-coloured ..."

"Vocation is like the clergy - giving themselves to God. We're not. We're getting paid."

"The word 'vocation' makes me cringe ... It means a desire to do a thing. I always wanted to nurse; this attitude can be a vocation."

"Nursing was a vocation. There's a lot of competition for other things now - nursing is getting to be a lower level. There is less mutual respect between patient and nurse. Old people respect nurses more than young people. It's a general change in social outlook."

4.12 : Social Ranking of Occupations.

Respondents were asked to rank fourteen occupations in order of social status. Nine were selected from the list used by Hall & Jones (1950), some of them slightly altered so that they would be more meaningful to Scottish respondents, and five were added: nursing, and some allied occupations.

The title "medical officer" has a variety of connotations for nurses and was replaced by "general practitioner"; it seemed possible that hospital nurses and community nurses might differ in their opinion of his social status.

The following occupations were finally used:

Bank teller
Chartered accountant
Company director
Dentist
General practitioner
Joiner
Medical social worker
Miner
Minister (Church of Scotland)
Nurse
Physiotherapist
Policeman
Primary school teacher
Railway porter

The /

The name of each occupation was written on a card. Respondents were handed the cards in random order and asked to arrange them according to the social status of the occupations, in relation to each other. No other instructions were given.

The reactions of the respondents varied. Some made no comment, sorted the cards quickly, handed them back. Others had difficulty under-:standing what they were to do. In the pilot study, one nurse who did not appear to know the meaning of the terms social status, social prestige or social class, asked: "Do you mean you want me to put them in snob order?" In subsequent inter-:views, when a respondent seemed unable to under-:stand any of the usual instructions, the term "snob order" brought immediate response.

A third type of reaction from respondents was one of distaste and, in a few cases, of aggression. Typical comments were:

> "It's all wrong, thinking about people like that."

> "All /

"All that class stuff is going out."

"What people do for their living isn't important. It's what they are in themselves."

One respondent refused to arrange the cards; six gave up after attempting to do so, one of them saying:

"I don't really know what I'm doing. I'm just putting them anyhow. I know what you want but I can't do it. I keep thinking of people I know, and then it's them I'm really sorting, not their jobs. What they do doesn't matter when you know people."

Although it would be difficult to assess the extent to which any of the respondents "sorted people", it seems reasonable to suppose that nurses, whose work brings them in contact with all social classes, might find the exercise more difficult than members of some other occupations. Of the six respondents who were unable to complete the exercise, three were themselves from a Class 3 social back-:ground, two from Class 4, one said her father was dead. The respondent who refused to make an attempt was from social Class 1. (1)

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(1) For purposes of the present survey, occupations were classified according to the Registrar-General's Classification of Occupations (Census, 1951), with Classes IV and V combined as Class IV. "O" indicates father dead, or occupation not known. (<u>see</u> Table 3)

It was not possible, within the limitations of the present survey, to discover the criteria on which respondents based their judgements, but the comments which they muttered while sorting the cards suggested that "social status" was being interpreted by a variety of standards:

> "Company director. Who's he, anyway? It's just the name. He's going down there."
>
> "Miners are often very intelligent people, very well-read. Better than me."
>
> "Ministers never do anything - except ask for money."
>
> "My! aren't I having fun? It isn't often I get the chance to put all these people in their place."

The final result, however, showed that the respondents had, on the whole, ranked the occupations according to the main divisions of the Registrar General's classification, with the exception of the bank teller: "He's just a laddie that keeps the books." The fact that some of the respondents, particularly those engaged in public health work, would be familiar with the classification, may have had /

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DIAGRAM 18 SOCIAL RANKING OF OCCUPATIONS

18.1 NURSING: RELATIVE POSITION (RANK ORDER)

18.2. PERCENTAGE OF RESPONDENTS PLACING EACH OCCUPATION ABOVE, BELOW, EQUAL TO NURSING (NOT PLACED:)

(Figures adjusted 0.5%, where necessary, to accommodate to scale)

see TABLE 16.

had some influence on the result, but it would not account for the wide variation of opinion regarding the relative position of the nurse.

Diagram 18.1 shows the percentage of respondents who placed nursing in each of 14 possible positions. It occupies every position from 1 to 12.

Every occupation except that of railway porter was placed equal to nursing by at least one respondent. The nurse who placed a nurse below a porter said that she "just felt like that to-day" (Diagram 18.2).

The scattered distribution could be the result of a number of factors:

(a) the wide range of social backgrounds from which the respondents themselves originated;

(b) confusion in nurses' minds about their own professional role;

(c) the variety of work which is included in the term "nursing", a paradox which Davis (1966) has /

has described as characteristic of nursing in the United States of America, and which is to some extent applicable to nurses and nursing in this country:

> "It is a paradox that, in popular parlance, the same unmodified nouns 'nurse' and 'nursing' should be applied so indiscriminately to a wide variety of health care activities, carried on in different settings under different institutional auspices, and to an occupation that includes some of the least educated members of society (such as aides and orderlies) and some of the most educated (such as persons with advanced degrees who serve as consultants to federal, state, and municipal health agencies)."

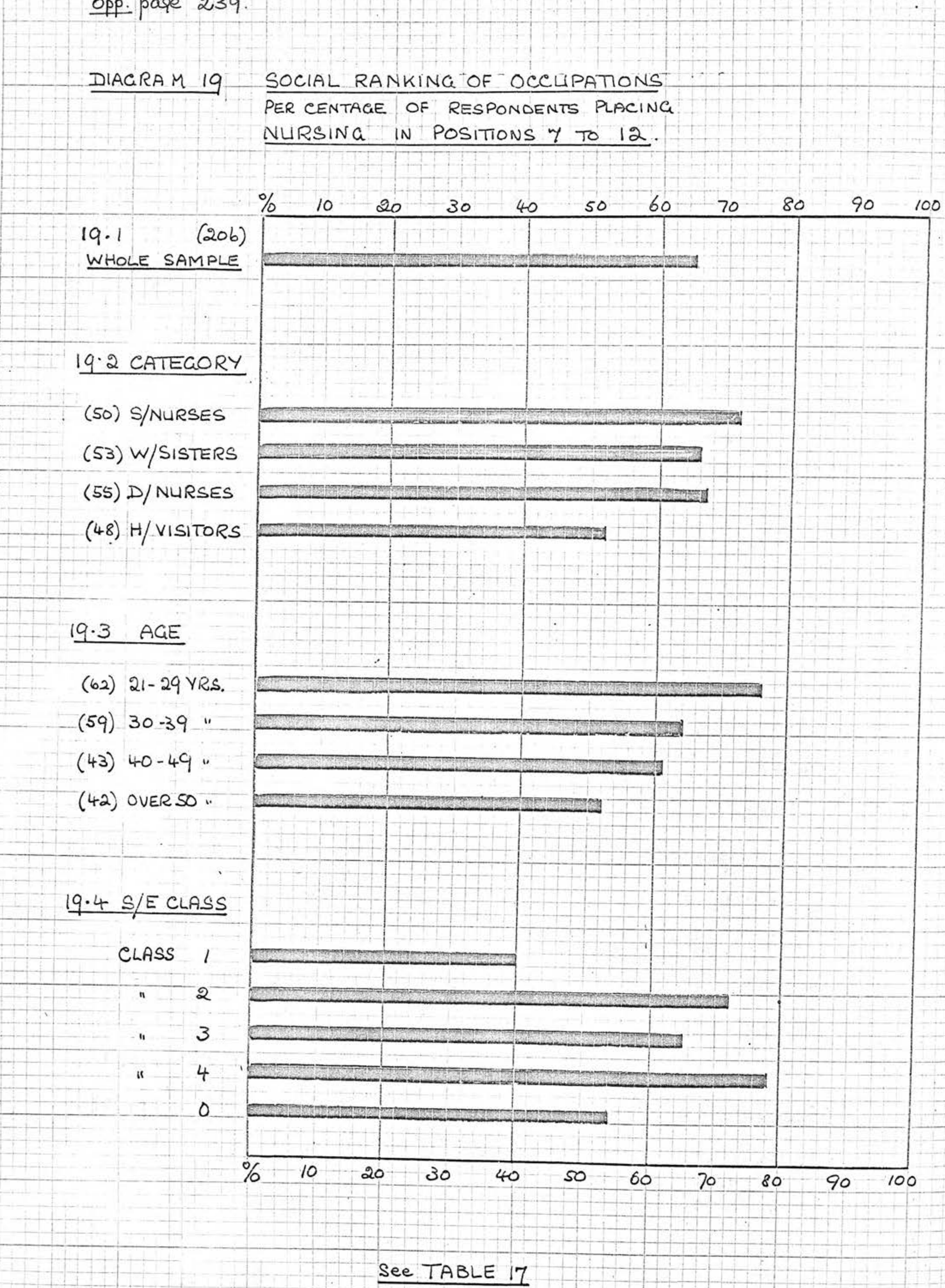
Opp. page 239.
DIAGRAM 19
SOCIAL RANKING OF OCCUPATIONS
PER CENTAGE OF RESPONDENTS PLACING NURSING IN POSITIONS 7 TO 12.
% 10 20 30 40 50 60 70 80 90 100
19.1 (206)
WHOLE SAMPLE
19.2 CATEGORY
(50) S/NURSES
(53) W/SISTERS
(55) D/NURSES
(48) H/VISITORS
19.3 AGE
(62) 21-29 YRS.
(59) 30-39 "
(43) 40-49 "
(42) OVER 50 "
19.4 S/E CLASS
CLASS 1
" 2
" 3
" 4
0
% 10 20 30 40 50 60 70 80 90 100
See TABLE 17

Diagram 19 shows that over 50% of respondents in the whole sample and of respondents in all the main sub-samples which were analysed, placed nursing in positions 7 to 12, with one exception: only 40.0% of respondents who were themselves from a Social Class I background ranked nursing in positions 7 to 12. The health visitor respondents placed nursing higher than did respondents in other categories.

Respondents who were over 50 years of age ranked nursing higher than did respondents who were under 30 years of age: that is, a significantly higher percentage of the younger age group placed nursing in positions 6 to 12. This appeared to be part of a trend to rank nursing more highly as the age of the respondent increased (Diagram 19.3) - perhaps a reflection of the increased prestige which age often brings to a nurse (regardless of her position in the professional hierarchy), or it could suggest that the status of nursing is declining in relation to other occupations now available to women. On the other hand, there was no significant difference between the views of nurses in the hospital and community samples, in spite of the fact that 78.6% of the hospital nurses were under 40 years of age. (cf. Table 1.)

There /

There was no difference between the opinions of respondents in the rural and the urban area.

The idea that nurses employed in hospital might have a different view of the social status of the general practitioner, compared with nurses in the community, was not substantiated by the results. Table 18 shows that there was no significant difference of opinion between the two samples.

Appendix 4 gives information regarding entrance requirements for medicine, and for occupations ranked above or below nursing by less than 80% of the respondents. It is interesting to compare the requirements of occupations allied to nursing and which were ranked close to nursing in the social scale. The detailed specifications of the Chartered Society of Physiotherapy (Appendix 4.6) and the "wide variation of practice" regarding qualifications required for medical social work contrast conspicuously with the brief statement issued by the General Nursing Council for Scotland (Appendix 4.5).

Appendix 5 gives examples of salary scales for the occupations described in Appendix 4. It would appear that the respondents' assessment of social status /

status was not closely related to actual or potential earning power, in terms of financial income.

The reluctance of some respondents to rank the occupations, and indications that many did not like doing so although they did not say so explicitly, is perhaps related to the uncertainty of nurses with regard to their own occupational status, and also to the conflict between the ethical concept of nursing service and the situation which exists within the profession itself.

Entry to the nursing profession, like nursing service, is "unrestricted by consideration of nationality, race, creed, colour, politics or social status". Nurses frequently show uneasiness when class distinctions intrude into their work, for instance, when they are expected to give special attention to "private" patients, although whether they are uneasy because they think fee-paying is unethical, or because they like attending to such patients /

patients and feel guilty because they like it, is not clear. Yet within its own rigid hier-:archy nursing has evolved a ruthlessly impersonal pecking order, based on factors which are not easily identified. The illogicality of the situation seems appropriate to an occupational group which, while claiming to provide "service to mankind", often appears indifferent to the needs of its own members.

SECTION 5 : SYNTHESIS

In this section, the attitudes of respondents are first summarised briefly and discussed in relation to variables relevant to the study.

Second, an attempt is made to identify some of the values on which nurses' attitudes seem to be based, with special reference to nursing education and professional nursing organisations.

In conclusion, implications of the results of the study are discussed in relation to general developments in nursing service and nurse education.

5.1 : "Attitudes"

5.1.1: Place of employment and professional category (Tables 19 and 20)

Hospital nurses are primarily concerned with institutionalised patient care. Community nurses are engaged in home nursing and health teaching. Because these two groups are concerned with different aspects of nursing responsibility, it is sometimes assumed that the attitudes and values of the individuals in each group must be different

Analysis of the results of the present survey has shown that only on one major issue were there significant differences between the views of hospital and community respondents; this was on the subject of the general education of nurses. But the hospital and community samples were not homogeneous groups: each included two categories of nurse. The replies of respondents in each of the four professional categories show that on a number of questions the views of ward sisters corresponded more closely to those of health visitors than they did to those of the staff nurses who were their hospital colleagues.

These results suggest that the popular concept of two groups, "hospital people" and "public health people", is based upon external factors, rather than upon an understanding of the individuals who compose the groups.

In this section, some of the characteristics presented by respondents in the four professional categories are summarised and discussed.

Staff /

Staff nurses.

The staff nurse sample was composed mainly of recently qualified nurses, 80.0% of whom were under 30 years of age. The small number in the 40-49 year age group were nurses who had returned to work after a break in service due to marriage. Of the whole staff nurse sample, 26.0% were married or widowed at the time of interview.

Although 62.0% were satisfied with the opportunities which existed for expressing their opinions, 70.0% said that nurses did not make use of their opportunities. The reason most frequently mentioned by staff nurses was that they were reluctant to oppose senior staff; yet on the question of whether there were any circumstances in which a nurse should refuse to carry out the instructions of a doctor, only one staff nurse said that a doctor's orders should always be obeyed.

Of the four professional categories, staff nurses contributed least to the membership of professional organisations: only 26.0% were members, compared with /

with 51.0% of the whole sample. Many of the staff nurses were newly qualified and were anticipating marriage rather than the immediate prospect of a career in nursing; some had the idea that they were "too junior" to become members. Their general vagueness about the existence and function of profess-:ional nursing organisations suggested that little effort had been made to interest them in such things during their training.

