RELATING EDUCATION TO PRACTICE

WITHIN A NURSING CONTEXT

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PREFACE

Although this is called a preface it is in fact an autobiographic note to introduce the reader to the background which prompted me to write about the subject presented in this study.

After finishing a four years B.Sc. Nursing programme at Alexandria University, Egypt, I was appointed as a junior lecturer at the Institute of Nursing from which I graduated. Two years later I was transferred to teach the B.Sc. Nursing programme at Cairo University.

Teachers of the Nursing programme at both Universities are responsible for both 'theory' in the classroom and 'practice' in the clinical area. During 'practice' the teacher is in charge of the care of patients/clients in that clinical area. Both 'theory' and 'practice' go hand in hand through the academic year.

The four years B.Sc. Nursing programme is divided into eight terms: two terms to each academic year. Each term introduces the student to a different field of nursing. The different fields are: Medical and Surgical Nursing and their specialities; Paediatric Nursing, Obstetric and Gynaecological Nursing, Public Health Nursing, Psychiatric Nursing and Nursing administration.

Teachers are usually distributed according to their field of interest. Sometimes shifting of teachers to other fields occurs because of teaching needs and change of
interest. In my case I took part in teaching the
different fields of the programme mainly because of
teaching needs. In the main I taught Psychiatric
Nursing.

Against such a background I became interested in and
intrigued by the relationship between what I taught in the
classroom and what later on I reinforced in the clinical
area.

After five years of teaching I was sent on a World
Health Organization fellowship to study for a post-graduate
degree. I could not then resist my interest to rule, in
choosing the subject of the research. A subject which
kept my mind preoccupied all along my years of education
and teaching, and no doubt will keep me thinking for the
rest of my professional life.

I shall leave it to the reader to realise what my
opinion is on the 'puzzle' of relationship between theory
and practice.

I declare that this thesis has been composed by
myself, and that the work was my own.

Hend Abdel-Az. 
The study presents the Thesis that Nursing, Education and Practice stand in a mutual interactive relatedness, which may be illustrated as follows:

The extent and degree of explicitness at the abstract level is reflected on the concrete level. The more explicit and comprehensive the understanding of Nursing, the clearer the purpose and guidance for both Education and Practice, and the more effective the relatedness between them. By contrast, the less explicit and comprehensive the understanding of Nursing, the greater the fragmentation and vagueness in Education and Practice; and the less effective the relatedness between them.

This decrease in effectiveness in relatedness is caused by the submersion of the general structure under a
welter of details - the wood cannot be seen for the trees. As a result, the structure is rendered disfunctional.

This Thesis is argued in the light of the relevant literature and its validity explored in a survey and in an experimental course of teaching in the context of the three years general nurse training in Scotland.

The potentials of the application of the presented Thesis is illustrated by an exposition of an understanding of Nursing with the implications of such understanding in Education and Practice.
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I should like to take this opportunity to express my gratitude to all the people who helped me throughout the research.

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I deem myself a lucky person for the invaluable experience I gained in human relations. As a final note of appreciation to all concerned I offer Margaret Reynolds' poem: Friendship.

Stories retold, and dreams and aspirations
Shared, and at times the needed consolations,
Add a sweet flower, a tear, a star for keeping
Close to my heart.

And at the autumn reaping
When I'm alone with memories attendant,
So will my mind be bright, be made resplendent
With thoughts of you.

Then will my hand reach out across the years
And grasp yours, and my small voice touch your ears
Saying, thankyou.

Hend Abdel-Al.
PART ONE

THE PROBLEM

Introduction

Chapter I : The Problem Through Literature
1. Change as it relates to Nursing
2. Characteristics needed in a Nurse
3. Role of the Nurse
4. Education versus Service in Nursing

Chapter II : The Problem Through Literature (Continued)
1. Definition of the Problem
2. Review of Literature
INTRODUCTION

Over the past forty years the feeling that all is not well in Nursing has been reflected in the setting up of numerous committees to investigate the profession. Cohen (1948) in the Ministry Report thought it fair to infer,

from the decision to set up a new committee of inquiry, that earlier bodies, however valuable the outcome of their deliberation have not been altogether successful.

Thompson (1959) in the introduction to the 'Report of Nursing Committee' expressed worry about the fact that satisfactory answers were hard to reach:

... no other profession, new or old, has been subject in the last forty years to so many inquiries and none has been dealt with at such great length in such numerous reports as nursing has been in that period. It has indeed been said that nursing has been in a chronic state of investigation and at times in danger of being submerged in a deluge of words.

As far back as 1946 'The Working Party on the Recruitment and Training of Nurses' (Wood Report) considered two basic questions within its remit:

What is the proper task of a nurse?
What training is required to equip her for that task?

Similarly, James (1972), twenty-six years later, discussing trends in nurse education observed:

Clearly answers to many of these questions (qualities to be assessed, methods of selection, entrance requirements) will depend upon what one considers to be the role of a nurse.
MacFarlane (1973) also referred to the specification of the nurse's role when speculating about the contribution of 'graduates' to the profession.

It is clear that the definition of the nurse's task or role has long been considered a problem. In spite of investigations over four decades no satisfactory answer has yet been reached and a great deal of doubt is still being expressed.

To my mind, the reason for such a state of affairs is the fact that no serious attempt has been made to clarify the frame of reference within which the problem can be investigated. Questions are asked which, though related to each other, are not related to a wider and more basic context. If it could be found, such a frame of reference would both relate the problems of nursing and encourage practical and useful answers. In the mass of reports and papers, some of which are quoted above, the conclusions seem interesting but do not give directive to action or even to a starting point, and so a vicious circle is set up where the same kinds of questions are repeated and the same kinds of problems persist. The remit of the Wood Committee in 1946 and that of the Briggs Committee in 1972 clearly illustrate this persistence.
Wood Report (1946)

'Review the position of the nursing profession' and examine questions such as:
(a) What is the proper task of a nurse?
(b) What training is required to equip her for that task?
(c) What annual intake is needed and how can it be obtained?
(d) From what groups of the population should recruitment be made?
(e) How can wastage during training be minimized?

The similarity between the two reports is further exemplified in some of their recommendations in the area of nurse training.

The Wood Report (1946) emphasised the need for full student status:

so far as the intrinsic requirements of nurse training permit

and concluded that if this could be done

a period of two years would suffice for a general training more comprehensive and more effective than the existing one. Students would have a five day week of 40 hours ... would learn the fundamentals common to all fields of nursing in the first 18 months and spend the remaining six months in concentrated study and training in a chosen field. (After registration they could be employed only) under supervision until completing satisfactorily a further year's work. This would be the sole portal of entry for all who wished to train in nursing and the roll of assistant nurses would therefore be closed at a given date.

They recommended that for such a plan to be successful additional staff would be required in the proportions,
roughly, of one third orderlies and two thirds qualified staff.

The Briggs Committee (1972) also recommended the closure of the roll and the division of training into an initial period of 18 months leading to the certificate in nursing, followed by another block of 18 months for specialisation leading to registration. The committee also wanted to secure student status for the nurse trainee, an increase in staff for the implementation of their programme.

The chief difference between the results in this respect is in the proportions suggested: two thirds aides/orderlies as against one third qualified staff.

On the basis of the argument presented above, a need for a frame of reference or a context within which relevant and potentially productive/operational questions could be asked is therefore imperative. The thesis presented in this study is based on such argument. The source from which a frame of reference or context can be developed is a deeper and more comprehensive understanding of what is meant by nursing. Our understanding is reflected and influenced by the ways in which we organise the nurse's training as well as by the ways in which we organise our work and perceive our role as nurses. Being uncertain or unclear about our role is the result of being uncertain of what we mean by nursing and how we should prepare the student nurse for this role. The mutual interactive relatedness of the three elements
Nursing, Education and Practice can be illustrated as follows:

This relatedness is maintained regardless of the content of what is meant by 'nursing' or what is included in 'education' or 'practice' and it is against this background that the relatedness of theoretical instruction to practical experience is studied. It is argued in this thesis that for the effective study of such relatedness two main levels should be considered:

(i) the contextual and conceptual, (abstract) i.e. the level at which the meaning of nursing is explored;
(ii) the applied and experimental, (concrete), i.e. the level at which teaching and practice occur.

The main emphasis of the present study is on the educational aspect of the above diagram. The field of study is the three year general nurse training programme in Scotland.

The Thesis presents the study in Six parts. These are distributed as follows:

Part I presents the 'problem'. In the first Chapter the relatedness of the meaning of Nursing to Education and Practice is presented and further explored through a selected literature. This is followed by a Brief review of literature dealing specifically with the
relatedness of theory to practice.

Part II presents the 'Survey'. Chapters Two to Six report on a survey of tutors' and student nurses' perception of the relatedness of theory to practice in their training programme. The survey also tested the extent of validity of the argued relatedness of Nursing, Education and Practice.

Part III presents the 'Experiment'. In Chapters Seven to Ten the results and discussion of the survey are used to suggest a solution in the form of an experimental course of teaching. The effect of teaching this course to an experimental group of student nurses is compared with that of teaching a control group a more conventional course. A specially constructed post-test is used for this purpose. Comments of the tutors and nurses participating in the experimental course are also taken into account in evaluating the results of the experiment.

Part IV presents a 'Philosophical analysis'. In Chapters Eleven to Fourteen literature presenting the meaning' of nursing is reviewed and an argument for the explicit exposition of a philosophical interpretation of nursing with its implications in terms of education and practice is also offered.

Part V presents the 'Nursing curriculum'. Chapters Fifteen to Seventeen discuss the curriculum as a whole within the context of 'nursing'; pointing out the role
of explicitness of such a context in rendering more effective and illuminating the study of the educational programme and the relatedness of theory to practice.

Part VI presents a 'Summary and concluding discussion'. Chapter Eighteen contains a summary of the Thesis. The various issues raised throughout are pointed out and discussed.
CHAPTER ONE

THE PROBLEM THROUGH LITERATURE

GENERAL INTRODUCTION

The question to be answered in this Chapter is: Would a critical study of the literature reveal the connection between the meaning of nursing held and its reflection on the educational programme and the practice of nursing? I intend to review mainly British rather than North American literature because of its relevance to the study. As the major concern of this thesis is educational four issues are chosen which are believed to be of concern to nursing education:

A  Change as it relates to nursing;
B  Characteristics needed in a nurse;
C  The role of the nurse;
D  Education versus service in Nursing.

A  Change as it relates to nursing

This section is based on the premise that 'change' is a phenomenon of our time and that it affects nursing both in practice and from an educational aspect.

As to the inevitability of change Bennis (1969 p.2) writes:

Most students of our society agree that one major invariant is the tendency toward movement, growth, development, process: change.

Oppenheimer (in Bennis 1969 p.2) notes the implications. How does change affect nursing as a profession? What part
does the educational programme play in preparing the
nurse to understand and deal with change? How does
'change' affect the nurse's everyday work? Before
attempting to answer these questions it seems meaningful
to study change as a mechanism.

1) The mechanism of Change

One source of change is increased knowledge in the
physical sciences and increase of the resources of
technology with the provision of mainly concrete
commodities as the product of change. Another is increased
knowledge in the social sciences where the product of
change is more abstract. Each of the above products of
change (whether concrete or abstract) calls for a response
in the individual who is affected by the change and who has
to deal with it.

In the nature of things, advances in the physical
sciences and in technology usually occur more rapidly than
corresponding advances in the social sciences. This
discrepancy in the rate of change is reflected in the
acceptance of the outcome of change by the individual.
Such acceptance calls for a reappraisal of values, defined
by Raths (1969 p.45) as,

(those) influences which give direction to our lives ... 
ideas that we will stand up for.

He goes on to say that our values underlie our beliefs and
attitudes and
represent an interpretation, our interpretation of our own life experiences... our totality of living.

From the numerous definitions of attitude reviewed by Greenwald (1968) it appears that an attitude is a disposition or predisposition of the mind, very much bound to emotions. Oppenheim, (1966) concludes that attitudes and values, like many other components of behaviour are pervasive abstraction, influencing a wide variety of cognitive, affective and conative manifestations. The problem is thus raised of identifying these attitudes and values as well as measuring them, in order to evaluate the process of their change. (Audi, 1972) Schein, (1964) in discussing the mechanism of change in relation to attitudes writes:

Any change in behaviour and attitudes... tends to be emotionally resisted because even the possibility of change implies that previous behaviour and attitudes were somehow wrong or inadequate, a conclusion which the change target would be motivated to reject.

Schein is of the opinion that for change to occur it must be preceded by an alteration of the (present) stable equilibrium which supports the present behaviour and attitudes. He uses Lewin's terminology and calls this first stage "unfreezing" directed to rendering less operative the defenses which would tend to arise. The next stage is that of "changing", which is the process of seeking out, processing and utilizing information for the purpose of achieving new perceptions, attitudes and
behaviour. Finally "refreezing" is necessary for the outcome of change to endure.

How is change considered in the nursing profession? The motivation for change comes from pressures both outside and inside nursing. Though the distinction between them is difficult to mark. It will suffice to consider the views of (a) leaders in the nursing profession, and (b) committees formed to investigate the situation in nursing and to recommend change.

(a) Miss Simpson (1971) Nursing Officer (Research) in the Department of Health and Social Security, discussed the influence of change on nursing research as follows:

... Impetus came also from changed social circumstances. Advances in medicine demanded reciprocal changes in nursing practice. The introduction of a National Health Service changed the face of hospital administration. The altered position of women in society, the advances in opportunities for education and the new technique of research now rapidly developing in the social sciences, made research into nursing problems both necessary and a realistic possibility ...

Professor Scott Wright (1973) in her Inaugural Lecture at Edinburgh University said that:

A viable profession is going to depend increasingly on its ability to adapt incessantly to meet changes in the social, economic and scientific environment. The need for nursing to adapt itself to changes from outside is clearly recognized.

(b) In the field of administration (mainly service) the Committee on Senior Nursing Staff Structure (1966 p.4) found that

Nursing appears to occupy a secondary position, this stems from the incoherence of the nursing administration itself ... Confusion arises from the indescriminate and imprecise use of the title 'Matron'
... There is also confusion about the functions of nurse administrators in the hospital organization.

The Committee then recommended a new staffing structure to be introduced gradually:

beginning with one or two groups in each region and with selected teaching hospitals. (p.115)

Most hospitals in Scotland have now implemented the recommended staffing structure.

In the field of Nursing Education, The Royal College of Nursing and National Council of Nurses of the U.K. (1964) in their Reform of Nursing Education reported that:

This system of nurse training can no longer be justified. It is wasteful of students and of educational resources, it discourages many potentially good students from entering nursing and it fails to produce adequate numbers of registered nurses of the type required, who wish to continue with the practice of nursing. (The Royal College of Nursing 1964 p.5)

Among their recommendations for "reorganization of basic nursing education" (p.38) which advocated quite fundamental changes were:

The nursing student should be financially independent of the hospital service for the first two years of training. (p.38)

and

Schools of Nursing should be independent of the hospital service. (p.38)

These committees' findings point to the need for changes in Nursing to alleviate dissatisfaction arising from within Nursing.
To cope effectively with change as it relates to nursing a clear understanding of the process of change and the process of nursing is essential. In a world which is on the move all the time a clear understanding of nursing will safeguard its identity and prevent nursing from being a helpless passive 'follower' or alternatively a neurotic vulnerable component trying hard to 'resist' any movement or challenge for fear of being demolished. Wherever there is a dilemma of identity such confrontations promote bitterness and tensions. Healthy competitive interaction stems from a secure identity.

(Soddy and Ahrenfeldt (Editors) 1965 p.54).

How does change influence nursing practice?

Technology brings to the nurse's everyday practice new products to deal with and new equipment to use, for example:

A monitor is introduced on a Ward. What does that mean for the nurses? The monitor is a machine fitted and checked by a technician. Someone will tell the nurses how the machine works, and what it is capable of doing. Usually an instruction manual is supplied as well and the range of its safety specified. The clearer the nurses are in their understanding of this piece of equipment the more easily and effectively they will use it. However, there are other factors involved: reading the rate of heart-beat from a dial rather than palpating a pulse (I will for the moment ignore all the other information
obtained from palpating a pulse) calls for a different kind of acceptance. It means that one has to learn to trust this piece of machinery to give one the right reading. It means less point of contact or touch between nurse and patient. It means less actual participation for the nurse in evaluating the patient's condition. Maybe one can get used to the 'presence' of a machine, but if it interferes with what one believes needs doing then acceptance is not such an easy thing. In fact, acceptance of the implications of such an introduction calls for a change of values. Examples of change calling for a different way of thinking and organization on the part of nurses are the introduction of a Nursing Care Plan, and of a Kardex system.

If values stem from our experience, it follows that any interference with experience will interfere with values. Changing the conditions of experience with a consequent reappraisal of values means upsetting the possibly deep-rooted values developed out of interaction with prior conditions. The deeper the previous involvement the harder it is to accept the change which challenges this involvement.

The increasing introduction of products of technology in patient care raises issues complex in nature. One of these being the psychological significance of touch which is believed to play an important part in our ability to communicate (Dominion 1971). What then, would a decrease in opportunity for contact between nurse and patient mean? If we believe that human beings, through sharing some
common characteristics and needs, express them in an individual way, we may reasonably conclude that a decrease in opportunity for contact between nurse and patient will affect individual patients differently. For some, at least, a decrease in opportunity for contact may mean an increase in insecurity: Dominion (1971) stresses the patient's need for security:

The need for security, reassurance and comfort are constant human emotional requirements ... These emotional needs are activated and increased at times of stress, particularly when the integrity of one person in terms of survival is threatened. Illness and hospital care are undoubtedly occasions during which people of all ages experience the anxiety of disintegration. Their needs for safety undoubtedly increase and physical contact becomes of great importance.

Perhaps this should be taken into account when considering the introduction of machinery for patient care. To give one example, the purpose of an article by Greenberg (1970) was to "stimulate nurses ... in senior administrative positions to press for their (major devices of technology) introduction," and to advise on the information available about such devices. Patients could be lifted in and out of bed, in and out of the bath, bottoms could be washed and dried by foot control (etc). But what about the patient's feelings? Would he/she like it? Would he/she feel secure between the steel arms of an 'Ambulift' for example? These mechanical introductions were concerned with lightening the physical load of the nurse's work. What effect do they have on her attitude? This leads on to another important consideration, the effect of introducing machinery on the
relationship between nurse and patient. To the nurse, no less than to the patient, the relationship must be rewarding and provide security, a two-way relationship. The nurse's contact with her patient is an important element in the establishment and maintenance of her identity as a nurse. Against this it might be argued that there are of course other opportunities for contact between nurse and patient. True, but these will need reappraisal and redefinition in the new context of takeover of some of the nurse's functions by mechanical devices.

From the above illustration, one can infer that the introduction of a product of technology is a complex enterprise and not one to be undertaken lightly. However, these difficulties and complexities compare favourably with those encountered when change is aimed at the nurse's attitudes. Factors which facilitate acceptance by the nurse of a product of technology and lack in the context of attitude change are:

(i) its concreteness, hence one has as a starting point an object perceived by the sense organs;
(ii) technological products come with instructions for use, hence one has an easily identifiable source of reference;
(iii) it has a specified function, hence it is easier to fit within the existing situation;
(iv) there is a department or firm responsible for the product, hence one can arrange for repair or replacement when it fails to function properly or at all.
2) **How does change influence nurse education?**

It seems that the greater part of the responsibility of coping with change lies within the preparation of the nurse. Such an enterprise requires knowledge and abilities, some of which are:

(i) **Ability to differentiate between a real necessity for change and a pseudo necessity for change;**

It is far from being self-evident that there is any virtue in communication as such, any more than there is any virtue in change as such ... But change to what purpose? (Klein 1972)

Even though change usually occurs in response to a need of some kind, this is not always the case. The nurse needs to develop a discriminative ability and be confident enough, as well as knowledgeable enough, to stand in the way of what is sheer profit-making commercialism. However, change for the sake of variety (if there is need for it) is legitimate provided it is not detrimental to more fundamental issues;

(ii) **Ability to qualify change, i.e. to judge whether the change in question is one of essence or detail.**

Does it call for a change in a basic value or a change in outlook or a change of method while keeping the same principle?

(iii) **Ability to bring together and deploy effectively, knowledge about change and knowledge about nursing.**

An awareness of what is involved in attitude change, and in adaptation to a product of technology, would help toward effective results;
(iv) Ability to go beyond the immediate and to think within a broader framework of a more complex nature.

This conjunction of knowledge and abilities would of necessity develop in the nurse flexibility of thought and action. Clearly, this would be a desirable development but I do not mean merely to make "recommendations" to the nurse; the organization and implementation of the nursing programme should provide the nurse with the necessary factors that would make her feel confident on actual grounds which would create the opportunity for the development of dynamic thinking and critical ability. In Professor Scott Wright's (1969) opinion the present nurse training programme lacks such provision.

B Characteristics needed in a nurse

What are the characteristics needed in a nurse? What are the provisions made for the development of these characteristics? Answers to these two questions could give us direct and valuable insight into what is meant by "nursing" and of the perceived image of the nurse and her role.

1) The characteristics needed in a nurse have been mentioned at length by both the Platt Committee (1964) and the Briggs Committee (1972). Among those characteristics are "leadership", "adaptability", "technical efficiency", "teaching", "administration" and "research".
The Platt Report (1964 p.10) stipulates that

Better prepared nurses are needed in increasing numbers in teaching, administration and research in hospital and public health services.

Such needs are also supported by the Briggs Committee (1972 p.15). However, no fundamental reasons are given as to why such qualities are needed and how they contribute to the effectiveness of nursing on a practical level.

For the nurse to possess these characteristics implies the organization of a programme of training which would allow for and plan so that the student develops such abilities. For the student to develop "leadership", "adaptability", and "technical efficiency" she must develop a critical way of thinking against a "scientific" background which will potentiate the use of knowledge acquired during training.

To develop a critical ability the student requires a certain degree of freedom of thought and supervised action. To study the situation she is confronted with and decide on a course of action. She should be allowed to question, refute and accept decisions according to her judgement in various situations which would entail gradually giving her the opportunity to take responsibility and to act responsively. The Report mentions "technical efficiency", but for the nurse to make effective and intelligent use of machinery on the Ward she should be familiar with basic principles of physics and chemistry.

The Briggs Report (1972 p.15) emphasized that
Just as every qualified nurse or midwife should be in some sense an educator, so every qualified nurse and midwife must be in some sense a manager.

What is the extent to which the nurse is to become an educator or a manager?

To be a teacher or an administrator could either be a primary function that a nurse in such position fulfils, in which case she gets some extra preparation for the fulfilment of such role. Or it could be part of the usual function of the nurse entailing the introduction of the principles of teaching and management early in the programme of training. It also requires that the student is given the opportunity to put such principles into practice.

Both Reports (Platt and Briggs) as well as numerous articles in the nursing journals point out the importance of research in nursing.

Professor Scott Wright (1971) stresses that

Nurses must develop research-mindedness at all levels.

While Holmes (1972) perceives that the future of the nursing profession is dependent on research;

A high level of professional competence ... Nurses will acquire it in the modern world when research becomes a duty of some, if not all, members of the profession.

(1973)
The Editor of the journal 'Nursing Times' believes that "research skills will make tomorrow's nurses".

The qualities needed for nurses to carry out research are reported by Bendall (1970) as:

Someone who has a perfectly open mind and is completely free from prejudice - in other words, a person who has been trained to be objective.

And by Scott Wright (1971) as:
Courage, integrity, determination associated with a high level of intelligence and a good sense of humour. Again how would research contribute to nursing was not clearly indicated.

Another characteristic which is gaining importance is that of being a 'graduate'.
A 'graduate' in nursing could belong to one of three categories:
- She could have had a University Degree in any field then joined nursing.
- She could have had one of the University Degrees in nursing, and these vary according to the University in which they are run.
- She could have had her nursing qualifications then joined the University to obtain a degree in the field of her interest.

The Briggs Committee (1972 p.97) recommends that up to 5% of nurses are to be graduates, without specifying the category.

How would a graduate contribute to nursing?
Professor Scott Wright (1973 p.4) says that:
What this positive contribution should be has never been too carefully defined.

McFarlaine (1973) found it difficult to assess the contribution of the graduates because:
A major difficulty in attempting to determine a role for the graduate in nursing was the problem in determining the role of the nurse.
2) The provisions made for the development of the required characteristics.

The first question to ask is whether the programme of training assumes responsibility for the development of the required characteristics.

From the literature this does not seem to be the case. These characteristics are mentioned mostly as 'required' in the recruit rather than as ability to be developed through the programme of training.

The Briggs Report (1972 p.96) recommended that:

The profession must recruit ... from people of widely different abilities and temperaments. Among them there must be people capable of initiating ideas, carrying heavy responsibilities and meeting on equal terms with opposite numbers in other professions.

And Scott Wright (1969) expressed the opinion for the need to attract into the profession tolerant experienced and well-educated people.

The next question to be answered is how many of the implications of the characteristics mentioned are provided for.

The development of a critical way of thinking seems to be difficult to achieve if work on the ward is organized mainly on the basis of task allocation, which leaves little or no room for the student to exercise her own judgement. Another factor which is reported in the literature which would contribute to such difficulties is the rigid hierarchical structure in hospitals. Coleman (1971) writes;

The powers that be are producing nurses who are quite incapable of thinking for themselves half the time.
Such intellectual abilities as a critical way of thinking are complex in nature. They are influenced by the person's value, knowledge, attitudes, emotions and the environment in which they develop. They also develop gradually over a period of time and therefore require a well organized plan for their development. Such organization could not be inferred from any of the literature consulted.

The answers to the question of whether the student is given the opportunity to put into practice her teaching and management principles (if) taught is negative both because of the organization of work on a clinical level and the lack of awareness on the part of the programme organizer for their role in that context.

As to the need for "technical efficiency" in nurses no specifications are made by the General Nursing Council as to the 'O' Level subjects required for entrance into nursing. This suggests that the General Nursing Council does not find a connection between the educational background of the recruit and the educational requirement of the programme of training.

The same line of argument applies when considering the expressed need for 'graduates' and for people capable of initiating action, when the environment in which they learn and work is highly pre-determined.

It could be concluded from the above discussion that there is no relation between what is required and what is provided for the implications of nurse requirements.
3) What is the nature of the meaning of nursing against such a background as that presented in 1) and 2) above. The characteristics are presented in terms of functions like "educator", "administrator", "researcher", "graduate". This reflects a way of thinking about nursing which is fragmented and specific. Such fragmentation makes relatedness between characteristics cumbersome and difficult as each function is looked upon in isolation instead of clarifying the common underlying ability.

The development of a given ability becomes more manageable in terms of achievement when perceived as common to several situations. A critical way of thinking is an ability which covers most of the characteristics required in a nurse in the literature. Nevertheless, it has been reported under several functions. It seems more meaningful to discuss the development through the programme of a given ability than describing it under so many "functions", which burdens the programme and confuses the issue.

The characteristics stipulated as required in a research worker are a good illustration. The enumeration of such characteristics complicates the picture of research and makes it unattainable for the majority. It also shows over concern with issues which though important are taken to unrealistic extremes, an example being "perfectly open mind" and "completely free from prejudice". It is difficult to imagine if one considers these requirements what the person carrying the research would be aiming at.
If research is to be undertaken in 'nursing' one has to have a frame of reference and a context within which to investigate problems. It follows that having a "perfectly open mind" makes research a vacuous exercise. Shipman (1972 p.3) questions the purely scientific approach even in scientific research. He writes:

the imaginative stage occurs as the problem is first defined.

Concern with such characteristics in a researcher reflects a lack of awareness of the possibility that there is such a thing as a frame of reference in nursing which would guide our thought and action.

The way of introducing the idea of a graduate in nursing reflects a picture of nursing where nursing is a pre-determined group of activities, which lack potential for development. What gives it this "quality of thinking" is a University Degree which can be in any field. McFarlane (1973) reporting about the graduate's contribution writes:

Assessing needs was a highly complex skill demanding a certain quality of thinking which was fostered only by a high level of education.

Somehow the ability to assess needs, which would seem to me to be an integral aspect of the nurse's role is ascribed to the 'graduate' part of the role and is separate from nursing. This again re-inforces the impression that nursing is a sum total of specific compartments, and the connection between them sometimes vague and sometimes non-existent.
C The Role of the Nurse

The role of the nurse is more obviously related to the meaning of 'nursing' than any of the previous issues to be considered.

Therefore, what constitutes the nurse's role and the meaning of nursing reflected in this role are discussed concomitantly.

What constitutes the nurse's role has been viewed from different aspects. What the nurse does in terms of tasks was studied by the Nuffield Provincial Hospitals Trust (1953). The nurse's role as perceived by the patients and the doctor was investigated by Anderson (1973), and the role of the nurse in a multidisciplinary team of community care constituted Altschul's (1973) inquiry. Hunt (1970) trying to unravel the "dilemma of identity" for health visitors, wrote:

There seems to be a common feeling among health visitors that their role is difficult to interpret to others and that it is not well understood or agreed upon by those with whom they work.

Cormack (1975) extensively reviewed the role of the psychiatric nurse and attempted to study that of the charge nurse in a psychiatric hospital.

The two most common approaches to define the nurse's role were to analyse what the nurse did at the time, or to speculate about what the nurse ought to be doing. A common background which would guide the appropriateness of what is present or what ought to be present was lacking in each case.
The Briggs Committee (1972 p.3) supported the General Nursing Council for England and Wales in their statements that:

The role of the nurse must always be closely related to the needs of the patients. These needs are never static, but vary according to individual patients, medical and technical advances. Thus the role of the nurse is continually changing.

Such an attitude of mind indicates that what constitutes a role is a sum total of details or tasks rather than a general structure governed by a given set of principles. This detailed view of a role would by implication be difficult to account for and could reach unmanageable proportions, and lacks any intrinsic value which would give the role a recognisable identity.

The programme of training as well as the range of responsibility of the nurse in everyday work also reflects an unclear identity.

Murphy (1970) considered "role extension" to be potentially dangerous. She defined it as "a unilateral lengthening process". She favoured "role expansion as a spreading out process of diffusion" in relation to the nurse's role. By definition expansion would possess a common core around which the role evolves (identifiable), while extension could be liable to get too far away from its point of origin. Murphy (1970) reviewed the literature pertaining to these conceptions and concluded that the role of the nurse whether extending or expanding had an elusively defined historical base:
Though the concepts "nursing" and "the role of the nurse" have not been clearly delineated in the past and perhaps never shall be, students are socialized into a role labeled "nursing" by means of a curriculum labeled "nursing education" and some position holders in the health care system are labeled "nurses".

She perceived the doctor to be responsible for role extension:

Generally, the authority base from which the extended role of the nurse emanates is the physician who "allows" nurses to carry out some of his delegated functions.

A study funded by the Department of Health and Social Security supports her warning of the danger of role extension. The study was carried out by a psychologist and a psychiatrist who trained a small number of psychiatric nurses as therapists. The nurses succeeded in treating "phobics" under the two authors supervision. Though the results might appear to be complimentary to the nurses' ability the reason for choosing the patient was far from being so,

phobic and obsessive compulsive disorders can be defined fairly accurately measured easily and treated with reasonable success.

The above mentioned study was reported in the Journal Nursing Times as a sign of progress in nursing. Looked at more carefully the issue is of a very serious nature. Above all it calls for an urgent need to clarify what is meant by nursing and consequently what is to be considered as a nursing activity. It also raises an ethical point. The training of these nurses were carried out to "ease the current critical shortage of treatment personnel in psychiatry". As it would be uneconomical to

Marks (1973).
train psychiatrists and psychologists "simply (my italics) to administer the newer psychological methods since so much of their training and skill is redundant to the therapeutic tasks involved".

When the patients' conditions "lend themselves to a social cost-effectiveness study in which the gains to the patient can be weighed against the cost of the therapy" (my italics). If nurses are capable "of the task originally envisaged for them," why not pay them the same salary as the psychiatrist or psychologist carrying out these treatments? This is a serious sign of exploitation and degradation of the nature of nursing. Nursing and Medicine occur in the same geographical area, but this does not mean, however, that they have similar nature. If this were the case, there would be no need to have two different types of training to equip the trainee to carry out the same job.

The example indicates the seriousness of the danger of the concept of role extension. This is not to say that use of the principles of behaviour modification cannot be used in nursing. A recent study carried out by Tierney (1973) illustrated successfully and practically the expansion of the nurses' role. She used behaviour modification for the purpose of toilet training some children in a mental subnormality hospital. This is part of the nurse's function and responsibility on the ward as it helps to:-
1) preserve the dignity of the patient;
ii) minimize the chance of 'sore bottoms';
iii) cut down on the unnecessary time spent by nurses doing a repetitive activity which could be avoided or decreased;
iv) keep the patient clean (part of his personal hygiene).

The study of the nurse as a therapist is a good illustration of taking nursing to mean a sum total of tasks, with the possibility of adding and subtracting tasks as suitable. Somehow a frame of reference and a core around which these tasks centre to form a coherent whole, is conspicuously lacking.

Cherescavich (1964), in the United States discussing the expanding role of the professional nurse in hospital, identified some of the changes introduced in patient-care due to change in medicine and hospitals.

- The hospital bed is more of a specialty department;
- A great deal of machinery for diagnosis and treatment is introduced;
- The number of people caring for the patient and their scope is much wider, both inside the hospital and on discharge;
- As the care of the patient becomes more involved there has been a change from a nurse-patient relationship to a patient-nursing team relationship;
- This nursing team is comprised of nurses with different qualifications.
She does not, however, see this as a drawback, as she considered the 'mothering' role of the nurse of the "yesteryears" narrow and incapable of dealing with the current demands. The "academically prepared nurse in the mid-sixties is a professional nurse knowledgeable in the science and skilled in the art of nursing, - her role in order of priority seems to be a clinical associate of the physician, a therapist, a teacher and consultant to technical nurses and nursing assistant, a health supervisor and teacher to the patient and his family."

What is at stake here, and of vital importance is the shift in the values of 'good nursing' from a 'subject' based one, i.e. contact with patient, to an 'object' based one, contact with machinery, products of technology, monitors or administrative functions, in any case away from the direct contact with the patient. As it was pointed out in Section A p.15, the 'contact' and relationship between the nurse and the patient is part of the identity of the nurse as a nurse. When the 'subject' of the contact shifts, the meaning of the identity shifts subsequently and becomes 'object' based.

The results of studies like The Nuffield Hospital Trust (1953) and The Work of Student and Pupil Assistant Nurses (1957) showed that students, pupils and auxiliary staff are the ones who are in direct contact with the patient. As the student nurse becomes more senior her direct contact with the patient decreases.
The professional nurse, in the United States of America, and the registered nurse in Britain, is not the one who gives 'care' to the patient, she is the one who 'assesses' his needs, 'supervises' his care, 'plans' the organization of the 'patient's care' ('patient' being a mere 'variable' in the process). But those who come in direct contact with the patients are either unqualified (nursing auxiliaries) or less qualified nurses (enrolled, students, pupils, technical nurses in the United States of America).

The qualified nurse is likely to become one of the following: clinical nurse specialist, administrator, senior nursing officer, tutor, therapist, etc. Because she is qualified she will have access to these positions, and paradoxically her role becomes narrower and limited to a particular function.

Qualified nurses get more preparation (formally and in terms of experience) to fulfil one function, while those 'caring' directly for the patient, which is by necessity of a wider scope (both in depth and extent) get no or little formal preparation. Murphy (1970) quite rightly warns that "Unless nurses resume the care component of their roles, the raison d'être of nursing will be challenged."

This is where the concept of 'nurse education' (which is derived from and influences the understanding of nursing) will decide the role of the nurse. The function of education is not merely to pass on knowledge and develop
abilities, it is also to weld these into a set of values within a nursing context. If higher educational standards are needed for their own sake and for the sake of prestige, the outcome is the professional nurse, (planning, budgeting, organizing, teaching) efficient and detached from the patient. However, higher educational standards could be a great asset if used to develop a nurse whose aim is direct patient care (in its emotional and professional sense), and whose highest estimated value is 'contact' with the patient. Because of the increased introduction of products of technology into patient care the patient needs more than ever before, human warmth and contact with a person capable of conveying a sense of comfort and security in such uncommunicative surroundings of machinery. Education should prepare a nurse, confident enough in herself and her knowledge, who would know how and when to draw a line at the introduction of machinery. Educational assets should be used to develop both:

1) an understanding of nursing as an entity rather than compartments of isolated tasks;
2) an integrated individual nurse rather than one with demarcated knowledge, abilities, feelings and behaviour.

The meaning of nursing conveyed by the literature discussing the role of the nurse is vague, unclearly defined, confused, compartmentalized and vulnerable.
D Education versus Service in Nursing

How is the relationship between Education and Service reported in the literature? What picture of nursing does it reflect?

From the literature, a certain degree of conflict is inferred as present between nursing education and nursing service. This is often referred to as the lack of relationship between theory and practice.

1) Nature of the Conflict

In 1957 the Report on 'The Work of Student Nurses and Pupil Nurses' was mainly concerned with the relationship of theory to practice. It had among its remits: (Smith 1957):

(b) to what extent is practical training subordinated to the needs of the nursing service of the hospital
(d) Whether the allocation of a student nurse's time is economically planned in her interest as a student
(e) What would be the most effective combination of theory and practice.

Their investigation showed that the practical training is greatly subordinated to the nursing service requirements of a hospital. This was influenced by local circumstances within each hospital as well as by staff shortage (p.30-31). As to the economical planning of student nurse's time they found that 87% of their time is spent on nursing activities concomitant with aspects of her practical training and 13% is spent on theoretical training (p.38).

An interesting observation reported was:

It is readily apparent that, whilst there is a great degree of uniformity in the allocation of time as between theoretical and practical instruction, there
is a lack of uniformity in practical experience as between the various hospitals. ... undoubtedly the greatest factor influencing the allocation of student nurse's time is the nursing administrative requirements of individual hospitals. (p.39)

Lastly, in relation to 'the most effective combination of theory and practice' the Committee asked the pertinent question "the most effective combination for what?" (p.42)

After some discussion they rightly state that: "The most effective combination of theory and practice must of necessity be related to numerous factors, many of which are imponderable". (p.43)

Another interesting observation made was that whether the "block system" or the "study-day system" of teaching the theory was used, students in both cases found that 'theoretical training was not related to practical work in the wards'. (p.42)

Several conclusions could be drawn from the above:

1. Student nurses are needed for carrying out the nursing care of patients on the wards.

2. Student nurses spend the major part of their training on the hospital ward, hence the greater part of the learning is more likely to take place there.

3. The small proportion of time allocated for theoretical preparation makes it nearly impossible to prepare the student in the classroom for the variety of work she is to carry on the ward, especially as the allocation to the latter is highly unpredictable, since it relates to service needs.

4. A number of factors decide how theory and practice
could be combined hence their identification or an attempt to do so at least is essential for an effective organization and carrying out of a programme of nurse training.

5. Regardless of the organization of teaching the theory (block-study/study day), the practice remains not related. This suggests that the problem is not only an administrative one of time sequence but rather that an analysis in depth is needed to find the extent of the problem.

Though this was the picture in 1957, still up to the present the gap between theory and practice is mentioned often enough to require attention. Two studies that mention this fact were carried out by Revans and by Bendall.

Revans (1964) in his study of the relationship of morale to effectiveness in General Hospital states that:

... many girls ... could see only contradiction between methods they had been taught in the training school, methods they were supposed to use on one ward and methods they were supposed to use on another.

Bendall (1971) clarifying a 'Nursing dilemma' writes:

A persistent complaint from students now is the dichotomy between what is taught in the school and what is practiced in the wards. (my italics)

The interest of education and that of practice as reported clash.

Suggested Solutions.

A solution was offered by the Platt Committee (1964)
which thought that, because "Within the existing pattern of nurse training the conflict between the needs of the service and the educational needs of the student is inevitable" recommended that the student must be a student in fact and not in name only, being financially independent from hospital for the first two years of training and that the school of nursing should be independent of the hospital service.

The Minister of Health rejected the Platt Committee's fundamental suggestions. Lapping (1967) reporting on this rejection wrote that the Minister of Health recognised that a relationship must be established between practical work on the ward and theoretical study so that the whole makes sense to the student, and that suggested that students:

should receive an outline of the programme aimed at, that some nursing staff ought to be earmarked for relief duties so that student nurses are not thrust into emergency work to the detriment of their training, that students' night duties should be kept within the limits recommended by the General Nursing Council, that time spent in any one ward should be related to the training need rather than the hospital service's need.

He also suggested more non-nursing auxiliary staff and greater provision for part-time nurses, and to encourage women over thirty to be trained as "enrolled" nurses. He recommended the amalgamation of Schools and an increase in tutors' population.

In 1968 the Nurse Tutor Working Party was set up

To identify the current and foreseeable educational and training needs of students and pupil nurses and the role of teaching staff in meeting these needs and to examine the resultant staffing pattern. (Raven 1970).
On the same principles as the Platt Report the Nurse Tutor Working Party suggested a programme of training arranged in modules of twelve weeks duration. First two weeks would be for preparatory study and the last two weeks for consolidation, and that teaching would include periods of clinical experience with associated clinical teaching.

The student would sit her final examination near the end of her second year and register during her third year; being allowed a period of 'full service' in between examination and registration. They recommended that "preparation for the register must ... be both a studentship and apprenticeship". They seem to use studentship to mean 'purely academic' hence the need for adding apprenticeship as nursing includes skills and activities.

They believed that:

the preparation for registration or enrolment is a process which rightly involves both training and education,

defining training as:

bring a person up to a desired state of efficiency by instruction and practice;

but regarding education as:

the broader process of intellectual development.

This understanding of education and training tallies with their understanding of "studentship" and "apprenticeship". They consider intellectual studies as 'education', the person doing them a 'student', while skills and practice are the domain of 'training', the person in training an 'apprentice'.

This general idea was also found in the Briggs Committee, and was criticized by Leach (1973)

the real trouble is ... that the report ... failed to examine properly the basis for either education or training. Indeed, it is not clear that the committee had a clear notion of the distinction between the two. There is no discussion about why nursing, alone of major professions, should conduct education and training in the same establishments.

The conflict between education and service presented in the reports and articles above was shown particularly in the relationship between the school and the hospital.

The independence of the school from hospital was introduced gradually following the Platt Committee's recommendations but more forcibly through the Salmon Structure in 1966. Nevertheless, the conflict between Education and Service still exists up to the present and has stimulated several articles in the nursing journals.

Student status, where the school would have control over student's practical experience, is another aspect of the school - hospital relationship. Bendall (1971) studied student status by comparing Britain with other countries. She found that in the United States where full student status and no staffing responsibility by school/students is in operation, they are now tending to require more rapprochement between schools and hospital "so that students will have more clinical experience and the school will assume some responsibility for service". Among the problems she envisages if full student status is adopted in Britain, are: (i) finding staff to replace service given by the student, (ii) the decision as to whose
responsibility student training in terms of selection assessment and withdrawal would be - the Department of Health or the Department of Education. The control and organization of schools of nursing do of course influence the training of students, but this is beyond the scope of my study as it concerns political and economic factors.

McGuire (1969 p.90) indicated one of the shortcomings of the school taking over control of students' training. She commented after reviewing some of the experimental training schemes that:

the experimental students felt that they were excluded from the ward team to a certain extent and that they were not allowed to assume responsibility.

One such experimental training scheme was conducted by the Scottish Home and Health Department in 1963 and was known as the "Experimental Nurse Training at Glasgow Royal Infirmary". The assessment committee reporting on the scheme stated:

... perhaps the most important underlying purpose of the Glasgow experiment - to establish a more satisfactory balance between nursing education and service than has existed previously ... the primary objective ... was to educate student nurses for service rather than by service, and the extent to which a correct balance has been established between these factors will be the ultimate measure of the value of the new course.

In relation to the final examination the students of the experimental schemes performed better than the control groups of students who followed the conventional course. The experimental students sat their final examination after two years of training.

When the experimental students' performance during
their "interne year" was compared with that of their control groups counterparts they were shown to be less competent (p.146). The reason given for this result was the lack of adequate balance between the students' educational and service needs in the experimental course (p.146).

Organization of theory and its distribution during the training programme is another aspect of the issue of school - hospital relationship. As pointed out in p. 35, the report on the "Work of Student Nurses and Pupil Assistant Nurses" referred to the students' perception of the lack of relatedness of theory to practice regardless of whether the "block study" or "day release" system was used.

From the above discussion it seems fair to conclude that the issue of the conflict between Education and Service in Nursing is of a fundamental and comprehensive nature.

2) The conflict and its relation to the meaning of nursing held.

Gonder (1970) explored some areas of conflict under the headings "Service Demands" (S.D.) and "Educational Demands" (E.D.). Her article is a good representation of the opinions of teaching staff and hospital staff given in various other papers.

I shall use her headings to discuss the conflict presented and how a way of thinking based on specifics creates conflict while a way of thinking orientated towards
similarities and differences potentiate and re-inforces relatedness.

S.D. E.D.

1) a. Pairs of hands are needed to undertake the routine care of patients. It is preferable that these nurses should be allocated to one ward or department for long periods in order to provide stability for patients. b. Student nurses need to gain some experience in all wards and departments. This involves frequent changes in the ward staff as students are moved about. Where the students form the majority of the team, this leads to an unstable staff both in numbers and quality. Under these conditions it is very difficult to plan the work efficiently.

The ward care given to patients is perceived as, "pairs of hands" are needed to undertake "the routine care of patients". The use of words is indicative that nursing is considered to consist of a pre-determined number of specific activities carried out 'mechanically'. "Stability for patients" is seen mainly as the presence of familiar faces on the ward. This also suggests that the probable organizational system on the ward is task allocation. Such a system is incongruous with stability for patients.

The rate of movement and allocation of student nurses on the ward is dependent on whether the ward organizational system is mainly one of patient allocation or task allocation. Students on the ward are an integral part of the employed body. Under E.D. the student nurse needs to gain some experience in "all wards and departments". This indicates that every department and ward provides a
different type of experience and to become a trained nurse the student has to pass through a given number of such experiences. In other words, it suggests that nursing is a sum total of a given number of specific activities.

S.D. 

2) 
a. Owing to the nature of our work it is quite impossible in acute hospitals to predict the workload in advance. This makes the fixing of satisfactory establishments an almost impossible task.

E.D. 

b. In these circumstances students may be either overworked or bored as the training regulations demand their presence in certain specified units for fixed periods of time. These fixed periods are related to the students' overall training programme and not to the service needs of the hospital or the amount of experience available in a department at any given time.

If the nature of work is unpredictable it is likely to be so in terms of days as well as weeks. If this is viewed as a day to day condition it does become unmanageable. However, a record of patient turn-over kept over a period of a few weeks or months could indicate the probability of bed-occupancy and could serve as a general guide.

The principle on which staff distribution is based, which might include a number of "float" nurses allocated according to circumstance to a given range of areas, could help make situations slightly different but not radically so. "Float" nurses are usually part-time staff. The picture conveyed of Nursing in Practice is one of fragmentation.

The arguments under E.D. suggest that nursing consists
of a set number of activities with no possibility of introducing any more, where the nurse interacts with the 'work' or the 'experience'. It disregards the interactions of the nurse with her patients and colleagues which contribute so much to her development.

S.D.  

E.D.  

3)  
a. The patient needs to be treated as a person. He frequently resents being used as teaching material.  
b. Judgement and skill can only be learned on the job. More and more clinical teaching is being demanded by the General Nursing Councils.

From the S.D. it appears that the teaching of nursing threatens the treatment of the patient as a person. It is shown that the student needs to learn about 'Things', but presumably at some point she needs to learn to respect the patient as a person. How or when she learns this respect is left unanswered. To teach the student on the ward is not seen as an opportunity of demonstrating how to care for the patient as a person.

Under E.D. judgement and skill are seen as 'procedures' to be only learned practically. Clinical instructors are portrayed as being only interested in the teaching of procedures, as they do by necessity use the patient as teaching material.

Both the appreciation of (i) the cognitive aspect of judgement and skill, which develops gradually and could be started in the classroom for the patient's safety, and (ii) the human interaction skill that could be conveyed through the teaching of the clinical Instructor, are lacking.
Nursing seems to deal with parts and specifics.

4)

a. The patient expects a safe degree of professional competence from all staff.

b. Some forms of professional competence can only be learned on the job.

The image conveyed under both S.D. and E.D. is one where professional competence is 'given' and exists somehow after training. Supervision is conspicuous by its absence. To perceive professional competence as an ability which develops through teaching together with supervision during training, would help to make ends meet if its purpose is the patient's safety. Basically nursing seems to be activity orientated rather than patient/person orientated.

5)

a. A degree of maturity is required of all who desire to help the sick; for example, the ability to take responsibility.

b. Some form of maturity can only be acquired after exposure to the pressures of the job.

The impression from S.D. is that students ought to be mature before joining nursing and that taking responsibility "just happens", while the impression from E.D. is that those responsible for the programme of training do not play an active role in developing a sense of responsibility and helping the student towards maturity. Both "Service" and "Education" are portrayed as being passive. The role of knowledge and gradual initiation by the programme is unrecognized.
a. In order to produce a good service the administration should employ persons with physical, mental and emotional stability who are also endowed with common sense and compassion.

Similar remarks as above apply in this instance also. The requirements are not seen as potentials to be developed through the programme, nor is it pointed out that both refer to a well informed sense of responsibility based on knowledge and the development of self-confidence.

b. In addition to the service demands, the education of the nurse requires the ability to study independently and to write clear and accurate reports.

Both demands indicate the fragmented picture of what is meant by Nursing. On the one hand Nursing is considered an intellectual profession and on the other regarded as manual employment. Nursing is not seen as a whole with interdependent variables.

b. Some with the necessary intellectual and educational qualifications cannot stand up to the emotional stress of contact with suffering and, therefore, leave.

The issue raised by these demands is both conceptual and ethical. The right to think is seen as conflicting
with a mature sense of responsibility. To say that the student ought to select the experience most meaningful to him or herself denies any professional standards and consideration of the patient as a human being. Again there is the impression that Nursing deals with experience not people. There is also the conflicting demands of wanting the student to be 'egocentric' during training and altruistic after training.

S.D. E.D.

9) a. Mistakes made by inexperienced nurses may cost lives or human misery. Therefore, the staff responsible for service tend to protect their patients and are slow to delegate responsibility to untried juniors.

Regardless of the fact that juniors are sometimes left with the responsibility for a whole ward on occasions, (see p.109), the same kind of comments as above apply here. Also the unrecognized role played by preparation in the school and by supervision. There is no distinction between guided or supervised practice and practice alone.

From the above discussion it seems that the conflict as described by Prudence Condor is caused by:

(1) unclear concepts used which are restricted in scope
(2) lack of study of the implications of the presented arguments
(3) vagueness and lack of explicitness of the meaning of nursing. Nursing is fragmented, procedure-
orientated, specific, passive, pre-determined and lacking in potential for development. Such a picture of Nursing does not provide a unifying purpose for Education and Practice and therefore creates a conflict. It also does not provide a rationale which would help direct thinking and action in Education and Practice:

(iv) emphasis on specifics makes Education and Practice clash. An orientation to the consideration of the similarities and differences between Education and Practice would help relate them and encourage the development of their potentials:

(v) lack of clarity as to the purpose to be achieved by educational programme.
CHAPTER TWO
THE PROBLEM THROUGH LITERATURE (CONTINUED)

DEFINITION OF THE PROBLEM

In the previous four sections the review of a selected literature indicated the nature of the meaning of nursing held. It also showed the connection between such meaning and what the training programme and the practice involved.

The meaning of nursing remains vague. It is not explicitly expressed or clarified. It is made up of a number of isolated 'specifics'. A rationale for nursing, education or practice is lacking. This high degree of specificity is cumbersome and creates a considerable amount of conflict, a great deal of which could be avoided. The aim of education and that of practice is also not clarified. The natures of Nursing, Education and Practice as conveyed are related. They were related in their rationale which was vague and undefined and in their nature which was specific and fragmented. What the ultimate aim of Nursing was, what the education programme achieved, and what purpose directed planning in practice, were not explicitly clarified.

As pointed out in the Introduction (p. 2) problems have been studied within a narrow and detailed frame allowing only 'symptomatic'-solutions. By symptomatic I mean solutions which would answer a specific question but
do not solve the problem as a whole. Examples are; introducing research rather than introducing a critical ability of thinking within the training programme; teaching management courses rather than integrating the principles of management at all levels of the student nurse's training.

What seems to be needed from the above review is: (i) the clarification of the concepts involved in nursing and the establishment of the relatedness between and among the implications that ensue; (ii) studying and trying educational programmes that deal with the problems of service; (iii) teaching from reality and increasing the awareness of the student toward the different variables present in a situation; (iv) developing in the student an ability to recognize and understand the situation as a totality, in order to base her decisionmaking on such understanding.

For solutions to be effective, the core of the problem has to be made clearer. In the case of Education one has to be clearer about the context in which it occurs, i.e. the meaning of nursing and about the purpose it is trying to achieve, i.e. Practice. In other words, one cannot find educational solutions in isolation, of either the meaning of nursing or the characteristics of practice.

Therefore, the problem investigated in this thesis could be summed-up as follows: In order to effectively study the lack of relationship between theory and practice, theory ought to include not only classroom instruction but also the educational
programme of the school as a whole. Practice ought to include not only procedures and techniques but also the organizational system of the hospital service as a whole.

To find out the causes of the lack of the relationship between theory and practice the different aspects of what is involved into the relationship ought to be analysed and taken into active consideration.

The context in which theory and practice are present ought to be not only recognized but also clarified and expressed in terms of frame of reference, organizational principle and concepts.

REVIEW OF LITERATURE

The literature reviewed in this section deals only with the relationship between theory and practice.

Literature survey includes studies carried out in nursing and in other disciplines.

I. Other Disciplines

A. In education Meredith (1949) used an approach he termed 'topic analysis'. His view was that "in Education, the materials and processes in the classroom form a close-knit unity, an organic pattern in fact, which cannot be taken to pieces experimentally for purposes of investigation." This view calls for the study of education on a multi-dimensional scale. Professor Meredith looks at the interaction of Lecture-theory with
classroom experiment. He sees Topic Analysis as an attempt to provide a cartography of knowledge, based on the fact that even though content of subject is widely different there are certain mental processes which are common to different subjects. Be eliciting the structure of knowledge and making its 'latent features' 'manifest' i.e. 'explicit generalising'; the process of transfer of learning is helped and knowledge taken as near to the learner's mind as possible, thus enabling the fragments of knowledge taught to be part of a whole picture, and preventing them becoming "a meaningless collection of facts and skills." He bases the analysis of subject on knowledge of "epistemic status" and modern logic.

Three teachers helped Professor Meredith put the above mentioned approach into practice (Meredith 1950). Their hypothesis was:

Common logical structure may be found, by analysis, in different school subjects and that by making these latent structures explicit to the learner the mental gains resulting from one subject can facilitate the learning of another subject possessing these common structures.

Through Topic Analysis, the elements of the educational process were identified in terms of ranges of experience and types of mental operation. The experimental subject was civics, the 'donor' subjects were geography, gardening, motor engineering and German which provided the relational structures for explicit generalisation and transfer to civic problems. Six epistemic structures
were made manifest to the experimental group. The groups were matched for inferential skills.

Three tests were used. The results were highly significant in support of the efficacy of the epistemic structures in producing transfer of training from these four subjects to civics.

The weakness of the experiment as pointed out by the author was the immaturity of the technique of Topic Analysis, which was remedied by the experiment itself.

B. Other experiments working on the principles of teaching on the basis of structure for transfer of training were carried out by Davis (1969) in the field of mathetics, and by Deenes and Jeeves (1965 and 1970) in the field of mathematics.

An idea similar to teaching on the basis of structure was used by Henshaw (1968) and was to do with developing analogical reasoning and testing its relatedness to creative abilities.

Grose and Birney (1963) edited a collection of studies about 'Transfer of Learning' in psychology and education.

C. Other studies in Education also dealt with the problem of teaching theory in a practical and relevant way to practice. In the field of teacher training, which has a number of similarities with nurse training; among such studies were:

1) Shipman (1966), who examined "the relation between
the academic, professional and social aspects of teacher training in a single college across a period of rapid change from 1961 - 1965." Among the credits of this work is the multi-dimensional approach to the study of such a complex problem.

He studied the pros and cons of a close relationship between teachers and students, as well as that of an increasingly impersonal relationship when the college was expanding and the college 'culture' started to change. He looked at the merits and demerits of 'concurrent training' and that of a concentrated period of theory followed by practice.

The problems identified in that study were strikingly similar to those encountered in nurse training, as well as the one I found in my present study. The general complaint remained the irrelevance of theory to the practice.

2) Thimme Gowda (1948) studied the attitude of teachers towards their course of training by using five attitude scales relating to
1. Principles of Education
2. Educational Psychology
3. General Subjects
4. Non-academical Subjects
5. Practice Teaching.

Through such a study he identified the problem of lack of relatedness between theory and practice as felt by student teachers.
II Nursing
A. Two nursing research studies have dealt more directly with the question of relating theory to practice.

1) Eve Bendall (1971a and 1971b) first carried out a postal survey of training schools to discover policy, practice and opinions with regard to the relationship of theory and practice and then designed a test to measure student's learning in each of three clinical areas: neurosurgery, gynaecology, and paediatrics, each test was made up of fifty items.

She studied the effects of three variables on the learning of third year students as measured by attainment test scores, these variables were:
(i) order of theory and practice
(ii) time interval between theory and its related practice
(iii) the educational level of students.

Nine schools were involved in the testing experiment with 201 students. From the survey she concluded that both order and time in the schools studied were haphazard.

From the experiment she concluded that order on its own made no difference, theory followed by a short interval before practice was most useful in enhancing learning. Time interval was important,
but she was unable to test the effect of educational level.

As it was not practical to plan all clinical experience for all students in training with theory first, she suggested that relevant theory should be taught not to "a group of students who happened to start training together ... but (to a) group who are at various stages of training but who are working, or will work soon in the areas involved."

2) Jennifer Hunt (1971) specifically studied nursing procedures to find out if they were

carried out in a different way on the wards from that taught in the school of nursing (this is an assumption that is commonly made by many nurses) and whether such differences, if they occurred, were significant both quantitatively and qualitatively.

She based her study on theories of acquisition of motor skills. She took correct procedure to be the one taught by the school, and using a detailed check list estimated the variation in carrying out the surgical dressing technique. She also used questionnaires to student nurses, sisters and staff nurses. Her sample size of students was sixty-four. Her conclusions were:

From the data that has been collected, it is obvious that nurses do deviate from the taught method, and that within each hospital a pattern is developed.

There is a difference between the tutors' and the sisters' concepts of a student nurse's ability and competence, particularly with regard to dressing technique which is a high status task.
The deviations may contravene the principles on which the procedure has been based, but this needs further agreement as to what items are most important in terms of their essentiality to the maintenance of the principles on which procedures were based. She recommended that further work is done using the theories of acquisition of motor skills as nursing procedures could be considered skilled performances. Analysis of the procedure on this basis could help its simplification and rationalization and "perceptually stringent elements ... isolated once the procedure has been itemised, could then be practiced separately and/or more frequently than the simpler elements."

B. Other nursing studies by

Oxford Area Nurse Training Committee (1961 and 1966);

Hutty (1965);

South-East Metropolitan Area Nurse-training Committee (1957 in Smith)

Bryden (1969); and Brotherston (1963) for the Scottish Home and Health Department (1963) point out the discrepancy between what is taught in the classroom and what is practised on the ward.
PART TWO

THE SURVEY

Chapter III : Planning the Survey
1. Introduction
2. Purpose and Sample
3. Pre-Pilot and Pilot Studies
4. Main study and research Tools.

Chapter IV : Reporting of Survey Results
1. School Profiles
2. Questionnaire Results

Chapter V : Reporting of Survey Results (Continued)
1. Interview Results
2. Open Discussions

Chapter VI : Discussion and Summary of Results
CHAPTER THREE
THE SURVEY

GENERAL INTRODUCTION

A. Identifying the field of study

As stated earlier, the interest and purpose of the study is in the relatedness of theory to practice in nurse education. In order to achieve such a study it was necessary to get better acquainted with the system of education and to know how the tutors (the providers) and the students (the consumers) perceived the relatedness in such a system.

My field of investigation was the three year registered general nurse training programme in Scotland. Information about the general system of nurse education in Scotland was necessary in order to see in better perspective the relationship of the general system to the applied programme of training in different schools.

Scotland has a separate legislative body and a separate statutory body controlling nursing, namely, the General Nursing Council (GNC) for Scotland, which was constituted under provisions of the Nurse Registration (Scotland) Act, 1919. The Council is made up of twenty-eight members (fourteen by election and fourteen by
appointment). It has three statutory committees: Finance, Discipline, Mental Nurses, and one non-statutory committee: Education. The latter is composed of eighteen members of the Council selected by the Registrar. The Education Committee's responsibility is to receive reports from inspectors about training schools, and from the regional nurse training committees, and to evaluate schemes of training. The responsibilities of the GNC are mainly the protection of patients by laying down minimal standards in the conditions of training for nurses, and the maintenance of a Register and a Roll of trained nurses. It lays down theoretical and practical requirements of nurses' training, sets examinations and approves hospitals as training schools. It keeps an index of students, a list of pupils in training, and a register of clinical teachers and tutors. It also examines the eligibility of overseas nurses for registration. The four registers are: i) General, ii) Sick Children, iii) Mental and iv) Mental Deficiency. The Fever Register is now closed. Nurses following any of the above-mentioned programmes of training are known as 'student nurses', while those following a programme for enrolment are known as 'pupil nurses'. Unlike the GNC for England and Wales, the Register in Scotland is kept up to date. Nurses in active practice pay a yearly fee.

The three year training programme for the General
Register has undergone some change over the years. In 1958 a plan for 'wider basic training' was drawn up, as the purpose of some of the special registers seemed obsolete. It was felt that there was a need to widen the basic general training by including a period of experience in psychiatric nursing, obstetric nursing and public health nursing. The syllabus included more time allocation for theory; it was hoped that the instruction would be closely integrated with practical work throughout the entire training period. In January 1966, the Council felt it was time to introduce comprehensive training. This was based on the idea that general should precede specialised education and that it would help students to decide on better grounds, which areas of specialisation most interested them. The tendency in this training was to avoid overloading the curricula, therefore minimal class hours were reduced from 353 in the 'wider basic training' to 317 in the 'comprehensive training'. As it was felt that there was a great amount of overlap in each syllabus of training, the elements common to all Registers were considered as basic elements. The hours of classroom instruction in the principles and practice of nursing in the wider basic training were reduced by 50, and the instruction brought to the ward situation.

The schools included in this study were following either the 'wider basic training' programme or Phase I
of the 'comprehensive training' programme.

The wider basic training programme is of 144 weeks duration, divided into 27 weeks of 'study blocks' (theoretical instruction in the classroom) and 117 weeks of practical experience on the hospital wards and in the community. Of the 117 weeks, 97 are allocated to specific areas of practice and 20 are unallocated. The requirement for recruitment is three ordinary level subjects, one of which must be English, or, alternatively, a passing mark on the GNC test. The student sits an intermediate examination after six months of training and the final examination at the end of two and a half years, but is not registered until the completion of three years (144 weeks). The State Final examination is held by the GNC three times a year, in February, June and October.

B. Reasons for limiting the study to Scotland

1. As stated previously, Scotland has a separate General Nursing Council.

2. Expanding the study to include, for example, England and Wales, would mean the introduction of an additional major variable, i.e., a different syllabus of training programme. A comparative study is not the aim.

* Since 1972 the GNC test has been abolished. Ordinary level subjects are 'O' Grade in the examination for the S.C.E. or 'O' levels in the G.C.E. examination.
My major purpose was the study of the nursing educational process in its totality. It seemed valid that the more one restricted oneself to meaningful variables the more precise could be the study of their interaction.

Scotland, being divided into five regions*, is a manageable geographical area for research.

Schools of nurse education in Scotland were easily accessible in my case, being at Edinburgh University.

Living in Edinburgh, and coming to know Scottish people as well as others living within the Scottish environment, facilitated an understanding of their values and culture. This appeared an important component of the type of research I was embarking upon.

I PURPOSE AND SAMPLE

A. Purpose

As referred to previously, being a foreigner to the country and to the system of nurse training, I felt it necessary to become familiar with the system of training as prescribed by the GNC and its implementation by the different schools of nursing. I wanted to discover the variables which relate to the system as specified, and those which relate to its implementation, and to

* prior to reorganization in 1973.
identify local factors, if present.

The survey which developed was based on the specific points of interest brought up by students and tutors in the pre-pilot and pilot periods, as well as on my own queries.

The main object of the survey (as stated on page 58) was to study the nature and extent of agreement between theoretical instruction given in the classroom and practical hospital experience; more specifically, this was to be studied in terms of:

1) Administrative aspects: time sequence of instruction at school and at hospital; nursing techniques or procedures as taught and as practiced; elements of the school or hospital administration, e.g., night duties, student allocation, responsibilities delegated to the student in relation to her stage in training.

2) Content: information and knowledge pertaining to specific subjects or procedures at school and at hospital.

3) Work-load: amounts of knowledge passed on to the student and of work delegated to her on the ward, e.g. projects, reading assignments and responsibilities in work done on the hospital ward.

4) Expectations versus preparation: do teaching staff at school equip students with the knowledge they expect them to have? Do training staff in the hospital prepare students for the various and different duties they expect them to know and carry out?
B. **Steps followed**

Having decided the general and specific purpose of the survey and the field of investigation, the following steps were considered essential for a study of the relatedness between theory and practice:

i) **a critical analysis of the syllabus of training as laid down by the GNC;**

ii) **a study of the interpretation of the syllabus by the schools participating in the study;**

iii) **a study of the perception of tutors\(^\text{*}\) teaching the programme of training, in regard to the nature and extent of the relatedness between theoretical instruction she/he gives in the classroom and the practical experience of the student on the hospital ward;**

iv) **a study of the perception of students at different stages of their training as to the relatedness of the theoretical instruction they receive in the classroom and their practical experience on the hospital wards.**

These steps by no means cover all the possible aspects of the study of the relatedness between theory and practice. However, they fulfil the required aim. A critical analysis of the 'factual' information given by a syllabus or its implementation does not seem enough, on its own, to give

\(^\text{*}\) The term 'tutors' refers to both tutors and clinical instructors, whether registered or unregistered.
a valid impression of its reality; hence, the importance of the tutors' and students' perception of it. The study of both aspects and their relatedness is more informative than the study of either aspect on its own. One limitation needing mention is that Sisters on the wards and nursing staff working in the hospital were not interviewed. Though the importance of their perception of the nature and extent of the relatedness is realised, the difficulties of deciding on the nature and the size of the sample of hospital nursing staff were insurmountable. The student nurses work the same shift and 'off duty' distribution as the rest of the nursing personnel working in the hospital. The number of student nurses working throughout the twenty four hours on a ward is relatively high in proportion to the Sister in charge. These factors make it difficult for the Sister in charge to work with all or most of the student nurses on her ward for a long enough period. This has also been found by McGuire (1968 p.281). Even though the Sister in charge has 'teaching students' among her responsibilities, in reality her circumstances do not allow for this to happen often enough.

The student nurse works with all grades of nursing staff as well as colleagues at all stages of training, and learns from them. These factors make it difficult to decide who is most likely to teach the student nurse (which is a study in itself). If a decision could be taken as to who teaches her, it would then be necessary to decide whether a stratified or a random sample were
the more appropriate and the size of sample which would be adequate. Decision would also have to be made as to which wards should be covered. Had the study been mainly a survey, these steps would have been justifiable. Since, however, the students were the pivot of the relatedness between theory and practice as well as its best reflection, it was decided to concentrate on them. Tutors, as an identifiable and main source of initiation of theory, were also considered essential to a reliable and valid picture of such a study.

The weakness of omitting hospital staff's perceptions was partly overcome by the fact that a number of clinical instructors and tutors, mainly unregistered, had recently been working on the wards. During the open discussion held with the students throughout the study, I was given the students' version of the opinions of hospital staff; opinions were either quoted by students or were perceived indirectly from their conversations concerning their general impressions.

Steps i) and ii) above, will be dealt with more fully in the discussion of the syllabus within the framework of literature pertaining to curriculum planning and organization. Steps iii) and iv) are dealt with in the following sections.

C. Sample size and distribution

a) Schools

Seven schools teaching the general nurse training
programme leading to Registration, also covering the five Scottish regions, (Scotland has since been divided into fifteen regions) were chosen.

The criterion for choosing a school was that it should have the largest student capacity within the region. The purpose of the study was explained to the Registrar of the GNC for Scotland and she was asked for information concerning the two schools of nurse training with the largest student capacity in each of the five Scottish Regions.

Names and addresses of the suitable schools were provided. In two of the regions only one training school existed. Of the two schools in one of the other regions, one had a large student population; the other training school was quite small and therefore was omitted by the Registrar.

All the schools suggested by the Registrar agreed to help.

Details of schools finally chosen are shown in Table I.
### TABLE I

**Distribution of General Training Schools over the Five Regions**

<table>
<thead>
<tr>
<th>REGION</th>
<th>No. of schools available ((a))</th>
<th>No. of schools chosen in the sample ((b))</th>
<th>((b)) as percentage of ((a))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Region</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>North-Eastern Region</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Eastern Region</td>
<td>4</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>South-Eastern Region</td>
<td>7</td>
<td>2*</td>
<td>28.5%</td>
</tr>
<tr>
<td>Western Region</td>
<td>17</td>
<td>2</td>
<td>11.7%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>30</td>
<td>7</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

\* A third school helped in piloting the questionnaire and interviews.

b) Students and tutors

The initial contact with the principal tutor or the director of the school was through an introductory letter explaining the study and offering a preliminary meeting to discuss it further and to answer any queries they might have. The second contact was either personal or by telephone to arrange times to meet the students and tutors. It was easier for the collection of data and for the school
of nursing to arrange to see students while they were in 'study block'.