52.0% of the staff nurses were in favour of payment for overtime; this view differed significantly from that of ward sisters, of whom less than one-third were in favour of payment.

Only 34.0% of the staff nurses said that the present educational standard for entry to nursing should be raised; several pointed out that if a girl who left school at 15 years of age could pass the examinations of the General Nursing Council there was no reason to raise the entrance level.

Of the 54.0% who said that a university education might be of some value to nurses who had the necessary ability,/

ability, some added comments to the effect that a degree "might come in useful later on if they wanted to teach or be a matron or something"; 30.0% said that a university education was of no value to a nurse.

In their comments on the "vocational" aspect of nursing, staff nurses seemed very anxious to avoid giving the impression that they were the "dedicated type". In spite of this, many of them had retained a good deal of the idealism which influenced them in the choice of a career. They were very conscious of the "human" aspects of nursing, possibly because they were directly concerned with patient care rather than with the problems of administration.

Ward Sisters.

The ward sisters were a relatively young group: 71.7% were under 40 years of age; 22.6% were married or widowed.

They seemed to be very much aware of the heavy responsibilities /

responsibilities involved in the running of a ward; 50% gave "indemnity insurance" as a reason for belonging to a professional organisation.

A relatively high percentage of the ward sister respondents were members of professional organisations, were satisfied with the opportunities available for expressing their opinions on profess:ional policy, thought nurses made insufficient use of such opportunity, and disagreed with the idea of payment for overtime.

A relatively low percentage of ward sisters were in favour of raising the educational entrance requirements for nursing, or with university education for nurses. Their views on education corresponded more closely to those of the staff nurses than to those of respondents in any other category. They appeared to be suspicious of "academic types" and to doubt the value of educational qualifications as criteria for selecting candidates for nurse training.

The ward sisters gave the impression that they

were /

were a rather conservative group, their views usually corresponding fairly closely to those of either health visitors or staff nurses. But, on the whole, they seemed to find their job satisfying, a fact which was commented upon by the Committee on Senior Nursing Staff Structure. They attribute this to the fact that:

> "... each exercises decentralised control and substantial delegated authority ... There is human interest and full scope for the exercise of professional and manager-:ial skills. These features often make it the height of a nurse's ambition."
> (Ministry of Health ... 1966.c)

However, the Committee also suggests that the ward sister has too much to do, that ward administration is unduly difficult owing to the complexity of services which have to be co-ordinated, and that "the job may have functions which belong to a higher level of manage-:ment for which the ward sister may not have been prepared". (op. cit.)

District Nurses.

The district nurse sample contained 61.8% respondents over the age of 40 years. Of these, 73.5% /

73.5% were over 50 years. 29.1% were married or widowed.

Only 47.3% of the district nurses were satisfied with the opportunities which existed for expressing their opinions on professional policy, compared with 87.5% of the health visitors who were satisfied.

The difference between the percentage of district nurses and health visitors who were members of professional organisations was also highly significant; 38.2% and 72.9% respectively. It might have been thought that the need for indemnity insurance would have been an incentive to district nurses to join an organisation. It was mentioned by 36.4% of the district nurses as being a reason for membership but they were able to suggest relatively few other reasons. In spite of the isolated work situation of many of the district nurses, only a small number seemed to think that the opportunity to meet their colleagues was an incentive to join; 20.5% said that they were unable to attend meetings because they were so far from the place where the meetings were held, and because they were on call for midwifery cases. They /

They also seemed to feel that their interests were different from those of the "hospital people" who "ran" the meetings.

Over half the district nurses said they would have no objection at all to being paid for working overtime, but that they would have difficulty deciding when they were working and when they were not. Of the district nurses who had no objection to the idea on principle, 64.3% did not think it would work in practice, particularly in a rural area where there was only one nurse.

In their social ranking of occupations, only 29.1% of the district nurses placed nursing in the upper half of the scale, compared with 48.5% of the health visitors who did so.

District nurses gave the impression that, of the four professional categories, they were the most contented with their lot. They had no illusions about their comparatively lowly professional reputation and admitted that their work was not mentally stimul-:ating. But their relatively well-defined role in the /

the community, particularly in rural areas, and the freedom to form the kind of practitioner-client relationships which suited their own personality, seemed to compensate for the unexciting nature of the work itself.

The following news item appeared in the Nursing Times, 28.10.66:

> "District Nurses - Wasting Their Skills
>
> There is a temptation for the district nurse to become a 'wise woman' rather than the highly skilled leader of a team which includes the family itself. This was said by Dr. J.H.F. Brotherston, chief medical officer, Scottish Home and Health Department, speaking at the annual meeting of the Queen's Institute of District Nursing, held at the Royal College of Surgeons on October 20. The meeting generally agreed that changes and developments in medical needs demand a revision of the existing activities of district nurses and that their highly technical skills are being wasted on tasks which could be done by others."

Health visitors.

Although the highest percentage of health visitors in any one age group were between 30 and 40 years of age, 60.4% were over 40 years. The percentage who /

who were married or widowed (6.3%) was significantly lower than that of any other category.

Table 20 shows that the health visitor sample contained the highest percentage of respondents in any category who:

- were satisfied with the opportunities which existed for expressing their opinions, but thought that the reluctance of many nurses to use such opportunities was due to the fact that they had been discouraged from expressing their ideas during training;

- were members of a professional organ-:isation and gave "representation" as a reason for membership;

- were in favour of raising the educational standard of entry to nursing, and thought that candidates who had the necessary ability should be encouraged to take a university degree;

- ranked nursing in the upper half of the list of occupations used in the social ranking.

On the subject of payment for overtime, the percentage of health visitors who disagreed with the idea on principle (61.7%) was similar to the percentage of ward sisters who disagreed.

A tendency for the views of the health visitors

to /

to resemble those of the ward sisters on a number of issues did not extend to the subject of education:

58.3% of the health visitors,
35.8% of the ward sisters were in favour of raising the entry standard;

79.2% of the health visitors,
50.9% of the ward sisters were in favour of a university education for all nurses who had the necessary ability.

Health visitors gave the impression that they felt themselves to be more highly qualified and probably more intelligent than the average nurse, and that they resented the fact that their work did not give them adequate opportunity to use their abilities. They appeared to be an unsatisfied group, somewhat disillusioned with their jobs.

Since this impression was obtained from only a small sample of the whole population of health visitors, it is not known to what extent the attitudes of the respondents were the result of local conditions. But a recent study carried out by Sangster (1966) into wastage among health visitors found that:

"(1) Within four years of qualifying almost four health visitors in every 10 are lost to health visiting in the U.K....

(2) /

> (2) The biggest single cause of this loss is personal, largely marriage and pregnancy; the second biggest is the attraction of posts overseas (more than one health visitor in every eight goes abroad to work); and the third biggest is transfer to other work in this country, with hospital nursing and hospital midwifery the most popular types."

In view of the differences and similarities of opinion between the ward sister and health visitor respondents, it is interesting to note some of the characteristics of the two categories. In a number of respects they are very different.

a) Age: although the majority of respondents in both groups were between 30 and 40 years of age, nearly one-third of the ward sisters were under 30 years, nearly two-thirds of the health visitors were over 40 years. The proportion of health visitors under and over 40 years of age corresponded more closely to that of district nurses than to that of ward sisters. (Table 1.)

b) Marital status: the percentage of married/widowed ward sisters was significantly higher than the percentage /

percentage of married/widowed health visitors. (Table 2.)

c) Qualifications: ward sisters are not required by law to have any qualification other than that of State Registration (although many of them do) and may not have worked outside the hospital in which they trained. Health visitors have completed at least six months' midwifery training and possess the Health Visitor Certif-:icate.

d) Professional interests and type of work: ward sisters have chosen to care for people who are sick in hospital. Health visitors have chosen to concern them-:selves with medico-social problems and with the prevention of illness in the community.

Similarities between the two categories are not so easily defined. But, with the exception of nursing staff engaged in fulltime teaching or administrative duties, ward sisters and health visitors represent the most highly qualified nurses in their own fields, and seem to be very much aware of the responsibility which their work involves.

A ward sister is responsible for the administration of her own ward or department. She is the co-ordinator of /

of all the services which impinge upon her patients and is the liaison between all the people who are concerned with their care; she has the overall responsibility of seeing that their needs are provided for. She is responsible for teaching nurses in the clinical situation and is possibly the person who exerts the greatest influence over student nurses.

The health visitor is a specialist in the public health field and, if she has also had experience as a district nurse, is in theory qualified to be the leader of a community nursing team. Although she is not normally responsible for the work of other nurses, she is the co-ordinator of, and the liaison between, the medical and social services and the people in the community. She is much concerned with health teaching.

The issues on which the opinions of the respondents in the two categories were most nearly in agreement seem to suggest a relatively high degree of "professional" awareness in relation to their own occupational group. The fact that they differed significantly in their opinions on the value of general education could perhaps partly /

partly be accounted for by a tendency of ward sisters to view the needs of the nurse in relation to the traditional, routine management of a hospital ward, and for health visitors to think in the wider terms of community health care.

On the question of the desirability of a university education for nurses, the majority of district nurses were in agreement with the health visitors; they stressed the need for "a broad outlook" and thought that nurses should have "as much education as possible". Many of the older district nurses gave the impression that they would have liked the oppor-:tunity to have had further education themselves, and that they could have made good use of it.

District nurses may possess as many as, possibly more professional qualifications than do ward sisters, and have had additional training and experience in domiciliary practice. Although it is recognised that they are usually employed in work below their professional capacity, it seems probable, district nurses being a somewhat independent group, that the present system will continue to /

to function on "the principle of allowing as many people as possible to go their own way". (Stocks, ibid.)

The attitude of the district nurse and health visitor respondents toward education seems to be reflected in a report published by the United States Department of Health, Education and Welfare, in 1965. It included the following information:

Estimated number of professional nurses employed in various fields, by academic degree, 1962:

	Master's or above	Bacca-laureate	Diploma or Associate Degree
	%	%	%
Hospitals and related institutions	0.9	5.7	93.4
Public health	17.25	35.45	47.3
All fields	2.1	7.9	90.0

5.1.2: Age of Respondents. (Tables 19 and 21)

The influence of the age of respondents on their professional values and attitudes would be difficult to assess from the results of the present survey. Significant differences between the under-and over-40 year age groups tend to be misleading, as are comparisons between the hospital and community samples, by obscuring differences between the component sub-samples.

A lack of any obvious differences can be equally misleading. For example, there is no significant difference between the percentage of respondents aged over and under 40 years who were members of a professional organisation; but in fact only 32.3% of those under 30 years of age were members, compared with 66.1% of those between 30 and 40 years. On the question of overtime payment, more than one half of the respondents aged under 30 and over 50 years were in favour of payment; only about one third of those between 30 and 50 years of age were in favour of payment.

In the present survey, designed primarily to study the attitudes of nurses in different professional categories /

categories, the wide age-range of the respondents, and the small number of interviews on which the survey was based, does not permit detailed analysis of the age variable.

Comparisons between the figures in Tables 20 and 21 do not suggest any easily discernable relation-:ships between professional category, age group and opinion. Generally speaking, however, it may be said that a higher percentage of the younger nurses were dis-satisfied with opportunities for expressing their opinions, were less convinced of the value of a higher level of general education for nurses, and were less willing to obey the instructions of a doctor than were older nurses. They also appeared to have a lower opinion of the social status of nursing.

5.1.3 /

5.1.3: Geographical Area.

The composition of the rural and urban samples was as follows:

Category	Rural		Urban	
	No.	%	No.	%
staff nurses	28	21.4	22	29.3
ward sisters	37	28.3	16	21.3
total hospital	65	49.6	38	50.7
district nurses	44	33.6	11	14.7
health visitors	22	16.8	26	34.8
total community	66	50.4	37	49.3
total	131	63.6	75	36.4

Because of the relatively small percentage of district nurses in the urban sample and of health visitors in the rural sample, further analysis has been confined to the hospital group in each area: 65 rural and 38 urban respondents.

Diagram 20 shows the differences between these two sub-samples (see also Table 22, Opinion Summary (d)).

The /

DIAGRAM 20. SUMMARY: HOSPITAL SAMPLE

(65) RURAL

(38) URBAN

% 10 20 30 40 50 60 70 80 90 100

RESPONDENTS'

20.1 MARITAL STATUS:

MARRIED OR WIDOWED

20.2 S/E CLASS (FATHER'S OCCUP.)

CLASSES 1 AND 2

% 10 20 30 40 50 60 70 80 90 100

20.3 SOCIAL STATUS OF OCCUPATIONS NURSING:

POSITIONS 1 TO 6

20.4 EDUCATION:

IN FAVOUR OF

(1) RAISING ENTRANCE STANDARD

(2) UNIVERSITY

RESPONDENTS'

(3) SCHOOL LEAVING AGE: >16 YRS.

20.5 PROFESSIONAL ORGANISATIONS

MEMBERSHIP

See TABLE 22 FOR OPINION SUMMARY.

The difference between the percentage of respondents aged under/over 40 years in the two samples is not significant.

The significant difference between the percentage of married nurses in each group (Diagram 20.1) may be due to the fact that the rural hospitals have more difficulty recruiting staff; evidence was not collected to support this, but the reluctance of many hospitals to employ married nurses suggests that the employment of married women is usually a matter of necessity rather than choice. It could also reflect social class differences and other factors which depend upon local circumstances. None of the ward sisters in the urban hospital sample were married.

The significant difference between the percentage of respondents from Class 1 and Class 2 backgrounds (Diagram 20.2) could be a sequel to the type of student selection by nursing schools in the area. The urban hospitals used in the survey would be able to select candidates for training more fastidiously, as regards both their educational and their social qualifications.

There /

There was no significant difference between the opinion of hospital respondents in the rural area, compared with those in the urban area, regarding the position of nursing in the social scale (Diagram 20.3).

Diagram 20.4 shows that:

(a) Nearly half the nurses in the urban hospital sample were in favour of raising the minimum standard of education required for entry to nursing. The fact that this figure approximates fairly closely to the percentage of respondents in the whole community sample who held this view provides further reason to doubt the validity of generalisations about nursing opinion based on nurses' place of employment. On this particular issue there was also a difference of opinion between the sub-samples: a higher percentage of nurses in the urban hospital sample were in favour of raising the entry standard, compared with the percentage of nurses in the rural hospital sample who said that standards should be raised.

(b) There was no difference of opinion between urban and rural respondents regarding the value of university education for nurses.

(c) A higher percentage of respondents in the urban hospital sample had remained at school until the age of 16 years or over.

The higher percentage of respondents in the urban sample who were members of a professional organisation (Diagram 20.5) could be associated with a number of factors: better facilities for meeting, a lower percentage of nurses with domestic commitments and also, again, with social class - the significantly higher percentage of respondents from Class 1 social background who were in member-:ship has already been mentioned in relation to the survey sample as a whole (cf. Diagram 7.5).

5.1.4: Membership/Non-membership of professional nursing organisations. (Table 23)

In view of the implications, frequently seen in the nursing press, that membership of an organ-:isation is a sign of "professional" awareness, a comparison was made between the opinions of member and non-member respondents on the main issues dealt with in the survey.

As /

As was to be expected, there were significant differences of opinion between the two groups with regard to the advantages and disadvantages of membership. It was also found that a significantly higher percentage of members read the Nursing Times, the journal which publishes the news of the Rcn.

On the subject of nurse education:

51.4% of members,
31.7% of non-members were in favour of raising the entrance requirements for nurse training. The difference is highly significant. There was no difference between the opinion of the two groups with regard to the desirability of university education for nurses.

Payment for overtime was disapproved of, on principle, by:

61.9% of members,
44.6% of non-members.

There is a highly significant difference between the two figures.

There is no difference between the attitudes of members /

members and non-members, as a whole, with regard to opportunities for expressing their opinion, although comparison of the results from individual categories (Diagram 8) suggests that there may be some relationship between satisfaction with opportunities and membership of an organisation. There also seems to be some indic-:ation that the nurses who felt they had been discouraged from expressing their views during training were more likely to join a professional organisation after they became qualified.

Difference between members and non-members can only be stated here in general terms. Larger samples would be required before more detailed analysis could be made of member/non-member opinions in relation to professional category, age and geographical area.

5.2 : "Values"

In the first section of this study the character-:istics of a profession were summarised according to the emphasis placed upon them by various authors who have tried to identify the ingredients of profession-:alism. Professional responsibility was described as the obligations of an organised occupational group to provide a service which requires a relatively high degree of education and specialised skill, based on an accepted code of behaviour; it was suggested that the factor which gave the concept coherence was the freedom of individual practitioners to decide how to act in the best interests of their clients, in accordance with principles acceptable to the professional group, rather than according to a standardised set of rules.

The parts of the present survey particularly relevant to these issues as they concern nurses are those relating to nurse education and to professional nursing organisations, and those which indicate the extent to which the respondents were prepared to

behave /

behave, or felt that they were expected to behave, as individual and relatively independent practitioners.

All the respondents, at some point during their interviews, expressed very decided views about some aspect of nursing responsibility. Yet an unexpectedly large proportion of them believed that nurses did not, on the whole, make sufficient use of opportunities to assert their opinions on professional policy and practice. There was no general agreement about the reasons for this. The respondents gave the impression that, although they thought the situation regrettable, there was very little that they could do about it.

Their attitude demonstrates some of the paradoxes in nursing. Nurses have been, and possibly are still being, discouraged in many hospitals and nursing schools from putting forward their personal views and from taking responsibility for their own decisions. Yet when nurses have completed their training they are criticised because they do not express their views, because they tend to accept their position without question and because they try to avoid making independent decisions /

decisions. If a nurse tries to do these things too early in her career she will be "put in her place" by her seniors in the professional hierarchy. If she does not do them by the time she reaches middle-age she is likely to be criticised for not taking her "professional" responsibilities seriously. Nurses in teaching and management positions seem to see nothing incongruous in criticising a junior colleague for learning so well the lessons which they have taught her and which they themselves often demonstrate at a higher level in the professional hierarchy.

The problem, unfortunately, is not confined to nurses. A group hospital secretary in England has described his own view of the situation:

> "Nurses are as able as the rest of the hospital community to express their thoughts and feelings; the marriage rate confirms that. Yet who has not recoiled in despair after the attempt to get nurses to give their own opinions about their own hospital? To use to-day's jargon, why don't they commun-:icate? Ask a nurse for an opinion on some hospital matter and you are likely to get the opinion she thinks the next senior nurse would expect her to give. And it gets worse as you get nearer the top." (Elliott, 1966)
> JAQUES

The /

The same writer is sceptical of the idea that a "change in teaching is bringing forth a different kind of nurse who can speak for herself" and asks whether "the loyalty and obedience system" will not blot out the developing initiative of the new staff nurses?

One basic difficulty in nurse training is that it must cater for students with very varied abilities and that nursing itself can only be learned "on the job" where small mistakes may have disastrous con-:sequences. The rigid system of controls which are intended to protect the patient can very easily stifle the initiative of the student. By so doing they may, in fact, be a danger to future patients, who run the risk of being cared for by inadequately prepared nurses.

> "For too long we have tended to emphasise blind obedience and even subservience to superiors ... We must accept the student's right to err, for often such negative learnings stimulate research and enquiry on the part of the student and lead to self-guidance, self-development, and self-evaluation." (Jessee, 1965)

Such /

Such statements sound excellent in theory and are becoming a familiar feature of the American nursing press. But an effective method of combining patient safety with student error has not yet been devised. In the meantime, it is perhaps understand-:able that the sins of omission are considered pre-:ferable to the sins of commission because, as one nurse expressed it, "in nursing you can't tear up your mistakes and start again". Rather than risk the irrevocable consequences of a wrong decision, a nurse who lacksconfidence in her own judgement can all too easily acquire the habit of keeping her opinions to herself and letting a more senior person take the necessary action.

The result is predictable: the desire to avoid the disapproval of such a senior person often becomes the primary issue, assuming greater importance than the effects of the decision on the patient. Insidiously, values become distorted and basic issues are liable to become obscured at all levels of responsibility.

Post /

Post-registration courses in administration and education are available to nurses to prepare them for higher positions in the professional hierarchy. But it is difficult to know how far these relatively short courses are effective in correcting deformities which may have resulted from earlier training and experience. In any case, opportunities to take them are limited, relatively few nurses have attended them (1), and their specialised purpose, following the structure of nursing service administration, tends to emphasise the functional divisions within the total occupational group.

It would seem that professional organisations could play a useful part in providing nurses with an opportunity to develop the communicating skills and group consciousness which, owing to the nature of nursing service and training, may otherwise have little chance to grow. The results of the present study suggest that they are doing this only to a very limited extent and that, in some cases, membership of /

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(1) The Report of the Committee on Senior Nursing Staff Structure (Ministry of Health ... 1966) states that of 4802 senior nursing staff in Scotland, only 198 had taken recognised courses in administration (Table 8B of the Report).

of a nursing organisation may have an inhibiting effect.

The Royal College of Nursing and National Council of Nurses of the United Kingdon (Rcn) is the largest and most powerful of the many nursing organisations in this country. It is therefore probable that the majority of respondents, particularly those not committed to any association, would have this body in mind when expressing their views about nursing organis-:ations and that their attitudes could bear some relation to the attitudes of the Rcn.(1)

The only reason for membership mentioned by more than one fourth of the respondents was the need for legal protection; other reasons were expressed in vague terms and were in some cases contradictory. This attitude seems to reflect the confused concept which the Rcn appears to have of its own purpose. It frequently gives the impression of trying to preserve a respectable social class image (cf. the higher percentage of membership among respondents from higher social class backgrounds) while at the same time claiming to /

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(1) Of the 105 respondents who were members of a professional organisation, 65.7% were members of the Rcn.

to do "everything that a trade union has the right to do"; it appears to take pride in its Education Division, yet there are signs that the courses provided are not keeping pace with the needs of nurses in the higher grades; members are scolded for not returning voting papers for election of council members, yet scanty information about the candidates for office prevents intelligent assess-:ment of their qualifications and raises doubts regarding the claims of the Rcn to be a "democratic" institution.

Periodically, Rcn officials also seem to have doubts about the effectiveness of their organisation. A large section of the Nursing Times (24.6.66) was devoted to explaining its structure and purpose. The writer admitted that there were signs that the Rcn was failing to meet the needs of many nurses and described the variations which were found between local branches, some of which

> "seem solely concerned to get together for tea and cakes, or to talk about flower arrangements ... For the young staff nurse, or indeed for any truly professionally aware nurse, such meetings hold /

> hold little attraction, and the task of over-coming such lethargy seems far beyond the capabilities of one junior nurse, even if she thought it was worth it."

Apart from the vagueness always associated with the term "professionally aware", this statement describes the situation very aptly. But the writer goes on to say that:

> "All this is to be expected and should not give rise to too much concern at HQ level."

This attitude appears to be reciprocated by the many practising nurses who are aware that they need help in fulfilling their responsibilities, both in their own special field of nursing and as "professionals" vis-à-vis other professionals, but who do not feel that they can get such assistance from their national nursing organisation.

It is perhaps encouraging that so many nurses, in spite of being constantly accused of apathy toward their professional position, nevertheless have the ability to withstand, passively or actively, the threats and blandishments of an organisation which does not appear to represent the collective values and attitudes of its potential members.

A /

A number of respondents volunteered the comment that nurses are becoming less reluctant to express their own opinions. When asked what they thought was the cause of the change, the most frequent reply was that it was "working its way up from the schools", or was part of a more liberal attitude toward young people generally. It did not seem to occur to the respondents that a change could be taking place in nursing schools as a result of new attitudes on the part of the nurse teaching staff.

It would be difficult to know how many nurse tutors are, in fact, aware of recent developments in general education. The headmistress of a technical high school had her doubts:

> "In school our educational aim included the development in each student of an independent critical faculty together with a growing awareness of the place of the individual in a society, and this results in a good-natured battle-field of mind upon mind, where problems are met by incisive questioning and criticism. Dare I ask how much of this is continued within the nursing situation? How many of the present outstanding questions could, in fact, be answered by nurses if only they had time to examine the difficulties objectively, and were perhaps /

perhaps less afraid of the effects of
changes which might, at first glance
seem almost disloyal to consider.
What sort of loyalties do we think we
ought to have in this modern age?"
(Fuller, 1965)

The question of loyalties is very pertinent to nursing. When nurses appear reluctant to oppose the views of senior staff, it may not be because they fear the consequences to themselves. They may be unwilling to appear disloyal to a respected older colleague who was herself brought up to regard professional opposition as a form of personal abuse. The term "loyalty" frequently appears as an item to be assessed in progress reports on student nurses, but there is rarely any indication of to whom or to what a nurse is expected to be loyal.

Because of the traditional equation of senior status with the ideals of nursing service, it may be difficult for older nurses to recognise and to acknowledge the potential abilities of junior colleagues. The wide range of ability which can be found in a class of student nurses, combined with a shortage of nurse teachers, makes it all too easy to direct teaching at "average" students,

to /

to give as much help as possible to the weakest, and to fail to encourage the ablest to develop their abilities to the fullest extent - particularly if their enquiring minds happen to cause embarrassment to the teaching staff.

Another writer from the field of general education states the problem in terms which could be applied equally well to schools of nursing:

> "Another tendency of the present time is that we have all become very much aware of the needs of the weaker members of our schools - the slow, the nervous, the limited ... Are we, on the other hand, always quite sufficiently aware of the needs of the ablest, who can go far, and fast, and deep? We should remind our-:selves that we may be teaching our betters, and we must see that they do not go short of stimulus and nourishment for the mind." (Andrew, 1958)

Although only 41.7% of the respondents in the present survey wanted to see the minimum educational standard for nursing raised, 63.1% said that nursing candidates who had the qualifications for a university education should be encouraged to take a degree. Many respond-:ents were suspicious of "academic types", yet the majority seemed to recognise the need to provide for "the needs of the ablest".

These /

These views were held by a significantly higher percentage of nurses in older age groups, many of whom might not have had the opportunity of further education. It would be interesting to know whether the young nurses of to-day will have changed their views in twenty years' time, or whether the girls now entering nursing, many of whom do not have the intellectual qualifications for any other career, are less convinced about the advantages of higher education in its present form.

New demands on nursing services, along with advances in the medical and social sciences, emphasise the need for nurses to be able to identify, investigate and to evaluate a variety of health problems. There is some evidence that British nursing education is beginning, cautiously, to recognise these new demands.

First, the revised syllabus of basic training approved by the General Nursing Councils includes aspects of nursing which were previously treated as specialties, but which are now recognised as an integral part of total health care. The concept of nursing has broadened /

broadened to include not only new methods of prevention and cure, but also new relationships between traditionally independent aspects of nursing responsibility.

Second, nurses are being forced to set themselves more exacting standards in administration, in order to cope with more complex responsibilities. The recently published Report of the Committee on Senior Nursing Staff Structure (Ministry of Health ... 1966.b) re-:commends that the study of management should be incorporated "at the level of the student nurse", and that nurses should be "systematically prepared and selected for senior posts".

Such changes of emphasis suggest that the concept of nursing is broadening both with regard to its content and to the nature of its administrative respons-:ibilities. But the attitudes of respondents in the present survey suggest that nurses should concern them-:selves with a third dimension of nurse education: the development of increased awareness of nurses by nurses, as individuals, rather than as professional symbols.

The /

The majority of nurses would possibly agree that they have a professional obligation to provide "the best service", together with facilities for the appropriate education and training. The element which they seem to have neglected is the equally professional obligation to respect each other's individual judgement and professional integrity. Without this, it seems doubtful whether the nursing services can, in fact, be as effective as they should be.

One other factor which should be taken into account when attempts are made to assess standards of nursing service or to study the attitudes of nurses has already been mentioned briefly: the nature of nursing itself. It was illustrated by an incident which took place during the survey.

A young staff nurse arrived very late for inter-:view. She apologised, and explained that just as she was about to leave the ward an elderly patient collapsed unexpectedly. The staff nurse had been looking /

looking after her for many weeks and was obviously very upset by what had happened. Speaking of the patient:

> "She has put up with so much, all this time, and now it seems as if it's no good ... I know I shouldn't get upset like this - I get mad at myself. I'm a staff nurse, I ought to be able to control my feelings, but I can't help it ... Why did she get better, just for this? What's it all *for* ...?
>
> I'm sorry. I've kept you waiting a long time as it is. What were the questions you wanted to ask me?"

The difference between a trade and a profession seemed irrelevant.