Students were given questionnaires and tutors were interviewed. The availability of students at the specified time determined the sample size to a considerable extent. It was considered that three groups of students would be a fair representation from each school.

The three groups were chosen as follows;

i  one group of students at the beginning of their training, with only a short period of hospital experience;

ii one group of students in mid-training with substantially more hospital experience and study blocks, i.e. in 4th or 5th study block;

iii one group of students at the end of their training, with varied hospital experience including psychiatric secondment.

All tutors and clinical instructors, whether registered or unregistered, who were teaching student nurses in the General Nurse Training course, were chosen.

Both students and tutors had the option of accepting or refusing participation in the survey. All students and tutors agreed to take part.

The collection of data for the survey was carried out from January to July 1971.

Table II shows the distribution of students and tutors.
TABLE II

Sample Distribution of Students and Tutors* over the seven Schools involved in the Survey

<table>
<thead>
<tr>
<th>STUDENTS' SAMPLE n = 521</th>
<th>TUTORS' SAMPLE n = 59</th>
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<tbody>
<tr>
<td>Schools</td>
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<td>II</td>
<td>47</td>
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<tr>
<td>III</td>
<td>23</td>
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<td>IV</td>
<td>25</td>
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<td>V</td>
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<td>VI</td>
<td>26</td>
</tr>
<tr>
<td>VII</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>196</td>
</tr>
</tbody>
</table>

* The term 'Tutors' refers to Tutors and Clinical Instructors whether registered or unregistered.
II PRE-PILOT AND PILOT STUDIES

A. Pre-pilot study

In planning the research, though my main interest
had always been the same, i.e. relatedness of theory to
practice in nurse education, I intended to carry out an
experimental study with students during their psychiatric
secondment, psychiatric nursing being one of my main
interests. However, I had to revise my plan and carry
out a survey first. Another reason for choosing the
psychiatric nursing secondment period was that with the
prospect of a comprehensive form of training to come, it
would be pointless to study a specialised Register
programme. Since the General Register is the largest
one, a study relating to it might be more generally
applicable and more meaningful. Also, since the
psychiatric secondment takes place in a hospital environment
it is similar in setting to the general experience. It
takes place over a specified period of time which is
manageable from a research point of view. During the
experience students are usually supernumerary, hence my
interference would be less disruptive and more acceptable.
Both theory and practice occur over the same period of time,
and so are more manageable from a research point of view.

Before starting any further definite planning I carried
out the following preliminary steps:

1) Observation
2) Student meetings
3) Psychiatric lectures.
1) Observation

It was necessary to have some idea of working conditions and atmosphere of a psychiatric ward in Scotland. I also wanted to investigate the possibilities of the application of the experimental course to the psychiatric secondment course. So, with such a vague purpose, I contacted, through my supervisor, the person who would be the equivalent of a Unit Nursing Officer in one of the psychiatric hospitals, and was introduced to a female admission ward. I spent a period of two to three hours a day observing the general running of the ward and participating in some group activities. This period of ill-defined observation extended over an interrupted month, (November and December 1969). Because of the shortness of the period, and because it was both inadequately planned and interrupted, the only purpose it served was to acquaint me with a psychiatric hospital.

2) Student meetings

It was necessary also to meet student nurses and to listen to their opinions about what I intended to do. My main interest was in what they would bring up as a problem area, but I realised that it would be difficult for them to begin discussing what they considered problematic with a stranger unless I specified to some extent the problem area.

The principal tutor of the psychiatric school affiliated to the hospital arranged a meeting with groups of students during their psychiatric nursing secondment.
I then got in touch with the principal tutors of the two general schools* from which the students came for psychiatric secondment. I explained to the principal tutors that I was interested in carrying out an experimental course of teaching student nurses during their psychiatric secondment, for the purpose of transfer of learning from theory to practice and from psychiatric experience to general hospital experience. I explained that meeting the students would be in the form of open discussions, using a tape recorder, if this was agreeable to the students. All contacts with principal tutors were personal ones following a telephone call. Through the good offices of these principal tutors I was able to meet:

1) two groups of student nurses, in their general school, before they were due to have their psychiatric secondment;

ii) two groups of student nurses, in the psychiatric school, while they were having their psychiatric nursing secondment experience;

iii) three groups of student nurses in their general school, after they had their psychiatric secondment and returned to the general hospital.

These meetings took place over April, May, June and July of 1970.

* These two schools were part of the final sample studied in the survey, but the students were not involved again.
The open discussion took the following form: I introduced myself to the students, asking their permission to use the tape recorder, explaining that as I would be interested to remember what they would tell me I had two options, either to write it down or tape it. The second option was preferable since it would promote a freer discussion. It would also ensure accuracy in reporting their opinions, which to me was very important: to start from what they felt rather than my own impressions of what they said. After the initial few minutes of adjustment, the sessions ran smoothly. I began by asking what they would like to discuss in terms of the difficulties they encounter in their training, especially in relation to psychiatric secondment (whether past, present or future). I explained that I was specifically interested in teaching for the transfer of learning. This usually started the discussion along the intended lines. It seemed easier however, for the students if I asked them what they thought of their psychiatric experience: what the different 'hearsays' they had from previous groups; whether they liked their general hospital experience; how well prepared they felt for their psychiatric secondment; what their opinions were about psychiatric illness; and how well did they consider that psychiatric secondment would help them in their work in the general hospital.

The findings are reported below, under headings roughly corresponding to the general topics of the discussions.
The general feeling about the secondment was rather "dubious" or "not welcoming it at all" for the pre-secondment students, and of "no great help" toward the general hospital work by students having had the secondment (post-secondment groups).

Hearsay from previous groups could be summed up as an experience full of anxiety and 'unknown', e.g. "You are supposed to speak differently to people and you don't know how to approach them." "You don't know what will happen next, how the patient will react and how you will manage." "It is an exhausting experience; one is glad to get away." "It needs a strong character."

Talking about General hospital atmosphere, the students felt that all was part of a mechanised system, and very little was allowed for the emotional aspect of communication or care of patients. They feared that the sister "catches you" talking to a patient, as the attitude of sisters and doctors to patients was that of considering them as "conditions and that's all." On the other hand, since the patient also considered the sister and the doctor as the "Sister" and the "Doctor", that is as "positions", and did not see them as individuals, it became difficult for patients to initiate any approach. Administrations considered student nurses as numbers, part of the "set up", and was concerned that the "work is done" "no matter how". The student was "always wrong"; a "justification of behaviour is impertinence"; the student*.

* All quotations are the students' own words.
was not allowed to "think for herself"; she was not to be asked for her opinion and even if she were it was not taken account of.

Preparation for psychiatric secondment. All students, pre- and post-secondment, as well as those having the experience at the time, wanted to know more about patients and their reactions, and how to deal with them. This was summarised by the statement of one student: "Because of lack of good preparation we missed the basic principles or reasons for our going; when we started to settle, we had to go away; out of ignorance we did not agree with the experience."

Actual secondment gave students in general, a feeling of "not knowing where you stand". "You sit down and feel guilty about it. In General hospital you dash around doing things." "You are required to observe the patient but you don't know what it means and how to do it." "You see some patients and wonder what is wrong with them." The students in general felt that they were "left out", "worthless", had an "undesired presence", that they were "probing" if they were asking questions, that they were "not to be trusted with patients", that they were not "included in the group". "You want to do something right, but you don't know how; it is frustrating." During discussion they felt they were pushed to discuss when "you don't have any knowledge," and the language used created some difficulties as they felt that unless "you know their jargon you could not communicate with them."
As for the areas of training, they felt that in the acute wards, even though "frightful", they could "see" what was wrong with the patient while in chronic wards the rate of change in a patient was so very slow that they could not observe any change during their period of stay. This tended to be "boring" and considered a "waste of time". It was fruitful and helpful to the student when sister explained about the patient's condition, but very few said that the psychogeriatric ward was helpful because of its similarity to the General hospital situation. To quite a number of students the experience in wards where psychotherapy was the main line of treatment seemed to be too strenuous to be effective most of the time. This opinion was supported by a study carried by Johnstone, et al. (1969).

Their opinion about mental illness did improve on the whole as some of them initially had had no idea what it was all about. "At the end of the experience you start to see part of the picture but not all of it, so you become more critical". This experience did help to a certain extent, but they didn't know precisely how.

3) Psychiatric lectures

I felt the need to become familiar with the actual classroom instruction given to the students. With the permission of both the psychiatrist and the psychiatric nursing tutor, I attended lectures during the psychiatric
nursing secondment of two groups of students over May-June 1970. Luckily the two groups of students had their lectures on different days of the week.

I got the impression that the psychiatrists' lectures were more of a casual talk. One psychiatrist did not seem to have in mind a definite number of topics to cover, and his lectures usually followed no sequence of any kind. He talked about a subject and if he did not finish it by the end of that session, he did not take it up or continue talking about it at the next. The other psychiatrist was slightly more organised in his lectures. More than one psychiatrist would teach the six hours of theory required by the GNC. The students found the psychiatrists' lectures difficult to understand because of the "jargon" used and of what they called "involved explanations" like giving the types of neurosis, the treatment, etc. without clarifying what "neurosis" was. The students also felt the session usually ended with them "giving information," rather than receiving any. I certainly could see what the students meant by this, as the psychiatrist would ask them if they had seen a patient with such and such a condition in the general hospital, how they felt about it, why, etc. Too often, the psychiatrist asked a lot of questions and did not answer any of them or discuss the students' answers. By contrast, the psychiatric nursing tutor's lectures were quite definite and well organised and the students found them helpful. Students, however,
considered the clinical instructors the most helpful as they were talking about patients who were "there" on the wards.

Conclusion to Pre-pilot period

From all the observations and information I got from the above steps and from the indirect inferences I could make through my contact with the students, the schools and the hospital, I was able to define more accurately the purpose of the study and the lines of investigation to be followed. Conclusions reached were,

i) It would be premature to attempt any experimental course of teaching the psychiatric seconded students before knowing more about their general training.

ii) Before the preliminary steps described above I had been thinking along the lines of studying more specifically the relationship of students' personalities and attitudes to the transfer of learning. The reality of the situation and the students' opinions now brought me to realise that a mainly psychological approach would not be satisfactory.

iii) The problem was too complex to be tackled from one aspect, namely, the psychological aspect only, without establishing some kind of relationship between the psychological and other aspects involved in the relationship between theory and practice.

iv) To explore students' attitudes and personalities
would not have been enough in studying a programme of education. A study of the curriculum and its application seemed more promising after the pre-pilot information.

B. Pilot Study

On the basis of the preliminary investigation a start was made by surveying the opinions of students on their general training, and those of their tutors, before planning the experimental study, timed to take place during the period of psychiatric nursing secondment. The number of students involved made a questionnaire seem appropriate. As the number of tutors would be small relative to that of the students, and as I needed the tutors' personal opinions to get a clearer picture of the programme, a semi-structured interview schedule was decided on.

Through personal contact, a school teaching the general training programme offered to help. It was not part of the final survey sample. The questionnaire was piloted twice in the same school with different students. One student, involved in both pilots, was very helpful in evaluating changes introduced in the questionnaire.

1) First pilot administration

Six students were involved, two from each year of training. The object at this stage was to test the degree of suggestion introduced in the questions, any
ambiguity of sentences, clarity of wordings and instructions, relevance of questions to problem areas, and length of time required to answer the questionnaire.

After completing the questionnaire, students were asked to give their general impression of it, mainly in terms of relevance. I then took each question in turn and asked for the student's evaluation of it in terms of the abovementioned points and also for any changes they might suggest. On the basis of their recommendations and my own increased insight through the students' reactions, the questionnaire was changed and piloted a second time.

ii) Second pilot administration

Mainly, the same points were tested again. The group involved comprised twelve students in their third year. The same procedures of student evaluation of the questionnaire were again followed. The questionnaire was changed accordingly and not piloted further. This intensive piloting procedure, with a small group in depth, seemed more appropriate to the purpose of the study than were extensive procedures in which a large number would have been involved and this amount of feedback not possible.

The interview schedule was piloted once with one tutor only, the purposes being:

a) to evaluate and check on the degree of suggestion which would be introduced by my own personal methods of interviewing. This was checked by my supervisor
who listened to the recorded interview between
the tutor and myself.
b) to evaluate the extent to which the interview
required structuring, the relevance of the questions,
and the time it took.
My supervisor suggested that one pilot interview
was sufficient.

III MAIN STUDY AND RESEARCH TOOLS

The main study covered the period from January to
June 1971. It included meetings with the principals or
directors of schools or colleges, interviews with the
tutors and questionnaires followed by discussion with the
students. Part of the larger study, was a meeting with
the Education Officer of the GNC for Scotland.

Several copies of a preliminary summary of the results
of the questionnaire and interviews were sent to all the
schools who participated in the survey in May 1972.* I
expressed my willingness to go back to the schools at
their convenience and discuss the results. All the
schools acknowledged receipt of the summaries. I was not
asked to return for discussion to any of the schools, some
of which mentioned the difficulty of arranging a time
suitable for all who had been involved.

A. Questionnaire

As discussed earlier, the questionnaire seemed to be
an appropriate way of collecting the students' opinions.

* Appendix I.
However, personal contact with the students gave me a much deeper insight into and understanding of their opinions. I, therefore, sought permission to have an open discussion with the students after they had completed the questionnaire which was found to take between twenty and thirty minutes to complete. Usually the school allocated an hour or an hour and a half for me to see the students. I found that the discussion following the questionnaire varied from five minutes in a few instances to up to eighty minutes, depending on the time available and the willingness of the group to discuss. These open discussions with students seemed to meet Shipman's (1967) recommendations for supplementing questionnaires by interviews, in order to take account of environmental influences on individual responses. On average, the discussion following completion of the questionnaires took thirty minutes.

Usually, I distributed copies of the questionnaire personally and introduced it briefly, emphasising that it was not an examination and that they were therefore allowed to talk to each other. Preliminary conversation was common, to establish when their training had begun, how many study blocks they had done, etc. but silence suddenly prevailed when the questionnaire itself was being answered.

The general principles which governed the construction of the questionnaire were:

i) that the questionnaire would be as clear and simple as possible to the students, to enable ease of reply;
ii) that the language used would be as similar as possible to the students' mode of expression;
iii) that the method of reply would not change often, and, if it did, that clear instruction should precede and follow such a change;
iv) that scope would be available to those wishing to make use of it for an open-ended elaboration of an answer.

These principles proved rewarding as in the main the students' comments about the questionnaire related to how relevant it was to their problems.

I answered any questions they had relating either to the study I was carrying out or to my own personal background and promised to report final results of study.

Information gained from these open discussion periods was sometimes useful in checking on my interpretation of the results of the questionnaires.

B. Interview

A semi-structured interview schedule was used. One copy was given to the tutor and I retained one copy. I asked her/his permission to tape the interview, giving the reasons mentioned earlier (p. 74), with the understanding that if she/he wished the recording to stop at any moment this would be done. On two occasions the tutor asked me to stop recording until she told me what she had to say. Some of the tutors who agreed to have the interview recorded were not very happy about it to start with, but either did not mind later on, or actually enjoyed the
fact that it was being taped. The interview took on average three quarters of an hour to an hour, though one interview lasted over two hours. It did not seem that a formal approach would either make tutors feel relaxed or would necessarily give me more accurate information. My main interest was in their subjective opinions and feelings about the points raised. Though I was careful and aware of the possibility of suggesting answers to tutors, I did discuss with each the different points raised, if she/he asked my opinion about it. I found that usually when I disagreed with the tutor's point of view, it made no difference to the stand taken, and did not cause the tutor to change an opinion. This interview approach, involving a give and take interaction with a bias towards taking, was more rewarding and enjoyable to both parties most of the time, than would have been the formal approach in which the interviewer is expected to remain un-involved and expressionless. The former approach, I felt, was more appropriate to my purpose. I should add that I found myself unable to be impersonal and detached - a personal limitation. This approach is supported by Rogers (in Bennis et al. 1969) and Jourand (1971). It is possible that my perception of the situation as rewarding and appropriate was a biassed one, but the amount of information I obtained and the number of times I was taken into confidence about the tutor's 'honest feeling' salved my conscience. I greatly appreciated the tutors help and confidence and much
enjoyed our meetings.

Transcriptions of the interviews later on was extremely time consuming, but worth the effort. Only the tutors teaching the Registered general nurse training programme were interviewed. However, a number of tutors teaching the enrolled nurse programme had volunteered and although these interviews were not included in the survey, they provided useful background knowledge for my understanding of the situation.

C. Meeting with the Principal of the School

I met the principal tutor or director of the college for different reasons and on several occasions: for establishing contact, and for arranging schedules for meeting the students and tutors. One meeting was held specifically to obtain the following information: i) the administrative affiliation of the school, ii) students' allocation, iii) number and frequency of student intakes, iv) type of training programmes, v) number of students in training, vi) number of tutors present, vii) forms of communication between hospital and school, viii) educational requirements, ix) wastage rate of student nurses.

The initial meeting with the director of the college was tape-recorded, but as I found that this type of factual information was often provided in pamphlet form, tape recording the meeting was neither necessary nor justified. The information obtained was recorded on a specially designed card. Occasionally further factual information
was required, or something was inadvertently missed at interview, and contact had to be made again. The information was then kindly and promptly provided even though it was in some instances over a year later. I have to date kept some sort of contact with most of the schools.

D. **Meeting with the Education Officer of the GNC for Scotland**

Information about the Council and the nurse training programmes was required. A meeting with the Education Officer after the completion of the surveys seemed most beneficial. By then all queries arising from my personal confrontation with the reality of the situation would have been collected. Anxious to avoid wasting the Education Officer's time, I made contact with the GNC only after the survey had been carried out, the data analyzed and results reported back to the schools. It would have been advisable and helpful however, if my collection of queries had been forwarded to the Education Officer before our interview. Because of this omission, additional contacts were required by telephone, both with the Education Officer and with the Registrar. These took place between the end of February and the beginning of March 1973.

The main purpose of the visit was to obtain information about the constitution and functions of the council, specification of the syllabus, development of the training programmes, the process of changing training programmes,
responsibility of the Education Committee, and communication between the council and the schools.
CHAPTER FOUR

REPORTING OF SURVEY RESULTS

Following a profile of the seven schools involved in this study, the results of the questionnaires and interviews are presented (copies of both are in Appendix I). A discussion of the students' answers and the tutors' opinions is included. All statistical tests applied to the results are described briefly in Appendix IX.

A. School profiles

Table III, p. 89a, shows the information gained mainly through meetings with principal tutors.
### SCHOOL PROFILES FOR 1971

<table>
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<th></th>
<th>Administrative Affiliation</th>
<th>Type of Training</th>
<th>Salary</th>
<th>Allocation of Students</th>
<th>No of Students</th>
<th>Intake Per Year</th>
<th>No of Intake Blocks</th>
<th>Number of Tutors</th>
<th>Communication</th>
<th>Geographical Proximity</th>
<th>Notes</th>
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<td>1</td>
<td>Y</td>
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</tbody>
</table>

**Notes:**
- WASTAGE Group: MospltA Board_Pegiona_Wider Basic Training_Comprehensive Phase I
- Frequency: Y = Year, M = Month, W = Week
- Levels: 1 = First Year, 2 = Second Year, 3 = Third Year
- Type of Training: Instructional, Administrative, Research
- Allocation of Students: In Training at the Time, In Training at the End, In Training at the Beginning
- Communication: Telephone, Telephone In Hospital, Shared Ground, Outside
- Geographical Proximity: Near, Far
- Notes: (old)
Some points in Table III may need clarification. In column 4 ('Allocation of students') 'shared' can mean either that the area of practice e.g. medical, surgical, etc., was decided by the school but the wards by the hospital administration, or that the first allocation of the students was done by the school and subsequent allocations by the hospital. In column 10, 'Communication' means any formal meetings between the school and the hospital. 'Top Level' involves the principal of the school/college with the top administrative staff of the hospital, e.g. interviewing for recruitment. 'Other' refers to meetings where the sisters and tutors took part, e.g. procedure committees. In column 12, 'Wastage' is reported for different years, depending on the statistics available at the school at the time or subsequently. It should be noted that some conditions changed in the schools after 1971. All schools have accepted the Salmon structure for nursing. One school then outside the geographical proximity of the hospital is now sharing the grounds with the hospital, and undoubtedly some of the student and tutor populations have changed.
Graphs A - G illustrate the organization of the student training in terms of 'theory', 'practice', 'holiday' and 'secondment'. The graphs represent the distribution of experience for one intake or one group of students within an intake, and is not therefore a constant distribution for all intakes. Virtually the only 'fixed' experience in the students' training programme is 'theory'. In most schools secondments are fixed only within a range of time, for instance during the second years, or at the beginning of the third year.
WEEKS
36
28
24
20
16
12
8
4
0
TH.  PR.  H.  TH.  PR.  TH.  REV.  TH.  H.
PR.  PSY.  SEC.  PR.  H.  TH.  PR.  H.
TH.  PR.  H.  P.H.  SEC.  PR.  H.  REV.  TH.
FIRST YEAR
52 WEEKS
SECOND YEAR
52 WEEKS
THIRD YEAR
52 WEEKS
TH. = Theory; PR. = Practice; H. = Holiday; P.H. Sec. = Public Health Secondment; Psy. Sec. = Psychiatric Secondment; Rev. = Revision; Th. Rev. = Theory Revision.
SCHOOL II

FIRST YEAR
52 WEEKS

SECOND YEAR
52 WEEKS

THIRD YEAR
52 WEEKS

Th. = Theory; Pr. = Practice; H. = Holiday; P. H. Sec. = Public Health Secondment
Psy. Sec. = Psychiatric Secondment.
Th. = Theory; Pr. = Practice; H. = Holiday; P.H. Sec. = Public Health Secondment;
Psy. Sec. = Psychiatric Secondment.
Th. = Theory; Pr. = Practice; H. = Holiday; P.H. Sec. = Public Health Secondment; Psy. Sec. = Psychiatric Secondment; Rev. = Revision.
SCHOOL V

FIRST YEAR
52 WEEKS

SECOND YEAR
52 WEEKS

THIRD YEAR
53 WEEKS +

FIRST YEAR
50 WEEKS

SECOND YEAR
54 WEEKS

THIRD YEAR
53 WEEKS

Th. = Theory; Pr. = Practice; H. = Holiday; P.H. Sec. = Public Health Secondment;
Psy. Sec. = Psychiatric Secondment.
SCHOOL VII

FIRST YEAR
52 WEEKS

SECOND YEAR
52 WEEKS

THIRD YEAR
52 WEEKS

B. **Questionnaire**

All students from the seven schools were analyzed as being part of one group. This method was employed primarily to make for easier understanding of results. Fortunately, agreement among first, second and third year students was high enough to justify this device. However, in discussing results, differences will be pointed out.

Kendall's Coefficient of Concordance 'W' is used to indicate the degree of agreement among students of first, second and third year in relation to each question. Results are reported as follows: First, the question, followed by i) the value of Kendall's 'W'; ii) the ranking of statements in order of priority corresponding to 'W' where 1, 2, 3, ... are ranks and a) b) c) ... indicate the statements under each question. Percentages are also reported to indicate relative magnitudes.

1. **Help derived by students from hospital experience**

(Q. 8) When faced with a hospital situation requiring quick action, which helps you most?

i) \( W = 0.8 \)

ii) Ranking:

1 = a)\# previous hospital experience in the same or similar circumstances \( (46\%) \)

2 = c) Student's own judgement of the situation \( (31\%) \)

3 = b) Classroom teaching in relation to situation \( (13\%) \)

\# The statements under each question in the questionnaire were designated a), b), c), ....
Bearing in mind that one can hardly know what helps most in an emergency, it is of interest to note that students felt that it was their previous experience in the hospital which helped them most. This, in a sense, indicates the value of learning by example. The percentage of students who felt that their own judgement of the situation helped most is rather high. This may indicate, on the one hand, the lack of preparation of the student or, on the other, the importance of developing her ability to judge and to act upon such judgement.

The results indicate that the student was aware in retrospect of what she 'saw'/experienced before and that she felt she was left to decide for herself. Theory might have played an important role but in the students' perception it seemed to play an indirect role in the background. This finding seems to indicate a need for theoretical instruction to be made more explicit in its relation to practice, as recommended by Meredith (1949).

(Q.11) To what extent do you feel that your practical hospital experience helps you to understand what is taught in the classroom?

1) $W = 1.0$

ii) Ranking:

1 $= a)$ it helps to a great extent (66%)
2 $= b)$ it helps to a moderate extent (30%)
3 $= c)$ it helps to a minimum extent (4%)

This ranking denotes considerable support in favour of hospital experience, i.e. the important role played by
'experiencing' a situation. Several interpretations are possible. Once the student has seen a patient with a heart condition, for example, she will be better able to understand the lecture explaining signs and symptoms of a heart condition. Whether she will be able to nurse better the next patient she has with heart disease is a different issue, to be discussed later. Another possible interpretation would be that the student's contact with the hospital ward generally sharpens her awareness of reality and helps her gain insight into the meaning of the information she obtains in the classroom. In other words, it is the general character of the experience rather than its specificity which helps her understanding.

The question did not specifically ask about which aspect of the hospital experience helped her understanding. The question elicited more general feeling about experience.

(Q. 12) How often does your tutor in the classroom use your personal experience in the hospital to illustrate her/his teaching?

1) \( W = 0.9 \)

ii) Ranking:

1 = b) Sometime \( (48\%) \)

2 = c) Seldom \( (24\%) \)

3 = a) Often \( (22\%) \)

4 = d) Never \( (6\%) \)

According to the students, the tutors make use of their hospital experience to explain their teaching.
2. **The change that students feel is needed**

(Q. 9) To what extent do you feel that the anatomy and physiology you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?

1) \( W = 0.9 \)

ii) Ranking:

1 = b) it needs to be more closely related than at present (39%)

2 = c) it needs to be a little more closely related than at present (29%)

3 = d) it does not need any change from the way it is taught at present (23%)

4 = a) it needs to be much more closely related than at present (9%)

This question was asked not specifically to gain information about the students' feeling of the relatedness of anatomy and physiology to practice but rather in order to avoid colouring their answers to the next question. In the pilot study only (Q. 10) was included but the students had asked what was meant by 'nursing care'? Had anatomy and physiology as well as procedures, or nursing procedures only, been meant? This revealed the emphasis put on anatomy and physiology in the nursing programme. Such an emphasis is shown in many ways which will be pointed out as appropriate.

Students on the whole would like to see anatomy and physiology taught in a more related way to the practice.

(Q. 10) To what extent do you feel that the 'nursing care' you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?
i) $W = 0.8$

ii) Ranking:

1 = b) it needs to be more closely related than at present  
   (34%)

2 = a) it needs to be much more closely related than at present  
   (24%)

3 = c) it needs to be a little more closely related than at present  
   (24%)

4 = d) it does not need any change from the way it is taught at present  
   (18%)

This ranking was supported by comments written under "In what ways?" by 60% of the total number of students who answered this part.

Answers were under five categories.

i) $W = 0.9$

ii) Ranking:

1 = c) lack of practicality or consideration of 'reality' of the situation by the school, hence the need for knowing how to manage practically  
   (43%)

2 = a) lack of communication between school and hospital, and, tutors' lack of contact with hospital  
   (20%)

3 = b) need for teaching on the wards  
   (17%)

4 = d) lack of consideration to the 'patient' by school  
   (7%)

5 = c) 'other' comments, e.g. rigidity of school teaching; difference between preparation and expectations; Sister's own way of doing things hindering the application of principles taught by the school  
   (13%)

These were small separate categories pooled for convenience.
The comments on this question showed that the students' understanding of 'nursing care' referred mainly to nursing procedures, which in a sense limits their interpretation of the question and hence reflects the restricted view of 'nursing care'.

Students would like to see 'nursing care' as taught in the classroom considerably more related to the practice on the ward. The students' comments point even more emphatically to such a need for change. The direction of change is mainly and generally toward the 'reality' of the ward situation.

Those giving instruction should be far more aware of what actually goes on in the ward situation and what procedures are being used; often they seem out of touch.

Other comments which not only show the need for consideration of reality but also of its variety and the need to know how to copy with such a variety, are as follows:

Different circumstances require different ideas. It is not sufficient to do what should be done at all times.

reality comes first. It is not just a case of the proper way to do a thing but the correct way to do something in a certain situation.

More should be said about difficulties.

The cry for help pertains to difficulties which go beyond those concerning the carrying out of a procedure. It rather expresses a need to know how to cope with the whole situation.

(Q. 13) How often have you been faced with a discrepancy between what is taught in the classroom and what is practiced on the wards?
1) \[ W = 1.0 \]

ii) Ranking:

1 = a) Often (Some students added 'very') (62%)
2 = b) Sometimes (33%)
3 = c) Seldom (5%)
4 = d) Never (0%)

Clearly the students felt that the discrepancy was considerable. This impression was also given by the tutors who felt that this was a perennial problem.

3. Educational objectives as perceived by students

Questions 14, 15 and 16 dealt with the ranking, in order of importance, of four educational objectives which I inferred from the Introduction to the Syllabus for General Nurses 1963 (GNC). The students were asked to rank these (i) in order of importance for themselves, ii) as they thought their tutors would rank them, and iii) as they thought the qualified nursing staff on the ward would rank them. Seven per cent of the total number of students either did not answer or gave incomplete responses and were therefore excluded.

The four objectives were:

A To prepare the student for her final examination
B To develop the student's personality as a nurse
C To increase the student's knowledge about nursing
D To prepare the student to deal with any practical problem which may arise in the wards.

Appendix II indicates the source of inference.
Students had a higher degree of agreement when they ranked the objectives for themselves than when they ranked them for other people. It is of interest to note that their degree of agreement about Tutors' and other qualified staff's way of thinking was equal. They agreed on the importance of knowledge about nursing with the Tutor (ranking C as 1) but on the importance of final examination they agreed with the qualified staff (ranking A as 3). They see Tutors as mainly interested in 'knowledge' and 'final examinations' and qualified staff as mainly interested in 'practical problems' and knowledge. This seems to be a fair estimation since they meet Tutors mainly in the schools (rarely on the wards) and the qualified staff on the ward only.

Developing the student's personality as a nurse was seen as of lowest priority. There were some difficulties pertaining to objective 'B'. The majority of students and some of the Tutors could not conceive of it as an objective at all. Generally speaking, students seemed to identify themselves more with qualified staff than

<table>
<thead>
<tr>
<th>Ranking for:</th>
<th>Objectives</th>
<th>Kendall's Coefficient of Concordance 'W'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Himself</td>
<td>A 3 B 4 C 1 D 2</td>
<td>1.0</td>
</tr>
<tr>
<td>Tutor</td>
<td>A 2 B 4 C 1 D 3</td>
<td>0.8</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>A 3 B 4 C 2 D 1</td>
<td>0.8</td>
</tr>
</tbody>
</table>
with tutors; this impression is supported by other parts of the questionnaire, mainly answers to questions 22, 23 and 24, as well as from open discussions with them.

4. **Areas of difficulty for the students (General and Specific)**

**General Difficulties**

(Q. 17) Which of the following have you found most difficult to cope with in your present programme?

1) \( W = 1.0 \)

ii) Ranking:

1. a) classroom material \((54\%)\)
2. c) both classroom material and practical hospital training, in some respect \((34\%)\)
3. b) practical hospital training \((11\%)\)
4. d) no difficulties \((1\%)\)

In the questionnaire d) was: 'If none of the above, please specify the most difficult thing to cope with.' It was found, however, that the difficulties basically pertained either to the school, the hospital, or both, and only on rare occasions did the student say she had no difficulties. The space was used to qualify their choice of a/b/c. These answers \((16\% \text{ of students})\) were re-distributed to a/b/c, and categorised as follows:

1. **Content:** If only one specific thing was mentioned like 'biology', 'night

\* The priority of difficulties associated to classroom work seem to agree with the priority of 'what worries students' at Bradford University, when given a list of 21 problems to rank in order of severity. Academic work and examinations were high on their list (Musgrove, F, 1969).
100
duty', or when the difficulty
pertained to the actual content of
what happens, e.g. 'relating
classroom material to hospital
practice since both are completely
different'.

2 Work-load:
If what was written indicated that
the student perceived it as too
much, like "Trying to keep up with
your studies while working on a
busy ward where you may only have
time to learn patients' names", and
'lack of time'.

3 Expectations versus
preparation:
When the student felt that she was
given responsibility without
previous preparation, like "Trained
members of staff expecting your
knowledge to be equal to theirs"
and 'Night duty, being put senior
in a ward too soon, and being
expected to know everything about
all the conditions and nursing of
the patients'.

4 Administration:
If they mentioned the way of doing
things, time sequence, things
relating to organization or
policies, when a relationship is
mentioned within the administrative
set up or when the administrative position is specified, e.g. "The attitude of the Tutors to you as though you were unable to think anything out for yourself", and "Trying to cope with standards, rules, regulations, traditions and obedience in the ward" and "The HIERARCHY."

Often it was quite difficult to place the comment definitely in one category rather than another, e.g. mentioning difficulties pertaining to night duty which could be listed under Administration, Expectations or Content. The criterion used was the general emphasis of the comment as a whole, using personal judgement in the evaluation. Table IV P. 101a, shows the distribution of comments in relation to the year of training and the different categories of difficulties as pertaining to the school, hospital or both school and hospital.
<table>
<thead>
<tr>
<th>Total No. of Students</th>
<th>Year of Training</th>
<th>ADMINISTRATIVE</th>
<th>CONTENT</th>
<th>LOAD</th>
<th>EXPECTATION</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>School Both</td>
<td>Hospital Total</td>
<td>School Both</td>
<td>Hospital Total</td>
<td>School Both</td>
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<tr>
<td>196</td>
<td>1st Year</td>
<td>3 3 7 13</td>
<td>2 4 2 8</td>
<td>1 5</td>
<td>- 6</td>
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<tr>
<td>198</td>
<td>2nd Year</td>
<td>2 - 11 13</td>
<td>1 3 - 4</td>
<td>- 5</td>
<td>- 5</td>
<td>- 6 6 6</td>
</tr>
<tr>
<td>127</td>
<td>3rd Year</td>
<td>- 7 8 15</td>
<td>1 6 1 8</td>
<td>- 1</td>
<td>1 2</td>
<td>- 1 2 3</td>
</tr>
<tr>
<td>521</td>
<td>Total</td>
<td>5 10 26 41</td>
<td>4 13 3 20</td>
<td>1 11</td>
<td>1 13</td>
<td>- 1 8 9</td>
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</table>
There is slight difference in distribution of the kind of difficulties among 1st, 2nd and 3rd year students. Some examples might illustrate the latter statement. A third year student wrote:

The attitude of senior nursing staff toward students (and pupils also) the demands made by many though not all of them, often interfered with patient care, which is wrong. For instance, on night duty, my first night in a strange ward, very busy, all I knew about the patients was the diseases and new admissions. The No. 7* told me my priorities were wrong because I hadn't sat down and learned all the patients off by heart and let my junior get on with it alone.

What is obvious from the student's comment is that the No. 7 did not convince this third year student as to why her priorities were wrong. Another example:

A marked inefficiency in some departments of senior staff both in training and in administration.