The staff nurse's experience is a familiar one. Such experiences are not peculiar to nursing, but they must frequently be encountered in the type of situation in which nurses, because they are nurses, are required to function. It is an area in which attitudes are sometimes difficult to interpret and where values tend to become either very confused or very clear. It can be a frightening place, for nurses as well as for their patients.

Respondents /

Respondents emphasised the fact that many different kinds of ability were required in nursing. Ability to communicate is one of them, but in nursing there are many ways of communicating and many situations in which words are not of much use. Yet nurses, having chosen to nurse, have an obligation to define the nature of the responsibility which they are prepared to take in relation to other occupational groups and toward the society which they profess to serve. If they are unable to express their opinions on matters about which their training and experience qualify them to speak, no one can do it for them.

Conclusion.

Changes in the concept of nursing have been brought about by a number of factors: changes in the social environment, general technological development, advances in medical treatment and by the fact that some of the work previously carried out by nurses has been taken over by other occupational groups.

Nurses are required to evaluate the new demands which are being made upon them, define their new responsibilities, and decide how nurses should be prepared to fulfil them. This involves looking beyond the limitations of any partic-:ular "system" of training, service or administration and being prepared to use all available resources: technol-:ogical, educational and administrative. In particular, it requires that nurses should review their own inter- and intra-professional relationships.

Nurse education

Recruitment of nurses with a higher level of general education could help to produce a more effective nursing service, but it is unlikely to do so unless nursing education is adapted to a different kind /

kind of student as well as to a new concept of nursing.

One of its basic problems has not been solved: nurses are needed as team leaders, teachers and administrators. In these positions they will be required to use their own initiative, make decisions and accept responsibility. Yet all nurses acquire their basic knowledge of nursing in a clinical situation where initiative and independent judgement can rarely be given freedom to develop except at the possible expense of the patients' comfort and safety. In such a situation, a hierarchical system of control may offer a convenient and often welcome escape from the kind of decision making which is expected of professional people, but conflicting loyalties can be an intolerable strain on nurses and may permanently inhibit their ability to evaluate situations objectively.

For obvious reasons, the term nursing education tends to be associated with the examination syllabus of the General Nursing Council, but its total effectiveness can only be judged by its ability to produce a total nursing service. The fact that a certain type of higher education is associated with professional status does not alter /

alter the fact that the first requirement of a profession is to provide its clients with the type of service which they need.

The main function of nurse education seems to be to ensure that all who want to nurse and who have some con-:tribution to make to the total health care of the commun-:ity are provided for in the total programme of nurse train-:ing; that those with limited ability should have the opportunity to use it to good purpose, and that those with greater ability should be given the encouragement and the opportunity to stretch their powers to the fullest extent, in clinical specialisation, in education and in management. The in-service training which will enable nursing auxil-:iaries to fulfil the requirement that those who care for the sick should do them no harm is as important as the education of the people who will eventually be responsible for planning their training and administering the service. The two should exercise a mutual control.

Raising the standard of basic education for entrants to the registered grade will not in itself produce nurses who are more willing to assert and defend their opinions

and /

and to accept responsibility for the consequences. It may have the reverse effect: the more intelligent the student, the more likely she is to be aware that many of the ideas expressed by nurses are based on "intuition" rather than on observable or measurable data, and to be wary of making statements which she knows cannot be sub-:stantiated.

Nurses and research

There has so far been little opportunity, in basic or post-basic educational pro-:grammes, for nurses to learn how to identify and investi-:gate problems [1], either their own or those of their clients. The principles on which research methods are based require a complete reversal of the traditional concepts of nurse training. They require a desire and ability to question, then to question the answers, regardless of the implications. Such attitudes are not "subjects" to be written into an already overcrowded time-table; they depend for their existence on those who teach, on /

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(1) The term "nursing problems" is sometimes used to describe situations which are part of nursing and which are only "problems" in the sense that clocks are "problems" to a clock-repairer. Without such "problems" neither clock-repairers nor nurses would exist. In the present study, the term refers to situations in which there are conflicting values and to which nurses, with their present knowledge and experience, seem ill-equipped to find a solution, for example, the issues involved in nurse education.

on the ability of teachers to encourage in their students respect for the power which Whitehead described as "free-:dom in the presence of knowledge".

Research techniques can help nurses to evaluate their own ideas and to present their findings coherently so that they may be understood by specialists in other occupations who have little knowledge of nursing. But such techniques will have limited use in nursing unless nurses themselves are prepared to develop attitudes which will allow them to evaluate the results, their judgements undistorted by pseudo-loyalty to the status quo.

Nursing administrative structure

The development of nursing service has been associated with times and places where large numbers of sick and injured people have been in need of attention. The Crimean War was a godsend to British nursing; coming at a time when women were eager to demonstrate their ability to do many of the things which previously had been done by men, it gave them an opportunity to prove that they were able to hold their own in the male-dominated sphere of military service.

An /

An administrative structure based on military principles was well-suited to Miss Nightingale's ideas for nursing reform, providing a chain of command which ensured control at every level of responsibility. But this does not explain why a similar attitude toward authority has persisted in countries not directly under British influence, nor why nursing should retain its traditional structure at a time when authoritarian methods in industry and in other social institutions are being replaced by more permissive and democratic forms of control.

Since nursing services and armed services are concerned with directly opposing attitudes toward human life, it seems reasonable that a similar system of controls should have advantages for both of them. In the type of situation in which nurses and soldiers operate, a rigid and impersonal administrative structure can be useful, either as a means of support or as an object of aggression, to individuals at all levels of the hierarchy when faced with circumstances over which they feel they have little control, particularly in situations where /

where human safety may depend upon the rapid and accurate carrying out of instructions.

Nursing itself is part of a continual battle to maintain or to restore a healthyrelationship between man and his environment. Conflict is implicit in nursing service, but a distinction has not always been made between conflict which is the raison d'être of nursing and conflicts for which nurses themselves are responsible. The same type of control is not necessarily suitable to both.

In the nursing services, an impersonal administration (characterised by the terms of address matron, sister, nurse, without the addition of a personal name) can provide a means of escape from the responsibility of independent decision making. It can also mask signs of emotional stress and the weaknesses of an educational system which gives students little guidance in dealing with emotional problems. The present situation in nursing involves a balance of power between general principles of education and an administrative system which cannot afford to acknowledge their existence except at the cost of its own.

Although /

Although nursing depends, to some extent, on a bureaucratic type of control, its hierarchical structure is unequal [1]. Promotion to senior posts has often depended on personal preference rather than on any objectively recognised qualification. Owing to the inherently "practical" nature of the work, promotion may require that a nurse should leave the area in which she has developed special skills and take a teaching or administrative appointment in which she has little interest, shows little aptitude, and for which she has received no adequate preparation. One result - not peculiar to nursing - is a deep division between those who work in the practical situation and their administrative superiors.

Proposals put forward by the Committee on Senior Nursing Staff Structure (op. cit.) include plans for a more graduated system of hospital management with a "channel of communication" which could narrow the gap between the upper and lower levels of the nursing hierarchy. The implementation of such proposals could result in a more unified occupational group, particularly if the same principles were extended to other branches of the nursing service.

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(1) The incorporation of nursing services into a nationalised health service will, of course, modify the ways in which the term "nursing" can be used in relation to its own internal administrative system.

Although nursing itself exerts a unifying influence based on common experience, it is inevitable that nurses engaged in different types of work should have different interests, different personal qualities and different kinds of power. The tendency of nurses to form groups according to their place of work or their position in the nursing hierarchy, together with their reluctance to express their opinions outside their own group, has probably exaggerated their differences and led to some mutual mis-:conceptions. Yet such divisions have served a useful purpose in providing places where critical abilities could be exercised (albeit somewhat narrowly) and where views could be expressed with impunity.

Functional diversity within nursing makes it all the more desirable that artificial and unnecessary divisions should be reduced to a minimum, particularly when multipli-:cation of specialisations, each with its own "professional" self-consciousness, must inevitably produce conflict as well as cohesion. It has for some time been considered fashion-:able to emphasise the need to nurse the "whole" patient; it is becoming fashionable to speak about educating the "whole" /

"whole" nurse; the advantages of having a "whole" nursing profession does not appear to have been generally accepted.

Professional nursing organisations

The efforts of a national nursing organis:ation to provide a central platform for nursing opinion are unlikely to be success:ful until nurses have reason to change their attitude toward remote, powerful and centralised administration. A unified and representative professional association can only materialise when nurses themselves are convinced that unity is desirable and when its purpose is clearly understood. Such an organisation, unrestricted by the immediate respons:ibility to provide nursing service, could give nurses the opportunity and the incentive to develop the critical faculty and the initiative which cannot be given freedom within the formal nursing curriculum or within the environment in which nurses practice.

The fact that the so-called "national" nursing organis:ation does not appear to be fulfilling this function, or eve to recognise its existence, should be the concern of all nurses and not only of organisation officials. But, by its very /

very nature, its failure cannot be fully appreciated until it has been remedied.

It is difficult to know how far nurses' lack of interest in their national organisation is due to the policies of the association and how much to natural reaction against any kind of organised activity outwith the structure in which nurses are required to operate; as one respondent put it, she was "sick of being organised".

Male nurses

On the subject of professional nursing organisations, it would be of particular interest to know the views of male nurses whose numbers are likely to increase in proportion to female nurses and whose trade union sympathies, although distasteful to many "professionally conscious" nurses, were until recently actively encouraged by the refusal of the Royal College of Nursing to admit them to full membership.

There is still some reluctance to accept men into an occupation which traditionally requires its practitioners to have a maternal attitude toward their clients. But because male nurses tend to remain in nursing after marriage, and because /

because their careers are not normally interrupted by child-rearing activities, they appear to have some advantage on the promotion ladder over their female colleagues. In future there will possibly be a larger proportion of men in higher management positions and hence an opportunity for them to fill a more paternal role.

Female nurses may perhaps feel that male nurses are an incipient threat to their authority but, by subjective observation, the attitudes of male nurses toward their work do in many cases appear to be different from those of female nurses. A comparative study of the attitudes of both male and female nurses toward nursing responsibilities, also of their education, professional training and careers, could provide a more substantial basis for opinion than exists at present.

Nurse-doctor relationships

A study of the professional nurse-doctor relationship would also be interesting with regard to the way in which their occupational attitudes are related to /

to sex roles. Nurses frequently maintain that a nurse's attitude toward patients is "different" from that of a doctor. They explain this by saying that a doctor "comes and goes" while nurses look after the patients "all the time", and that this type of responsibility requires greater emotional involvement. Nurses are sometimes heard to defend a doctor who is criticised for not showing a sufficiently personal interest in his patients by saying that "that's not primarily his job". This appears to be only one aspect of the dominance of the medical profession in a field of practice which now includes a variety of ancillary services.

The concept of a team in which each member is concerned with a specific aspect of health, in its widest sense, and in which there is a rotating leadership according to the type of decision which has to be taken, is one which may not appeal either to those accustomed to exercising unquestioned authority or to those not prepared to accept responsibility. But it seems to be generally recognised that an increase

in /

in the number of specialist occupations associated with the more well-established professions must inevitably result in some diffusion of responsibility and a change in the form of practitioner-client relationship which has in the past been considered a unique feature of professional practice.

The medical practitioner may feel that such developments will detract from his traditional position of authority, but they can also reduce the threat of professional dilution by partially qualified practitioners. The tendency of occupations related to medicine to claim recognition as independent pro-:fessions seems to provide a means by which the medical profession can relinquish fringe responsibil-:ities gracefully while preserving its own exclusive-:ness. This would appear to be of some advantage to doctors at a time when nurses are becoming increas-:ingly less dependable as professional buffers [1].

It is not easy to define the role of the nurse in the "health" team. As other occupations become more /

(1) The latter role has of course not been entirely to the disadvantage of nurses: the existence of the feldsher seems to be a factor contributing to the low status of nurses in Russia.

more specialised, nursing responsibility becomes more generalised. This appears to be its special responsibility.

Nursing responsibilities and professional status

The nursing tradition is compounded of varied and sometimes incompatible elements: biological needs, Christian ideals, military discipline, social ambition. Each still exerts varying degrees of influence in different situations and in different cultures. The personal qualities and abilities required in nursing are equally diverse - as diverse as the needs of the individuals who require nursing care.

Before the existence of large-scale state-organised social services, nurses were self-conscious about their occupational uniqueness and tended to stress the importance of their specialised occupational skills. They concerned themselves with "nursing" education rather than with the principles of education, with "nursing" administration rather than with the theory /

theory of management, with special techniques rather than with the people on whom the techniques were carried out. Attempts are now being made to correct this bias, with the result that the special function of nurses may be obscured.

While considering the whole field of respons-:ibility in which nurses are involved, it is necessary to keep in focus the area which is peculiar to nursing: the place where the essentially objective attitude of the medical and social sciences meets the essentially subjective concern of one person for another and of each individual for himself.

Nurses who took part in the survey on which this study was based were aware that nursing requires a proportion of people with the ability and the education which will enable them to fill responsible administrative positions in all sections of the nursing services and in nursing education. But their attitude also seemed to suggest that the degree of personal involvement which nursing requires of nurses may not always be consistent with the demands which a wholly profession-:alised /

professionalised service makes on its members; nurses who develop a high degree of sensitivity toward their patients' needs are not necessarily those who take the most active interest in the affairs of the whole occupational group.

In one direction, in the higher management levels, nursing ceases to be nursing. In the other direction, at its furthest point, nursing ceases to be professional. Failure to recognise the full range of nursing respon- :sibility would reduce the quality of nursing service and thereby invalidate the claims of nurses to profess- :ional status.

Tables

Appendices

References and bibliography

Table 1.

Age of Respondents

sample	% 21-29 years	% 30-39 years	% 40-49 years	% over 50 yrs.	total
s/nurses	80.0	6.0	14.0	none	50
w/sisters	30.2	41.5	18.9	9.4	53
total hospital	54.4	24.3	16.5	4.9	103
d/nurses	9.0	29.1	16.4	45.5	55
h/visitors	2.1	37.5	35.4	25.0	48
total community	5.8	33.0	25.2	35.9	103
rural area	26.7	29.0	19.1	25.2	131
urban area	36.0	28.0	14.0	12.0	75
whole sample	30.1	28.6	20.9	20.4	206

Table 2

Marital Status of Respondents

sample	% single		% married or widowed*		total	
s/nurses	74.0		26.0		50	
w/sisters	77.4		22.6		53	
total hospital		75.7		24.3		103
d/nurses	70.9		29.1		55	
h/visitors	93.7		6.3		48	
total community		81.5		18.4		103
21-29 years	87.1		12.9		62	
30-39 "	79.7		20.3		59	
total $<$ 40 yrs.		83.5		16.5		121
40-49 years	69.8		30.2		43	
over 50 years	76.2		23.8		42	
total $>$ 40 yrs.		72.9		27.1		85
rural area	75.6		24.4		131	
urban area	84.0		16.0		75	
whole sample		78.6		21.4		206

*No respondents said that they were divorced.
One respondent (included in these figures) was separated from her husband.

Table 3

Socio-economic Class (1) (Father's Occupation).

sample	% classes I & II	% classes III & IV	% 0	total
s/nurses	36.0	60.0	4.0	50
w/sisters	39.6	52.8	7.5	53
total hospital	37.9	56.3	5.8	103
d/nurses	32.7	60.0	7.3	55
h/visitors	31.3	62.5	6.3	48
total community	32.0	61.2	6.8	103
21-29 years	38.7	59.7	1.6	62
30-39 "	37.3	59.3	3.3	59
total < 40 yrs.	38.0	59.5	2.5	121
40-49 years	27.9	58.1	13.9	43
50-59 "	33.3	57.1	9.6	42
total > 40 yrs.	30.6	57.6	11.8	85
rural area	30.5	62.6	6.9	131
urban area	42.7	52.0	5.3	75
whole sample	35.0	58.7	6.3	206

(1) Classification is by the Registrar - General's Classification of Occupations (Census, 1951) with Classes IV and V combined as Class IV.

"0" indicates father dead, occupation not known, etc.

Table 4

Wages and Hours Bill, 1930.

sample	% accept	% reject	% compro-mise	total
s/nurses	28.0	32.0	40.0	50
w/sisters	35.8	35.8	28.3	53
total hospital	32.0	34.0	34.0	103
d/nurses	45.5	25.5	29.1	55
h/visitors	31.9	23.4	44.7	47
total community	39.2	24.5	36.3	102
21-29 years	35.5	27.4	37.1	62
30-39 "	28.8	40.7	30.5	59
total < 40 yrs.	32.2	33.8	33.9	121
40-49 years	41.9	16.3	41.9	43
Over 50 "	39.0	29.3	31.7	41
total > 40 yrs.	40.5	22.6	36.9	84
rural area	43.5	34.4	22.1	131
urban area	21.6	20.3	58.1	74
whole sample	35.6	29.3	35.1	205

Table 5

Opportunities for expressing opinion.

sample	% satis-factory	% unsatis-factory	% don't know	% opportun-ities not used	totals
s/nurses	62.0	34.0	4.0	70.0	50
w/sisters	73.6	26.4	none	79.2	53
total hosp.	68.0	30.1	1.9	73.8	103
d/nurses	47.3	38.2	14.5	50.9	55
h/visitors	87.5	12.5	none	77.1	48
total comm.	66.0	27.2	6.8	63.1	103
21-29 years	61.3	33.9	4.8	66.1	62
30-39 "	61.0	33.9	5.1	67.8	59
total < 40yrs	61.1	33.9	5.0	66.9	121
40-49 years	79.1	18.6	2.3	83.7	43
over 50 "	71.4	21.4	7.1	59.5	42
total > 40yrs	75.3	20.0	4.7	71.8	85
rural area	64.1	30.5	5.3	67.9	131
urban area	73.3	22.7	4.0	70.7	75
whole sample	67.0	28.2	4.9	68.9	206

Table 6

Reasons why nurses do not express persoaal opinions.

sample	% discouraged during training		% reluctant to oppose seniors		total	
s/nurses	24.0		38.0		50	
w/sisters	32.1		24.5		53	
total hospital		28.2		31.1		103
d/nurses	27.3		27.3		55	
h/visitors	41.7		14.6		48	
total community		34.0		21.4		103
21-29 years	25.8		29.0		62	
30-39 "	42.1		22.0		59	
total < 40 yrs.		33.9		25.5		121
40-49 years	30.2		30.2		43	
over 50 "	23.8		23.8		42	
total > 40 yrs.		27.1		27.1		85
rural area	25.2		26.0		131	
urban area	41.3		26.7		75	
whole sample		31.1		26.2		206

Table 7

Membership of professional nursing organisations.

sample	% membership	total
s/nurses	26.0	50
w/sisters	69.8	53
total hospital	47.6	103
d/nurses	38.2	55
h/visitors	72.9	48
total community	54.4	103
21-29 years	32.3	62
30-39 "	66.1	59
total < 40 yrs.	48.8	121
40-49 years	58.1	43
over 50 "	50.0	42
total > 40 yrs.	54.1	85
rural area	43.5	131
urban area	64.0	75
Father's Occupation S/e Class (i)		
1	72.0	25
2	59.6	47
3	41.8	98
4	43.5	23
0	61.5	13
whole sample	51.0	206

(i) <u>See</u> Table 3 for classification of occupations

Table 8

Professional Nursing Organisations:

Reasons for Membership.

sample	% insurance (1)	% duty (2)	% representation (3)	% Education (4)	total
s/nurses	34.0	14.0	14.0	10.0	50
w/sisters	50.9	32.1	5.7	17.0	53
total hospital	42.7	23.3	9.7	13.6	103
d/nurses	36.4	16.4	7.3	14.5	55
h/visitors	27.1	29.2	37.5	18.8	48
total comm.	32.0	22.3	21.4	16.5	103
21-29 years	45.2	14.5	9.7	12.9	62
30-39 "	45.8	27.1	18.6	16.9	59
total < 40yrs	45.5	20.7	14.0	14.9	121
40-49 years	25.6	34.9	23.3	18.6	43
over 50 "	26.2	16.7	11.9	11.9	42
total > 40yrs	25.9	25.9	17.6	15.3	85
rural area	29.0	18.3	6.7	13.7	131
urban area	52.0	30.7	30.7	17.3	75
whole sample	37.4	22.8	15.5	15.0	206

(1) Indemnity insurance/legal advice.

(2) "It is the duty of nurses to support their professional organisatiaons."

(3) Means of putting forward opinions.

(4) Courses in administration and education; lectures, study days, etc.

Table 9

Professional Nursing Organisations.

Reasons for Non-membership.

sample	% not int. (1)	% not enc. (2)	% high fees (3)	total
s/nurses	48.0	18.0	8.0	50
w/sisters	20.8	11.3	3.8	53
total hospital	34.0	14.6	5.8	103
d/nurses	36.4	9.1	16.4	55
h/visitors	8.3	6.3	8.3	48
total community	23.3	7.7	12.6	103
21-29 years	45.2	12.9	8.1	62
30-39 "	16.9	11.9	10.2	59
total $<$ 40 yrs.	31.4	12.4	9.0	121
40-49 years	20.9	14.0	14.0	43
over 50 "	28.6	4.8	4.8	42
total $>$ 40 yrs.	24.7	9.4	9.4	85
rural area	35.1	9.2	7.6	131
urban area	17.3	14.7	12.0	75
whole sample	28.6	11.2	9.2	206

(1) Not interested/too busy/haven't bothered.

(2) Not encouraged to join/never been asked.

(3) Can't afford it/not worth the money.

Table 10.

Payment for working overtime.

sample	% in favour	% not in favour	% don't know	totals
s/nurses	52.0	46.0	2.0	50
w/sisters	32.1	64.2	3.8	53
total hospital	41.7	55.3	2.9	103
d/nurses	51.0	44.4	3.7	54
h/visitors	38.3	61.7	none	47
total community	45.5	52.5	2.0	101
21-29 years	53.2	45.2	1.6	62
30-39 years	31.0	67.2	1.7	58
total < 40 yrs.	42.5	55.8	1.7	120
40-49 years	37.2	60.5	2.3	43
over 50 "	53.7	41.5	4.9	41
total > 40 yrs.	45.2	51.2	3.6	84
rural area	46.5	50.4	3.1	129
urban area	38.7	60.0	1.3	75
whole sample	43.6	53.9	2.5	204

Table 11

Educational entry standards for nursing:
present requirements.

sample	% too high	% satis-factory	% too low	totals
s/nurses	16.0	26.0	34.0	50
w/sisters	9.4	37.7	35.8	53
total hospital	12.6	32.0	35.0	103
d/nurses	10.9	29.1	40.0	55
h/visitors	4.2	31.3	58.3	48
total community	7.8	30.1	48.5	103
21-29 years	21.0	25.8	35.5	62
30-39 "	10.2	42.4	35.6	59
total < 40 yrs.	15.7	33.9	35.5	121
40-49 years	none	32.6	51.2	43
over 50 "	4.7	21.4	50.0	42
total > 40 yrs.	2.4	27.1	50.6	85
rural area	11.5	32.8	35.1	131
urban area	8.0	28.0	53.3	75
whole sample	10.2	31.1	41.7	206

Table 12

University Education for Nurses

sample	% in favour	% not in favour	% nurse training first	% don't know	total
s/nurses	54.0	30.0	14.0	none	50
w/sisters	50.9	24.5	17.0	1.9	53
total hospital	52.4	27.2	15.5	1.0	103
d/nurses	69.1	14.5	12.7	1.8	55
h/visitors	79.2	12.5	none	2.0	48
total community	73.8	13.6	6.8	1.9	103
21-29 years	51.6	29.0	16.1	none	62
30-39 "	57.6	20.3	15.3	3.4	59
total < 40 yrs.	54.5	24.8	15.7	1.7	121
40-49 years	76.7	9.3	4.7	2.3	43
over 50 "	73.8	19.0	4.8	none	42
total > 40 yrs.	75.3	14.1	4.7	1.2	85
rural area	58.8	29.8	7.6	7.6	131
urban area	70.7	4.0	17.4	2.7	75
whole sample	63.1	20.4	11.2	1.5	206

Table 13

School Leaving Age of Respondents:

16 years and over.

sample	%	totals
s/nurses	58.0	50
w/sisters	60.4	53
total hospital	59.2	103
d/nurses	47.3	55
h/visitors	56.3	48
total community	51.5	103
21-29 years	54.8	62
30-39 "	62.7	59
total $<$ 40 yrs.	58.7	121
40-49 years	53.5	43
over 50 "	47.6	42
total $>$ 40 yrs.	50.6	85
rural area	48.1	131
urban area	68.0	75
whole sample	55.3	206

Table 14

"Are there circumstances in which a nurse should not obey the instructions of a doctor?"

sample	% Yes	% No	% No experience	total
s/nurses	52.0	2.0	46.0	50
w/sisters	52.8	11.3	35.8	53
total hospital	52.4	6.8	40.8	103
d/nurses	36.4	16.4	47.3	55
h/visitors	47.9	12.7	39.6	48
total community	41.7	14.6	43.7	103
21-29 years	46.8	3.2	50.0	62
30-39 "	55.9	8.5	35.6	59
total < 40 yrs.	51.2	5.8	43.0	121
40-49 years	44.2	14.0	41.9	43
over 50 "	38.1	21.4	40.8	42
total > 40 yrs.	41.2	17.6	41.2	85
rural area	45.0	12.2	42.7	131
urban area	50.7	8.0	41.3	75
whole sample	47.1	10.7	42.2	206

Table 15

Social Ranking of Occupations: number of times each occupation was placed above, below or equal to nursing.

Position	G.P.	Minister	Company Director	Dentist	C.A.	M.S.W.	Pt. Sch. Teacher	Physio	Bank	Police	Miner	Joiner	Railway Porter	Totals
Totals above	194	184	168	162	155	117	103	101	68	32	0	0	1	1285
12+	-	-	-	-	-	-	-	-	-	-	-	-	-	-
11	-	-	1	-	-	-	-	-	-	-	-	-	-	1
10	1	1	8	-	3	-	1	-	-	-	-	-	-	14
9	7	4	23	1	6	-	1	-	2	-	-	-	-	44
8	16	11	27	4	8	1	-	2	-	-	-	-	-	69
7	28	23	24	13	17	1	2	-	2	-	-	--	-	110
6	34	22	21	24	22	1	3	1	2	-	-	-	-	130
5	33	36	23	21	19	9	5	4	8	1	-	-	-	159
4	26	28	21	36	32	11	16	11	12	4	-	-	-	197
3	21	24	11	27	24	27	24	22	15	3	-	-	-	198
2	16	19	7	21	18	28	18	32	11	8	-	-	-	178
1	12	16	2	15	6	39	33	29	16	16	-	-	1	185
Equal	2	3	1	4	2	14	15	16	7	6	3	2	0	75
1	1	2	4	9	6	23	23	26	16	45	3	17	3	182
2	-	2	3	5	6	14	24	21	26	24	12	31	9	177
3	-	2	4	6	8	12	13	15	26	26	38	26	16	192
4	-	2	5	6	4	5	10	6	20	21	33	34	37	183
5	-	1	2	-	5	6	2	6	15	25	27	24	28	141
6	2	1	2	3	2	5	5	4	10	8	25	22	32	121
7	-	-	1	3	3	-	-	1	4	7	24	19	21	83
8	-	1	4	1	3	2	-	-	2	1	13	14	23	64
9	-	1	1	-	2	-	-	2	1	3	13	5	15	43
10	-	-	1	-	1	1	-	-	2	-	4	4	9	22
11	--	-	2	-	1	-	-	1	2	-	3	-	3	12
12+	-	-	-	-	-	-	-	-	-	-	1	1	2	4
Totals below	3	12	29	33	41	68	81	82	124	160	196	196	198	1224
Not placed	7	7	8	7	8	7	7	7	7	8	7	7	7	94

Table 16

Social Ranking of Occupations: percentage of respondents who placed each occupation above, below or equal to nursing.

Occupation	% Above	% Equal	% Below	% Not placed
General practitioner	94.2	1.0	1.5	3.4
Minister	89.3	1.5	5.8	3.4
Company Director	81.6	0.5	14.1	3.9
Dentist	78.6	1.9	16.0	3.4
Chartered accountant	75.2	1.0	19.9	3.9
Medical Soc. Worker	56.8	6.8	33.0	3.4
Primary Sch. Teacher	50.0	7.3	39.3	3.4
Physiotherapist	49.0	7.8	39.8	3.4
Banker	33.0	3.4	60.2	3.4
Policeman	15.5	2.9	77.7	3.9
Miner	-	1.5	95.1	3.4
Joiner	-	1.0	95.6	3.4
Railway porter	0.5	-	96.1	3.4

See Appendices 4 and 5 for information regarding the entrance requirements and Salary Scales of Occupations ranked above or below nursing by less than 80% of respondents.