I have found difficulty in personality clashes, per se, restrictions and ideas from various authoritative staff, and lack of organization and communications on an administrative level.

Two quotes from 1st year students:

Senior nurses think they are God.

The constant disregard for your integrity and intelligence, i.e. usually grading you as an auxiliary practical nurse - because of inexperience alone. Not I feel correct, to the girl entering nursing from other jobs. I suppose you could say it destroys your self-confidence.

Two quotes from 2nd year students:

Treatment from senior nurses who regard the 'junior' as unintelligent; This is a very difficult situation to which one must adapt, especially after having been treated like an adult at school in final year!

Relationship with some of the senior qualified staff.

* A 'No. 7' is the short title given to a unit nursing officer of the Salmon administrative structure.
In relation to 'Content', difficulties seem to pertain mainly to the connections between school and hospital as the majority of the comments (13) are under 'both'. Here comments are similar whether from first, second or third year students.

Some examples are:

Adapting to different methods used in different wards all of which differ from that taught in classroom.

Applying the classroom material to the practical work.

Maintaining a high standard of nursing while altering one's practical approach to accommodate the preference of the ward sister without losing sight of the reasons for the classroom method which (at first) one knows best. In this the nurse, rather than the patient, suffers as she has to remember both methods, and then practice the appropriate one.

Difficulties pertaining to the 'school only', are mainly 'administrative' and of 'content'. Those pertaining to the 'hospital alone' are on the whole administrative in nature.

It is of interest to note that difficulties pertaining to 'expectations' are almost exclusively related to the hospital context. Some examples of comments relating to 'expectations' are:

Trained members of staff expecting us to know things that have not been taught.

So often, what should be practical training is just being left to do the job; not being trained to do it.

Night duty in respect that you can be in a busy ward as the senior nurse when you are still a very junior nurse trying to deal with situations you have never seen or nursed before.

Difficulties which mentioned both the school and the hospital in order of priority related to:
(1) Content which, on the whole was concerned with relating school to hospital

(2) Work-load

(3) Administration

(4) Expectations

Here the difficulties mainly referred to were the time factor and how one carries out a hard physical job for a whole day and is expected to study at the end of it, e.g.:

swotting for exams in the evenings after work in classroom/ward,

trying to find time to study in 'off' duty when working on the wards,

I find that the most difficult thing to cope with is the fact that you are expected to study after a working day on the wards. I often find myself too tired to even think about it,

classroom material; and the end of block exams should be two to four weeks after the end of block. Night duty, and the student nurse seems to work more weekends than any trained staff. Summer holidays in October, winter holidays in March, Money?

In summary it could be said even though students find a great deal to criticise in their hospital/practical experience, they do not perceive it on its own as the most serious problem. Only 11% (p.99) found that hospital training was the most difficult thing to cope with. At the same time the majority, 54%, found classroom material most difficult to cope with but did not specify these difficulties.

Specific Difficulties (School and Hospital)

School difficulties

(Q.18) Statements describing the students' difficulties with classroom work.
1) \( W = 0.8 \)

ii) Ranking:

1 = a) too much material to study in the time available \((27\%)^*\)

2 = d) 'nursing care' as taught in the school is different from its practice on the hospital wards \((22\%)^*\)

3 = b) too much 'ideal' knowledge that the student feels has no practical application in the hospital situation \((15\%)^*\)

4 = e) being treated as though you are 'expected to know' \((13\%)^*\)

5 = g) not being treated as a responsible person \((10\%)^*\)

6 = f) having to decide for yourself (the student) how to apply knowledge gained in the classroom to the practical hospital situation \((7\%)^*\)

7 = c) not enough 'teaching' about different subjects and their use in practice \((6\%)^*\)

Ten students out of the 521 had no difficulties with classroom work.

Comments on 'other difficulties' given by 11% of the total number of students are, in order of severity related to:

1 content \((55\%)^*\)

2 relationship \((20\%)^**\)

3 work-load \((16\%)^*\)

4 administration \((9\%)^*\)

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* The percentages in the above rankings are of the total statements, as the students were allowed to tick as many statements as were applicable to themselves.

** Relationship refers to the way students feel about interaction with members of staff and the way they were treated by them.
Some examples of these comments follow.

1 content:

too much repetition, e.g. lectures and tutorials on the same subjects.

trying to stay awake during boring lectures.

too much time spent on things which are of no importance to a nurse

I feel that the work is of a very high standard and many of the details given are irrelevant to basic nursing

too much emphasis on practical side of nursing not enough theory. 'Last minute' swotting for examinations

classroom work is very boring and so not made interesting enough to hold our attention

not enough time to go into certain subjects more; subjects tend to consist of bits and pieces.

2 relationship:

The specific mention of relationship between students and tutors was relatively frequent to justify having a category on its own. Examples of these comments follow.

tutors and students are on a totally different wave length.

being treated like a school child while in block

The tutor-student gap (as far as some tutors are concerned) over-shadow the generation gap.

The importance of a positive relationship of student and tutor and its influence on nurse-patient relationships was the basis of a study by Gunter (1969).

3 work-load:

difficulty in keeping up with a study pattern when 3 x 1 hour lectures given on a certain day are to be revised in the evening along with other subjects

Too many projects, etc. to do during the six weeks of lectures plus all the tests
not enough spare time to study. It cannot all be learned during one's 'own' free time.

extra project work is given to do while working on the wards

too much importance is given to project work and there is not enough time available to do them as one would wish - as it is, both the classroom work and the project suffer.

4 administrative:

No clinical instructors from one year to the next on the wards

some lectures are of little value at the time given and would be of greater use in a better planned programme. Lack of adequate studying facilities.

Grouping statements of difficulties with classroom work according to their nature gives the following picture:

1 content:  
(b) 22\% + (d) 15\% = 37\%

2 work-load:  
(a) = 27\%

3 expectations/relationships:  
(e) 13\% + (g) 10\% = 23\%

4 administrative, in terms of teaching organisation  
(c) 6\% + (f) 7\% = 13\%

The content of what is taught is the source of most problems. This finding, as well as the answers to Q. 17 agree with Fox, Diamond and associates (in Gunter 1969c):

"Satisfaction in nursing education comes primarily from nursing aspects, while the stresses in nursing come primarily from the educational aspects." This also agrees with Gunter (1969c) whose findings showed that the pressure of school work was students' major concern.
Hospital difficulties

(Q. 19) Statements describing the students' difficulties with practical hospital experience.

1) \( W = 0.7 \)

ii) Ranking:

1 = b) difficulty of applying principles taught in classroom because some of the qualified nursing staff disagree with them (20%)

2 = d) not enough instruction as to how to carry out different nursing techniques on the different wards (19%)

3 = f) being expected not to argue with the qualified nursing staff or not to express their (the students) own opinion (17%)

4 = c) fear of being 'caught' by the responsible nursing staff while talking to a patient who the student felt needed to be talked to (15%)

5 = g) not being asked your (the student's) point of view in discussion about ward organisation or patient care requirements although you feel that you are close to the patient and know a lot about him/her (13%)

6 = e) lack of orientation to ward management and policies, procedures and personnel (12%)

7 = a) difficulty in getting along with the qualified nursing staff on the ward (4%)

Comments on 'other difficulties' given by 9% of the total number of students are, in order of severity:

1 relationships (54%)

2 administration/expectations (39%)

3 work-load (7%)

* The percentages in the above rankings are of the total statements, as the students were allowed to tick as many statements as were applicable to themselves.
Examples of these comments follow.

1 relationships

Not being able to approach the charge nurse and being able to discuss with him/her. To much responsibility is put on the 1st year nurse.

Trained and untrained ward staff treating one as an outsider to the ward.

Continually being treated as inferior. I have already mentioned this but I feel it should be emphasized.

Not enough attention by administrative staff of social and mental problems. Each PTS (preliminary training school) should have someone they can talk to about their problems and become a person instead of a number.

In some wards qualified staff regard themselves as the elite of the hospital. Sometimes they act towards junior as if she has no common sense.

On one ward a student may be given a fair amount of responsibility and on another treated like a school child.

Cannot use my own opinion because always being told by the senior staff.

Almost all staff is position and status conscious. This causes animosity among nurses and the atmosphere is not what it should be.

2 administration/expectations:

Being given so much responsibility on night duty then going back to day duty and being treated as if you had just begun your training.

Nursing administration is generally authoritarian and does not permit dissension from traditional standards or democratic discussion with superiors.

Responsibility of administering drugs while in first year with no senior nurse in attendance.

Every nurse seems to have different methods of doing things and you are expected to act the one way when she is on duty and act another way when someone else is on duty.
One is expected to 'know everything'.

People are too busy doing bits and pieces on their own. More team work would give a better atmosphere and a better patient care.

What and how much I as a nurse am expected to tell a patient regarding diagnosis, as saying 'Doctor will tell you' sounds quite horrifying to the anxious patient.

A nurse is expected to fly around in a mad rush whether the ward is busy or not.

3 work-load:

I feel that 'ward routine' is generally more important than the patients. The work must be done even if a patient is too tired to be washed, etc....

Having to look busy when the ward is quiet, cleaning cupboards unnecessarily.

Qualified staff ... leaving you with all the work to do.

Given too much responsibility without adequate training.

Grouping statements of difficulties with hospital training according to their nature gives the following picture.

1 Administration  (b) 20% + (g) 13% + (e) 12% = 45%
2 Expectations  (f) 17% + (c) 15% = 32%
3 Content  (d) = 19%
4 Relationship  (a) = 4%

Administration and expectations, which seem to be highly related in practical setting, are the main source of difficulties to the students.
5. Patients emotional needs and behaviour

(Q. 20) Extent of difficulty felt by students in understanding emotional needs and behaviour of patients.

i) \( W = 1.0 \)

ii) Ranking:

1 = c) minimum extent \((61\%)\)
2 = d) not at all \((22\%)\)
3 = b) moderate extent \((16\%)\)
4 = a) great extent \((1\%)\)

Students seem to agree that understanding emotional needs and behaviour of patients is relatively easy. The questions might have been vague causing inaccurate replies. It is also possible that the students were unaware of the fact that 'understanding' involves a deeper level of appreciation than 'recognition'.

Another interpretation of the results is that students actually and genuinely have found it comparatively easy to understand needs and behaviour, but they might have difficulty translating this understanding into behaviour. This assumption, of course, cannot be verified from this question.

(Q. 21) The frequency with which students are faced with the situation where they feel that a patient is upset although not showing it.

i) \( W = 0.9 \)

ii) Ranking:

1 = b) sometimes \((63\%)\)
2 = a) often \((19\%)\)
3 = c) seldom \((16\%)\)
4 = d) never \((2\%)\)
This question was meant to act as a 'probe' to the extent of sensitivity of the student to the patient feeling, but it does not seem very well worded and nearly defeated its own purpose. It was meant to find out whether students would be able to tell that the patient was upset, even if the patient did not manifestly cry or sit looking miserable. But of course, this is difficult to evaluate unless one is actually working with the students on the wards. All that can be established from this question is the student's own perception of her sensitivity to the patient's feeling, which is of value. According to the students their sensitivity seems to be fair.

(Q.22) The behaviour of students when faced with the situation where a patient is upset although not showing it.

1) \( W = 1.0 \)

ii) Ranking:

1 = c) after finding out the cause of the patient's upset the student would consult another person she/he believes could best help in dealing with the situation. (56%)

2 = b) the student would talk to the patient and try to find out about his/her troubles and do what she could to soothe him/her. (29%)

3 = d) before talking to the patient who the student feels to be upset, she/he would consult another person on the ward (12%)

4 = e) 'Other' alternative behaviour chosen, e.g. "I would leave patient alone, some patients resent being intruded upon." 'Interfere when I am specially asked for help," and "depend on the patient and how well I know him/her." (3%)
From the comments on this question it was apparent that two factors generally motivated the students' behaviour: one is authority, the other, approachability, mainly, of the person in charge. The students' first choice is to refer the patient to the person in charge, e.g. "Senior on the ward", or "more senior such as Sister" or "depends on which ward situation arises, I may tell Sister or staff nurse." The second consideration is how approachable the sister or person in charge seems, e.g. "maybe the ward sister if her nature was understanding, if not next best senior nurse." Other examples showing concern about approachability, e.g. "A member of the staff one could speak freely to and not Sister" or "an understanding senior nurse."

Whenever students specified whom they would go to it was someone in authority; in order of priority they would go to sister (73%), other nurses (17%), other personnel, e.g. almoner, social worker (6%), and to the doctor (4%).

(Q. 23) Elements/factors helping students most in understanding situations related to patients' emotions and behaviour.

1) \( W = 1.0 \)

ii) Ranking:

1 = a) student's own intuition and personal experience outside the hospital or school (61%)
2 = d) a combination of items (a) to (c) of the questions. (The large majority thought it was a combination of (a) their own intuition and personal experience outside the hospital or school, together with (c) the manner in which qualified people on the ward tackle the situation.) (22%) 

3 = c) the manner in which people on the ward tackle the situation. (The large majority of those who ticked this item said it was the sister or nursing staff (88%) while the remainder said it was the doctor.) (8%)

4 = b) specific subjects taught during study blocks. (the commonest subjects being: psychiatric experience, and psychiatric training to those who were Registered Mental Nurses, and psychology lectures.) (7%)

5 = e) 'Other' factors were mentioned, e.g. "putting yourself in their position". (2%)

Both Q. 23 and 24 are similar in alternatives of behaviour but they ask two different questions, one is concerned with understanding, and the other with action. It is of interest to note that students rely mainly on their own intuition and personal experience gained outside the hospital or school. Though it is probably difficult to know the exact source of one's understanding, the fact that the students 'felt' it was not the school/hospital which contributed to such understanding is of interest. The agreement seems to be high among the different years of training as to what helps them understand. Added knowledge in the classroom or experience on the hospital wards, does not seem to influence the source of their understanding, i.e. themselves.
(Q. 24) Elements/factors which help students most in dealing with situations relating to patients' emotions and behaviour.

1) \( W = 0.9 \)

ii) Ranking:

1 = a) student's own intuition and personal experience outside the hospital or school \((40\%)\)

2 = d) a combination of items (a) to (c) of the question. (The large majority thought it was a combination of (a) their own intuition and personal experience and (c) the manner in which qualified people on the ward tackle the situation.) \((28\%)\)

3 = c) the manner in which qualified people on the ward tackle the situation. (The large majority of those who ticked this item said it was the Sister or nursing staff.) \((25\%)\)

4 = b) specific subject taught during study blocks. (Again the commonest subjects being psychiatric experience and psychology lectures.) \((5\%)\)

5 = e) 'Other' factors were mentioned. \((2\%)\)

Even though the order of priority is the same as the previous question, the degree of agreement is slightly less, and the percentages of students choosing the different alternatives is less if compared to the distribution of percentages in Q. 23. When action is required a more concrete model seems to be needed. This seems to indicate that students learn by example as far as the practical situation is concerned and this is implied in most of their answers and comments in general.
6. **Psychiatric secondment**

Psychiatric secondment does not usually start before the second year of training, so only those second year students who had completed their secondment and third year students are included in the tables.

Registered Mental Nurses doing their General Training were excluded from the group for this part of the questionnaire. Also excluded are those who had not had the experience yet, or refused to answer. This latter combination constituted 14% for the first question and 16% for the second question.

The following two questions were asked mainly as a preparation for the subsequent experiment. They are attempting to probe the student's awareness of what the General Nursing Council is hoping to achieve.

The first question was based on the GNC's recommendation in relation to secondment:

Careful planning of the content and conduct of the course should ensure that the basic aim is achieved - namely, the imparting to the student of such insights and skills as will help her to become a good general nurse.

The second question refers to the GNC's object that

... an increased understanding of and tolerance for the non-rational behaviour patterns developing in patients in response to stresses such as serious physical illness and hospitalisation; and possibly a consequent increase in self-understanding and general maturity.

(a) (Q. 25) The extent to which students felt that psychiatric secondment helped them in their General Training.
(b) (Q. 26) The extent to which students felt that psychiatric secondment helped them understand themselves.

<table>
<thead>
<tr>
<th></th>
<th>Moderate extent</th>
<th>Great extent</th>
<th>Minimum extent</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td>29%</td>
<td>34%</td>
<td>17%</td>
<td>7%</td>
</tr>
</tbody>
</table>

On the whole, response to the first question was more favourable than to the second question. The general feeling seemed to be that secondment was more helpful for general training than in increasing self-understanding.

87% of students answering the first question took the invitation offered to comment 'In what ways was the secondment helpful?' Their comments reflect the degree of lack of awareness by the student of the emotional aspect in patients up till then.

It helped me to understand that the patients in general hospital also have a mind and soul which require as much care as the body.

I have learned that by just listening to the patients helps to relieve them of some of their anxiety.

It helps you to understand that patients in general wards may have problems like the psychiatric patient but before we go on the secondment you don't think of this, only of the patient's physical illness.

To understand that a physically ill person also can have feelings, emotions and even mental disturbances that are so easily overlooked.
By realising the problems patients feel, and how to notice these by even general conversation.

A large number of the comments are vague, e.g. "help understand people's basic needs" or "understanding of people's emotional needs." This appears to indicate that understanding is superficial, but at least a new way of thinking is offered to the students.

Some of the comments show the quick acquisition of jargon without necessarily acquiring the depth of understanding which should go with it. This has also been noted by Shaw (1973) with B.Ed. students. Examples of this are:

I now think of a patient's particular make up and characteristics when dealing with individual care instead of classing the patient as a body.

To understand more of people's pattern of behaviour, how their family background and environment affects them, more sensitive to their emotional needs.

Some comments also refer to the fact that it helped students talk to patients and relatives.

62% of students answering the second question commented on the way in which it helped them personally. Their comments reflected difficulties they had most of the time, rather than the help they got.

I found myself becoming depressed and then started looking for, in myself, the symptoms of my patients. I felt, as a result, very emotionally unstable myself, though only for a period of three months, after which I got myself sorted out.

I now think of what could be psychiatrically wrong with me, which is mostly in my imagination - I hope!
For a while after being seconded I tended to question all motives, etc., as psychiatric nurses seem to do. Now, I think, I'm not so bad.

In general the same comments as above about acquisition of jargon, and vagueness could also be applied here. One student simply expressed it by saying, "I don't really know why." Another who felt it helped her to a minimum extent said, "Perhaps I am even more confused!" Some comments related to general value rather than help pertaining to the student herself.

It helped me to be more understanding of others.

It has made me understand about psychiatric hospitals and nursing although I feel I could not commence my training in such a hospital.

In lots of ways which I cannot explain, inside me to realize that these patients are ill.

Some of the comments raise worries about the seriousness of the effect on the student and one cannot help but wonder whether the student had enough explanation and support. This was apparent in most of the comments under difficulties above, and:

After seeing ill patients and understanding their illness I now realize that I shall probably end up with 'obsessional neurosis'.

These results seem to support what the students in the pre-pilot stage (p. 75) had said about their preparation and reaction.
A. **Interviews**

All interviews with tutors were tape recorded as explained on page 84. Often, the tutors said they would have liked to read the questions in advance, to give them time to think about them. This was difficult because of the need to standardise the procedure. The method of arranging appointments varied from school to school, and time intervals between contact and interviews were unpredictable. It was explained to the tutors that my interest was in their spontaneous response, as this was bound to be more original and individual than a prepared response. The following were headings under which responses were recorded.

1. **Educational objectives**

**What is, in your opinion, the aim of classroom teaching?**

I wanted tutors to express their aims in their own way before presenting what I inferred the GNC was aiming at. The word *aim* rather than *objectives* was intentionally used as the latter refers to specifics which it was unrealistic to expect from the tutor in an interview situation with no previous preparation. It should be noted that the question as it stands is difficult and answers to it should be interpreted accepting that the tutor's lack of ability to verbalise her/his aims at times...
is no reflection on the existence of such aims or of their qualities. An answer could be regarded as a reflection of how the tutor spontaneously perceives her role and at the same time of what the role of the tutor actually is. An example of the latter is the reply of one tutor whose frame of reference can be inferred from her answer to the question.

To explain principles behind techniques employed, explain why certain things are done for patients' comfort and safety, as well as to show ideal ways of doing things.

This respondent was an unregistered tutor responsible for teaching procedures.

By GNC regulations only Registered Tutors can teach 'pure' anatomy and physiology, while anatomy and physiology applied to nursing is, in the main, the responsibility of unregistered tutors. The answers of unregistered tutors and unregistered clinical instructions reflected their concern about application in terms of procedures or ward activity which was their role. The answers of registered tutors and registered clinical instructors reflected both their role and their orientation as influenced by their courses of study to become registered tutors. More educational jargon was used, e.g.,

I see the aim at the moment, to present to the students as they come in, in one form or another, subject material which will extend their knowledge, in some cases and can relate it to previous experience because some of these students would have had experience in what I was saying. I hope I would aim at extending their knowledge, building up, and perhaps introducing new material for some students because they come with such varied experience and maybe sometimes what they have made of that experience.
To stimulate interest in the group in front of you and to lead them into the correct line of learning that you want them to participate in.

Both were answers by registered tutors. Two tutors objected to the use of the word 'classroom' teaching.

I find it very difficult to see just classroom teaching, because I don't think of teaching as being confined to a classroom, at least I find it very difficult. It is really part of your whole educational programme and, unfortunately, you are not able to have the peace and the quiet and the facilities available to teach people things actually on the spot and for convenience. Some of the teaching has got to be done in the classroom.

From the answer, it seems fair to imply that what the tutor understood by classroom teaching, was teaching about activities, most probably procedures.

The second tutor said,

Well, of any teaching, you can't have just classroom teaching. We should have all round teaching, but I suppose in classroom, you give the basic principles and you substantiate it with visits, ward rounds, etc.

Categorising the answers to this question presents some difficulties. An answer could be looked at in terms of content of what was said; or in relation to whether it deals with short- or long-term aims; or again, it could be categorised in terms of the objectives as stated by the GNC. These objectives were presented to the tutors as the second question in the interview and they were asked to rank them in order of importance.

An example of a tutor's reply is,

Off the cuff, it is to form a basis of knowledge for their practical experience.
In terms of content, this answer is mainly concerned with theoretical knowledge. It seems to indicate a short-term aim concerned with theory for the sake of practice. As to the inferred GNC objectives, it seems to agree with objective 'C': "to increase the student's knowledge about nursing."

To help get as clear a picture as possible, results were analyzed in all three categorisations.

a) Results as they relate to content of answers:

63% of tutors thought that the aims mainly dealt with background theoretical knowledge and the correct methods of procedures and their principles.

11% thought of the aims as integrating theory to practice.

10% thought the aims to be to stimulate students to go on with the knowledge gained.

9% thought the general aim was to teach students about their role as nurses.

7% of tutors gave various other replies, for example,

To give the girl a clear concept of what nursing is which is a very difficult thing to do, and secondly, a clear concept of principles of techniques we use and a clear understanding of things like infections so that she can go into any infectious situation and deal with it, or at least think how to deal with it. You have got to get them to understand how the human body works in a sense how the hospital works, how the services work. It is not easy to keep this clear because she has so much to learn about nursing techniques. This is a very difficult question!

... to give them an insight into things and also we try to make them see that teaching is necessary because a lot of them think, probably because of what is said, that nurses are born not made, and they think that any woman should be able to nurse, and I think this is wrong.

Be safe and enjoy what they are doing.
Necessary to equip them with a certain amount of confidence before going into the ward.

b) Results in terms of short-term goals and long-term goals.

The majority of tutors (79%) expressed their aims as short-term goals, laying emphasis on theory. The remaining tutors (21%) expressed their aims as long-term goals, again laying emphasis on theory. The following Table V, shows the distribution of answers in relation to qualification of tutor.
TABLE V

DISTRIBUTION OF CATEGORIES OF AIMS OF CLASSROOM TEACHING
ACCORDING TO TUTOR'S QUALIFICATIONS

<table>
<thead>
<tr>
<th>Qualification of Tutor</th>
<th>Long Term Aims</th>
<th>Short Term Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Th.</td>
<td>Pr.</td>
</tr>
<tr>
<td>Registered Tutor</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Unregistered Tutor</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Registered Clinical Instructor</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unregistered Clinical Instructor</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Theory  Th = theory
Practice Pr = practice
both Th.&Pr.  
Th.→Pr.  \( \rightarrow \) = for the sake of or for application to.
In general, more unqualified tutors and registered clinical instructors emphasized practice than did unqualified clinical instructors and registered tutors. In that context, it is important to bear in mind that unqualified tutors mainly teach procedures and applied anatomy and physiology as only registered tutors are allowed to teach 'pure' anatomy and physiology. Answers considered to express long term aims implied the development of an ability or reference to the student's future role after training. Example of an answer dealing with long term goals with emphasis on both theory and practice is:

Any teaching in nursing, is to produce a professional person, a good bedside nurse with skill in nursing techniques, communicate with patients, one who can understand and has the capacity to listen to patients and help them. In the classroom, scientific knowledge and nursing skill.

Answers considered to express short term aims referred to the actual training, for example:

Is to make the student able to look after the sick patients, give appropriate treatment, understand what she is doing. So much of what they learn is learned in the ward situation but we give them here a basis for what they see.

c) Results in terms of the inferred objectives from GNC syllabus.

Table VI shows the results:
### TABLE VI

**DISTRIBUTION OF AIMS OF CLASSROOM TEACHING CORRESPONDING TO GNC EDUCATIONAL OBJECTIVES ACCORDING TO TUTOR'S QUALIFICATION**

<table>
<thead>
<tr>
<th>Tutor's qualifications</th>
<th>(a)</th>
<th>(b)</th>
<th>(c)</th>
<th>(d)</th>
<th>Number of Tutors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered tutor</td>
<td>1</td>
<td>3</td>
<td>19</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>Unregistered tutor</td>
<td>-</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Registered Clinical Instructor</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Unregistered Clinical Instructor</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>4</td>
<td>29</td>
<td>25</td>
<td>59</td>
</tr>
</tbody>
</table>
In order of magnitude, the results are similar to those obtained in the next question, where tutors ranked in order of importance the four objectives presented. Bearing in mind the possibility that I may have misjudged the categorisation of answers it seems that the order in which tutors consider their aims is the same whether they express these aims freely or rank the aims when presented with them in the form of objectives.

**Ranking of GNC educational objectives by Tutors**

Tutors ranked the four educational objectives inferred from the GNC syllabus in order of importance. These objectives were also given to students to rank, (see page 98). Tutors were asked to rank them in the following way:

1. for themselves
2. as they thought the GNC would rank them
3. as they thought the students would rank them, and
4. as they thought the qualified staff of wards would rank them.

The four objectives were:

A. To prepare the student for her final examination
B. To develop the student's personality as a nurse
C. To increase the student's knowledge about nursing
D. To prepare the student to deal with any practical problem which may arise on the wards
Some observations on the above Table are:

1) The extent of agreement \( w = 0.9 \) among tutors is higher when ranking the objectives for students and qualified staff, than when ranking the objectives for themselves.

The tutors' first reaction to the part of the question "how do you think the GNC would rank these objectives" was very often, "I have no idea" and with further prompting they would answer but keep repeating that it was only a guess. Though the degree of agreement is the lowest, it does not suggest complete randomness as would have been the case if the value of \( W \) had been below 0.5. Often the tutor would say, "Oh! no doubt exams come first for the GNC", then after some reflection would say, "maybe I am not being fair, knowledge probably comes first."

It should be noted that 21% of tutors were excluded from Q. 2, i.e. 12 tutors, mainly due to the fact that they could not think how the GNC would rank their objectives.
ii) Tutors share the importance of their first objective (ranked C as 1) with their perception of the GNC and the importance of their second objective with their perception of the students (they ranked D as 2).

iii) Tutors see themselves as the only group interested in developing the "student's personality as a nurse".

Objective 'B' was the one that created most controversy in the tutors' reactions, as some tutors felt that it was unethical to influence the student's personality. The meaning of this was often queried. Generally the objective was read out again, then if there was still no reaction, the tutor was asked how she would interpret it. Finally, I would say what I thought the GNC meant: "how to help the student develop as a nurse". This final step usually made the tutor feel it was of importance as it was her domain. Tutors felt that qualified staff were not at all interested in this, only in the work the student can offer.

iv) The final examination was the least in importance for tutors, though it is considered by the GNC as "the portal for registration."

This impression, given by the tutors in relation to objective 'A' was that such objective was 'bad' as it suggests that the interest pertains to the examination rather than to the students, and, therefore, the tutors were trying to destroy this impression; "none of us should aim to prepare the student for examination" was one comment.

I do not think this comment reflects the tutors' lack of appreciation of the value and importance of the
examination, but rather on their basic objection to this almost utilitarian or instrumental approach which did not appear to them very 'educational'. Some tutors almost apologetically said "after all, exams are important." They almost purged themselves of the 'sin' of considering examinations as important by projecting this importance on to the student. When ranking the objectives for students, they almost always said, "Oh yes, I have no doubt how they would rank them, examinations are all they care for." Some tutors put the examinations in perspective in relation to students by saying this is what worries them most.

2. The preparation of the student in the classroom to deal with an emergency situation on the hospital wards

(Q. 3) 73% of tutors felt it was part of their job to do so.

21% of tutors felt it was probably part of their job, but had their doubts.

5% of tutors did not think it was part of their job to do so.

How to prepare the student in the classroom for hospital emergency was seen as follows:

48% through increasing the student's awareness that emergencies occur and the discussion of related issues, e.g. religious, policies about dealing with aspects of resuscitation.

32% through teaching procedures, e.g. First aid.

20% through leaving the responsibility to the hospital staff to carry out.

Some of the reasons why the tutors felt it was part of their job were:
because students expect to be taught at school, so you have to give them what they expect.

because it is an artificial situation where you can teach when they are calm, cool and collected, while on the ward during emergencies you cannot do that without risking the patient's life.

To become familiar with the equipment.

They don't go and panic whatever happens, that they can get help, prepare them mentally to the fact that they occur.

for two reasons: you don't want the girl to be overwhelmed, and because she has a responsibility toward the patient.

Some tutors felt that it was of little value:

The actual emergency cannot be taught in the classroom; one can go through the motion but since the sense of emergency is not there, the whole exercise is defeated. It must be in hospital.

There is no real grasp and understanding until they go to the ward; everyone reacts differently under stress.

3. The relationship of classroom teaching to practical hospital experience

(Q. 4) Regarding students' experience on hospital wards:

68% of tutors did not think that classroom teaching was related to students' experience on hospital wards, or thought that it was related only to a limited extent:

Not related at all to the subject matter taught and its application.

Not related timewise, but related in experience because of present set-up of block system of education.

No, oh no, I think basically it comes to the fact that many of the teaching staff do not realise what the situations are, for example, equipment is lacking, some say it is not teaching, it is administration, but you still have to teach in a deficiency situation, which nobody seems to consider. They don't say, 'The situation in this hospital is therefore you must', they say they are training for a national pool. 'We have a long way to go before we can marry these two'. (theory and practice)
... but one tries because of the idea that classroom is one thing and hospital another, perhaps geographically they are too much apart and not easy to get over to hospital.

not at all, because of insufficient attention paid to relating actual experience, the type of ward they are nursing in, to their teaching at the time and vice versa. It is a tutor who does the teaching in classroom and unless they are marvellous people they can't be up to date with wards and changes of procedure and equipment, et. ... they try but inevitably they fall down on that, so we speak about things that are not the current procedures from ward, which adds confusion to the nurses and she despises the fact that the tutor is out of touch which puts a terrific barrier between tutor and student who is basically concerned about how she is going to cope with the ward.

related to a certain extent because the tutor uses her own experience and illustrates by examples.

27% of tutors thought that it was related, on the whole, but not specifically:

We are limited by the syllabus, its amount and specification of subject you have to teach, although you can consider it as a guide, so one cannot teach details as one wishes to.

On the whole yes, if it is actual content, but method or procedure, no, school tend to teach impractical ways ...

because we teach the ideal which is impractical sometimes.

5% of the tutors said that it does not apply to them:

I don't really know as I am new but heard from students that there is a difference but they always say so anyway.

The reasons given for unsatisfactory relatedness are:

33% of tutors blamed the school for the lack of relation in terms of the educational system, syllabus or tutors (including themselves as well).

23% of tutors blamed the hospital administration or the relationship problem with hospital.
The classrooms are doing the right thing, the fault lies in the ward. They should accept classroom teaching but they lack equipment and time because of shortage of staff.

We like to think that what we teach is done in the various hospitals. There are problems because we have six hospitals in the group and students in some classes are integrated. We try to keep up to date, by being in contact with ward and ward sister, I don't see any solution with the large numbers of students. That's why I feel clinical conferences, while they are in college, is helpful.

23% of tutors blamed the lack of liaison between the school and the hospital:

It is difficult in a big place. Maybe in a smaller hospital with a smaller group and the co-operation of administrative and teaching staff one manages it... It is difficult for student nurses to understand principles and it would be difficult for students to oppose the sister.

20% of tutors blamed the ability, personality or attitudes of students:

A student's sense of responsibility and her personality, the clinical instructor can do nothing about it. She has been taught to give the very best to patients, but they cut corners thinking they are saving time. She (the student) is the one to decide what type of service to give.

From the student point of view she is or she is made to be aware that hers is a practical occupation and back from the start, theory should have second place. I know she starts in the college but she gets involved in ward situations and is more alert, alive and this is maybe what she wants, and places theory as secondary. The more she gets involved in the practical situation the greater the gap is, and this is not supported by the people who are senior to her, who find it difficult because they are involved, and have little time to influence her to study.

From the comments it seems fair to say that what most of the tutors took relationship of theory to practice to mean, applied mainly to procedures. The tutors' answers supports the students' answers to Q. 10 (page 95) which
was similar in both the interpretation of the question
and the general nature of the answers.

(Q. 5) **Regarding the training of students:**

The tutors were asked whether they would consider
that for effective training of the student, classroom
teaching and practical hospital experience should be
separate entities.

79% of tutors thought that they should be
together and related:

I feel that they have to be correlated as much as
possible, more so than it is just now. We should
try and get into the ward and teach there.

No, I don't think they should be separately taught
because basically it is the patient, so it should
be tied up.

13% of tutors gave 'other' answers:

If possible for the first 2 years it should be
separate, going (to the ward) only to see things,
then third year go to the hospital. Although they
are terrified this is good experience to combine
the two, but it is a very hard life what they have
now. You can get that with medical students, so it
could be done with nurse students.

Half of me wants to say yes and half wants to say no,
because you can see problems both ways (either very
theoretical person lacking practice or practical
person lacking knowledge; both have difficulties).
I think the two have got to have some continuity.

No, I think that if possible they shouldn't (be
separate). But, maybe in a big place, maybe it is
better if they are. In fact, it is almost inevitable
that they are.

I don't know the answer. It is a good thing for them
to be as integrated as much as possible. It needs
measurement and investigation.

It is difficult, and I don't think it matters the
location in which you teach student her theory. You
cannot teach nursing without being at the bedside.
You can teach principles in the classroom, no matter where the student is, you must have a good liaison with the hospital. It can work even if there is a central school.

5% of tutors thought that they are separate now: the way the system is working now, lectures are separate from training which is advisable sometimes but not as much as that.

... but as a matter of fact they are separate now.

they have to be separated at the moment to get it done - to give them basic knowledge and hope they will get on.

3% of tutors thought it would be good if they were separate:

I would say in some instances, yes, you have got to have some sessions just for theories, which is quite separate from hospital. There is room for development in relating teaching to practice.

I think it could be effective if they are separate provided the hospital experience is available. I don't think you can divorce the two completely. If the school or college moves outwith a hospital jurisdiction, like the colleges of education, I think that's fair enough provided you can get the clinical experience somehow.

The majority of tutors thought that a director of education was an important element in the effectiveness of the training programme of student nurses. They felt that a director would be prepared and interested in education, while Matron has the patient care as her first priority. Some of the tutors, however, argued for the advantage of having the Matron also responsible for education, as the student is then closer to the Matron. Some tutors thought that who is responsible for education would make no difference as long as it is a nursing authority and
communication is good between school and hospital, and that Matrons nowadays are more educationally oriented.

Two of the schools involved in the survey had the Matron at the head of the school.

(Q. 6) Regarding the sequence of relationship between classroom teaching and practical hospital experience. The question of whose responsibility it is to relate classroom teaching to practical hospital experience.

On the whole the tutors wanted the students to relate what they get in the classroom to what they practice or vice versa. There is no clear cut opinion favouring a process of relating from the classroom to the practice or to the other way, but the general feeling is that it is the student's responsibility to relate theory to practice; students need help, which is mostly seen to be the duty of the hospital staff.

The question was based on a quote from the GNC Syllabus for General Nurses, saying:

The student nurse must learn to observe and appreciate what is seen and taught in the wards and relate it to the theoretical instruction she receives.

The first reaction of one tutor to this was:

It is rather typical of the GNC, it says what the student must do but does not say how to go about it. It sounds beautiful but!...

The reactions of tutors to the above quoted sentence varied:

They may be allowed to observe but not to appreciate on her own because she does not have previous knowledge. One cannot tell her, 'go and observe'. It does not make sense ... they must be taught to observe and find someone to ask 'what is that about'?
It is a stupid sentence, it is all very well to ask the person to learn and appreciate and relate but where is the tutor to point out ... the student must learn but with instruction and guidance.

I think if you are teaching properly in the classroom that it should be fairly obvious, if you are teaching what the nurse is going to need to use. I think obviously it must relate.

It is a pretty fair sentence. I tell the students not to study books, but to go and study their patients and compare them and this is how they should be taught at ward level.

Glad you have pointed it out. I have never seen it. It is a very good aim. I think that few students follow this instruction, that they do things for the sake of doing them, and they are not appreciating the relationship between theoretical and clinical aspects, and perhaps, if we emphasize this sentence more often, we might achieve better results.

I then asked the tutor: "you mean by pointing the sentence out to the student?" and the answer was "yes". The tutors' reactions varied as they perceived their roles as varying in degree of participation from taking charge of the whole responsibility to acting as a guide or to "I don't think we (tutors) can be held responsible, what we hope is that what we teach is sound."

Again, the tutors' answers, in the main, support the validity of the students' answer. Students either turn to themselves (using their own judgement) or to ward staff when they have to deal with any situation.

(Q. 7) In regard to the effect of sequence of experience and teaching, and tutors' preferences.

69% of tutors felt that previous hospital experience of students helps her to understand the related topics taught (5% thought that this helped only sometimes).
11% of tutors do not favour the previous hospital experience of students.

They feel that if students think they know they do not 'take it in', or that it is difficult to change their ways after having acquired them on the ward, or that 'you get some prejudice' because there is a difference between what the tutor says and what they have seen on the ward which creates a barrier between student and tutor.

19% of tutors said that it was not applicable to them, mainly clinical instructors who do not usually teach in the classroom.

The tutors' sequence preference was as follows:

48% would like theory to come first, to build the student's confidence and back her practice with sound knowledge, as it would be safer for the patient.

40% would like to have an alternating sequence, sometimes the theory first followed by the practice, and sometimes the practice first followed by the theory, e.g. for post-operative care and cardiac arrest they need their instruction first. To understand a patient's condition she gets the meaning better once she has seen the signs and symptoms, as "recall is easier with visual picture."

7% of the tutors would like the practice first.

7% would like different 'other' things, e.g. if enough clinical instructors were available as well as the time then they would like
practice first, but not otherwise, or that they would follow theory by ward teaching by clinical instructors, which needs good liaison between sister and clinical instructor.

4. The General Nursing Council (GNC) Syllabus

(Q. 8) Is it possible to teach the whole of the syllabus in the time available?

The general feeling was that either it was not possible or that there is no choice but one had to do it. This opinion was expressed by 66% of the tutors, while 24% said yes, it was possible. For 10% of tutors the question was not applicable.

The question was open ended and a number of different points worth mentioning were brought up. The tutors who did not think it was possible to teach the syllabus in the time available thought this way because it was so detailed and "a lot pushed in a short time". As one tutor expressed it, she would like to see a few things taught well. The various responses of the tutors seem to agree with Livingstone (1946p.7)"... and overcrowding, in education as in housing, means ill-health, and turns the school into an intellectual slum ... it does not teach the pupil the meaning of knowledge."

The feeling of tutors that the syllabus is too much for the time available accords with the students' difficulties with classroom material, in that they feel
that one of the major difficulties is "too much to study in the time available" (page 105).

Tutors felt they needed more time, as on the one hand a great deal of the doctor's work, e.g. blood pressure measurement, injections, has been transferred to nurses; while on the other, even though the syllabus is the same, teaching time has been cut. This makes the syllabus possible "on paper", but not in practice. One tutor, asking whether this was an honestly meant question, then:

It is possible, because we have got to do it, if it is desirable, I think this is a different question. No, I think, one could do with much more time to teach no more. Instead of trotting out fact, if you have more time, involve the girls in teaching, in gathering their information, more time for discussion, instead of a cram as it often is, instead of lecturing you could teach. And I think there is a difference there. You can cover it. This does not mean you taught the nurses anything.

Even though some tutors felt that it depended on how tutors or the school interpreted the syllabus, some still considered it only possible to teach in terms of principles but not in details. Some felt that details were asked for, as the examination and examiners, who are not necessarily those who teach, ask for details so they had to prepare the student for specifics/details.

(Q. 8 Contd.) Is the syllabus too academic, about right or not sufficiently academic?

The word 'academic' was interpreted differently by different tutors. It could mean theoretical, intellectual, university type, technical knowledge, non-practical,
or even equating academic with teaching biology. To some 'academic' means more uniformity and encouraging bright students to read. To some it means what pertains to the profession.

42% of tutors thought it was about right for a variety of reasons, some of these were the present qualification and entrance requirements or the mixture of requirements relating to the standards set down for entrance.

28% of tutors could not really decide about academic standard, giving different reasons like the fact that the syllabus was 'vague', or 'hospital biased' or that 'you can do what you like with it.'

20% of tutors said it depends upon how one interprets the syllabus, which seems to be related to the ability level of students accepted by the school.

5% of tutors thought it too academic, one tutor equated academic with biology and felt that there was too much emphasis on this. Other tutors thought it too academic because "they (students) are given a lot of academic details, i.e. technical details, and not enough practice."

Another tutor wondered "are we going to produce better nurses with more technical knowledge? Nurse-patient relationship which is of vital
importance, do we have better nurses that way?"

3% of tutors said that it depends on the students' qualifications and ability and the kind of nurse you want to produce though the tutor did realise that the student nurse is not a university student, yet she felt that there is a tendency to 'dilute things down a little bit'.

1% i.e. one tutor, said "you know, so often I feel the syllabus is just words. I just don't think it is realistic."

5. **Areas of difficulty for the students**

(Q. 9) Tutors were asked if students go to them with problems relating to:

Discrepancy between procedure techniques taught at school and those used on the ward. Again, the following results accord with those of students as reported on Q. 13, page 97.

97% of tutors recognised this as a problem:

yes, for the last 23 years I have had this ...

Oh yes, despite having a procedure manual, a procedure committee which sits morning, noon and night, all year round, we often, in fact we always have the girls coming, you know, it is not a fact of an isolated incident. It persists.

Oh yes, they love that because we bring it to ourselves there is a discrepancy not only between school and hospital but also between wards, equipment is lacking, we make the work difficult for ourselves. Difference lies in methods but not in principles.

Yes, it's chronic.
3% i.e. two tutors, did not regard this as a problem as one of them was new and mainly concerned with operating theatres and the other tutor went to the ward to check before teaching any procedure.

Many reasons were given by tutors for the presence of this problem. One tutor summarised most of these reasons:

- short cuts, saving time and it becomes accepted practice and sister is unaware of this short cut.
- Mobility of the profession: people coming from different hospitals, student nurses going to an unqualified person for help and they haven't the knowledge, and they do things out of routine. Some students adopt their own habits and techniques and they don't see the need for following the steps we introduce.

and another tutor traced it back to:

- GNC examination was a practical examination in the classroom, in which part of it was trolley setting and tended to become a ritualistic type of examination, which was not in fact related to how they were setting trolleys in the wards. Also things change very quickly and classroom ways do not change fast enough but it is mainly due to discrepancies between techniques.

Other reasons mentioned were to do with shortage of equipment, staff and time on the ward, and the establishment of the C.S.S.D. (Central Sterile Supply Department), the sister's own way of doing things, and also the differences in trainings of staff. Students' attitudes and lack of communication between school and hospital were offered as additional reasons.

Student's inability to understand patients' behaviour

42% of tutors recognise this as a difficult topic saying that students brought this up eventually
without realising that it had to do with emotions and behaviour. This supports the impression I got from the students' answers to Q. 20, where the majority said they either had slight difficulty or no difficulties in understanding patients' emotions. They probably were unaware of the depth or meaning of the emotion though they could recognise it. The majority of tutors felt that the ability to understand developed with experience but depended on the student's personality. They felt that the student through trial and error will know how to cope with different patients, and that they could be encouraged. There was no mention, though, of any active planning by the tutor to develop this understanding. Some felt that it could be included more often in discussion about the patient, or that it is a function for the psychology lectures or the psychiatric experience. On the whole the majority felt that sister has a more active role to play than they do, partly because they were more involved when they were sisters in charge. How one tutor dealt with it was,

I do discussion groups of third year students, and sometimes this comes up. They don't realise that it is patient behaviour. They get offended and the patient doesn't want to co-operate. Instead of having one of his nice moods, the patient is 'unreasonable'. They don't understand what is happening, and this is very difficult. And I tell them we will have pre-ill like pre-natal classes and teach the patient. (laughs) You can't do it with earlier students.
33% of tutors said that they did not meet this problem.

I haven't come across this because I lay a great deal of emphasis on approach to individual patients and psychology and I haven't had anyone coming.

I haven't had this very much, I think possibly because we had discussion following day release, e.g. in a gynae ward, with abortion. Someone says "if she has an abortion my attitude changes towards her". You say why and discover that it is because of a patient's behaviour, then we start from that. I try to get that very early because I feel that their behaviour will be influenced by patients' behaviour more than anyone.

I give them a picture of how the patient might react, of how every patient is different and how every patient has to be approached differently (so when they meet the situation) they come and say, 'I have seen a patient behaving that way, now I understand what you were saying'.

25% of tutors said 'other' things, such as

Not so much now. They gain a great deal from psychiatric experience. They used to be very worried about a confused patient. Now they have a much better understanding of patients' behaviour after psychiatric experience.\*\*

In the main they cope very well, there is a great deal nowadays being said about young people being selfish in comparison to what they used to be long ago. I don't find this, and I find that the young students have tremendous sympathy and understanding of the need of the patient, but I have had students say that they did not know how to cope.

Not quite so much as a matter of fact. They try to understand.

Some tutors felt that these problems will be referred to the psychologist or social worker or chaplain rather than to themselves.

\*\* Psychiatric experience in this school is at the end of the second year of training.
Personal problems of the patients mentioned to the tutor by the students.

60% of tutors said that it would not be mentioned to them as these problems are usually taken to the sister on the ward.

23% of tutors said this was not applicable to them.

19% of tutors said that the students do mention patients' personal problems:

they bring up problems that a patient has had in general discussion, sometimes not being aware that this has been a problem to the patient.

Some tutors felt that students brought these problems more often after they have had psychology lectures.

Students' personal problems rather than patients' seem to be more in the registered/unregistered tutors' domain as 76% said that students come to them with personal problems. These problems usually pertain to study or accommodation. The remaining 22% said that it was not applicable in their case.

6. Expectations of tutors in relation to the psychiatric secondment of students. (Q. 10)

53% of expectations are in the form of gain for use in the general hospital (psychological aspect of patient care), like:

apart from what she learns about psychiatry, it helps her to see patients more as people, she learns a bit about herself, it gets out of her head the myth that you don't talk to patients. They 9 students) say it helped them understand the patient and how to relate to them.

Understanding of psychiatric condition, an ability to deal with psychological problems in patients and what
she can bring back and use with all her patients is the ability to communicate with people more.

The idea behind secondment that every nurse gets a view of the patient as a whole. This is very good and they benefit from it. They can deal with what they called a difficult patient in general hospital.

14% of expectations are a combination of expectations, all of which include those set out in the above category.

Help them understand some of the problems patients have, behavioural problem, and the fact that mind can get as sick as the body. People sympathise more with something they can see like a broken arm, or an amputated limb but difficult with a deaf person. I think the student could help educate the public about mental illness because of stigma attached to the mental hospital. I felt in my training that nurses are more aware of the patient's mental suffering than the doctor.

11% of expectations are gains for psychiatric hospital experience for its own sake.

another hospital functioning. I hope more than that to get more understanding of the work psychiatric nurses are to do, and some of the problems that psychiatric patients face or don't face, and perhaps a little bit of understanding for patients when she comes back to general field, who will need psychiatric help. Whether it helps or not, I don't know; their comments are vague, 'gave her more insight.'

Don't know, because it is so short, maybe an insight into what psychiatric training is like.

8% said that the question was not applicable to them as they wouldn't know or that they haven't had the experience themselves. They could only offer what students say, e.g. "According to students, I would say not very much. It depended on where they have been and staff of the ward."

Another 8% of expectations were varied, e.g.,
two or three things, first it is bound to be borne on her by the size of the hospital that patients suffering from mental illness are not a minority group, and by the bed complement in these big psychiatric hospitals that this is indeed quite a problem; second, it is good for her to realise that illness can not only strike the body but also strikes the mind, and I feel also that she has got to think about the whole man. I think the other thing is that she appreciates that the environment in a psychiatric hospital is different from the general hospital and a specialised hospital dealing with physical disease, and I think she learns her patient and his problems, and that domestic and environmental problems are things that she will probably realise are very important in the way of being in people.

7% of expectations are related to the student's benefit, e.g., improve her self-understanding" and to understanding of her colleagues, or that she will develop 'a broader and more tolerant outlook of life'.

7. Teaching

(Q. 11) Tutors were asked which they found more helpful, British or American books?

48% of tutors prefer to use British books, especially medical ones.

16% of tutors would prefer to use American books, especially nursing ones.

20% of tutors would use both American and British books, according to their needs.

16% of tutors in the main clinical instructors said that the question did not apply to them.

Tutors were asked whether they gave references to students.

60% of tutors did so.

29% said that the question was either not applicable or that it depended on the situation.

12% did not give references as students would not have time to read them, or would not read
them anyhow.

The aim of this question was to find out the extent to which tutors use foreign literature, as it was felt that this might add to students' difficulties in establishing the relatedness between theory and practice. The contents of books is different enough from reality even if their authors are indigenous to the country where the practice takes place. The other half of the question aimed at finding out the degree to which students are encouraged to study independently. There is a general feeling among tutors that nurses do not keep up-to-date with reading. Some of the tutors' difficulties in this context and of the students is discussed in the following question.

(Q. 12) Presence_and_frequency_of_tutor-student_discussions

The majority of tutors found that the acceptability of the tutor/student discussions varied from one group to another and depended in part on the educational ability of the students and in part on the time available. Even though tutors would prefer discussion, they were pushed for time and had to lecture instead.

Some tutors felt that students would discuss when they knew more about the subject or when it related to their experience, or sometimes they would discuss if provoked. Some tutors said that they compromised by giving a lecture-cum-discussion and some by allowing three to four minutes
for discussion at the end or in the middle of a lecture as appropriate. Tutors responsible for revision found more opportunity for discussion.

I asked tutors who had had the opportunity to discuss with students whether the patient was introduced by students as an 'individual' or as 'signs and symptoms'. The tutors thought that on the whole the students during training were worrying about 'signs and symptoms', and that the stage of training also decided how they would introduce the patient. It was felt that students, usually thought about signs and symptoms when in school, because they were thinking about examinations, but that they did not lose sight of the 'individual' when nursing on the wards.

OPEN DISCUSSIONS

This section refers mainly to the open discussions with students (see page 83) after completion of the questionnaires, and to those parts of the interview which allowed for elaboration of opinions and suggestions from the tutors. A considerable amount of insight was gained through these contacts as well as 'being around' the school for coffee, lunch and tea on several occasions.

1 Students

The group concerned was comparatively young. Of the 521 students, 17 were male students. Generally they were
pleasantly outspoken. They showed a genuine interest in their training, and gave me the impression that what happened in their training mattered to them. They were anxious to be fair in their general evaluation of the situation, and they did not give the impression that they were 'picking at' the training or that they were just complaining because they were given the opportunity to do so. They appreciated the tutors' point of view and problems most of the time.

a) Relation of school and hospital

They thought that the school is simply not up to date with what happens in the hospital, and that the move should come from the school, i.e. to face the reality of the hospital, because what is taught in the school is not practical. School and hospital are "very different. "Theory is one thing and fine, but practice is different." What differed was not only procedures but generally all that was taught in the classroom was unrelated to reality, even signs and symptoms sometimes. Students felt that too much fuss was made of trolleys and their preparation for the least thing, which to them seemed so unnecessary and ineffective. Because the doctors made 'remarks' about the trolley preparation and use, they felt that doctors 'should be taught about the way of doing procedures.' They coped with the differences in procedures between school and hospital by having 'two minds, one for the school and one for the hospital', but they worried about

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*This same opinion is elaborated at a philosophical level by Hirst (in Tibble ed. 1966).*
that difference near the time of their final examinations and they still did not know which way to carry out a procedure. They felt that the procedure depended on how the examiner, coming from different parts of the country, would do it, and would want it done. Students felt that they are taught the 'right' method at school but not given any alternatives in case one item of equipment was missing. "They don't teach you how to adapt; it is either this or wrong!" This comment was clarified by the tutors' remarks on the same subject. Tutors felt that students were puzzled by the differences, so they told the student that "there is more than one way of doing the procedures, and we teach you the best," or they stated that there are several ways but "we teach you one of them." As I saw it the students were mainly concerned about developing their ability to adapt and adjust; what was needed was varied, sometimes it was missing equipment, sometimes a different way of doing a procedure, sometimes lack of time and sometimes several tasks to carry out. Learning one or more ways of doing a procedure did not therefore meet their problem.

b) School

Students also felt that they were given too much knowledge in a short time and this did not make sense because "you won't use it." This was specially felt by first year students who found content irrelevant because
"a lot of anatomy and physiology is taught and we don't use it in practice." When asked whether they use knowledge gained in the classroom to understand what takes place in the ward, they said that they did not usually think about why they were doing things when on the ward: "you don't have time." Usually they did not think about the school while on the ward. This might be because they are told by Sister what they are required to do. They work mostly on the basis of task allocation, and are not required to think for themselves. Bruner's comment here seems appropriate: "a cut and dried routine task provokes little exploration ..." (Bruner, 1966 p. 42). Nearly all the students said that they enjoyed hospital more than school which they considered as a break in their routine. One student, however, said she was happier at school as she enjoyed the "intellectual stimulation." Some students expressed the view that the syllabus was far too long, and some found medical lectures irrelevant. They also felt that they moved 'too often' which made it difficult for them to settle. At the beginning of training they were faced with a wide variety of lectures, which through lack of time they could not assimilate and therefore did not understand, and these they could not discuss. Because all was so new to them they could not use the knowledge. They wished they could study on their own after tutorials, but they were not allowed to do so.
They felt that the 'pieces fitted together only if you nursed the patient talked about in the classroom.'

c) Hospital

Students enjoyed their hospital experience, and were against students being supernumerary, as they would 'hate to hang around doing nothing.' What they did find difficult in their hospital experience was the amount of night duty, because it provided little opportunity to learn much about the ward and its routine. Even though the GNC recommends ten weeks only of night duty, they did more than that. They felt they either stayed too long on a ward or too short a time, sometimes less than two weeks. It depended where they were needed rather than on their own needs to understand and learn. Also they moved a great deal from ward to ward and hospital to hospital. The latter was especially true of group schools who had more than one hospital attached to the 'group' rather than of schools affiliated to a hospital board. (See Table IV) Excessive movement gave a student the feeling that she was "living out of a suitcase." This deprived her of the feeling of 'belonging' to a hospital. Significantly, students refer to the 'parent' hospital. An added factor which took students away from their 'parent' hospital was their secondment to other areas or hospitals.

d) Teaching in hospital

The person students would have liked to see on the
ward all through the three year training was the clinical instructor, but they did not seem to have this satisfaction. When asked if they would like to have the tutor on the ward some students said they would rather not. The Sister could have taught them, but they felt that she did not consider teaching part of her job.

e) The Patient

The wish for more time for patients was expressed because of the feeling that they did not have enough time to talk to patients. They thought that the patients were "put off by the hustle and bustle of the nurses", and therefore would not initiate a discussion with them. As juniors, they avoided talking to patients as they feared being asked something they could not answer through ignorance. They were generally worried as to what to do or say or how to approach the patient. As they became more senior they were more confident, and had gained the experience necessary to speak to patients more easily. Patients were not given due consideration in the students' opinion, they were all "fitted into the routine". Those students who worked on the basis of patient assignment in the intensive care unit believed the system to be better because "you have time for your patient." Some other students argued that with the number of staff at the moment patient assignment was not possible; some wondered how you could say to the patient who asked for something: "I am not working with you today".
From an administrative point of view, they thought that the nursing auxiliaries held possession of the wards, and treated the students "like a stupid person" and that nothing could be done about it, as Sister relied on them so much. They had been there so long that "they know a lot about the ward and they are delegated a lot of responsibility." The juniors were the ones who suffered most from this undermining attitude of being treated as though they did not understand or know anything. They felt that sometimes they knew the patients better than Sister herself because they worked so closely with them. What puzzled them most was the inconsistency with which they were treated. Despite the fact that they were made to feel stupid, they were left in sole charge of the ward. Another inconsistency the students were faced with was that senior nurses who told them to treat patients as human beings did not apply this principle among themselves or with the students. They also thought that there was a very strong hierarchy in the different grades of nurses.

One point about hierarchy related to the Salmon report. Because of this hierarchy they felt that their complaints were 'pushed up' along the line, and by the time it reached "the Number 9 or 10" (nursing officers) remote from the situation, it appeared insignificant to her/him. By this time also, their problem "becomes public knowledge". Students lost respect for senior nursing officers because of the way they treated their subordinates.
After further analysis of some questionnaire results, the remaining groups in the sample were asked to comment on the statement that "the programme seemed to throw a great deal on the students' shoulders, with comparatively little preparation for all that." There was general agreement that this was fairly true and some students provided supplementary incidents in illustration. While realising this to be a fact rather than rebel against it, students accepted it as a reality to be coped with.

In an attempt to bring the hospital and school practice closer, one of the schools took the students on to the wards, during their 'block' study periods to demonstrate procedures rather than carry them out in the classroom. When asked for their opinions about this seemingly sympathetic attempt on the part of the school, students said it was senseless going to the wards for demonstration because they had already been practicing this procedure in the different wards, and it was done differently in each. The students felt that such a move on the part of the school would have been more appreciated by them had it been during their first block, rather than in their second block, as it was the case to them this denoted the lack of appreciation of reality on the part of the school.

Reaction to the questionnaire

In general this was favourable. Comments were that it was "very relevant", "very good because it expresses
all that you want to say, and one does not need to add to it, because your opinion is expressed in your own language."

One group of second year students found the questions difficult both to understand and to answer, "because things are so different between school and hospital."

They also found difficulty with the questions dealing with patients' emotions and behaviour.

One student commented that the answers to the questionnaires had to be "either pro-school or pro-hospital, while it can be a bit of each."

Some students expressed considerable interest in the research and the reasons for doing it. Some asked why I chose students to ask about this problem. When I replied, "Because you are the ones involved," the reaction was that it was "high time students were considered". They inquired as to whether the results were going to improve methods of teaching, what would happen next, and what was the value of the research. I have to admit that I found this too good a psychological opportunity to lose for teaching them something of the nature of research and its benefits.

These open discussions with students have gone part of the way towards Shipman's (1967) recommendations to supplement questionnaires with individual interviews and open discussions in order to take account of environmental influences on individual responses. It was valuable also for me, to be present to administer the questionnaire, and to see the geographical and environmental context of the school and the classroom in my opinion.
Tutors

During the interview a great number of the tutors' comments supported the students' opinions either directly or indirectly.

Examples of this are:

There is too much stress as to how the sister likes it and wants it done. Students don't think for themselves. They don't question. They do exactly as they are told, no time to think for themselves", or that

It is off-putting to the patient, the rushing appearance of the nurse.

Some of the tutors felt that sisters' lack of teaching was not only related to lack of time but that sisters were promoted young and were inexperienced in and without preparation for teaching. Others, explained this by saying that "it is accepted here that nurses (students) are meant to cope with things and sister or staff nurse are not to be bothered/asked, sometimes because they don't know the answers themselves. So it adds stress on the student to cope on her own." They thought that whether the student was going to get a lot from her ward depended on the ward sister. In thinking about principles behind procedures, they felt that "you never think about principles behind procedures when you are working. It is afterwards in off-duty that you remember what way you did it."

a) Examinations

Tutors generally agreed that it is the examiner who chooses the correct method of doing a procedure. The
students' difficulty in examinations was to put on paper what they thought. When they answered they thought of what they did on the wards, but "it does not always tie up with the points we have taught them in the classroom."

b) Tutor's dilemma

The registered tutor, with the amount of theoretical material she is given and expected to teach, can do nothing but concentrate on that. Consequently she does not go to the ward and so loses touch with change in the hospital. This leads to irrelevance in what she teaches and results in the students losing confidence in her as a tutor.

Another factor which adds to this remoteness in the tutor, is being away for two years doing the tutors' course. When she comes back she feels out of touch with people and hospital. Although some tutors felt that people on the ward were willing to help, they found it frustrating to go to see the student on the ward as they knew nothing about the patients, or "where things are kept." Despite wishing to comply with ward ways of doing things this was difficult "because with the best will in the world, there will be a modification of the procedure book; because in practice you go back to what you first learnt."

Another reason why some tutors wanted to be on the ward was the fact that nursing is done on the ward and that is where they felt the student should be taught. Some even thought that they should cut down on theory and provide more illumination for their students on the ward.
Some tutors did try to teach procedures on the ward but the nursing staff in the hospital would rather have students learn about them more in the school and practice them before going to the hospital. "Before they (students) are let loose on the ward," the staff thought that patients feel like guinea pigs when they know that the students are coming to the ward to practice on them. Some tutors suggested that basics should be taught in school and more time given to students to perfect a skill before practicing it on the ward.

Some tutors felt that what was really needed was more clinical instructors, as the student on the wards needed to have more contact with someone teaching her what is going on. Some tutors sympathized with the ward sister as for example in the case where sister has only two students and one staff nurse. When three "green" students are sent to the ward all needing continuous supervision, how can sister possibly supervise them?

Some tutors were of the opinion that clinical instructors ought to teach at school while the tutor should be on the ward with students. Others believed that they were qualified to teach in the classroom, but the clinical instructor was qualified to teach only on the ward. They therefore felt that the clinical instructor was the best person to bring theory and practice together. But, some tutors queried the necessity of having tutors separate from clinical instructors and of giving them different
training: "What we ought to have is one training. We cannot have somebody who can work in the classroom all the time or vice versa."

One tutor was of the opinion that classroom does not really matter, or that it mattered for a few students only and she sometimes wondered, "What is it all about?"

c) Training

Some tutors felt that the nurse's training would have to change as they were teaching the wrong way. Blocks were too short, there was a need to make students into proper students, to give them more theory and more extensive experience. Students needed to be made happier and more secure with knowledge.

One tutor felt that there was a need to 'educate' the student and 'train' the pupil. She saw a subtle difference between the two, because of "the limited thinkability or intellectual ability of the pupil." She found the tutor-student proportion very objectionable. Another complained that though the tutor had no say in selecting the student, she was blamed for student failure or wastage. She also felt that teaching was over-simplified as it was thought to be "the mastery by the students of a few points which they can produce at a drop of a hat."

Another tutor with a long experience in teaching felt it important for the student to possess some capacity for academic knowledge, and not only manual skill which seemed
to be of prime importance to many students. She found that in her experience, theory and practice had become separate.

Some tutors expressed the difficulty of "judging" the students as to do so one had to work with them.

d) Organisation of teaching

Different ways of organizing the teaching were followed by different schools. An advantage accruing when a group of tutors taught an intake (of students) all through their three years was that while the student was starting nursing and was new there existed a good opportunity to establish a relationship with her, which could be kept up. On the whole this relationship seemed satisfying as the students would tend to go to the tutor with their problems whether personal or related to study. The tutor could also appreciate the student's effort, "you know the student and know how much she puts in or tries to achieve". You also "know her background, therefore are better able to help." From the students' point of view they get to know the tutor's methods and standards. I think this was also seen as counteracting the fact that the programme was very fragmented.

One tutor expressed concern about the laissez-faire attitude of teaching the students. She felt that unlike any other (academic) students, the nurse is dealing with life and death, and the tutor should have the right to ensure that the student studies and "knows what she can
give in return." She felt that as tutors, they were responsible to produce a certain standard and for that reason there must be a clearer policy concerning the student's guidance and teaching. Tutors are prepared differently and hold different ideas, and as they are left to do what they like, the differences puzzle the students.

3 Clinical Instructors

The clinical instructor seems to hold a key position in relating theory to practice. Her position was of interest in many ways. She was looked upon as the major person to help transfer learning from classroom to hospital. The clinical instructors themselves felt that such an activity was time consuming, but found difficulty in having the ward sister accept the fact that they took a long time with the students to carry out a procedure for instance.

Some of the clinical instructors still identified themselves with the sister and thought it difficult to have "two sisters on the same ward," as "even though you are teaching you are really a ward sister." Some felt that despite a very good relationship with sister, after a whole day on the ward, "sister would get tired of you." This made them go only for a limited period on each ward. Most clinical instructors expressed a lack of job satisfaction, mainly because they did not feel very helpful.

When the clinical instructor went to the ward it was to carry out a specific procedure, which might be arranged
beforehand, In her presence it could be carried out according to the book, but if she happened to go to the ward unannounced, the student would be doing it differently.

She could not be very familiar with each ward's situation because she had a large number of them to cover, and therefore felt an outsider to these wards. If attached to one ward, however, she might be looked on as a source of help rather than as a spy coming to see that everything was done properly. This would also avoid creating a false atmosphere, the nurses would know that she was there most of the time and know what to expect from her. Even though the tendency was to discourage attachments of clinical instructors to one ward because of the risk of becoming another "pair of hands", they thought that if they were to teach properly, they needed to be involved in the actual situation.

Their widespread responsibility over several wards made it difficult for them to know the patient as a person. The clinical instructor only knew the signs, symptoms and diagnosis of the patient. She could not always know about his day to day condition, in consequence, her teaching was very "diluted" and she felt frustrated. After seeing a student in her first year she would not see her again until she was a senior student. If by then the student had acquired bad habits it was too late to correct them. No follow-up of students was possible because of the long gaps between seeing them.
Reaction to interview schedule

At the end of the interview I asked both tutors and clinical instructors for their opinions of the interview schedule and whether they considered that anything of importance had been missed.

Comments were generally favourable. It was considered that the interview schedule had covered the topic "comprehensively", or "very well" and that the questions were "well tied up". One tutor commented that the questions were pertinent and that "burning hot questions" were included. Another felt that the schedule was very much classroom orientated. One remarked that if I gave a questionnaire to students I would get the "real hard core". Finally, one said that "these are quite good points. People sometimes are afraid to ask these questions."
CHAPTER SIX
DISCUSSION AND SUMMARY OF RESULTS

A Discussion of results

Results are discussed under two headings:
1) Students and their training and
2) Tutors and the syllabus.

This is done for ease of reading. Whenever applicable similarities or differences in tutors' or students' answers are indicated. The general impression from the results was that students' and tutors' answers support each other. For instance, when students said that the tutors were not sufficiently aware of the reality of the hospital situation, tutors had expressed the feeling of being remote from the ward situation and therefore "out of touch".

1) Students and their training
   a) Emphasis on details What seemed to magnify the difference between school and hospital was to a great extent the emphasis laid, by both the school and the hospital, on details. In the school details of steps of procedure were taught and at hospital procedures differed but steps were emphasised on the ward. Students carried out the procedure according to "Sister's way" or to the "way it is done on this ward" as they were unable either to question or disagree with ward routine. During their final examination, they were again asked for details.
Procedure committees are a good reflection of the importance of details in the student training. The solution to this "everlasting problem", a tutor's term for the discrepancy between what is taught and what is practiced, was mainly seen in terms of procedure committees. These discuss how a procedure should be carried out, and standardize the steps. This continuing emphasis on details perpetuated and magnified the discrepancy between school and ward.

While changing in constitution, procedure committees go on being formed, although during their existence of at least twenty five years they have not proven to be effective. Procedure committees, on the whole, were formed from administrative staff of the hospital and the school, though some included tutors and ward sisters.

One reason given by a tutor for the failure of these committees was:

lack of interest at committee level. You need somebody who stirs things up. The staff (school) does that a bit now.

In response to a question whether it would help to have students on the committee, she replied:

Now that you suggest it, I think we should try and let the student in it, because they constitute the largest percentage of people on the ward.

Another tutor felt that sisters on the procedure committee wished to appear on the same academic level as tutors, and therefore agreed to, or suggested methods that would be "academically" acceptable to the school.
This last comment highlights the kind of intangible variables which play an important role within a group of this type. It also indicates the hospital staff's attitude to the school, or the impression conveyed to the hospital staff by the staff of the school. 'Academic' is taken to be high in status and therefore ought to include the 'right' answer. The constitution of the committee, then, becomes of importance. The tendency to introduce more tutors on the procedure committees, as reported by the schools, would then emphasize the difference between school and hospital, rather than bridge it.

If it is generally agreed that procedure committees are the answer, it would seem appropriate for the hospital to suggest guidelines for one or two methods. The school would follow these in their teaching and supply the principles behind the methods. This would help minimize or eradicate the feeling on the part of the hospital staff that the school is superior, a feeling which hinders free communication on equal terms between school and hospital. This suggestion would also go some way towards dealing with the reality of the situation, as students practice at the hospital and follow the hospital method anyway. Suggesting more than one method as a guide would imply a certain degree of flexibility as well as a licence to use more than one method without being penalised for doing it the "wrong" way. It is improbable, as long as details are
emphasized, that an agreement be reached. If these committees are to go on along the same lines they followed for twenty five years, settlement or agreement will be very difficult to achieve.