Table 17

Social Ranking of Occupations:

Position of nurse.

sample	% in positions 1-6	% in positions 7-12	% un-placed	total
s/nurses	26.0	72.0	2.0	50
w/sisters	28.3	66.0	5.7	53
total hospital	27.2	68.9	3.9	103
d/nurses	29.1	67.3	3.6	55
h/visitors	45.8	52.1	2.1	48
total community	36.9	60.2	2.9	103
21-29 years	24.2	75.8	none	62
30-39 "	30.5	64.4	5.1	59
total < 40 yrs.	27.3	70.2	2.5	121
40-49 years	34.9	60.5	4.7	43
over 50 "	42.9	52.4	4.8	42
total > 40 yrs.	38.8	56.5	4.7	85
rural area	31.3	67.9	0.8	131
urban area	33.3	58.7	8.0	75
father's occup.(1)				
s/e class 1	52.0	40.0	8.0	25
" " II	27.7	72.3	none	47
total: I & II	36.1	61.1	2.8	72
s/e class III	31.6	65.3	3.1	98
" " IV	21.7	78.3	none	23
total: III & IV	29.8	67.8	2.5	121
0	30.8	53.8	15.4	13
whole sample	32.0	64.6	3.4	206

(1) <u>See</u> Table 3 for classification of occupations.

Table 18

Social Ranking of Occupations

General Practitioner

position	% staff nurses	% ward sis- ters	% total hosp- ital	% dis- trict nurses	% health visi- tors	% total comm- unity	% total
1	18.0	18.9	18.4	25.5	18.8	22.3	20.4
2	28.0	37.7	33.0	29.1	33.3	31.1	32.0
3	30.0	24.5	27.2	32.7	39.6	35.9	31.6
4	8.0	7.5	7.8	5.5	6.3	5.8	6.8
5	6.0	1.9	3.9	1.8	-	1.0	2.4
6	2.0	1.9	1.9	1.8	-	1.0	1.5
7-11	4.0	1.9	1.9	1.8	-	1.0	2.0
not placed	4.0	5.7	4.9	1.8	2.1	1.9	3.4

Table 19

Opinion Summary: (a) hospital/community
age of respondents, under/over 40 years.

	% Hospital	% Community	% < 40 yrs.	% > 40 yrs.	% whole sample
Opportunity for expressing opinion					
Satisfactory	68.0	66.0	61.6	75.3	67.0
Not utilised	73.8	63.1	66.9	71.8	68.9
Discouraged	28.2	34.0	33.9	27.1	31.1
Professional organisations					
Membership	47.6	54.4	48.8	54.1	51.0
Overtime payment					
Disagree	55.3	52.5	55.8	51.2	53.9
Nurse education: in favour of					
Raising minimum	35.0	48.5	35.5	50.6	41.7
University	52.4	73.8	54.5	75.3	63.1
Respondents' school leaving age					
> 16 years	59.2	51.5	58.7	50.6	55.3
Occupation status ranking					
Positions 1 to 6	27.2	36.9	27.3	38.8	32.0
Father's occupation					
S/e Class 1 and 2	37.9	32.0	38.0	30.6	35.0
Total number of respondents	103	103	121	85	206

Table 20.

Opinion Summary: (b) Professional Categories

	% staff nurses	% ward sisters	% district nurses	% % health visitors	% total
Opportunity for expressing opinion					
Satisfactory	62.0	73.6	47.3	87.5	67.0
Not utilised	70.0	79.2	50.9	77.1	68.9
Discouraged	24.0	32.1	27.3	41.7	31.1
Professional organisations					
Membership	24.0	69.8	38.2	72.9	51.0
Overtime payment					
Disagree	46.0	64.2	44.4	61.7	53.9
Nurse Education: in favour of					
Raising minimum	34.0	35.8	40.0	58.3	41.7
University educ.	54.0	50.9	69.1	79.2	63.1
Respondents' school leaving age					
$>$ 16 years	58.0	60.4	47.3	56.3	55.3
Occupation status ranking of Nursing					
Positions 1 to 6	26.0	28.3	29.1	45.8	32.0
Father's occupation					
S/e Class 1 and 2	36.0	39.6	32.7	31.3	35.0
Total respondents	50	53	55	48	206

Table 21.

Opinion Summary: (c) Age Groups.

	% 21-29 years	% 30-39 years	% 40-49 years	% over 50 years	% total
Opportunity for expressing opinion					
Satisfactory	61.3	61.0	79.1	74.4	67.0
Not utilised	66.1	67.8	83.7	59.5	68.9
Discouraged	25.8	42.1	30.2	23.8	31.1
Professional Organisations					
Membership	32.3	66.1	58.1	50.0	51.0
Overtime payment					
Disagree	45.2	67.2	60.5	41.5	53.9
Nurse Education: in favour of					
Raising minimum	35.5	35.6	51.2	50.0	41.7
University	51.6	57.6	76.7	73.8	63.1
Respondents' school leaving age					
> 16 years	54.8	62.7	53.5	47.6	55.3
Occupation status ranking of nursing					
Positions 1-6	24.2	30.5	34.9	42.9	32.0
Father's occupation					
s/e Classes 1 & 2	38.7	37.3	27.9	33.3	35.0
Total respondents	62	59	43	42	206

Table 22.

Opinion Summary: (d) Hospital Sample:
Rural and Urban Areas.

	% rural hospitals	% urban hospitals	% total hosp.sample
Opportunity for expressing opinion			
Satisfactory	64.1	73.7	68.0
Not utilised	75.4	71.1	73.8
Discouraged	24.6	34.2	28.2
Professional Organisations			
Membership	38.5	63.2	47.6
Overtime Payment			
Not in favour	55.4	55.3	55.3
Nurse Education: in favour of			
Raising minimum	27.7	47.4	35.0
University	47.7	60.5	52.4
Respondents' school leaving age			
> 16 years	50.8	73.7	59.2
Occupation status ranking: nursing			
Positions 1 to 6	23.1	34.2	27.2
Father's Occupation			
S/e Classes 1 & 2	27.7	55.3	37.9
Total Respondents	65	38	103

Table 23

Opinion Summary: (e) Members and Non-Members of Professional Nursing Organisations.

	% Members (105)	% non-Members (101)	% whole sample (206)
Wages and Hours Bill: attitude towards official policy:			
agreed	31.4	26.7	29.3
disagreed	31.4	39.6	35.6
Opportunity for expressing opinion			
satisfactory	72.4	61.4	67.0
not utilised	68.6	69.3	68.9
discouraged during training	34.3	27.7	31.1
Professional Organisations reasons for membership:			
indemnity insurance	47.7	26.7	37.4
"düty"	37.1	7.9	22.8
representation	25.7	4.9	15.5
educational facilities	22.9	6.9	15.0
opportunity to meet	20.0	5.0	12.6
Reasons for Non-Membership:			
fees too high	4.8	13.9	9.2
can't attend meetings	3.8	13.9	8.7
dislike of meetings	8.6	6.9	7.3
never been asked to join	4.8	9.9	11.2
"too impersonal"	3.8	4.0	
Overtime payment			
disagree	61.9	44.6	53.9
Nursing Journals read: (1)			
Nursing Times	47.6	36.6	42.2
Nursing Mirror	58.3	73.3	65.7
Nursing education: in favour of			
raising minimum	51.4	31.7	41.7
university	62.4	63.8	63.1
Total respondents	105	101	206

(1) % based on 103 members, 101 non-members.

APPENDIX 1: STATUTORY NURSING BODIES

1.1: General Nursing Council for Scotland.

Constitution of the Council

Nurses (Scotland) Act, 1951

First Schedule

1. The Council shall consist of -
   (a) thirteen persons elected as hereinafter mentioned;
   (b) eleven persons appointed by the Secretary of State;
   (c) two persons appointed by the Privy Council, of whom one shall be appointed to represent universities in Scotland.

2.- (1) Of the elected members of the Council-
   (a) seven, who shall be nurses (including male nurses) registered in the general part of the register, shall be elected by nurses so registered;
   (b) two, who shall be registered mental nurses or registered nurses for mental defectives, shall be elected by nurses so registered, and one of the persons so elected shall be a man and one a woman;
   (c) one, who shall be a registered fever nurse, shall be elected by registered fever nurses;
   (d) one, who shall be a registered sick children's nurse, shall be elected by registered sick childern's nurses;
   (e) two, who shall be persons holding certificates given by virtue of paragraph (f) of subsection (1) of section six of this Act (which paragraph provides for the giving of certificates to persons trained in the teaching of nursing) shall be elected by such persons.

(2) Each of the nurses to be elected in pursuance of the last foregoing sub-paragraph shall, on the date of election, be engaged in Scotland in nursing or in other work for which the employment of a registered nurse is requisite or for which a registered nurse is commonly employed.

3. The members of the Council appointed by the Secretary of State shall include-
   (a) two registered nurses employed in services provided under Part III of the National Health Service (Scotland) Act, 1947, appointed by him after consultation with such persons and bodies as he thinks fit/

being persons and bodies having special knowledge and experience of the work of nurses so employed;

(b) duly qualified medical practitioners, appointed by him after consultation with such organisations representative of the medical profession as he thinks fit;

(c) persons with experience in hospital management, appointed by him after consultation with such persons and bodies having experience in hospital management as he thinks fit;

(d) persons with experience in local government, appointed by him after consultation with such local health authorities, or such organisations representative of local health authorities, as he thinks fit; and

(e) a person or persons with financial experience.

Appendix

1.2: Nurses and Midwives Whitley Council.

Membership of Staff Side, 1965.

	Number of Representatives
Association of Hospital Matrons	1
Association of Hospital and Welfare Administrators	1
Association of Scottish Hospital Matrons	1
Association of Supervisors of Midwives	1
Confederation of Health Services Employees	4
Health Visitors Association	2
National and Local Government Officers Association	2
National Union of General and Municipal Workers	1
National Union of Public Employees	4
Royal College of Midwives	3
Royal College of Nursing and National Council of Nurses of the United Kingdom	8
Scottish Health Visitors Association	1

APPENDIX 2: NURSES IN THE NATIONAL HEALTH SERVICE IN SCOTLAND, 1964

2.1: Nurses in Training

Male and Female Students training for the General and Mental Registers.

(a) Hospitals other than mental and maternity

	Male	Female	Total
Students training for the general register:	251	5556	5807
Pupils training for the roll	43	1380	1423
Total	294	6936	7230

(b) Mental hospitals

	Male	Female	Total
Students training for the mental register	560	550	1110
Pupils training for the roll	48	93	141
Total	608	643	1251

Total number of male nurses in training: 902 (10.6%)

.. .. .. female .. .. .. : 7579 (89.4%)

8481

See Scottish Health Statistics, 1964. (H.M.S.O.1966)

2.2: Qualified Nurses in the Hospital Service: Male/Female

Figures include nurses working whole-time and part-time.

(a) Hospitals other than mental and maternity

Category of Nurse	Male	Female	Total	% Male Nurses
Staff Nurses	89	3566	3655	2.4
Wd.Sister/Ch.Nurse	105	1979	2084	5.0
Total	194	5545	5739	3.4
Above Wd.S/Ch.N.	23	966	989	2.3
Total	217	6511	6728	3.2
State Enrolled Nurses	95	1687	1782	5.3

(b) Mental Hospitals

Category of Nurse	Male	Female	Total	% Male Nurses
Staff Nurses	929	647	1576	58.9
Wd.S/Ch.Nurse	573	556	1129	50.8
Total	1502	1203	2705	55.5
Above Wd.S/Ch.N.	183	193	376	48.7
Total	1685	1396	3081	54.7
State Enrolled Nurses	294	817	1111	26.5

See Scottish Health Statistics, 1964, H.M.S.O.1966.

2.3: Qualified Nurses in the Hospital Service: Whole/Part-time.

Figures include male and female nurses.

(a) Hospitals other then mental and maternity

Category of Nurse	Whole-time	Part-time	Total
Staff nurses	1760	1895	3655
Wd.Sister/Ch.Nurse	1877	207	2084
Total	3637	2102	5739
Above Wd. Sister/Ch.Nurse	957	32	989
Total	4594	2134	6728
State Enrolled Nurses	1035	747	1782

(b) Mental hospitals

Category of Nurse	Whole-time	Part-time	Total
Staff Nurses	1358	218	1576
Wd.Sister/Ch.Nurse	1094	35	1129
Total	2452	253	2705
Above Wd.Sister/Ch.N.	373	3	376
Total	2825	256	3081
State Enrolled Nurses	990	121	1111

<u>See</u> Scottish Health Statistics, 1964, H.M.S.O.1966.

2.4: Qualified Nurses in Local Health Authority Services.

Field Staff

Category	Whole-time	Part-time	Total
Health Visitors	863	17	880*
District Nurses: R.G.N.	258	98	356+
District Nurses: S.E.N.	7	3	10+
Domiciliary Midwives	259	20	279
"Combined duty" Nurses:			
District Nurses/Midwives	348	12	360+
District Nurses/Midwives/ Health Visitors.	605	31	636*+
District Nurses/Health Visitors	13	1	14*+
Total	2353	182	2535

* Total number of nurses employed as health visitors: 1530, of whom 1051 were qualified as health visitors.

\+ Total number of nurses employed as district nurses: 1376, of whom 1105 had received training in district nursing.

Senior Staff

In addition to the above, there were 134 nurses employed in administrative and teaching positions.

Figures supplied by the Scottish Home and Health Department, St. Andrews' House, Edinburgh, November, 1964.

2.5: AGE OF NURSES TRAINING FOR COMMUNITY WORK.

2.5.1: District Nursing: Queen's Institute of District Nursing, Edinburgh.

Year	% 22-29 years	% 30-39 years	% 40-49 years	% over 50 years	Total
1950	57.8	34.4	7.8	none	65
1955	75.3	15.6	9.0	none	77
1960	64.1	28.1	6.3	1.6	64.
1965	64.7	20.0	14.1	1.2	85

2.5.2: Health Visiting: Health Visitor Training Centre, Edinburgh.

Year	% 22-29 years	% 30-39 years	% 40-49 years	% over 50 years	Total
1955-6	none	32.1	50.0	17.9	28
1960-1	8.3	62.5	25.0	4.2	24
1965-6	21.4	57.1	21.4	none	28

APPENDIX 3: PROFESSIONAL NURSING ORGANISATIONS.