The emphasis on steps of procedures was illustrated by some tutors and supported by students in open discussion. One tutor said that "students memorize the number of steps in the procedure for their final examination and think that this is what the examiner will be looking for."

The further problem arises, that the examiner has his/her own way of doing a procedure which is unpredictable to the student. The emphasis on details in teaching can be inferred from one tutor's comment, on the reason for lack of relatedness between theory and practice:

We like to think that what we teach is done in the various hospitals. There are problems because we have six hospitals in the group and students in some classes are integrated. We try to keep up to date, by being in contact with the ward and the ward sister. I don't see any solution with such large numbers of students. That's why I feel clinical conferences while they are in college are helpful.

b) Group Schools Grouping of hospitals, as an administrative policy seems to have introduced a new type of worry to the students. Students feel that they are "living out of a suit case," having to move so much in the different hospitals of the group. To investigate this complaint, I calculated the number of movements in terms of types of experience for the group schools and the non-group school.*

* Type of experience includes practice, theory, secondment and holiday. Not taking the number of students' movement within the period of practice into account in this calculation, but was known to be considerable.
On applying the appropriate test (student t) the result is significant at the 20% level, which means that the evidence is suggestive but not conclusive. Table VII illustrates the above calculations.

**TABLE VII**

NUMBER OF CHANGES OF EXPERIENCE PER SCHOOL OVER THE THREE YEARS OF TRAINING

<table>
<thead>
<tr>
<th>Group Schools</th>
<th>Total No. of Experience</th>
<th>Non-group Schools</th>
<th>Total No. of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>School I</td>
<td>22</td>
<td>School II</td>
<td>18</td>
</tr>
<tr>
<td>School IV</td>
<td>26</td>
<td>School III</td>
<td>22</td>
</tr>
<tr>
<td>School VII</td>
<td>30</td>
<td>School V</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>School VI</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>78</td>
<td></td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>( \bar{x} = 26 )</td>
<td></td>
<td>( \bar{x} = 21 )</td>
</tr>
<tr>
<td></td>
<td>( t = 1.8 )</td>
<td>( d.f. = 5 )</td>
<td>( p &lt; 0.20 )</td>
</tr>
</tbody>
</table>

Another issue raised with grouping of hospitals is the feeling of loyalty and belonging to the hospital. With increased movement among hospitals, students do not have the time to develop any feeling of belonging to the hospital. This was pointed out by both Tutors and students. Such feelings seem to act as a 'motivator' of student learning in two ways. One is by establishing a certain subculture of the hospital and its way of doing things.

\( \text{The number of experience is the number of columns on Graphs A - G of the seven schools.} \)
for the student to follow. This gives the student a definite set of values and over the three years of training develops and enhances her sense of identity. The other is by giving the student a sense of pride in sharing a group's behaviour, for better or worse, so that she becomes automatically an active member in whom the perpetuation of the tradition is assured.

Two of the seven schools studied, were attached to a hospital board, therefore students will be recognized as nurses of this particular hospital. These two schools were: School VI which had the lowest wastage among the schools studied, i.e. 5%, it also had the highest educational requirement; and School III, which had the smallest range of wastage rate among the seven schools, i.e. 16 - 9% (Table III p. 89a). This observation seems to agree with the argument presented above about a sense of belonging.

Variability occurs among schools as regards size and frequency of student intake, educational requirement and frequency of study blocks.

Table VIII, illustrates the variability of intake and its size.
TABLE VIII
STUDENTS INTAKES FROM 1966 TO 1971
OVER THE SEVEN SCHOOLS

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>196</td>
<td>198</td>
<td>127</td>
<td></td>
<td></td>
<td></td>
<td>521</td>
</tr>
<tr>
<td>1st year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>46</td>
<td>125</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>196</td>
</tr>
<tr>
<td>2nd year</td>
<td></td>
<td></td>
<td>2</td>
<td>37</td>
<td>110</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>198</td>
</tr>
<tr>
<td>3rd year</td>
<td></td>
<td></td>
<td>86</td>
<td>21</td>
<td>2</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>127</td>
</tr>
</tbody>
</table>

The year of training is not a determinant as to when the student started training. Students who already qualified in another field of nursing join the general training programme at different stages.

Among 1st, 2nd and 3rd year students of the sample studied, 32% (164 students) of the student sample had had previous nursing experience. Only 51 students of these, had obtained a nursing qualification like SEN, (state enrolled nurse), RSCN (registered sick childrens’ nurse). Those with a previous nursing qualification get a shorter period of training as pointed out earlier in Table VIII. The variability of study block distribution is illustrated
by Table IX, for 1st, 2nd and 3rd year students over the seven schools.

**TABLE IX**

**NUMBER OF STUDENTS IN EACH STUDY BLOCK OVER THE SEVEN SCHOOLS**

<table>
<thead>
<tr>
<th>Year of training</th>
<th>Study Block</th>
<th>Total number of students</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>151 25 - 20</td>
<td>196</td>
</tr>
<tr>
<td>2nd year</td>
<td>13 41 68 13 45 18</td>
<td>198</td>
</tr>
<tr>
<td>3rd year</td>
<td>3 3 2 33 17 45 18 8</td>
<td>127</td>
</tr>
</tbody>
</table>

The number of study blocks between schools vary. Distribution of theory is also variable. Graphs H, I and J show the variability for the seven schools according to each year of training.

Table X shows the number of weeks allocated for theory for each year in each school.

**TABLE X**

**DISTRIBUTION OF THEORY AMONG THE SEVEN SCHOOLS**

<table>
<thead>
<tr>
<th>School</th>
<th>School</th>
<th>School</th>
<th>School</th>
<th>School</th>
<th>School</th>
<th>School</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>V</td>
<td>VI</td>
<td>VII</td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>18 20</td>
<td>19 16</td>
<td>12 12</td>
<td>16 16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd year</td>
<td>4 8</td>
<td>6 11</td>
<td>14 12</td>
<td>10 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd year</td>
<td>6 0</td>
<td>3 4</td>
<td>2 4</td>
<td>2 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28 28 28 31 28 28 28
FIRST YEAR

SCHOOL I
52 WEEKS

SCHOOL II
52 WEEKS

SCHOOL III
51 WEEKS

SCHOOL IV
53 WEEKS

SCHOOL V
52 WEEKS

SCHOOL VI
50 WEEKS

SCHOOL VII
52 WEEKS

EXPERIENCE
THIRD YEAR

SCHOOL I
52 WEEKS

SCHOOL II
52 WEEKS

SCHOOL III
53 WEEKS

SCHOOL IV
52 WEEKS

SCHOOL V
53 WEEKS

SCHOOL VI
53 WEEKS

SCHOOL VII
52 WEEKS
In all schools the bulk of theory is taught during the 1st year of training with the exception of school V, where the bulk is taught during the second year of training. Disregarding the content or sequence of the theory in relation to the practice, we see that theory and practice do not run hand in hand distribution wise through the three years of training. This suggests that theory does not feed practice all along. The uneven distribution of theory over the three years, with concentration in one year also gives an impression of fragmentation. Some schools deliberately planned to finish the programme in the first two years of training, in accordance with the Platt Committee's recommendation. This way of planning theory suggests an arrangement at a purely functional level. Theory is taught and finished with in the hope that it can then be used. Such an arrangement does not take sufficiently into consideration the more complex nature of relatedness of theory to practice or the nature of the nursing vocation for which the programme was planned.

Of particular interest in the variability from one school to the next of the distribution of the different types of experience, illustrated by Graphs A to G. The difference between schools in this respect for each year of training is especially apparent in Graphs H, I and J. This variability among schools notwithstanding, answers of both students and tutors to the questionnaire and

* This area will be elaborated in Part V.
interview displayed a high degree of consistency. It could be argued that the consistency might be due to the "closed-end" nature of the questionnaire. However, this argument cannot hold for tutors' answers, or for open-ended comments and discussions with students, all of which were strikingly similar. Having regard to the fact that the seven schools studied were geographically remote from each other, and that students were recruited from different communities with different subculture, the similarity is all the more striking.

c) Role of theory From answers to Q. 8, 9, 10, 11, 23 and 24, it may be inferred that students do not view theory as playing an active role in informing their understanding of, or way of coping with the reality of the situation.

Examining the possible reasons as to why the student did not perceive 'theory' as effective and helpful, one could hypothesize that:

(i) those who plan and those who teach the theory are not fully convinced of or clear about its role;
(ii) students do not consider theory useful because they don't think it is needed at all;
(iii) students find theory difficult, and therefore cannot make the most out of it;
(iv) the communication between students and tutors is not adequate, which makes theory appear difficult and not very helpful.
(i) Unclear role of theory

The Report of the Committee on Nursing (Briggs 1972), which is the latest nursing report, offered plans for the future of the nursing profession. They emphasized that:

formal qualifications are important not in themselves but as evidence of development within the profession. (p.80) (my underlining)

The Briggs Committee seemed to distinguish between the practical nature of basic nursing and the academic nature of further study. They viewed basic nursing as requiring eighteen months preparation, while further study and qualification for "nurses with an 'academic bent'" (p.80) needed longer time of preparation. The fact that the committee drew a distinction between practical nursing and academic quality denotes that they were not very convinced that practical nursing needs much theoretical background. This impression is supported from other studies and reports in nursing, reviewed by Edwards (1962) where those who came into direct contact with the patient, (practical nurses) were either unqualified like auxiliaries, or in the process of qualifying like pupil nurses and student nurses. The same impression is reinforced by the Briggs report itself. The committee expressed the opinion that 'nursing aides' were

indispensable members of the health team

and that

the profession depends on them.

Nursing aides are the unqualified members of the team,
who carry the major part of practical nursing.

All through the interviews with the tutors, who teach the theory, the impression was that the majority of them, with the exception of a few, did not perceive theoretical instruction as playing an 'active' role in the students' learning of nursing. The tutor's view of theory, in the main, was one which was directly connected with the practice, hence the need to teach on the ward, expressed by one tutor (p. 133). One tutor's comment illustrated this direct, nearly functional connection of theory to practice, by saying:

We like to think that what we teach is done in the various hospitals. (my underlining)

From the above argument it could be said that this first hypothesis was supported to a fair extent.

(ii) **Unimportant role of theory**

According to the tutors, the students did not give sufficient importance to theory and "place theory as secondary." One tutor said that Classroom is not important (to the students). Another tutor gave an explanation to the students' attitude,

A lot of (the students) think, probably because of what is said, that nurses are born and not made and they think that any woman should be able to nurse. From the results of the questionnaire and the open discussions with the students, the impression is that students do not find theoretical instruction very "useful",
or "helpful". They describe their classroom teaching as: "ideal", "impractical", "alright in the classroom where there is plenty of time, equipment and no patients", in other words unrealistic. Even though, the teaching is connected to practice, in the sense that it is mainly dealing with procedures, they do not find it useful.

The students' complaints are directed to the lack of flexibility of the teaching.

This is apparent in comments like,

more should be said about difficulties.

It is not just a case of the proper way to do a thing, but the correct way to do something in a certain situation.

different circumstances require different ideas. It is not sufficient to do what should be done at all times.

All these comments as well as tutors' and students' answers generally seem to refer to the concern with details which complicates the issue. It was argued earlier (p. 96) that 'nursing care' was interpreted by both students and tutors to mean procedures. Because the teaching of nursing concentrated on the teaching of procedures in detail, a vicious circle was established. The greater the specificity, the tighter becomes the restriction on applicability, and hence the narrower the range of use.

Students, though they did not find theory very helpful, did not seem to undermine its role. When ranking the educational objectives (p. 98) they ranked objective (c) 'increase their knowledge about nursing' as first in priority. Therefore, students considered
theory as important but were disappointed in it, mainly because of the way it was taught.

(iii) Difficulty of theory

The fact that students found theory difficult, was clearly indicated by their answers to Q.17 (p. 99). Classroom teaching was the most difficult thing they encountered in their training.

Regardless of school or year of training, 54% of students agreed (W = 1.) that classroom teaching was causing most concern. The content of what they were taught and the way in which they were taught, were the main problem, ( p.99 to p.107).

In Q.18 students were asked to specify their difficulty with classroom instruction. The mean number of 'ticked' difficulties per student, whether calculated for each year or for the three years as a group was approximately three. Using the chi-square test to study the distribution of frequency of difficulties mentioned by year of training, we reach the conclusion that (i) the number of first year students mentioning three difficulties is lower than expectation, (ii) that of second year students mentioning three is higher than expectation, and (iii) the number of third year students is very near expectation.

\( \chi^2 = 25.25, \ d.f. = 12, \ p < 0.02. \) See Table A in Appendix III)

From this table two further calculations prove to be significant at the 5% level.

More third year students mentioned one difficulty than first or second year students. Using the Kolmogorov-
Smirnov test: only, the difference between third and second year students is significant with
\[ x^2 = 6.12, \quad \text{d.f.} = 2, \quad p < 0.05. \]

More first year students mention four difficulties than third year students. Again, the Kolmogorov-
Smirnov test was used.
\[ x^2 = 6.11, \quad \text{d.f.} = 2, \quad p < 0.05. \]

In considering these results, one should bear in mind the concentration of theory during the first year of
training as pointed out above (p. ) with either 'no theory', 'revision' or very little 'theory' taught in
the third year of training (Graphs A - G). Possibly, the effect is that the more senior the student becomes
the less importance she attaches to theory. Support for this is provided by some tutors' comments. One
tutor, talking about lack of relatedness between teaching and hospital practice, said that this
puts a terrific barrier between tutor and student who is basically concerned about how she is going
to cope with the ward.

Another tutor said:

... (Student) starts in college but she gets involved in the ward situation and it is more alert, alive and
this is maybe what she wants, and places theory as secondary, the more she gets involved in the practical
situation the greater the gap is.

From the tutors' comments, the impression gathered is that the students' involvement with practice, over time,
made them pre-occupied with practice at the expense of theory. How much difficulty does the practice create
for the students then?
Students, in Q. 19, which asked about difficulties with hospital experience, 'ticked' 1,672 difficulties as opposed to 1,507 difficulties ticked for Q. 18; therefore students had 'more' difficulties with hospital experience than with classroom teaching.

Following the same pattern as for Q. 18, the mean number of difficulties 'ticked' in Q. 19, per student for each year was calculated. Again the mean was approximately three difficulties. The application of the chi-square test to study the distribution of frequency of difficulties mentioned by year of training revealed no significant difference among the three years, \( \chi^2 = 7.27, \text{ d.f.} = 12, p < 0.90 \); see Table B, Appendix III).

The answer to the above question appears to be that though students had more difficulties, quantitatively with practice, these difficulties were not of a serious nature.

Table XI summarises the perceived difficulties mentioned by the students in relation to school and hospital (in other words theory and practice).
### TABLE XI

**DIFFICULTIES AS MENTIONED IN RELATION TO SCHOOL AND HOSPITAL**

<table>
<thead>
<tr>
<th></th>
<th>School</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>Total number of difficulties ticked</td>
<td>1,507</td>
<td>1,672</td>
</tr>
<tr>
<td>Kendall's Coefficient of Concordance 'W'</td>
<td>0.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Percentage of students who specified 'other difficulties'</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Mean no. of difficulties mentioned by each student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>$\bar{x} = 3.0$</td>
<td>$\bar{x} = 3.18$</td>
</tr>
<tr>
<td>2nd year</td>
<td>$\bar{x} = 2.9$</td>
<td>$\bar{x} = 3.29$</td>
</tr>
<tr>
<td>3rd year</td>
<td>$\bar{x} = 2.56$</td>
<td>$\bar{x} = 3.15$</td>
</tr>
<tr>
<td>All 3 years</td>
<td>$\bar{x} = 2.90$</td>
<td>$\bar{x} = 3.21$</td>
</tr>
<tr>
<td>Distribution of frequency of difficulties by year of training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\chi^2 = 25.25$</td>
<td>$p &lt; 0.02$</td>
<td></td>
</tr>
<tr>
<td>$\chi^2 = 7.27$</td>
<td>$p &lt; 0.90$</td>
<td></td>
</tr>
</tbody>
</table>

Significant difference between year of training in relation to frequency of difficulties:

- **+ ve**
  1) between 3rd & 2nd year for one difficulty
  2) between 3rd & 1st year for 4 difficulties
It could be inferred from previous results, students comments, and Table XI that:

a) hospital experience is more varied in nature and content than experience in the classroom, hence,

b) hospital experience offers more opportunity for a variety of activities to take place: application of the knowledge gained in the classroom, carrying out procedures, learning about a variety of activities, dealing with a variety of people (patients, other nurses, doctors, relatives, physio-therapists, etc.), all this leads to

c) students having more difficulties (quantitatively) with hospital experience because of the presence of greater and more varied interactions. But they do not perceive them with the same degree of seriousness as the difficulties experienced with the school, as those were more specific and concentrated

d) difficulties with school seem more acceptable or manageable with years of training (p. 180, and Table XI),

e) difficulties with hospital do not seem to be related to the stage of training (refers to Table XI),

f) it is of interest to note that 'workload' (Q.17, p.99) was hardly mentioned in connection to hospital experience, and if so it was not serious. (It was a weakness of the question not to include 'workload' among the statements of Q. 19).

(iv) Lack of Adequate communication in the theory.

From the tutors' comments there is an indication that students do not take theory seriously and that they cannot
see its usefulness. Another indication of how tutors see this is given by their ranking of what they considered to be the students' educational objectives (p. 127). Tutors think that students would rank objective 'c', i.e. 'increase the student's knowledge about nursing' as third in priority. However, the students themselves rank this same objective as their first priority. This disparity suggests that there is a lack of adequate communication between the students and tutors. This has also been suggested by the students' comments and is supported indirectly by the tutors' comments as reflected in the students' and tutors' perceptions of how each would rank the four educational objectives (p. 127) and p. 98).

If one compares the tutors' perception of how the students would rank these objectives with the actual ranking of students for themselves, a certain amount of discrepancy is found.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>(exams)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tutors' perception of students' ranking</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Students' perception of themselves</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

They agree about objective 'B' (personality) which was not understood by the students in the main, and objective 'D' (practice).

On the other hand, if one compares the students' perception of how tutors would rank the objectives to the actual ranking by tutors themselves,
Students' perception of tutors' ranking | A | B | C | D | 'W'  
---|---|---|---|---|---  
(exams) | 2 | 4 | 1 | 3 | 0.8  
(personality) | 1 | 2 |  |  |  
(T: practice) |  |  |  |  |  

<table>
<thead>
<tr>
<th>Tutors' perception of themselves</th>
<th>4</th>
<th>3</th>
<th>1</th>
<th>2</th>
<th>0.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>(exams)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(personality)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(T: practice)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

the only agreement is on their first priority (theory). It is of interest to note that students do not feel that tutors are concerned about preparing them for practice to the same extent as the tutors feel they are. Students feel instead that tutors are more concerned about examinations than about practice, and students also miss the tutors' concern about students' personality.

The extent of agreement among tutors when ranking the objectives for themselves is less (W = 0.7) than the extent of agreement among students when ranking the objectives for themselves (W = 1).

Students behave more as a group and tutors more as individuals. The same sort of findings have been reported by Greenwood et al (1973).

Another possible reason which would impair the communication between tutors and students, is the educational background of the students. The GNC educational requirements are a minimum of 3 'O' levels, but some schools require more than that as illustrated in Table III (School profiles p. 89a). The tutors assessed
students as of varying educational standards, and this made it difficult to adjust the teaching level. This difficulty is exacerbated by the fact that GNC does not specify the type of 'O' levels, except that one of them must be English: no further specification is made. The problem therefore presents itself in terms of standards if it is assumed that the greater the number of 'O' levels or 'highers' the better the standard.

Moreover, those students who studied science orientated subjects would have a different frame of reference than those who would have studied literary-orientated subjects. This was found to be the case in the studies carried by Hudson (1966 and 1968). This too needs taking into account in the interpretation of the tutor's teaching.

Because of the pressure of time (p. 148) the tutor 'lectures' and has little opportunity for discussion with the student. But it is during discussion that the tutor could find out about and rectify if necessary the student's interpretation of the teaching she receives. Discussion also provides opportunity to learn about the student's values, a matter of great importance in getting to know the student and in teaching for 'learning' as recommended by Raths (1969). In the absence of adequate discussion theoretical instruction is in the main a one way system from the tutor to student, for which lack of time on both tutors' and students' parts and variability of the student's educational background are basically responsible.
Because of lack of time students are not encouraged to read and to seek opportunity to discuss what they read with the tutor (p.148).

Teaching by lectures, lack of time for independent reading and lack of opportunity for discussion all militates against a two way process in learning. Such give and take is the basis of developing the student's ability to think, which is both an integral aim of education and an essential factor in relating theory to practice. Tutors felt that it was the student's own responsibility to relate theoretical instruction to practical experience but no provision was made for the student in that respect. Tutors were mainly constrained by the syllabus requirements but the student was the one who suffered. She was expected to fulfil such difficult tasks as that of relating when not prepared basically for it. As pointed out on p. 135, tutors felt that the ward staff ought to help the student relate theory to practice. They also felt it was the student's personality and educational background which influenced such a process, yet they missed the dynamic key of the process, the student's ability to think. It was commonly agreed and accepted that students are not required to 'think' and in fact, don't. Of course, one cannot say that the student does not think just because she was neither encouraged nor required to do so; this would be to deny the student her own potential as a person. Such statements relating to lack of thinking, are a dramatization of the situation.
But the type of thinking required for the process of relating is of a special nature and depth but was not provided through teaching.

In concluding, the discussion of the student's contribution to the process of relating theory to practice, it seems fair to suggest that the student's educational background ought to facilitate this process by preparing her in a general way. Any similarity in terms of frame of reference and way of thinking, between the subjects she studied in her general education, and her nurse training should be brought to bear in the process of relating. But, all this needs to be sustained and developed through the 'approach' of the teaching (the way it is organised and delivered) and not merely through the method of teaching during her nursing programme either in the classroom or in the practical area.

d) Role of practice As discussed in (c) above the importance given to the practice is considerable. This is true whether one looks at the GNC syllabus, the schools' interpretation of the syllabus (see Graphs A - G, p. 90), or whether one examines the tutors' or students' answers and comments. Practice is considered to be real 'nursing'.

Students better understood their theory as well as situations relating to patients' emotions and behaviour in the light of their practical hospital experience. As illustrated by their answer to Q. 8, 24, practical experience was what guided their action.
Most of their learning occurred on the hospital ward, as pointed out by tutors (p. 125) and inferred from the proportion of time spent in practice. This also gave students more opportunity for criticism, as there was 'more' to criticise. Criticism, however, did not necessarily mean dissatisfaction. Though, their hospital experience provided a great deal of help and not too much serious difficulty (p. 99, Q. 17), they seemed also to rely on their own judgement. The extent to which this occurred requires considerable attention.

Breakdown of the data by year of training suggested that this variable did not seem to influence students' reliance on their own judgement in most instances. This is specifically illustrated by their answer to Q. 23, which, it will be recalled, asked what helped them most to understand patient's emotions or behaviour.

The proportion in Table XII indicates that the distribution of answers among first, second or third year students was similar in all years.

<table>
<thead>
<tr>
<th>Year of training (own)</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>0.63</td>
<td>0.06</td>
<td>0.06</td>
<td>0.21</td>
</tr>
<tr>
<td>2nd year</td>
<td>0.59</td>
<td>0.07</td>
<td>0.10</td>
<td>0.22</td>
</tr>
<tr>
<td>3rd year</td>
<td>0.57</td>
<td>0.07</td>
<td>0.09</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Table XII

PROPORTION OF STUDENTS CHOOSING EACH ITEM IN Q. 23
Particularly striking is the high proportion, common to all years, opting for 'own intuition' and personal experience. Added knowledge in the classroom or experience on the hospital wards, seems to them to have added little to their understanding.

Further light is shed on this issue by a similar breakdown by year of training of the students' answers to other questions. Q. 21 asked about the frequency with which students were faced with situations where the patient was upset though not showing it. Table XIII shows how the year of training influenced their evaluation of this.

As in the previous table, Table XIII, shows the proportions of students' answers to each item by year of training.

**TABLE XIII**

<table>
<thead>
<tr>
<th>Year of training</th>
<th>a (often)</th>
<th>b (sometimes)</th>
<th>c (seldom)</th>
<th>d (never)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>0.10</td>
<td>0.65</td>
<td>0.20</td>
<td>0.04</td>
</tr>
<tr>
<td>2nd year</td>
<td>0.22</td>
<td>0.59</td>
<td>0.17</td>
<td>0.02</td>
</tr>
<tr>
<td>3rd year</td>
<td>0.26</td>
<td>0.64</td>
<td>0.09</td>
<td>0</td>
</tr>
</tbody>
</table>

The following is noted:
- using the Kolmogorov-Smirnov Test the only significant difference in these proportions was between first and
third year students. \( (x^2 = 9.25, \text{ d.f.} = 2, p < 0.01) \) significantly more third year students than first year students spot patients who are upset but do not show it.

- the proportion of students choosing 'c' (seldom) and 'd' (never) is increasingly more for second and first year than for third year of training.

- the proportion of students choosing 'b' (sometimes) is the highest in proportion among the other three alternatives (a, c, and d) probably because it is 'moderate' in nature, it has similar value for the three years of training.

Answers to Q. 20 (p.III) showed that on the whole the extent of difficulty felt by students in understanding patients' needs and behaviour was not great. This result might be interpreted in several ways. First, the questions might have been vague, and so have elicited inaccurate answers. Secondly, possibly, students were unaware particularly at first, of the depth that 'understanding' can reach. If this is so there may be differences between the responses of first, second and third year students reflecting increasing awareness with increasing practice. Table XIV, shows the proportion of students' answers to the different items by year of training.
The Kolmogorov-Smirnov test reveals no significant differences among the distribution of proportions in the three years.

However, the pattern of answers suggests that smaller proportions of second and third year students than of first year students perceive 'no difficulties' in understanding needs and behaviour of patients. This would support the inference that experience increases their awareness of the extent of needs and the complexity of understanding about needs and behaviour. The longer this experience, the more aware they are of the difficulties. It must be remembered, however, that the statistical evidence is inconclusive, and the inference is tentative at best.

A third interpretation of the results is that students actually and genuinely have found it comparatively easy to understand patients' needs and behaviour, but might have difficulty translating this understanding into their own behaviour. This interpretation of course, cannot be verified from the question as it stands.
Q. 22 and Q. 24 asked about the students' behaviour in some hospital situations. What decided the students' action was of interest.

It will be recalled that Q. 21 asked about the frequency with which students were faced with the situation where they felt that the patient was upset but not showing it. Q. 22 asked about students' behaviour when faced with this situation (p.112).

Two factors generally seemed to motivate students' behaviour: one was authority, the other the approachability of the person in charge. Students' comments showed that their first choice was to refer the patient to the person in charge, for example,

Senior on the ward
more senior, such as Sister

depends on which ward situation arises; I may tell Sister or Staff Nurse.

But another consideration in choosing the sister of the next in authority, depended on how approachable the sister or person in charge was:

maybe the ward sister if her nature was understanding, if not, next best senior nurse.

A member of the staff one could speak freely to and not sister.
an understanding senior nurse.

Whenever students specified whom they would go to, it was someone in authority; in order of priority, sister 73%, other nurses 17%, other personnel like almoner or social
worker 6%, and to the doctor 4%. This might suggest the inaccessibility to the student of any other people than nursing staff.

Using the Kolmogorov-Smirnov test to compare first year and third year students' behaviour, it was found that significantly more third year students would consult sister than first year, \( (x^2 = 9.25, \text{ d.f.} = 2, p < 0.01) \).

Also, significantly more first year than third year students would try their best to deal with the situation on their own \( (x^2 = 6.17, \text{ d.f.} = 2, p < 0.05) \). This could mean that third year students have come to know either by 'training' or by 'realisation' of the extent of responsibility involved, or by 'experience', that everything gets referred to the person in charge. In other words, they are not to take the responsibility. First year students' greater tendency to take the responsibility of dealing with the situation themselves, might reflect their fear of authority, the difficulty they feel in approaching senior people, so frequently expressed in different ways throughout their comments and answers to the questionnaire, and seemingly made difficult by the senior people themselves.

Alternatively, this might mean that because of their 'rawness' they are unaware of the seriousness of the matter.

It might have been expected that the opposite would be the case, that with more experience the student could take more initiative and responsibility. However, the

*Table C, in Appendix III.
impression comes through that students become trained to behave, in a rather stereotyped way, following a routine rather than developing individually as nurses. A student's comment in response to question 19 lends support to this interpretation:

cannot use my own opinion because always being told by the senior staff.

The emphasis seems to be on hierarchical structure where decision is referred upward and the 'workers' have a passive role of mechanical executors - a role which does not encourage thinking.

Q. 23 asked about factors which helped the students understand patient's emotions or behaviour, Q. 24 asked about factors which helped her deal with such a situation. The answers to it suggest that when action is required a more concrete model is needed. This seems to indicate that students learn by example as far as the practical situation is concerned; this has also been implied by most of their answers and comments in general.

The distribution of proportions of students' answers according to year of training is shown by Table XV.

<table>
<thead>
<tr>
<th>Year of training</th>
<th>a (own)</th>
<th>b (intuition)</th>
<th>c (theory)</th>
<th>d (practice)</th>
<th>e (mixture)</th>
<th>f (other)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>0.43</td>
<td>0.03</td>
<td>0.25</td>
<td>0.25</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>2nd year</td>
<td>0.42</td>
<td>0.08</td>
<td>0.23</td>
<td>0.25</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>3rd year</td>
<td>0.29</td>
<td>0.02</td>
<td>0.28</td>
<td>0.35</td>
<td>0.03</td>
<td></td>
</tr>
</tbody>
</table>
The Kolmogorov-Smirnov test showed that a significantly larger proportion of first year students than of third year would rely on their own intuition and personal experience in taking action \((x^2 = 6.17, \text{ d.f.} = 2, p < 0.05)\). Second year students were similar to first year students but the difference between second and third year students did not reach significance. This finding is in line with that of Q. 22 above. As well as the pattern of proportions of first and third year students under items (c) and (d), third year students tended either to refer the responsibility to the senior staff, or if they acted, to 'copy' the senior staff's behaviour. First year students tended to identify less with senior staff. As said earlier, this might be because of the way they were treated by senior staff. Second year students seemed to swing either way sometimes being closer to third year students and sometimes to first year students.

These findings suggest a process of 'moulding' taking place during student training, but, significantly, it occurred only on the ward.

Another area where the practice plays an important part is their psychiatric secondment. Questions 25 and 26, directed specifically at students on psychiatric secondment, asked them to what extent this secondment helped them in their general training (Q. 25) and in understanding themselves (Q. 26).

As shown from answers to both questions, the usefulness of secondment seems less than it might be. Only 29%
thought it helpful to a 'great extent' in their general training, and only 14% in 'understanding themselves'.

These figures might reflect insufficient preparation of the student before her secondment experience. The students' surprise and realisation of the presence and importance of the psychological aspect to human beings indicates a lack of preparation in this area. Tutors seem to rely on the psychiatric secondment to introduce the psychological aspect of patient care. This has its disadvantages. The psychological aspects are introduced in an 'illness' context. In psychiatry the emphasis of the illness is within the psychological domain while in general hospital it is in the physical domain. Even though the human being is an integral whole and all aspects of personality influence each other, the emphasis influences the type, extent and depth of the relationship between the different aspects of personality which require a different approach. Hearing about emotions as a separate entity from physical illness leads to fragmentation and is another reflection of specificity in the programme.

Preparation for the psychiatric secondment, also needs more careful preparation, as the students did not seem to sufficiently realise what was the purpose of the secondment. The psychiatric hospital could be a traumatic experience to many students, due both to its novelty and its character. It would appear that emotions are contagious and students need to be prepared as to what
to expect through a 'give and take' session aimed at relieving some of their misconceptions. Before they start they could feel terrified and communicate this feeling to the patient who would react in accordance with his condition and personality. The student would also suffer handicap through being deeply upset by the patient's emotional problems.

It might be that adequate preparation would maximise the potential of the situation for the student and make the experience enriching, enlightening and for some possibly enjoyable.

One of the biggest dangers in this situation, especially with lack of preparation and teaching is the quick acquisition of jargon and half-baked understanding of complex emotional states. Piet Hein's (1968) grooks* in this instance seems to be very apt:

We leave wisdom to starve and thirst
when we cultivate knowledge as such
The very best comes to the very worst
when ignorants know too much.

2) Tutors and the syllabus

The tutors were less homogenous than the students as regards their year of qualification, either as a nurse or as a tutor. The age distribution ranged widely from those who qualified fairly recently to those retiring in the very near future. Likewise their experience varied considerably. Some tutors had worked overseas. Only a small proportion were married. There were five men tutors out of the 59 interviewed. All clinical

* Grooks are short rhymed epigrams.
instructors' courses were of one academic year's duration, while the tutors' courses were either a one year or a two year course. The place where the course was conducted also varied.

a) Theoretical instruction

A copy of the syllabus for General nursing, of the guide to the syllabus and a copy of the GNC allocation of number of hours to the different experiences is included in appendix II.

(i) What does the theoretical instruction in the syllabus consist of?

Table XVI, summarises briefly the type of theory, who teaches it and the number of class hours allocated to it.
## TABLE XVI
SYLLABUS OF GENERAL TRAINING

<table>
<thead>
<tr>
<th>Taught by</th>
<th>Subject</th>
<th>No. of class hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse tutor or experienced nurse</td>
<td>Principles and practice of nursing, including supervised practice and demonstration</td>
<td>75 (50) *</td>
</tr>
<tr>
<td></td>
<td>Personal &amp; Community health</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>First aid</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Operating theatre</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Psychiatric nursing (secondment)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Obstetric nursing (secondment) tutorials only</td>
<td>(20)</td>
</tr>
<tr>
<td></td>
<td>Public health (secondment) tutorials and demonstration</td>
<td>(25)</td>
</tr>
</tbody>
</table>

| Registered nurse tutor or registered medical practitioner whose grading is at least that of a registrar | Human biology | 50 |

| Registered medical practitioner, surgery and surgical nursing whose grading is at least that of a registrar | Pharmacology | 6  |
|                                                                                                          | Psychiatry (secondment) | 6  |
|                                                                                                          | Obstetric (secondment)  | 8  |

| Total                                                                 | 130 + (95)               |

| Specialist in the subject | Elementary psychology | 12 |
|                          | Almoner               | 1  |
|                          | Rehabilitation and resettlement | 6 |
|                          | Psychiatric service and social work (during psychiatric secondment) | 2 |

| Total                                                                 | 21                        |

GRAND TOTAL 311 + (95) = 406

* Hours enclosed between brackets are allocated to demonstration or tutorials.
In general the syllabus is seen to be biased toward organic and physical aspects of patient/client care. It is fragmented and what is considered to be nursing is mainly of a practical and technical nature. This impression was gathered through the interview and supported by what is included under subjects taught by 'nurse tutor or experienced nurse'. The only subject with nursing in its title (other than a secondment subject) is "Principles and Practice of nursing", which is allocated 75 class hours and 50 demonstration hours. The highly technical 'Operating Theatre' is given special recognition, rather than included in a subject like surgical nursing for instance. Such recognition indicates the tendency towards a technical-practical understanding of nursing. Another indication of this tendency is the title of the nursing subject 'Principles and Practice' of nursing. 'Rehabilitation and Resettlement' is considered as a separate subject, though a number of nursing textbooks consider rehabilitation an integral aspect of nursing which takes place from the moment the patient is admitted to hospital. This fragmentation is reinforced by the subject being taught by an 'expert' and not by a nurse.

The bias of the syllabus toward organic and physical aspects of care is shown by several factors. Human biology is considered on its own and is allocated a comparatively large proportion of the number of 'theory' hours - 50 out of 311, (16% of total number of class hours). Medicine, surgery and their specialities, pharmacology and
secondment subjects are also allocated a considerably large portion of theory hours. They are taught by registered medical practitioners, although the syllabus is one of nursing. Medicine, surgery and their specialities could be considered derivatives or branches of human biology, as they represent a deviation from 'normal' anatomy and physiology are allocated 35% of total number of class hours. The number of hours allocated to psychology and social services is almost negligible, 21 hours out of 311, which is 7% of the total number of class hours. This emphasis on human biology and its branches is further reinforced by its considerable weighting in the final examination, and still further by the fact that the syllabus strictly specifies that these 'special' subjects be taught only by a "registered medical practitioner whose grading is at least equivalent to that of a registrar". Teachers of other subjects than these 'special' ones are less strictly specified.

Human biology is the only subject which requires the nurse teaching it to be a 'registered nurse tutor', while 'nursing' could be taught by an unqualified tutor. The 'registered nurse tutor' should teach 'pure' human biology, while human biology 'applied' to nursing could be taught by an unqualified tutor or an 'experienced'...

* Though students feel that a lot of time is spent teaching anatomy and physiology but not much time is given to it in the final examination paper, this could be explained by the fact that the examination question does not correspond in nature with the way anatomy and physiology is taught.
nurse. This appears to be logically inconsistent with what is involved in the two teachings. This is the same type of inconsistency where further qualification is needed when administration and teaching are at issue but not direct patient contact.

To teach a subject A, entails basically knowing A and knowing how to teach, regardless of how difficult or complicated A is. To teach how A applies to another subject B entails knowing both A and B, knowing how to teach and knowing how to relate knowledge of A to B. Of necessity, this process of relating entails a deeper level of knowing both subjects on the part of the teacher if she is to perform the process of application through understanding of the fundamentals of each of the two subjects involved. The second type of teaching is therefore far more complex and difficult and requires of the teacher the ability to deal with concepts which occupy the higher levels of Bloom's taxonomy. Logically, then the second type of teaching requires more preparation that the first. Since this does not happen, the impression gained is that 'nursing' is of lower 'status' and importance than the pure sciences. It seems implied that 'nursing' does not require any type of 'extra' knowledge, preparation or ability. This impression is supported by the fact that the registered medical practitioner is entitled to teach 'Medicine and medical nursing' and 'Surgery and surgical nursing'. What appears to be implied is that the medical practitioner
with a great amount of knowledge about surgery or medicine ought to have 'inclusively' a knowledge of nursing which is of a 'lower order' than his knowledge of surgery or medicine. 

What is meant by nursing as reflected by these interpretations is that it is of a technical and practical nature only. As to the syllabus it seems to be biased toward human biology. To emphasise only the technical and practical aspect of nursing to the exclusion of the other aspects is to give an unfinished picture of nursing. To have a biased syllabus also causes unbalance in the orientation and ability of the students prepared through it.

(ii) What role does theoretical instruction play in the student training?

The tutors feel that what they are trying to do is help the student understand the 'theory' behind what she is practicing on the ward. But what constitutes 'theory' in most instances is the teaching of signs and symptoms of the disease (p.149).

From the above statements, I think that the relationship between theory and practice as seen by the tutors is direct and superficial. Practice dictates theory and theory is taught to explain practice. In other words, it is an unidirectional relationship from

* The thesis I put forward in Part IV, is that nursing shares with medicine a certain amount of knowledge and ground, but that it is different in nature. Nursing and medicine are on different scales rather than, what seems implied generally, that Nursing and Medicine are on different levels of the same scale. There is a nursing scale and a medical scale.
practice to theory.

The fact that tutors in the main interpreted 'nursing care' to mean procedures, then reinforces the influence of practice on what happens in the classroom. The fact that students did not find theory helpful ought not to be interpreted to mean that theory is therefore useless. Theory plays an important but indirect role, as its relevance is rather concealed. This might, however, explain the students' lack of appreciation of the help they get from their theoretical instruction.

Tutors were asked whether it is part of their job to prepare the student for emergency situations in hospital. Their answers were mainly in the affirmative. Some thought that the artificial situation of the school was an advantage as students would learn about the situation without accompanying tension. Others felt that it was a disadvantage in that a sense of emergency was lacking which made the whole exercise futile. These seemingly contrary statements are in fact complementary. The student needs to be familiar with the factors or elements constituting a situation if she is to deal with it more adequately. Her final knowledge about the management of an emergency will only be completed after she has experienced such situations herself. What the classroom should have done was to direct her orientation to the steps required. As some tutors pointed out the mental preparation of the student for the fact that 'emergencies
occur' 'without warning' is of prime importance. Statements like "I also tell them never to panic" though unrealistic, help in guiding the student towards the required behaviour and desirable value. This, of course, develops through several exposures to the situation. By the process which Bruner (1960 pp 7-8) refers to as the 'unconscious nature of learning structures' the learner can use the rules although unable to say what the rules are. Such preparation is rather abstract in nature, it acts as a background which might explain why students felt it was their own judgement or previous hospital experience which helped them most in an emergency (p. 91). Students seemed to depend on the 'conscious' and 'obvious' in their evaluation of what is helpful.

Tutors, though preferring a certain sequence of theory and practice (p. 137), realise that what actually happens and seems helpful is different (p. 136) and that relatedness entails more than sequence. One tutor said,

if you are teaching what the nurse is going to need to use, I think obviously it must relate, student must learn but with instruction and guidance.

On the whole the tutors perceive the relationship in 'functional' terms using words like 'pointing out', 'guiding', 'giving knowledge'. It is also important to remember that the majority of tutors thought it the students' responsibility to relate theory to practice with help from the hospital staff (p. 135).
Relating theory to practice is a complex process which requires a number of adjustments in different spheres. It will suffice here to say that the tutor saw the relatedness in the main on a unidimensional scale. They realised the lack of relatedness, and that they had a part to play, but their realisation of what this part was, was either superficial or vaguely stated.

b) Load and distribution of teaching

As shown from answers to Q. 8, tutors find the syllabus quite a strain to teach in the time available. This implies that in order to 'cover' the syllabus, they needed to rush, to lecture rather than to discuss (p.138), and to spend too short a period of time on every topic. Because of the quantity to be covered, quality had to suffer. As one tutor put it;

You can 'cover' it (syllabus). This does not mean you taught the nurse anything.

What makes the quantity seem bulkier was the emphasis on details (specified by GNC) and procedures. This was pointed out by some tutors who felt that more time was needed to teach what has been handed over by the doctors, such as blood pressure measurement and injections. Instead of this class hours had been cut down. Much of the tutors' effort seems to be wasted if the students' learning is impaired because of the rushed and irrelevant theoretical instruction, especially if the main part of nursing 'theory' is procedure demonstration, because procedures are different at school and in hospital.
The conclusion seems to be that 'theory' and 'practice' are not related. I would argue that they are not related because of specificity, but that they are related in nature. What I mean by related in nature is that: In school because the syllabus is overloaded with details to be taught in a short time, the tutors put in a great deal of effort to 'cover' the syllabus by quickly lecturing, without enough feedback from the students as to how much they learned of what is essential for their education as nurses.

In hospital because work is on the main organized on the principle of task allocation, the number of tasks become cumbersome and overload the nurse's working day. Nurses 'rush' to get the work 'done' without enough feedback from the patients as to how they feel and how do they perceive their own condition, which is essential for a personalized and effective type of care.

What happens in school and what happens in hospital is strikingly similar.

The ratio of tutors to students in each school was calculated from Table III of the school profiles, and is given below in Table XVII.
From information gained from schools the ratio of 1 to 30 tutor/students had been mentioned as a GNC recommendation. Only two of the seven schools seem to comply with that recommendation. But to look at the ratio in these crude terms might be misleading. Several other factors play a part. Depending on their qualification, some tutors would be teaching certain subjects, e.g. registered tutor would teach human biology. The sizes of student intakes vary but usually they are all taught in the one class. The frequency and distribution of 'block' means sometimes that more than one 'block' is at school at the same time. Sometimes a group of tutors teach one student intake right through their three years of training and sometimes they teach a certain 'block', e.g. 3rd block, all the time. Another factor which decides teaching distribution is the availability of
classrooms in terms of space number in the one school. These factors which ought to be taken into consideration when allocating a number of students to a tutor, are not reflected by a crude ratio. To have small groups of students requires a different organisation of the programmes of training as well as availability of rooms for the groups to meet in. None of these facilities and requirements seem to be obtainable at the moment so that tutors are overburdened also in a material sense.

Turning to the clinical instructor, we note that the ratio of clinical instructors to students is at a seriously low level. Table XVIII, gives the calculations:

<table>
<thead>
<tr>
<th>School</th>
<th>No. of clinical instructors</th>
<th>No. of students in training at time of survey</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1</td>
<td>230</td>
<td>1 to 230</td>
</tr>
<tr>
<td>II</td>
<td>1</td>
<td>390</td>
<td>1 to 390</td>
</tr>
<tr>
<td>III</td>
<td>4</td>
<td>168</td>
<td>1 to 42</td>
</tr>
<tr>
<td>IV</td>
<td>-</td>
<td>364</td>
<td>0</td>
</tr>
<tr>
<td>V</td>
<td>3</td>
<td>120</td>
<td>1 to 40</td>
</tr>
<tr>
<td>VI</td>
<td>4</td>
<td>435</td>
<td>1 to 109</td>
</tr>
<tr>
<td>VII</td>
<td>1</td>
<td>355</td>
<td>1 to 355</td>
</tr>
</tbody>
</table>

In the case of clinical instructors the situation is so dramatic as to be pointless. This explains a great deal of the dissatisfaction expressed by clinical
instructors (p.163). The fact that the clinical instructor has no career opportunity in terms of promotion gives many of them a claustrophobic feeling. The clinical instructor is led to restrict her service to a limited group of students, e.g. first years only or students going to their first ward, and to limit the frequency of seeing the student, often to once in a year or even in the duration of the whole training period. Again the effort appears fruitless. Such restriction in time and human resource, expended over a large area like a hospital, makes the clinical instructor's knowledge and contact with the actual everyday running of the ward difficult. All these factors restrict the clinical instructor's teaching to that of 'procedures' or signs and symptoms of the patient as she herself has no opportunity to know the patient as a person (p.164).

Students find the clinical instructor helpful when they have the opportunity of seeing her, they only wish it was more frequent. But the number of clinical instructors is not sufficient to be really effective. Moreover, their number is not likely to increase dramatically because of its 'no through road' type of career prospect. Furthermore, a registered clinical instructor is 'inferior' in status to a registered tutor, which again raises the same type of inconsistency, mentioned above (p.201). Although the clinical instructor is the one who teaches the 'application' of the different types of knowledge to the practical situation, she nevertheless
gets less preparation and achieves less status.

c) The student's role in training as perceived by tutors

The tutor on the whole perceived that the student had a large part to play in her own training. Some tutors even gave the student the responsibility of the standard of care performed on the ward (p. 132), as "she (student) was told the right way in the school." Such a statement needs careful consideration. Telling or even showing the student the right way of doing things is no guarantee of her understanding what she is taught. Understanding may happen if the teaching is flexible and includes a process of give and take. The whole process of teaching a given programme should be aimed at enabling the student to gradually build a certain frame of reference, which will guide her thinking and action. In this she takes an active role, active in the sense of working out for herself the understanding she needs through what she is presented with. 'Telling' or 'showing' does not necessarily bring about active participation on the part of the student. 'Telling' the students will not necessarily help develop a frame of reference common to all. At present, the student interprets what she is told within her own frame of reference, and a group of students might receive the same information without necessarily developing the same frame of reference. Communication between tutors and students or among nurses generally would be improved if a frame of reference
were made explicit. This idea of making explicit what is latent for improved transfer and hence communication was advocated by Meredith (1948 and 1950).

A student working in the ward though 'left in charge' as a junior for a given length of time, does not have any authority and as illustrated earlier (p. 115) does not take initiatives. How then can she improve standards when her opinion is not usually sought (p.109, Q. 19)? How can she go against the Sister's or ward's way of organising work and doing things? This was also pointed out by one tutor (p.132). Even people with authority like the senior nursing officer might encounter a great deal of difficulty in 'changing' a way of organisation or certain practices as this involves more than issuing orders. It entails among other things a change of values and attitudes, a difficult domain as discussed previously in Part I.

A domain that requires a great deal of attention is that of the psychological aspect of patients' care. Tutors recognise that the student has difficulty in 'realising' that some of the problems they encounter pertain to emotions and behaviour. This denotes a serious lack of awareness of the student to this area. Tutors recognise the importance of this area but they leave this difficult task to the psychiatric secondment, probably because of lack of teaching time. One way of making the student aware of these emotional aspects is to develop her orientation in that direction and to see the psychological aspects of care as integral to the
frame of reference to be developed in nursing. A vast part of such orientation is the responsibility of the tutor who is teaching the knowledge and part of that knowledge ought to be concerned with psychological aspects of care and its implications. This should be a continuous process, rather than in the form of a group of psychology lectures or of a psychiatric secondment. Continuous and consistent reference by the tutor to the psychological aspect of patient care during teaching would help the student realise that psychological aspects are an integral aspect of patient care. Differentiating physical and psychological aspects is another reflection of fragmentation. Psychological aspects need to be introduced from the very beginning. One tutor's observation points out to this.

The junior is the one getting the problems because they are close to patients, because they are doing the basics, and that is what counts. This observation is also of interest because it shows that it is through basic care that patient-contact is closest. Therefore the person who carries out basic care should be brought to understand that information about the patient's needs as a person in the given circumstances is essential in deciding upon and organising his care. Is the junior student capable of such understanding and judgement? Is her preparation adequate for such responsibility or even for the reality of what she will encounter? The answer to the first question is surely that it is unfair to expect such level
of thinking from a beginning student. To the second question the answer is simply 'no'. There does not seem to be any conscious or planned effort to prepare the student for responsibility. The tutor teaches her at school, leaves it to her to relate her knowledge, and hopes for the best (p. 132). At the hospital the sister is too busy to teach the student, or she is not working the same shifts as the student. Clinical instructors are a rarity, so the student is left to herself. All that is left for her is to copy other nurses, both her colleagues and the qualified staff.

The effectiveness of the psychiatric secondment orientation to the psychological aspects of individual care was in one tutor's view related to the maturity of the student:

a very impressionable or sensitive girl might gain absolutely nothing from her psychiatric secondment; she might not be able to relate her psychiatric lectures to the rather conflicting and bewildering behaviour of her patients. I would think if she is mature, she might be able to rise above the experience of psychiatry. You have to be very objective from what I have learned. I don't know what I will expect her to gain, perhaps some insight, perhaps she might not get anything from it.

This is an interesting comment. Though it comes from one tutor, it does reflect a way of looking at things which is probably more wide-spread, especially the idea of 'objectivity' which it mentions and which seems to be equated with non-involvement, or even 'lack of feeling'. What is worth noting in the comment is the subtle relation
between maturity and objectivity, on the one hand, and sensitivity and the lack of intellectual ability in relating what she sees to what she studied, on the other. This issue, to my mind, is of vital importance in the preparation of the 'nurse'. I regard both intellectual ability and sensitivity of feelings essential characteristics in a nurse's work and not in any way mutually exclusive. The general tendency, even outside nursing, is to talk about them as contrasting. This lead the philosopher Peters (1972) to protest that

... the use of reason is a passionate business and that the emotional life can be more or less reasonable. Instead of the usual contrast between reason and passion I have substituted that between different levels of life each characterized by distinctive levels of awareness and feeling ... it is a matter of more or less.

This thesis has also been maintained by Wilson (1973) in discussing the measurement of emotions. The value we give as nurses to our ability to sympathize or empathize, and to understand and accept both on an intellectual and an emotional level, reflects our understanding of what we mean by nursing. If intellectual ability and sensitivity of feelings are considered as contrasting and the former is rated as 'good' and 'desirable' and the latter as 'hindering' and 'undesirable', then we as nurses in education or practice will concentrate on producing a nurse efficient in terms of motor skills and amount of knowledge. We will organize the work on the ward so that these 'tasks' are completed in the shortest time possible with the least damage possible to the
patient. Organisation, and values will lean toward the 'impersonal' and the 'objective'. This would reflect an understanding that the patient requires certain activities carried out for him, which is radically different from requiring someone to 'care' for him, that is, carrying out these activities with feeling and an awareness of him as Mr. Smith.

In conclusion to this discussion of the student's contribution, it seems that tutors expect from students more than they prepare them for. This seems to be basically because the GNC expects the tutor to prepare the student without providing appropriate preparation for those who teach. At the same time the GNC ask for much detail and provides insufficient time for this amount of instruction.

B Summary of Results
The survey was trying to answer two main questions.
1) What is the nature and extent of relatedness between theoretical instruction and practical experience as perceived by the students and tutors?
2) How much of the difficulties in relatedness pertains to the syllabus as such and how much to its implementation by the different schools?

1 Nature and extent of relatedness
The nature of relatedness had been studied in terms of: Administration, Content, Workload, and Expectation
versus Preparation. It was fairly clear all along that it was difficult to decide if a comment or result fell into one category only. The general emphasis decided the categorisation. This difficulty was a good illustration of the relatedness of these four categories. It is also a reflection of the complexity and variety of reality. These categories were used mainly as a guide to the inquiry, for ease of reporting and as an illustration of the relatedness of the variables in any given situation.

Bearing this in mind, I shall report the results under these four categories.

a) Administration: sequence of theoretical instruction and relevant practical experience.

From the interviews as well as the school profiles (p. 89a) and the Graphs (p. 90), it is clear that theory and its relevant practice are not related on the 'time' dimension. Study blocks are fixed in date, duration and content. Practical experience is fixed only in date and duration as a whole. A great deal of variety exists within such allocation. The school decides the theory, but it is the hospital administration which ultimately decides the type of ward in which the student is to receive her practical experience and for how long in each ward. There is no control as to what the student is asked to do once she is allocated to a ward, and to the extent of responsibility she is given in relation to her stage of training. At school, teaching is geared to the
subjects and procedures. Teaching responsibility of
tutors is divided according to whether the tutor is
registered or not. Tutors on the whole are allocated to
a study block. At hospital, work is geared to tasks.
Nursing responsibility is divided roughly into task
execution and management where in the main the more
qualified are responsible for management and the less
qualified and unqualified carry out tasks. Direct
patient contact is on the whole allocated to students.
There is a considerable degree of similarity between
school organisation and hospital organisation as far as
basic structure is concerned. The relationship of the
people running the organisation (nursing staff, tutors)
to the customers of such organisation (patients, students)
is basically functional and impersonal.

b) Content:

Students and tutors agree on the lack of relatedness
between what is taught and what is practiced. Methods
and techniques are different. The teaching of signs
and symptoms of disease is not always consistent.
Sometimes principles are also different. The school
deals with one thing at a time, at hospital more than one
thing happens at the same time. School does not teach
about how to deal with the complexity of reality. The
school's teaching is unidimensional; the hospital's
experience is multidimensional.
c) Workload:

Tutors and students perceive school teaching as too much to cover in the time available. Students find difficulty in coping with the number of hours of work at the hospital along with the amount of study they have to do simultaneously. Though they have more difficulties quantitatively with hospital experience, they perceive the school's difficulties as more specific and harder to cope with.

d) Expectations versus preparation:

The syllabus is biased toward biological sciences. Yet educational requirements do not refer to a specific background.

The student is expected to know, to take responsibility. Yet she is not prepared for the responsibility and is not guided toward learning in the sense of understanding and is not given time enough to study.

She is not encouraged to take initiative either in school or in hospital or think for herself. Yet she is left in charge on the ward with scant regard for her ability to undertake this degree of responsibility.

School tries to consider the student nurse as a 'student', letting her participate in the teaching through giving her projects to do and giving her a great deal of knowledge. Yet at the hospital she is considered an employee and an apprentice (with little emphasis on 'teaching on the job'.)

Lack of tangible help forces her to rely to a great
extent on her own judgement. Yet her ability to use her own judgement is not consciously developed by tutors or staff at hospital.

The tutor feels that the GNC expects her to teach the whole of the syllabus in the time allocated. Yet the time is less adequate for teaching than for transmitting information with no guarantee as to results.

Unqualified tutors and clinical instructors are required to perform the process of relating theory to practice. Yet their preparation for this is either absent or less than that of the registered tutor who teaches the more straightforward subjects.

In short, the GNC's expectations, as stated in the syllabus, are not related to the feasibility of their implementation. The load of the syllabus is not related to the time allocated for its execution. The tutors' preparation is not related to what they teach. Students' educational requirements and background are not related to the abilities she is required to develop. Theoretical instruction is not related to practical experience. Both tutors and students perceive the lack of relatedness as a major problem. Tutors consider the problem of lack of relatedness superficially and functionally, that is, in terms of time sequence or procedure techniques.

2 Difficulties of relatedness

Though the seven schools studied varied to some extent
in the way they implemented the syllabus and in their geographical location and consequently in their subcultures, they agreed to a high degree about the extent and nature of lack of relatedness. This finding suggests that the main source of the difficulties encountered spring from the syllabus itself. These difficulties are due to the following:

The syllabus is based on, or geared to, details which pertain mainly to techniques. This automatically makes the difficulties 'variables'. Since practice changes more rapidly than the syllabus, the latter is inevitably often out of date and irrelevant to current practice. But, to change the syllabus, parliamentary laws are needed. A council to decide upon its content and organisation takes time and effort. The GNC as a statutory body is in the nature of things more restricted and static than 'practice' which is changing and less restrained.

Emphasis on details gives a picture of nursing which is technical and fragmented, which automatically makes knowledge of secondary importance.

This emphasis also constrains both tutors and students to equate nursing care with procedures. In the midst of such preoccupation with details, there is no clear indication as to how tutors can help students develop their abilities as nurses.

The lack of clear communication between the GNC and tutors (p. 127) as to objectives is reflected in unclear
communication between tutors and students, though to a lesser extent. Each group - GNC, tutors, students, nursing staff on ward - is overwhelmed with what it has to do. There is also a lack of real communication between school and hospital other than at the 'top' level, e.g. between Director of nursing at school and principle nursing officer in hospital.

A lack of any sense of rigour is evident in the planning, organisation and execution of the syllabus and its implications, whether at GNC, school or hospital level.
PART THREE

THE EXPERIMENT

Chapter VII : Introducing the Experiment.
1. Concept of a situation
2. Process of Inference.
3. Relationship between 1 & 2.

Chapter VIII : Purpose and Sample.
1. Purpose
2. Sample Size & distribution
3. Pilot Study and Preparation for the course.
4. Main Study and Research Tools.

Chapter IX : Results.
1. Opinions of Tutors and of Students
2. Results of Questionnaire
3. Course evaluation results
4. Results of Tests.

Chapter X : Discussion and Summary of Results.
1. Teaching on the basis of a situation
2. The Questionnaire
3. The course evaluation schedule
4. The Tests
5. Summary of Results.
CHAPTER SEVEN
INTRODUCING THE EXPERIMENT

GENERAL INTRODUCTION

It has been argued all along in the previous chapters that theory and practice are not related, that this lack of relatedness is due to:

i) the lack of clarity about the context within which theory and practice occur;

ii) the lack of organisation of both theory and practice in a way which would make them more related to each other on a more fundamental level/basis;

iii) the lack in the programme of the development in the student of an ability which would enable her to relate teaching to practice, namely the development of her inferential ability.

Pointing out difficulties and leaving it at that does not seem to be a very useful or productive exercise. Therefore an attempt was made through an experimental course of teaching to explore the possibility of dealing with such difficulties.

Ideally, to attempt to achieve what is needed for relatedness, a curriculum of nurse education would have been actually planned and organized. But to do this would have necessitated gaining permission from the GNC, developing and implementing a course of preparation for
the teachers and an induction programme for the hospital personnel involved, as well as three years to carry out the programme. It would also have been necessary to devise a controlled experiment to compare the new with the existing programme, taking a large number of variables into account. In my case this was obviously not possible and an alternative was to design an experimental course of teaching within the general nurse training programme. The psychiatric secondment period was chosen as convenient and of interest as explained earlier in p. 71.

As the psychiatric secondment was eight weeks out of a three year programme, I could not at that stage introduce a different understanding of nursing to use as the context within which the experiment was to be developed. Therefore no attempt was made in that direction, but it was possible to introduce an approach to teaching which would act as a background and framework to direct the organization of teaching in such a way as to make it more related to the reality of the hospital situation.

An attempt was made to achieve this by the introduction of the concept of a 'situation' on which the teaching was to be based.

Since any nursing situation is a highly complex set of interactions, it seemed necessary to provide a simple guide which would help introduce the complexity of each element involved in the situation. This had to be done in such a way that it directed attention to the variables
pertaining to the elements and put into perspective the overall interaction between these elements.

Teaching on the basis of a complex situation and pointing to the interacting forces within it, by necessity, entails a different way of thinking from both teacher and taught. Such a way of thinking I considered to be one of 'inference'.

It may be useful at this stage to introduce the reader to the concept of the 'situation' used in the experiment, to what is involved in the process of inference and to make clear the connection between the concept of a situation and the process of inference.

1. Concept of a situation

One way of reaching the concept of a nursing 'situation' is by identifying its common elements.

In nursing we are dealing with human beings: patients or clients, their families, other colleagues (nursing or others). Nurses are themselves human beings. Each of these groups of people makes an appearance for specific reasons or plays a certain role. For example, patients because of health impairment, doctors for diagnosing and prescribing treatment for patients, nurses for caring for these patients or clients. Nurses are usually affiliated to an institution or an organization for patient's/client's care. Such 'places' have their policies and regulations as well as their culture and organizational life.
The work of the nurses, especially those who are hospital based, covers the 24 hours of the day all the year round. Some of the patients or clients need attention and care for a shorter interval of time over a given period.

Taking instances from an everyday nursing situation, we can consider the following. In a hospital ward situation the variables to identify may be: patient, nurse, doctor, social worker, the condition of which the patient complains, the description of the ward (e.g. Medical, Surgical, Acute Admission (psychiatry) etc.), policies and regulations affecting the hospital in general and the ward in particular which guide the behaviour of the people working there, and the time factor. In a home nursing situation where the nurse is present as a health visitor or district nurse, some of the variables will be: nurse, client, possibly other members of the family, the home of the client, the neighbourhood and its effect on home conditions, the social interaction between family and community, the reason for the visit, and the time at which the visit takes place.

So far these variables are presented as 'presence' but lack the 'life' of a real situation. What is lacking is the relationship between the people, their way of talking, of feeling, thinking etc., the care required in the hospital ward and home situations. Also for
consideration is the mood of the people at the time, and their general temperament - the subtle 'atmosphere' which is difficult to put into words, but which plays an essential part in our behaviour.

An additional deficiency of the above mentioned variables in the three situations, is the lack of cumulative information; the extent' and depth of involvement of each of these variables, which may possibly influence the prominence of one variable rather than another.

From the foregoing presentation, a situation may be said to have the following dimensions:

1 a structured frame made up of the following elements:
   (a) individuals who play a certain role which is related to the situation, each individual playing more than one role both independently and simultaneously over a given period; e.g. a 'patient' in hospital is a 'father' at home, a 'director' at work;
   (b) place - where the situation occurs;
   (c) environment - all that gives 'life' to the individuals or the place to make it what it is, e.g. policies, culture, traditions, and all that decides this indefinable 'atmosphere'; the material and immaterial components involved;
   (d) time - at which the situation takes place.

2 Dynamic forces which are: all of the possible interactions between and among the elements, e.g. interaction
between individuals, between individuals and the environment, the environment and the place, the place with time, time with individuals, and of all the elements with each other.

3 A volume which comprises: the extent to which each element is affected and is influential, and the depth to which each element is affected and influential, e.g. the extent to which a patient's disability is interfering with his profession or his personal life, the depth to which such a condition affects the patient psychologically.

Both Graph K and L on page 227a, illustrate the concept of a situation.

Graph K is believed to be a better representation of what is meant by a situation.

Graph L has the shortcomings of including more than the four sides corresponding to the four elements of a situation. This makes Graph L a less accurate illustration than Graph K.

Graph L has the advantage of illustrating better on paper the idea of volume and interaction between and among the elements. This advantage is gained by Graph K when constructed as a model with cardboard, for instance.
These identifiable dimensions (1, 2, 3) have each more than one dimension, and their relatedness, in my view, constitutes the concept of a situation. The totality of the relatedness gives the situation its identity. An 'incident' which might show up in the ward or community field (it does not have to be a critical 'incident' or one that denotes a crisis) is usually the outcome of this total relatedness. In other words, a situation illustrates an event within a given context.

It then seems natural that in order to deal effectively with a situation, this total relatedness has to be taken into consideration when 'making decisions' pertaining to a given situation. Of course, if I think it natural to take into account the total relatedness of a situation, then my argument is based on the premise that the situation is a totality of relatedness among and between its dimensions. I have no empirical data of my own to refer to in this matter. (Professor Peters who kindly read this part, did not feel that empirical data are needed in this instance, and that it would be rather worrying to think along these lines of proving the point empirically).

These concepts were arrived at on the basis of analytical thought about that which happens when one carried out nursing care, visits a family, etc., backed by personal experience in the different fields of nursing (a type of introspection).

Influential in shaping my concept of a situation are:

1. some of the concepts of Psychology, Sociology,
Anthropology, Biology, Biochemistry, Philosophy;

2. some of the studies done in nursing (or articles written) referring to the complexity of the variables involved, in nursing generally or in a given situation in particular.

Hammond et al (1966) concluded that:

the data suggest that none of the cues analyzed has provided (by itself) the basis for action.

Hämelin (1968) pointing to the factors influencing the role of nursing, wrote:

Factors which influence the role of nursing in any country are the role and functions of the medical profession, the division of functions between medical and nursing professions, and the number and type of other categories of health worker.

A working group convened by the Regional Office for Europe of the World Health Organization for the "Evaluation of Nursing Education" reported that:

However, the educational process is a complex set of interacting influences and no attempt should be made to evaluate it through a single all-inclusive study.

This last quotation fulfills two functions: first, to support the point I was making about the complexity of the situation; and second, to indicate the prevalent attitude of mind in identifying the elements involved in a situation, then studying them separately which, to my mind, is at the base of the majority of difficulties encountered in nursing. Whichever way the situation is considered, there are certain facts which remain true:

a) all the elements and variables of a given situation occur together at the same time;

b) to study the variables separately and then put them
back into the 'whole' of the situation does not necessarily mean that they will 'fit', or that this will give more information about the 'whole' situation.

Parlett (1972) says:

... rarely can 'tidy' results be generalised to an 'untidy' reality

and Pilliner (1973) writes

the results of the experiment are neater and more precise. The account written for the appropriate journal has the appearance of a four-square and complete job - yet the whole exercise may turn out to be of dubious relevance to the teacher in the classroom and the children under his care, simply because it is too antiseptic, too 'cleaned up'.

This separation of variables will also cause disappointment in practice because of the number of 'misfits' that will result.*

It is necessary to clarify some points about the concept of 'situation' before going any further to discuss the different dimensions of its elements.

A Shape or emphasis

Graph K or L is an illustration of the general idea. The 'emphasis' which is the force (referring to dynamics), extent and depth of involvement of each variable is going to decide the shape of the situation. An individual has needs which embrace his personality in toto, i.e. biological, psychological, sociological, spiritual, intellectual.

* In my opinion, this idea of separating the elements, studying them on their own and returning them to the whole has a great deal to do with this common dichotomy between theory and practice.
If one aspect comes to be threatened or attacked, priority is given to this aspect, bearing in mind the totality of the person. An example might be that of a patient with acute appendicitis where bias in the care given to him will be towards physical care. For the sake of argument, the physical needs will occupy something like 80 per cent of the care and 20 per cent is left for other needs which, according to their relation to the type of physical crisis, will occupy different shares. Once the danger phase is passed the physical care might become 50 per cent leaving more room for the other needs. It is important to note here that priority/emphasis does not automatically exclude other aspects of care. In the main it is a matter of matching the care with the cause of the problems presented.

Two aspects are involved in considering the 'emphasis' of a situation:

1. the first aspect deals with emphasis in relation to the nature of the different elements. It may be clearer to understand this idea by using a statistical concept, namely that of 'central tendency'. In hospitals known as general hospitals, the middle tendency (mean, median, mode) could be used as illustrative of types of affliction found (and not types of patients, who react as individuals to the same condition) on the different wards, for example on a surgical ward the majority of patients are treated by surgical intervention which does not preclude them
from suffering from other conditions than the one for which they are to be operated on. The use of such a concept as central tendency has two functions: a) it indicates the direction of 'emphasis', e.g. 'surgical' or 'orthopaedic' wards; b) it keeps in perspective the other variables involved within the situation and their relation to the 'emphasis', e.g. accompanying ailments.

2. the second aspect deals with emphasis in relation to the stability and distribution of the different elements and their variables. This is better illustrated by the concept of Psychic energy in Freudian Psychology. Psychic energy "may be transformed from one state into another but can never be lost from the total cosmic system". (Hall and Lindzey (ed) 1957 p. 36). Because of this, if a great deal is taken up by one section, less is available to the other sectors, but it is not a constant state of affairs as it keeps shifting according to needs and their impetus.

B Interaction of Elements

It is of utmost importance to note the difference between

(1) realising what the elements (and their variables) are that play a part in a 'situation' and
(2) understanding a 'situation' by the implication(s) of interactions between and among the elements.
To use an arithmetic concept to illustrate what is meant in this instance:

If we consider '2' and '4' as elements, the outcome of $2 + 4 = 6$ is different from the outcome of $2 \times 4 = 8$ though the elements are the same in the two instances. The outcome is different because of the difference in the operation involved.

If the patient is diagnosed as suffering from depression and is admitted to hospital, the decision to give that patient electroconvulsive therapy (E.C.T.) depends upon the knowledge of the 'usual' personality of the patient (his/her temperament, mood before illness etc.), any diseases the patient is suffering from, his present condition and the knowledge and preference of the doctor as to the treatment of depression. It is the interaction of all these (and other) variables that shapes the decision. Though the patient may seem to be deeply depressed, drugs (anti-depressant) might be given instead of E.C.T. because of the patient's health status, even though drugs will take longer to show an effect. Patients with the same clinical degree of depression could receive different treatments because so many other variables play a part.