3.1: Great Britain and Northern Ireland

3.1.1: Organisations to which only Registered Nurses are admitted as full members.

(a) Royal College of Nursing and National Council of Nurses of the United Kingdom

Henrietta Place, Cavendish Square, London, W.1.

Membership: 41,787[(i)] - nurses whose names appear on any part of the Registers kept by the General Councils of the United Kingdom.

Aims (Article III of the Royal Charter):

"To promote the science and art of nursing and the better education and training of nurses and their efficiency in the profession of nursing

To promote the advance of nursing as a profession

in all or any of its branches

To promote through the medium of international agencies and otherwise the foregoing purposes in other countries as well as in Our United Kingdom

To assist nurses who by reason of adversity, ill-health or otherwise are in need of assistance of any nature"

Represented on the Nurses and Midwives Whitley Council: 8 seats.

National representative organisation on the International Council of Nurses.

Scottish Board

43/44 Heriot Row, Edinburgh, 3.

Membership: approximately 4,000.

(i) Annual Report, 1965.

(b) Association of Hospital Matrons

17 Portland Place, London, W.1.

Membership: 2,070 - registered nurses on any of the Registers maintained by the Councils of the U.K. who are, at the time of application for membership, matrons of hospitals, whether the hospitals are training schools or not; members of the nursing services of the Armed Forces who hold the substantive rank of matron.

Represented on the Nurses and Midwives Whitley Council:

1 seat.

(c) Association of Scottish Hospital Matrons

Ayr County and Heathfield Hospitals, Heathfield Road, Ayr.

Membership: 390 - "registered nurses who at the time of their application hold the office of matron of a hospital or institute for the care of the sick, of a maternity hospital, or who is a superintendent of a key training home of the Queen's Institute of District Nursing."

Aims: "to enable members to take counsel together on matters affecting the profession, to take action if necessary upon législative and administrative proposals, secure satisfactory terms of service for members, and maintain the honour and further the interests of the nursing profession."

Represented on the Nurses and Midwives Whitley Council:

1 seat

(d) Health Visitors' Association

36 Eccleston Square, London, S.W.1.

Membership: 4,500 -"a person who holds the Health Visitor Certificate and is or has been a health visitor, tuberculosis visitor, school nurse or clinic nurse; a home nurse domiciliary midwife and health visitor holding a combined appointment; a principal/chief/superintendent nursing officer."

Aims: "to safeguard the interest and improve the status of persons in the public health service"

Represented on the Nurses and Midwives Whitley Council:

2 seats.

(e) Scottish Health Visitors' Association

19 Second Avenue, Lenzie, Glasgow.

Membership: 600 - all qualified health visitors in Scotland.

Aims: "to promote and protect the interest of members at local and national level, advance professional education and to advise and help individual members."

Represented on the Nurses and Midwives Whitley Council:

1 seat.

3.1.2: Organisations open to nurses other then those who are on the Registers of the General Nursing Councils.

(a) Royal College of Midwives.

15 Mansfield Street, London, W.1.

Membership: 13,884 - all midwives whose names are on the Roll of either of the British Central Midwives' Boards, or the Joint Nurses' and Midwives' of Northern Ireland.

Aims: "To improve the efficiency and raise the status of midwives for the benefit of mothers and babies of the country."

Represented on the Nurses and Midwives Whitley Council:

3 seats.

(b) National Association of State Enrolled Nurses

1 Vere Street, London, W.1.

Membership: 5,250 - nurses on the Roll maintained by any of the Councils of the U.K.

Aims: "A professional organisation representing the interests and views of enrolled nurses. Provides an indemnity insurance up to £4,000. Affiliated to the Royal College of Nursing."

(c) Student Nurses' Association

1a Henrietta Place, London, W.1.

Membership: 14,000 - students in training for registration with the General Nursing Councils of the U.K.

Aims: "To promote the science and art of nursing and the better education of student nurses and to provide support and protection for its members and to develop their executive ability."

See Nursing Times, 13.5.66 for further information regarding twenty-one nursing organisations in the United Kingdom.

Appendix

3.2: International Council of Nurses:Membership

Sixty-three national nurses' associations in membership with I.C.N. March,1966.

Australia	Haiti	Pakistan
Austria	Hong Kong	Panama
Barbados	Iceland	Peru
Belgium	India	Philippines
Brazil	Iran	Poland
British Guiana	Ireland	Rhodesia
Burma	Israel	Sierra Leone
Canada	Italy	Singapore
Ceylon	Jamaica	South Africa
Rep. of China	Japan	Spain
Chile	Jordan	Sweden
Colombia	Kenya	Switzerland
Denmark	Korea	Thailand
Egypt (UAR)	Liberia	Trinidad
Ethiopia	Luxemburg	Turkey
Finland	Malaya	United Kingdom
France	Mexico	USA
Gambia	Netherlands	Uruguay
Germany	New Zealand	Venezuela
Ghana	Nigeria	Yugoslavia
Greece	Norway	Zambia

3.2.1: International Council of Nurses:

Code of Ethics as applied to Nursing.

Adopted at the International Council of Nurses in Sao Paulo, Brazil, July 1953 and revised by the I.C.N. Grand Council, Frankfurt, Germany, June, 1965.

"Nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery and stress the prevention of illness and promotion of health by teaching and example. They render health-service to the individual, the family and the community and co-ordinate their services with members of other health professions.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service based on human need is therefore unrestricted by considerations of nationality, race, creed, colour, politics or social status.

Inherent in the code is the fundamental concept that the nurse believes in the essential freedoms of mankind and in the preservation of human life. It is important that all nurses be aware of the Red Cross Principles and of their rights and obligations under the terms of the Geneva Conventions of 1949.

The profession recognises that an international code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

(1) The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health.

(2) The nurse shall maintain at all times the highest standards of nursing care and of professional conduct.

(3) The nurse must not only be well prepared to practise but shall maintain knowledge and skill at a consistently high level.

(4) The religious beliefs of a patient shall be respected.

(5) Nurses hold in confidence all personal information entrusted to them.

(6) Nurses recognise not only the responsibilities but the limitations of their professional functions; do not recommend or give medical treatment without medical orders except in emergencies, and report such action to a physician as soon as possible.

(7) The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.

(8) The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.

(9) The nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides.

(10) Nurses do not permit their names to be used in connection with the advertisement of products or with any other forms of self advertisement.

(11) The nurse co-operates with and maintains harmonious relationships with members of other professions and with nursing colleagues.

(12) The nurse adheres to standards of personal ethics which reflect credit upon the profession.

(13) In personal conduct nurses should not knowingly disregard the accepted pattern of behaviour of the community in which they live and work.

(14) The nurse participates and shares responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public - local, state, national and international.

APPENDIX 4: ENTRANCE REQUIREMENTS:

Medicine, Nursing and Occupations ranked above or below nursing in the social scale by less than 80% of respondents

4.1: ACCOUNTING

Extracts from: Choice of Careers No. 59: The Accountant. prepared by the Ministry of Labour and the Central Office of Information. 4th ed. 1965.

Educational standards required for entry

There are a number of "recognised professional bodies" responsible for the training of accountants. Their entrance qualifications differ.

The Institute of Chartered Accountants of Scotland requires the following preliminary qualifications:

> "(a) the Scottish Universities' Preliminary examination, or the Scottish Certificate of Education with Higher grade English and six Ordinary grade passes, or three Higher grade passes and one Ordinary grade pass; or (b) the General Certificate of Education with seven Ordinary level passes, or one Advanced and five Ordinary level passes, or two Advanced and two Ordinary level passes; or (c) the Senior Certificate Examination of the Ministry of Education for Northern Ireland, or the Cambridge OverseasSchool Certificate Examination with passes at standards equivalent to those listed in (b)."

University courses:

"Under a scheme arranged by a Joint Committee representing the Institute of Chartered Accountants of England and Wales, the Association of Certified and Corporate Accountants and certain universities in England and Wales, a prescribed degree can be obtained which carries both a reduction of two years in practical experience and exemption from the Intermediate examination of the professional bodies concerned."

4.2: BANKING

Extracts from: The Institute of Bankers in Scotland: Examination Syllabus and Regulations, 1967.

"Eligibility:

The examinations of the Institute are open only to those who are, or have been, in the service of one of the Scottish Banks of Issue.

Intermediate Examination. - Candidates must have passed in at least four subjects, including English, at Ordinary Grade in the examinations for the Scottish Certificate of Education, the General Certificate of Education, or such other examination(s) as may be accepted by the Institute Council.

Final Examination. - Candidates must have passed, or have been exempted from, the Intermediate Examination and must have paid their subscriptions as Student Members for the current year....

4.3: MEDICINE

Extracts from: Choice of Careers No. 108 Medicine and Surgery. Prepared by the Ministry of Labour and the Central Office of Information. H.M.S.O.1964.

"Medicine is a profession which must be entered not only with a scientific interest but also with a sense of vocation and a desire to be of service to others...."

(cf. 4.4: Medical social work)

Educational qualifications:

A student must first show that he has matriculated or passed an entrance examination of a university of England and Wales or of Northern Ireland or of the Republic of Ireland, or other examination recognised by such a university as equivalent thereto. Expressed in terms of the General Certificate of Education the minimum requirements, which are not identical at all universities, are generally two or three Advanced level passes and passes at Ordinary level in certain subjects as required. A Certificate of Attestation of Fitness issued by the Scottish Universities Entrance Board is necessary for admission to a Scottish university." (1)

(1) Requirements for entry to dental schools in Scotland are similar to requirements for entry to medicine.

4.4: MEDICAL SOCIAL WORK

Extracts from: Choice of Careers No. 102. Social Workers. Prepared by the Ministry of Labour and the Central Office of Information. H.M.S.O. 1965.

"The social worker... is primarily concerned with individuals and families who for physical, mental, emotional or ervironmental reasons are in need of help and guidance so that they may take full part in the life and work of the community. Discovering the right method of dealing with persons needing help is not sentimental work; it is scientific work, requiring observation, reasoning and carefully thought-out action..." (cf. 4.3: Medicine)

Training:

Students who enter straight from school are usually advised by universities to take a three-year degree course which includes study of social science subjects followed by a diploma course lasting up to one year...

For certificate and diploma courses entry is normally restricted to candidates of 19 years and over. Candidates are selected on their individual records of education and experience and some universities also have a special entrance examination; there is a personal interview...

Medical Social Workers: young people who wish to train as medical social workers are often advised to spend some time after leaving school working at any job which will bring them into touch with people of varying ages and backgrounds. To become medical social workers they must obtain a degree in social studies or related subject followed by a year's professional training...

Owing to a wide variation of practice it is impossible to give full details..."

Appendix.

4.5: NURSING

Entrance qualifications for training for Registration on all parts of the Register.

Extract from: information supplied by the General Nursing Council for Scotland, 1965.

"The educational qualifications which came into force on 1st January, 1963, read as follows:-

(a) a minimum of two passes on the Ordinary Grade of the Scottish Certificate of Education, one of which must be English; or

(b) an educational examination of equivalent standard, which is acceptable to the Council;or

(c) for an interim period, until a date to be determined by the Council with the consent of the Secretary of State, an educational examination set by the Council."

4.6: PHYSIOTHERAPY

The Chartered Society of Physiotherapy

Regulations for admission to training

I The minimum qualification accepted for admission to a School of Physiotherapy is one of the following:

(1) The General Certificate of Education or the Scottish Leaving Certificate.

(2) The Senior Certificate of the Northern Ireland Ministry of Education.

(3) The Leaving Certificate of the Irish Department of Education, or the Matriculation Certificate of the National University, Dublin, or of Trinity College, Dublin.

(4) The School Certificate of the Universities of England and Wales.

(5) The Scottish Certificate of Education.

(6) The Cambridge Overseas School Certificate or West African School Certificate, irrespective of the Division gained, provided the candidate has passed at credit level in the five subjects as indicated under Regulation (III).

(7) A certificate admitting to a degree course in a University outside Great Britain or Ireland.

II In all cases passes in a minimum of five subjects (as specified in paragraph III) must be gained. Subjects taken at different levels will only count as one subject. Preference will be given to candidates offering one or more subjects at Advanced level.

III Candidates must offer a pass in the following subjects:

(i) English language
(ii) a subject from Schedule A (see below)
(iii) a subject from Schedule B (see overleaf)
(iv) a further subject from either Schedule A or B
(v) any other subject

SCHEDULE A

Mathematics
Physics
Chemistry
Physics-with-chemistry
Science
General science
Additional general science

General science 1
General science 11
General science(2nd subject-Cambridge G.C.E.)

Botany
Zoology
Biology

Mechanics
Applied mechanics

(note: Human biology, Anatomy, physiology and hygiene cannot be accepted as Schedule A subjects but may be offered as a subject under (v))

SCHEDULE B

- English literature
- Geography
- Physical geography and elementary geology
- Geology
- History
- History of science
- Economics
- Economics and Public affairs
- Religious knowledge
- Greek
- Latin
- Modern languages other than English
- General paper

When English language and literature are taken as one subject it will be accepted for (i) overleaf, but cannot be counted again as English literature in Schedule B.

In the case of (7) if the native language is not English, the Certificate of Proficiency in English for Foreign Students of the Universities of Cambridge or London will be accepted in lieu of (i).

IV Candidates are advised to cover as wide a curriculum as possible, which should include physical education and physics and chemistry. Candidates whose certificate does not include physics and chemistry are advised at least to cover the physics and chemistry syllabus issued by the Chartered Society (postage 4d).

V Some Schools of Physiotherapy have special entry requirements and prospective students are urged to make early enquiry from the school of their choice.

VI Candidates holding certain professional qualifications may, on application, be considered for exemption from the Regulations for admission to training.

VII Applications Applications for entry to training should be made to the Principal of a School of Physiotherapy at an early date. Date of birth and full details of educational qualifications should be given. Candidates must be 18 by the 1st October of the year of entry (or by 1st April when entering in the spring).

4.7: POLICE(EDINBURGH CITY)

A candidate for appointment must be able to produce satisfactory references as to character and, if he has served in any branch of Her Majesty's Naval, Military or Air Forces or in the Civil Service or in a Police Force, produce satisfactory proof of his good conduct while in such Service or Force. A person dismissed from any such Service or Force is not eligible for appointmant, and a Service character of a lower degree than "Very Good" will not be considered.

Candidates must be:

1. between 19 and 25 years of age.
   Candidates over this age limit with special qualifications may be considered;

2. at least 5 feet 10 inches in height (without shoes) and have a chest measurement of at least 36 inches under clothing (without expansion);

3. strong healthy and physically fit.

   The bodily complaints for which candidates are most frequently rejected are as follows:

   varicose veins; varicocele; tumours; rupture; flat feet; skin disease; stiffness of joints; cough; narrow chest; weak sight; defective teeth; physical peculiarity or deformity, etc.;

4. of sound moral character and of undoubted sobriety;

5. able to read and write well and have good knowledge of English, Arithmetic and General Knowledge (Third Year Secondary School standard.)

Appendix

4.8: TEACHING

Extracts from: Choice of Careers No. 117. Teaching. Prepared by the Ministry of Labour and the Central Office of Information. 1965.

Teacher training inScotland:

"The Teacher's General Certificate. This certificate qualifies the holder to teach primary school subjects. It is awarded to:

(1) graduates who complete a one-year course of teacher training at a college of education;

(2) non-graduate women* who complete a three-year course of training at a college of education. The minimum age of entry to the three-year course is 17."

* "With the exception of holders of recognised diplomas who qualify for the award of the Teacher's Technical Certificate all men intending to become teachers in day schools in Scotland must be university graduates."

Preliminary Educational Qualifications (Scotland)

"Non-graduate level. The minimum requirements for admission to training for the Teacher's General Certificate are:

(1) a certificate of attestation of fitness of the Scottish Universities Entrance Board; or

(2) four Higher grade passes in the S.C.E.; or

(3) three Higher grade and two Ordinary grade passes in S.C.E.; or

(4) two Higher grade and two Ordinary grade passes in S.C.E.

All non-graduate candidates must have a Higher grade pass in English and a pass in arithmetic or in mathematics. There is no limitation to the number of examination sittings."

APPENDIX 5: SALARIES

Medicine, Nursing and Occupations ranked above or below Nursing in the Social Scale by less than 80% of respondents.

5.1: ACCOUNTING

Extracts from: Choice of Careers No. 59. The Accountant. Prepared by the Ministry of Labour and the Central Office of Information. 4th ed.1965.

"The salary depends on the ability, experience and qualifications of the individual and on the size and circumstances of the firm, but a newly qualified clerk can generally e xpect to earn from £900 to £1200 in London and rather less, perhaps £800 to £950, elsewhere in the country. A managing clerk may earn a much greater figure..."

In industry and commerce: "For the executive posts salaries of from £1500 to £2500 are common and they may be considerably higher for some appointments."

In government service: "The commencing salary is at present from about £1000 to about £1400 a year according to age, the minimum age of entry being 25 years; on promotion to senior accountant a salary range of from £1400 to £2,000 may be received. Chief accountants receive up to about £2500 while there are higher salaries for a few senior posts."

In local government service: "The salary scale for a qualified accountant appointed to a post requiring a recognised accountancy qualification is £1090 a year rising to £1340 and senior accountants may earn considerably more. In larger authorities higher salaries may be paid."

Appendix

5.2: BANKING

Extract from: The Scottish Banks: Career Guide published by the Institute of Bankers in Scotland on behalf of the Scottish Banks.

"During the early years of service salaries are paid on progressive scales which lay down minimum rates of pay. Starting salaries depend on the age and qualifications upon admission - at eighteen the minimum figure is almost £400. For those who hold a Scottish Certificate of Education of approximately University-entrance standard the initial salary is usually £50/100 above the scale figure.

Salaries increase annually and by the age of thirty-two will be over £1,100. By that stage, however, anyone who has passed the required examinations and has shown ability in other ways will already be earning considerably more than the salary scale and will hold or will be under consideration for an official appointment....

The salary of a branch manager naturally varies according to the size of the branch and increases with age and experience. Minimum salary for such appointments is about £2,000 and there are many posts with salaries over £2,500."

A typical minimum scale for women is as follows:

Age:

16 . .	£360	21 . .	£565	26 . .	£680
17 . .	375	22 . .	600	27 . .	695
18 . .	445	23 . .	635	28 . .	705
19 . .	500	24 . .	645	29 . .	720
20 . .	530	25 . .	665	30 . .	745

Appendix

5.3: DENTAL & MEDICAL PRACTITIONERS

1)	House officer	£770 - 940
2)	Senior house officer	£1195 - 1255
3)	Registrar	£1425 - 1595
4)	Senior registrar	£1710 - 2395
5)	Consultant	£2910 - 4445

Terms and conditions of service, Amendment Sheet 1. (T.C.S. (H.S.) 63/1)

5.4: MEDICAL SOCIAL WORK

<u>See</u>: Whitley Councils for the Health Services (Great Britain) Professional and Technical Council "A" Circulars No. 116, 124, 125.

Medical Social worker	£787 - 918
Senior M.S.W.	£918 - 1055
M.S.W. in sole charge) Head M.S.W. Grade I)	£918 - 1131
Head M.S.W. Grade II) Teacher)	£1017 - 1207
Head Grade III	£1093 - 1289
Head Grade IV	£1169 - 1431
Deputy Head I	£934 - 1076
" " II	£961 - 1103

Appendix

5.5: NURSING

See: Whitley Councils for the Health Services (Great Britain) Nurses and Midwives Council Circular No. 122.

5.5.1: Nursing Staff in General Hospitals

Staff Nurses: £690-850
(£880 after a further 3 years)

Ward Sisters: £890-1205

Nursing Administrative Staff

Matrons:

No. of hospital beds		Training school	Non-training
Max.	(over 1000	£1910-2235	
	(over 700		£1495-1770
Min.	under 100	1270-1480	£1210-1370

Deputy Matron:

over 750 beds: £1285-1495

500- 749 " £1245-1455

Nurse Teaching Staff

Principal Tutor

(a) £1245-1455

(b) £1245-1410

Registered Nurse Tutor

£1105-1320

Appendix

5.5.2: Nursing Staff in Public Health and Domiciliary Work

District Nurses

R.G.N. with district training £785-1135

R.G.N. without district training £755-1105

R.G.N. plus S.C.M. (double duty)
- with general district training £840-1155
- without general district training £810-1125

R.G.N. plus S.C.M. plus H.V.Cert.(triple duty)
with general district training £920-1235

without general district training. £890-1205

Nurses doing 'triple duty' without H.V. Cert. are on the same salary scale as 'double duty' nurses.

Health Visitors:

£920-1235

Health Visitor Administrative Staff:

Superintendent Nursing Officer

Max	1000 staff and over:	discretionary
	500-999 staff:	£1615-1995
Min	10-24 staff:	£1240-1400

Deputy Superintendent

1000 staff and over:	discretionary
500-999 staff:	£1330- 1570
25-29 staff:	£1120-1280

Health Visitor Teaching Staff

Principal Health Visitor Tutor: £1245-1410

Health Visitor Tutor: £1105-1320

5.6: PHYSIOTHERAPY

See: Whitley Councils for the Health Services (Great Britain)
Professional and Technical Council "A".
Circulars No. 116, 124, 125.

Physiotherapist (newly qualified). . . . . £700-900 (7 incr.)

Senior Physio. . . . . £840-1075 "

Superintendent: Grade I (min. staff 2) . . £890-1130

" " V (20 staff & over). £1180-1530

Assistant Supt. Grade I (6-13 staff plus Supt.)£860-1095

" " " II (14 & over plus Supt.) £890-1130

Teaching Staff

Certificated Teacher £1075-1405

Principal of Training School Grade I

average student intake: 10-24 £1310-1620

" Grade II

average student intake: 25 & over £1390-1700

Assistant Principal £1135-1475

5.7: POLICE

See: Your career: life in the Police. Prepared for the Home Office and the Scottish Home and Health Department by the Central Office of Information, H.M.S.O.1964.

Men:

Constables:	start at £700 (£800 if 22 or over)
	after 9 years: £1040
Sergeant:	£1170-1255
Inspector:	£1375-1470
Chief Inspector:	£1540-1645

Women:

Constables:	start at £630
	after 9 years: £935
	after 22 years: £995
Sergeant:	£1055-1130
Inspector:	£1240-1325
Chief Inspector:	£1385-1480

Plus: free uniform and shoe allowance
rent allowance or free living quarters

Appendix

5.8: TEACHING (Scotland)

Extracts from: "Teaching in Scotland" issued by the Scottish Education Department and the Central Office of Information. 1965.

Basic Scales:

Teacher's Certificate: Secondary Education

a) 1st or 2nd Class Hons. graduate	£900-1750
b) 3rd Class Hons. graduate	£870-1750
c) Ordinary graduate in secondary sch.	£820-1470

Teacher's Certificate: Primary Education

a) Graduate	£730-1370
b) Non-graduate: 4 yr. training	£675-1275
c) Non-graduate: 3 yr. training	£600-1190

Responsibility elements added to Basic Scales:

Primary School, depending on size: Head Teacher £175-850
Secondary School, " " " : " " £300-1700

"It is estimated that about a third of the men with honours degrees may expect to become head teachers of secondary schools and earn salaries ranging from £2050 to £3450 per annum; almost all the rest can expect to become depute head teachers or principal teachers, either of primary schools or of certain secondary schools, and earn salaries ranging from £1545 to £2695."

APPENDIX 6: THE SURVEY

6.1: Interviewing Schedule

(1) Opinion

1. I was recently asked by someone who is not a nurse why we called ourselves the nursing "profession". She suggested that nursing was a trade. What would you say was the difference between a trade and profession?

2. In 1930 a Member of Parliament drew up a Bill "to lay down minimum wages and maximum working hours for the nursing profession". At that time, nurses' salaries were not standardised, hours varied from one employing authority to another, and there was no Nurses and Midwives Whitley Council. The proposed Bill would have introduced conditions very much to the nurses' advantage but, unfortunately, their opinions were not asked. The Nursing Times opposed it on principle, stating that a "profession" shoudl not be controlled by legislations about which they had not been consulted.

Do you think the Nursing Times was right to oppose the Bill?

3. Do you think that nurses nowadays have sufficient opportunity to express their opinions on matters affecting the profession as a whole? Do they make use of their opportunities?

4. Are you a member of any nursing organisation?

If "Yes": Which one?
What would you say were your reasons for belonging?

If "No" : Have you any special reason for not belonging?

5. Do you read any of the nursing journals: regularly, sometimes, never/hardly ever?

6. At present there is a good deal of discussion about the standard of education which nurses should have. As you know, there used to be no national entry standard. The G.N.C. now requires either two subjects at "O" level, or a pass in their own test. The "Platt" Report recommends 5 "O" levels. There is wide disagreement on the subject. Have you any ideas about it?

Should the standard of entry be a very definite one, or should there be a "loophole" for special cases, for instance, in the sase of older women?

7. Supposing a girl who wants to be a nurse has the qualifications and the opportunity to go to university. Do you think a university education would be of any value to her in nursing?

8. Do you think there are any circumstance in which a nurse should not obey the instructions of a doctor?

9. Who do you think are the best people to judge the standard of nursing care: nurses, doctors or patients themselves?

10. Are there any circumstances in which nurses should go on strike?

11. Do you think nurses should be paid for working overtime?

First, have you anything against it on principle?
Second, do you think it would work all right in practice?

(2) Personal information

12. Sex. 13. Marital Status. 14. Nationality 15. Age.

16. Occupation on leaving school.

17. School leaving age.

(18. Did you have the opportunity to stay on longer at school?)

19. Was there any other type of work which you would have preferred to nursing?

If "Yes": What?
Why could you not have done this?
Do you still wish you could have done it?

20. Father's occupation.

21. Have you any special interests outside nursing?

22. We sometimes hear discussion about whether nursing is or is not a "vocation". The word seems to mean different things to different people. What do you think it means? How do you think it applies to nursing? Is it a good thing or a bad thing for a nurse to have?

(3) Occupational Status Ranking

There are 14 cards here on each of which is written the name of an occupation. I would like you to arrange them in order according to their social status - not the order in which you yourself would place them, but according to their social standing in the community.

Bank teller
Chartered accountant
Company director
Dentist
General Practitioner
Joiner
Medical social worker
Miner
Minister (Church of Scotland)
Nurse
Physiotherapist
Policeman
Primary school teacher
Railway porter

Appendix 6.2

Nursing Studies Unit,
19 Chalmers Street,
Edinburgh, 3.

Dear

I am writing to ask you whether you would be willing to take part in a survey which is being carried out from the Edinburgh Nursing Studies Unit.

As you will know, there have in the past been a number of enquiries into various aspects of nursing and, as a result, the working conditions of nurses have improved. So far, however, little attention has been paid to nurses' attitudes to nursing itself, and the responsibilities which it entails towards both patients and colleagues.

The present survey is being carried out by interview, so that individual nurses will have the opportunity to express and discuss their views about such things. We would like to get a wide range of opinion, from nurses at different levels, working in and outside hospital. Your name has been picked from a list of .... and we hope very much that you will be willing to take part. Anything you say will, of course, be treated as confidential and your name will not be recorded in connection with any opinion you express.

(Space here for stating arrangements for interview, etc. as arranged with each matron/nursing officer)

Enclosed with this letter is a stamped addressed post card. Could you please fill in the day and time at which it would be convenient for you to meet me (or, better still, give a choice of times) and return the card by .... If you could give me a 'phone number this might facilitate arrangements. It is expected that the interview will take about an hour - depending on how much you have to say!

I shall look forward to meeting you, and I hope you will find the project interesting.

Yours sincerely,

A Lancaster

(Miss)A. Lancaster, R.G.N., S.C.M.

Appendix 6.3

INTERVIEWS AND RESPONSE RATES

	No. of interviews		% Response rate	
Professional categories				
Staff nurses	50		66.6	
ward sisters	53		80.3	
total: hospital		103		73.0
district nurses	55		67.9	
health visitors	48		78.7	
total community		103		72.5
Hospital authorities:				
Victoria Hospital, Kirkcaldy	9		60.0	
Bridge of Earn Hospital	40		75.5	
Perth Royal Infirmary	16		80.0	
Western General Hospital Edinburgh	22		71.0	
Edinburgh Royal Infirmary	16		72.0	
Local Health Authorities				
Fife	28		90.3	
Perth and Kinross	38		90.5	
Edinburgh	37		53.6	
Rural area:				
hospital authorities	65		73.9	
local health authorities	66		90.4	
total rural		131		81.4
Urban area:				
hospital authorities	38		71.7	
local health authorities	37		53.6	
total urban		75		61.5
TOTAL		206		72.8

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