Given A and B, three possible alternatives of dealing with the situation present themselves:

1. To be able to recognise the different elements in a given situation, but to be unable to use such knowledge,

2. To be able to recognise and identify the different elements in a given situation and to see the relation
between only one or two elements or variables,

3. To be able to recognise and identify the elements involved and their variables and work out the implication of the presence of the different variables as well as the overall implication of the whole situation.

**Dimensions of Elements of a situation**

a) **Time**

There are more ways than one of considering Time, all of which influence the situation concurrently:
- Time of period, e.g. 1920, 1970, each period having its own ideas and characteristics;
- Time of year, e.g. winter, summer;
- Time of month, beginning, middle, end, - (this takes on a special importance for women because of menstruation and possibility of premenstrual tension);
- Time of day, morning, afternoon, etc. and what it implies in terms of expectations;
- Time in relation to event, before, anticipated, expected or unexpected events, e.g. before lunch, during the consultant's round, after an emergency situation;
- Time required for something to happen; the time needed for growth of a tooth, time it takes for maturation to take place.

b) **Place**

A ward, for example, is a geographical location with its own characteristics and 'atmosphere'. It has a
name, such as Long-term, Orthopaedic; it is a ward in a hospital of a certain type, such as General, Psychiatric, Mental Subnormality; and the ward or hospital also has a reputation. The hospital could be in a city which has its unique characteristics as well, and the city in a country whose policies and politics influence the health service.

c) Environment

The environment relates to the material and immaterial (cognitive, affective conative) outcome of an element. In other words, environment has a concrete dimension as well as an abstract one.

Examples of the material outcome are: hospital policy, ward routine, a community's tradition, content of a lecture, a manual skill. Examples of the immaterial outcome are, character of a place, a pleasant atmosphere, a feeling of love toward another person, pressure of time.

d) Individual/s

One could look at the individual as a whole with his intellectual, social, psychological dimensions, and/or at the interaction of the individual with another individual, a group of individuals, his environment and his life events, or a combination of all these.

Characteristics of Elements

Each element of a given situation has a given identity which facilitates interaction. To understand the interaction which takes place, one has first to specify the variables that influence each other, and if these
variables have vague and undelineated boundaries one cannot give them a name and refer to them in the interaction. If a variable or an element is not identifiable it is more liable to disintegration and will be in a constant stage of change, hence difficult to refer to. Lack of identity of a person capable of response, gives a feeling of insecurity to that person due to the threat to his/her integrity.

It is this same working principle which decides the effectiveness of work in a team. The greater the number of the people involved in an activity, the greater the need to specify the responsibilities and limitations of each member (i.e. identifying each member) to allow satisfying interaction and a productive outcome.

Another characteristic of the elements of a situation is the implicit presence within each element of the other three. Time for example, is an integral part of the individual, of the environment and of the place. An individual matures through time, guided and influenced by the 'environment' which is influenced by the 'place' and ideas of the 'time'.

Potentialities of using a model

The first thing that comes to mind about using a 'model' for studying a situation for decision making in practice or education, is the danger of producing a stereotyped and inflexible way of thinking. However, the model is to be thought of as a guide. The
principles on which it is based fosters flexibility, as its characteristic lies in the fact that it ought to change according to the emphasis of the different dimensions at which each variable presents itself. Kerr (1968 p. 32) points to the usefulness of a model,

... The model makes some theoretical formulation and empirical study of curriculum matters possible and limits the occasions when a crude pragmatic approach has to be used. It also promotes an interactive relationship between educational theory and classroom practice, and checks the false separation of theory from practice about which teaching and student teachers, with justification, complain ...

Even though the above extract describes a curriculum model, the general idea is a valid one. To increase the sensitivity and awareness of nurses (students or qualified) to the different variables and their implications within a situation, the model could usefully be used as a guide in that instance, emphasising all the time the value of the implications involved. Most studies and reports in nursing have been of the 'descriptive' type, i.e. identifying the variables, but little appears to have been done to see either how these variables relate to each other, or to study the implication of the presence of certain variables. An important outcome of such an increased sensitivity (to the different variables and their implications) would be the broadening of vision and the necessary development of a 'critical' awareness. Increased sensitivity would also necessitate a flexible way of thinking and would help the understanding of the relationship between and among variables.

Having a model to guide one's action, planning and
organisation of education and decision making in everyday nursing, has its value in that one gains a clearer idea of aims. There is a starting point, a guide line and a purpose to reach, which might make any behaviour related to that instance more meaningful. The fact of using the same model for study, decision-making in everyday work as well as in education is a step towards relating ends and means as well as towards relating theory to practice.

To sum up the potentialities of the concept of a situation, it will help relatedness of elements (on theoretical, practical and theoretical-practical levels) and their identification.

It could be argued that this structure of a situation as presented above is not uniquely applicable to nursing. This comment is valid. However, it is the context within which this structure occurs which decides the frame of reference used.

2. Process of Inference

Kelly and Hammond in a series of articles studied clinical inference in nursing. They were interested in finding out about the way in which a nurse selects, assembles and uses signs and symptoms and other information in reaching a judgement about the state or condition of patient.

Their main purpose was descriptive. But they also wanted to see how this could be used in teaching. They defined inference as 'a conclusion or judgement drawn from data.'
Hammond (1964) states that

If a nurse overly depends on poor cues and fails to rely sufficiently on good ones, she will not be a good judge of the patient's state.

He goes on to say that no attempt has been made to study the cue-utilization behaviour of a nurse even though this is at the heart of the nurse's professional task.

Kelly and Hammond undertook a series of studies to provide a list of the kinds of inferences and decisions used by nurses. They seem to have perceived the role of the nurse as mainly an extension of the physician's eyes for the purposes of observation of the patient.

The physician prescribes the therapy and leaves directions for observations which are to be made, however he cannot leave directions for all possible contingencies. Although the patient is under the general care of the physician in most cases constant surveillance of the patient by him is neither possible nor practical.

And along the same lines of thought about tasks which require empirical knowledge and those which require theoretical knowledge Hammond (1966 No. 1) writes

A choice must be made, for nurses cannot be so fully trained that they become physicians.

They are also mainly preoccupied with symptoms and signs of 'disease'. Kelly (1966 No. 1) states that the nurse is concerned with the etiology of a symptom and its alleviation ...

In a further article about analyzing cognitive tasks representative of nursing problems Hammond et al. (1966 No. 2) conclude that in the past nurses have been primarily focused on seeing and doing rather than thinking,
but they believe that modern nursing emphasizes cognitive skills. They undertook two field studies to establish the kind and number of cognitive tasks as well as their characteristics. They concluded that these cognitive tasks encountered by nurses on the ward are many and varied ... (and) the cognitive characteristics of this nursing task (abdominal pain following abdominal surgery) were found to be complex with respect to 1) the number of cues involved, 2) the number of responses to the task and 3) the relation between cues and action.

In a subsequent article they attempted to discover what the message units of such tasks are using a paper and pencil test in which:

the forms provided all the signs, symptoms and other information available for a particular case (of a patient).

Nurses participating had to specify what action they would take in the given 'case' based on 'what cues', and to indicate how useful each item of information was. They were also asked to indicate their certainty about their decisions and if they needed added information. The result was that the effort failed ... no single cue was found to convey more than a trivial amount of information to the nurse-subjects. Nor were groups of cues, arranged in various ways found to be related to the inferences made by the nurse-subjects about SOP (state of patient). And finally it was learned that these nurse-subjects did not consciously discriminate between the usefulness of various cues, nor did their confidence in their decisions vary over cases.

In another article Hammond et al. (1966 No. 4) describe a method for the analysis of the manner in which nurses use various strategies for seeking information from patients when such information must be selected by the nurse.
An experiment was set in which five female registered nurses (were) presented with a task in which it was assumed that she had been led (by some evidence) to formulate an hypothesis about SOP. She was then required to seek information which would enable her to accept or reject the hypothesis.

This information was provided in the form of an array of cues arranged in appropriate categories displayed on a board. Nurses differed in their performances and their information-seeking strategies.

The criticism I would make to these studies is that cues are taken as 'presence', which is not necessarily the case as the orientation of the nurse determines to a great extent her awareness of the presence or absence of 'cues'. Specifying cues and 'cognitive tasks' (as they call them) focuses on part of the picture and ignores the totality of the situation which plays a decisive part, as they themselves found out later:

the data suggest that none of the cues analyzed has provided (by itself) the basis for action. (Hammond et al No. 2).

It seems as though such a focusing would provide what Hammond (1966 No. 1, A Psychologist's view) calls a "Taxonomy of cognitive tasks." Adding to the number of tasks the nurse is to carry out is cumbersome and confusing.

The process of inference as discussed and presented is linear in nature while the multiplicity of cues defy such linearity. The role of the nurse as perceived by Hammond et al is restricted to help in establishing diagnosis. They also assume that cognition, perception and action are unrelated and that the nurse does not
'think'. This however is difficult to say as the nurse thinks but it is the quality of thinking which is probably at fault. But after drawing a distinction between doing and thinking they equate the kind of action with the kind of cognition.

What kinds of cognitive tasks occurred?

was further discussed under the heading "What kinds of actions were taken? From their definition of inference they seem to include both the logical process of deduction (conclusion) and what, to my mind, is more in the realm of inference (judgement), i.e. a more subjective evaluation.

Sarbin et al. (1960) studied the relationship between cognitive theory and clinical inference. They differentiated between three forms of inference, formal, statistical and clinical, but they believed that (p. 5)

All share the definition of inference as a cognitive process in which characteristics of a general class are attributed to an individual taken as an instance of that class.

Formal logic deals with explicitly stated axioms, postulates and operations, for example Aristotelian logic and mathematics. Statistical inference is founded on probability and variability and where

the truth value of the major premise is an important determiner of the accuracy of the inference when subjected to confirmation procedures,

while in informal logic the truth value of the premise is inconsequential.

In clinical inference characteristics of the inferring person influence both the choice of data and the manipulation of terms.

Also the content of clinical inference is statistical.
Because of what they called "contaminating variability ... within the clinician" they suggested a cognitive theory of clinical inference. One of their main objectives was to extend the applicability of the syllogistic model with appropriate alterations for probability features. (p. 6)

Such a model they feel is an adequate device for representing the process by which one person knows another (p. 7). Their main aim was to render more 'objective' the process of clinical inference and to render it of "the highest credibility" by replacing "clinical 'feel'" by codified inductions.

The main criticism which applies to the approach taken by Sarbin et al. (1960) is the same as that made by Hamlyn (in Mischel (ed) 1974, p. 31,32) about Flavell's model for the child's coming to see another's point of view, he says

I would suggest that Flavell's model is too cognitive, too much concerned with 'intellectual' questions about others, and needs some supplementation at least by some reference to what relationships exist between the children in question, to, if you will, a context of interpersonal dynamics.

The question of "personal-perception" and "understanding others" is dealt with at length in the joined effort of some psychologists and philosophers in Mischel (ed) 1974. Hayakawa (1964) defined inference as:

a statement about the unknown made on the basis of the known.

He illustrates different instances of inference indicating
the role played by knowledge and previous experience in the
process. He writes that:

Inferences may be carelessly or carefully made. They may be made on the basis of a broad background
of previous experience with the subject matter, or no experience at all.

The common characteristic of inferences as viewed by
Hayakawa is that they are "statements about matters which
are not directly known, statements made on the basis of
what has been observed". Inference as conceived by
Hayakawa takes into consideration the multitudes of
variables present in the process. It is more of an
ability applicable to a wide range of situations. Some
of his examples illustrate this point:

We may infer from the material and cut of a woman's
clothes her wealth or social position; we may infer
from the character of the ruins the origin of the
fire that destroyed the building; ... we may infer
from the sound of an engine the condition of its
connecting rods.

The fact that inferences are fallible denotes that there
is scope for the improvement of their accuracy.

3. Relationship between the concept of a situation and
the development of an inferential ability

From both 1 and 2 above the following could be noted:

a the nursing 'situation' as it presents itself is a
complex and varied set of interacting elements and
variables;

b to deal with such variety and complexity requires an
ability involving: increased awareness to the
variables present, interpretation of the different
variables within the context of the 'situation', a
sufficient amount of knowledge which would enable
the nurse to take decisions confidently;
because such decisions may need to be made quickly
(sometimes), and involve big and small decisions there
is more need for the development of what Sarbin et al. 
(1960) called the clinician "feel";
nursing decisions do not only involve the patient's
condition but are also influenced by the policies
and the rules of the hospital and the country in which
the nurse is practicing, as well as by the culture of
the ward and the nurses' preparation or education.
Such factors do not support a linear or deductive
type of inference;
In Sarbin's et al. (1960) view "the choice of data
and the manipulation of terms" is influenced by the
person doing the inference. Therefore there is a
very influential role played by the 'orientation' of
the student nurse during her programme of education.
Two needs seem to emerge from the above notes.
i a need for a frame of reference which will guide the
nurse's orientation to the presence and meaning of the
variables present in a situation;
ii a need for an ability which will enable the nurse to
manage such variability by working out the implications
of the variables singly and as a group within the frame
of reference of the 'situation'.
I believe that the concept of the situation could be useful
as a frame of reference in increasing the nurse's awareness
and directing her orientation, and that the ability she needs to develop, relevant and compatible with the characteristics of a nursing 'situation' is an inferential ability.

Talking about inferential ability rather than 'inferential task' as called for by Hammond et al is an important distinction. An ability is more economical and productive in terms of usage than a task. An ability is also embrasive and is not bound to a specific task. This makes it more 'universally' applicable. The form of inference needed for a nursing situation ought to be of a multidimensional nature, i.e. not only cognitive. In an attempt to explain the form of inference I advocate I shall compare inference with deduction. Deduction is linear and based on formal logic, i.e. what is deduced is already present in the premise. Inference is more of a global type of presentation, and the inferred relies on intuition sometimes. A multiplicity of cues help inference as found by Hammond et al. Inference relies a great deal on the subject's perception and orientation and therefore uses knowledge, feelings, ideas, cultural factors etc. In other words, it is 'subjective' while deduction is more 'objective' as it relies only on 'facts', information and rules. Inference seems to be more applicable in the case of complexity while deduction is more applicable when dealing with 'specifics', or with factors 'one at a time'. This makes inference more of an
ability and deduction an intellectual procedure.

Somehow, inference appears more congenial to education and deduction to training. Inference is multidimensional and multidirectional while deduction is unidimensional and unidirectional. The form of inference advocated is the ability to recognize and understand relationships between two or more elements within the context of their combination. The process of recognizing and understanding relationships involves the study of implications and that of passing from the 'specific' to the 'general', and from the 'general' to the 'specific'.
A **Purpose**

As stated in the introduction, the experiment was planned as a suggestion to meet the problems which arose from the survey. The lack of relatedness between theory and practice and the fact that teaching was unidimensional and practice multidimensional was at the base of the complaint from students and tutors taking part in the survey. This was also found to be the case in the critical analysis of the GNC syllabus. Therefore the results of the survey suggested the approach and the purpose of the experiment. The specific purpose of the experiment could therefore be stated as:

1. to explore the possibility of teaching on the basis of a real 'situation' using the concept clarified in the introduction;

2. to evaluate the teaching on the basis of a 'situation' in terms of
   a) its effect in relating theoretical instruction in the classroom to the practical situation on the ward;
   b) its effect in developing the student's inferential ability namely that of (i) recognising fundamental relationships between and among variables, and that of (ii) passing from the 'general' to the 'specific' and vice versa;
   c) its effect in helping the student to view the
situation she is dealing with into and to increase her awareness of the variables playing a part in a situation.

B Steps followed
In view of the purpose and aims specified above the following was needed:
1. an opportunity to evaluate the viability of the concept of the 'situation' when used in teaching;
2. a means by which to evaluate the effectiveness of teaching on the basis of a 'situation' in terms of the degree and extent of relatedness between theoretical instructional and practical experience and along the lines followed in the survey (p. 63);
3. a means of evaluating the extent and nature of the development of the student’s inferential ability, when taught by the approach suggested;
4. a means of ensuring that the student’s learning of the basic nursing knowledge in the area involved was not impaired by the approach used.

In order to achieve the steps presented above, it was necessary to plan and carry out an experimental course of teaching and, as suggested in the introduction, the psychiatric nursing secondment was a possible and convenient period.

The psychiatric nursing secondment period is usually planned and carried out by the psychiatric nursing school affiliated to a psychiatric hospital. The latter would be
either within the same area as the general nursing school in the case of hospital board schools or of the same 'group' in the case of group schools.

As the psychiatric nursing secondment varied in its location within the programme of training among schools there were no specific times of the year when it took place. It depended mainly on (i) 'local' conditions of the general nursing school, e.g. frequency, time and size of student 'intake', the stage of training for which the secondment was planned, (ii) 'available' time offered by the psychiatric nursing school, as these schools apart from their own programme of psychiatric nursing training could offer psychiatric nursing experience for more than one general nursing school within the 'area' or 'group' and provide experience for a variety of other groups of students, for example, post registration students registered on one of the other three registers held by the GNC (see p. 59) and wanting to qualify for the mental register.

Sample size and distribution

Four psychiatric nursing schools finally applied the experimental course of teaching. One of the four provided the psychiatric nursing experience for two different general nursing schools within the same period of time, but each group of students had a different team of tutors and practiced in different parts of the hospital.
The criterion on which the school was chosen was the willingness of its principal tutor to apply the experimental course of teaching. Willingness in this case usually meant available number of staff to undertake the teaching. Each group of students was divided into two sub-groups (an experimental sub-group and a control sub-group) and this necessitated two tutors or clinical instructors for each group (one for each sub-group).

Another deciding factor in the choice of school was the availability of a psychiatric nursing secondment group within the period the experiment could run. The number of psychiatric nursing schools involved was also a factor of availability within the given period. Five groups of students were considered to be a fair number for a first trial by my supervisors and myself. Schools were contacted personally by myself, suggestions for contact came from the principal of the general nursing schools I had already been working with or through the principal of the psychiatric nursing school which took part in the experiment.

Two schools unable to take part in the main study were nevertheless very enthusiastic about the experimental course and co-operated in piloting the 'inferential test' which I had constructed.*

---

* Both schools implemented experimental courses on their own, one of the schools keeps a record of the students' evaluation of the teaching on the basis of a situation. The results constantly favoured this approach.
Table XIX shows the number and distribution of schools among the Regions.

**TABLE XIX**

**PSYCHIATRIC NURSING SCHOOLS IN THE FIVE SCOTTISH REGIONS**

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Schools available</th>
<th>No. of Schools included</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>North-Eastern</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Eastern</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>South-Eastern</td>
<td>5</td>
<td>3</td>
<td>1 of the 3 used for piloting inferential test</td>
</tr>
<tr>
<td>Western</td>
<td>12</td>
<td>2</td>
<td>1 of the 2 used for piloting inferential test</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>6</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

Table XX shows the distribution of students among the schools finally taking part. One of the schools had only eight students in the group which made division into experimental and control sub-groups meaningless, therefore a previous group was used as their 'control'.
### Table XX

**DISTRIBUTION OF STUDENTS**

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental group</th>
<th>Control group</th>
<th>Total finally included</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial No.</td>
<td>Final No.</td>
<td>Initial No.</td>
</tr>
<tr>
<td>I</td>
<td>8</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>III</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>IVa</td>
<td>12</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>IVb</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>41</td>
<td>3</td>
<td>38</td>
</tr>
</tbody>
</table>

Student wastage represents those who did not sit the final tests or who did not complete the questionnaire.

All the initial numbers of students followed the course of teaching and practical experience with the exception of one student who was ill. The total number of tutors (tutors in this case includes registered tutors and clinical instructors) involved was nine, six men and three women myself included. The odd number of tutors is due to the school whose student group was too small to be divided therefore having no concurrent control group.

The first school contacted was a large teaching school, providing psychiatric secondment experience for two different 'general' schools of nursing. a and b represent the group of students from the general school.
Five tutors and two clinical instructors were registered, one clinical instructor was unregistered and myself having had a different preparation.

PILOT STUDY AND PREPARATION FOR THE COURSE

A Tutors' preparation

The availability of schools was limited because of the restriction of time and distribution of psychiatric secondment.

It seemed inappropriate to carry out a pilot of the experiment as a whole for the following reasons:

a) one pilot would not have been enough in deciding change in the approach, and several trials were not possible;

b) after the tutors had been introduced to the approach to the teaching they would still use their 'interpretation' of the approach. A long period of initiation is needed to make their 'interpretation' and mine closer;

c) one of the purposes of the experiment was to find out the possibility of using the concept of the 'situation' in teaching, and one way to do this was to let it be tried out by as many tutors as possible.

It would have been desirable, however, to prepare the tutors involved in the teaching, through a series of seminars. This would have helped in giving them enough time to assimilate the intended meaning of teaching on the
basis of a 'situation'. The limitation of time, distance and of not knowing which of the tutors would be involved, decided the omission of such preparation.

The alternative therefore was: after contacting the principal of the school I met him/her and explained further about what the teaching would involve, then I met the tutors to be involved. I presented a general picture of the approach, what would be required from the tutor teaching the experimental group and from the tutor teaching the control group. I then met the tutor of the experimental group as often as possible before he taught the group. If the tutor had difficulty in understanding what I meant, I offered to re-write his lecture notes within the frame of reference I had in mind, as a guide to my explanation.

During the trial I visited the school frequently in case any help was required, but left it to the tutor to decide the amount of help he required. When planning the experiment it was hoped that the tutor teaching in the classroom would also give some clinical instruction on the ward, but various other commitments of the tutor made this impossible, and therefore it was omitted.

B Inferential ability test

I could not find an existing test which would test inferential ability and therefore set out to construct a test.

Like any other test, the 'inferential test' needed to

* Appendix IV includes a copy of the test.
be piloted for: (i) clarity of instruction, (ii) comprehension, (iii) ambiguity, (iv) any practical point of application and set up, (v) validity.

The test which was eventually used consisted of three parts: Part 1 involved recognition and explanation of fundamental relations between words, Part 2 involved matching specific instances to a general principle, and Part 3 involved matching the general principle to the specific instance.

Pilot tests

Two pilots were performed.

1st pilot: 20 students were involved in completing the test. I briefly introduced the study and explained the help I required from them. They were told that in the first part of the test if they did not know the meanings of any of the words used I would pass over a dictionary or if it was not available I would tell them the definition of the word used. They were also told that at the end of 20 minutes they would be asked to stop and put a mark on the paper at the place they had reached by then and then carry on until they finished.

Twenty minutes was estimated on the basis of one minute per question plus an extra minute for reading the instructions. At the end of the test they were asked for their opinions and suggestions. They felt that time should not be restricted and suggested some change in the instruction to each part. They also felt that in
Part 2 of the test it was better to write down the number of the principle rather than the principle itself. They felt that the test was "strange", unlike anything they had done before, but that it was "stimulating". After the trial and marking of the test the following changes were made:

1. a written instruction on the front page was included instead of my oral instruction to the group;
2. a space for the student to write down the time before she began the test, on the front page, and another equivalent space at the end for the time she finished;
3. instructions at the beginning of each part of the test were modified;
4. in Part 1, slight change in content was made;
5. in Part 2, only two situations instead of three were used as illustrations for the principle and the number of the principle was required rather than the principle itself to be written out. The psychiatric nursing principle sheet which was identical with the handout was adjusted to include seven principles;
6. in Part 3 some rewording was needed in Question 1.

2nd Pilot: The test was piloted a second time with another group of sixteen students. Again students were asked about their opinions and suggestions. Instructions to Part 3 of the test and some alteration in Question 1 were suggested. The students felt that the test was difficult and made them "think very hard"; some
students found it interesting and enjoyed it.

The suggested alterations were made and the rest of the test remained unchanged.

An attempt at content validity of the test was made by giving the test to four teachers, acting as professional judges. They were asked two questions, (i) whether what the test was evaluating was what they would call inferential ability, (ii) whether they perceived such an ability to be necessary for nursing. All four teachers agreed to both questions.

C Course preparation

Some standardization was needed in deciding upon objectives, content and approach of the course of teaching, in order to be able to evaluate the course at the end.

The first school, in chronological order, to apply the experiment was providing experience for two different schools (School IV). It was decided then that I would teach one experimental sub-group to gain further insight in the practicality of teaching on the basis of a 'situation'. Three other teachers were then involved in planning and teaching the course. No alteration in the content of what was usually taught, the hours of teaching, or in the period of the secondment was intended.

The only variable to be introduced would be the approach to teaching. The word approach rather than method was used as method refers specifically to the delivery of knowledge, e.g. lecture, discussion, project,
while approach means a way of organizing the knowledge to be taught along a given line for a more general purpose. In this instance, to increase the awareness of the student of the variables present and of their implications, and to develop the ability of the student to think in terms of relatedness, i.e. similarities and differences of variables and their implications, (inferential ability). This was to be done using a 'situation' and its management. The same approach can use several methods of teaching.

The first three tutors involved were asked to write down, before the experiment was due to start, their objectives for the psychiatric nursing course, and what topics they would be covering with some idea about the content. This, together with the GNC's objectives of the psychiatric nursing secondment, guided my own formulation of the objectives for the course. The main purpose of writing down the objectives of the course was to standardize the instruction given to all the schools involved and also help direct the student's expectation from the secondment. One of the complaints made by students in the pre-pilot study of the survey (p. 76) was the fact that they did not really know what to expect or why they were having the psychiatric secondment.

The three tutors' objectives are in Appendix V. Formulation of objectives, of content or of principles of psychiatric nursing was to be framed in a jargon-free
language. The objectives finally reached were:
To help the student:
1. to recognize the meaning of behaviour in different situations;
2. to know how, given the limitations of her/his abilities she/he can go about meeting a situation.
Meeting a situation could be done on one's own or with help from others, or by referring the situation to the next person responsible, or a combination of these alternatives;
3. to obtain information about different methods of treatment used in psychiatric care.

When the students were given the sheet of objectives and principles (Appendix IV) their attention was drawn to the use of words. The word 'recognize' rather than 'understand' was used as it was unrealistic to expect the student to understand in depth the meaning of behaviour within such a short time as eight weeks. It was hoped that the student would be able to recognize 'distress', 'fear', 'depression' etc. in the patient.

On the whole, what was expected from the student and what her expectation should be was on a superficial level. This was made clear to the student and limitations of time explained. I felt that it was important to orientate the student's attention to the depth and complexity of human behaviour and to emphasize the importance of more knowledge, experience and time to understand and
know how to deal with human behaviour. To minimize such importance is in my view to endanger professional standards and responsibility.

The content of the course was also decided along the same lines as the objectives. Appendix V gives the tutors' notes in relation to content. The final topics to be taught, were:

1. Personality and its development;
2. Behaviour;
3. Observation;
4. Therapeutic communication;

Among the papers usually distributed to the students by the psychiatric school was a print out of ten psychiatric nursing principles. These seemed to be a useful guide to the student but to enhance understanding of the principles, some kind of reasoning for the principles or a context (frame of reference) was needed. Therefore these ten principles were reworded and reorganized accordingly. The modified principles were:

Principles of Psychiatric Nursing.

I Patients come to the hospital for help, because they found it difficult to cope with the community outside the hospital. They need to be:

a. accepted and respected as they are.

b. permitted to express their feelings, whether pleasant or unpleasant.

c. taken at their own pace in working out their problems.

d. helped to control their behaviour, if they are unable to do so by themselves.

* Copy in Appendix V.
II As a nurse helping in the care of the patient, one needs to remember that:

a. the patient is an individual in a difficult situation who needs, above all, to be cared for as a person.

b. the patient's behaviour is meaningful. It is the way in which he/she expresses himself/herself.

c. when patients are trying to "tell you something" by their behaviour, they expect a response from the people caring for them.

d. it is important to take into account one's own feelings about a situation, since these feelings might influence that situation.

e. the same situation might be interpreted differently by different people (whether patient or nurse).

f. even though some situations are difficult to cope with, it is more beneficial for the patient if one gets help to face the situation, rather than avoid it.

The reorganized objectives, contents and psychiatric nursing principles were discussed again by the three tutors to correct any misinterpretations on my part. No further adjustment was needed. The general idea behind the teaching was as follows:

**Behaviour**: is a way of doing, influenced by stage of development, by personality of person involved and by the situation this person happened to be in, as well as the role played by this person in this situation at the time.

**Individual's development**: is influenced by the personality of the people with whom the individual comes in contact with, the different situations the person experiences through life, and the role the individual takes in this situation.

**Personalities**: are outcome of heredity and interaction of the person with his environment.
Observation: is influenced by the person's perception, which is the way the outside world communicates with the person's inside world. Perception is influenced by knowledge stemming from without and within the person, in other words, what one learns, and one's interpretation of events on a cognitive and emotional level.

Communication: is based on the interplay between perception of sets of behaviour by persons involved. In psychiatric nursing the general aim is to modify or influence communication on the basis of knowledge to reach a certain purpose or set of behaviour. Therapeutic communication is therefore an interference aiming at modifying behaviour to help the person cope with what they find difficult to cope with. This is done in various ways through interpersonal relationship on a one to one basis and/or group, helped with physical treatment and chemotherapy/drugs accordingly.

The tutors teaching the experimental sub-group were given a written guide-line of teaching on the basis of a situation, along with a verbal explanation (Appendix IV). No serious difficulties were encountered with the other three schools when applying the experiment, and using the objectives set along the lines of the first school.

MAIN STUDY AND RESEARCH TOOLS

1. Experimental Design

The experimental design represented by Graph M, (page 263a) illustrates the different stages of the experiment.
EXPERIMENTAL DESIGN
(8 weeks)

Key
E = Experimental group.
C = Control group.
Al = Adult I verbal reasoning test given to both E and C group.
HO = Handouts given to both groups. These included objectives of the course, principles of psychiatric nursing, observation guide, and legal notes. All were written in jargon-free language.
T = Teaching (which was the only different activity). The topics taught were the same, but the approach different.
Ev = Evaluation of the course by the students of both groups. This was in the form of a rating scale of the different activities (eg nursing lectures, hospital seminars, work on the ward), and the handouts, as to the extent each of these helped them understand and work on the ward.
Qu = Questionnaire about the students' perception of the relatedness of the theoretical instruction to the practical experience.
F = Factual test, for general knowledge gained during the experience.
I = Inferential test, specially constructed to test the inferential ability of the students.
1-8 = weeks, psychiatric secondment being of eight weeks' duration.
Following the experimental design, Graph M, page 263a, each stage is discussed in chronological order.

**Subgrouping**

Every group of students coming for their psychiatric nursing secondment experience was divided into two subgroups, an experimental subgroup and a control subgroup. It was initially intended to divide the group randomly, but this proved difficult. The hospital administration, rather than the school, was responsible for allocating the students to the different wards. To interfere with the student allocation would have created some upheaval from an administrative point of view and would entail difficulties, which if surmountable with some hospitals would not necessarily be the case with the others. As the period of secondment was short, in order to avoid 'cross-fertilization' of the two subgroups, students were divided according to their allocation to wards. If two students worked together in the same ward they had to belong to the same subgroup. I usually tossed for starting to divide students into experimental or control subgroups, then alternated the distribution. The intention here was to minimise administrative upheaval and to avoid mixing students on the ward. As the students at this stage were unknown to me this procedure for allocating students to experimental and control subgroups was virtually random and bias was avoided. Allocation was done before the students started secondment at the time.
I visited the school for the arrangement of the experiment.

In school I, since the total number of students available was eight, within the restriction of lack of availability of tutors, it was decided to leave the entire group as an experimental group and to have a control group for the inferential test. A group of students who had finished their psychiatric nursing experience two weeks previously, were considered as a control group. This group of nine students were given only the Adult I and the inferential test.

For the eight weeks of secondment the GNC requires that the student spends four weeks in acute admission area and four weeks in long term area. This rule, however, was not strictly followed by all schools, mainly because of lack of facilities in the psychiatric hospital. Within these eight weeks the student received six hours of psychiatric nursing lectures by a psychiatric nurse/tutor/clinical instructor, and six hours of psychiatry taught by a psychiatrist. After consideration, the six hours taught by the psychiatrist were left as variables, which it was difficult to standardize. More than one psychiatrist usually taught these six hours to the same group of students, hence it would have been difficult to prepare those who would be teaching as they would be unknown until the last minute. The possibility of using these six hours as part of the experiment was discarded
because of the difficulties mentioned and an added financial consideration. Psychiatrists get paid for lecturing to nurses and it would have been interference on my part to deprive them of such privilege.

**Introduction of the students to the Experiment**

The first day the group arrived I explained that a 'trial' in teaching was taking place. I explained the study, gave them a brief background about the survey, and told them that they would be divided into two subgroups, A and B; the content, number of hours, distribution of teaching hours etc., would be the same with the difference that one group would be taught in one way and the other in a different way in order to evaluate which way theory and practice could be more related. I told them about the tests and papers they would be required to fill in, how long this would take and when it would take place. I also explained that their participation in the experiment was voluntary. None of the students had any objections, and even though they were not told which was the experimental and which was the control subgroup it was not difficult for them to know which was which after the first lecture (and right away for the group I taught, as I was the one interested in trying out something new).

They were then told which group, A or B, they were in and who would be teaching them. They were all given the Adult I test and three handouts.
Adult I is a test of verbal reasoning for people over seventeen years of age. It tests the ability to reason in the verbal medium. The reason for using the Adult I test was that it measures the same kind of ability that the experiment was planning to develop. As the students were not 'matched' in experimental and control group the results of the test could be used as a form of statistical standardization using the analysis of co-variance with Adult I as the independent variable.

The test lasts 45 minutes exactly and the student was not allowed any questions at all. The student was told that she could know the results of the test at the end of the eight weeks if interested.

Handouts. Three handouts* were given to every student (Experimental and control subgroups) together with a brief explanation.

The first handout consisted of the 'objectives of the course' and the 'psychiatric nursing principles'.

The second handout was a resumé of observation guide to orient the student as to 'what to observe', the latter having been a complaint of the pre-pilot group of the survey, (p. 76). This was taken and adjusted from Maddison et al. (1970) Psychiatric Nursing.

The third handout consisted of legal notes about the

* Copies of these are found in Appendix IV.
condition of hospitalisation of psychiatric patients, starting with the main principles on which the Act is based, followed by condition of admission: informal, emergency and certified. The reason for giving this handout was for reference, in view of the fact that such conditions are too difficult to remember for the student who is working in psychiatry for a short period.

This introductory session usually lasted for an hour and a half, after which the students went on duty.

Lecturing

Both subgroups were given their lectures on the same day and time of the week. They joined for the psychiatrist's lectures and separated for the nursing lectures.

The control subgroup was taught the same content as the experimental subgroup in the 'usual' way that the tutor had always taught, which means that the way of teaching varied with the tutor. The experimental subgroup were taught the same content as the control subgroup but on the basis of a 'situation'. Several points need to be clarified at this stage.

It was difficult not to introduce the tutor teaching the control subgroup to the experimental approach, as both tutors had been introduced to the experimental idea and it was left to them to decide who would be willing to apply it. Introducing the tutor teaching the control group to the experimental approach might be considered as
'contamination' of the control group's teaching. Often both tutors wanted more information about the experiment and it was difficult not to give it. In one school the whole explanation of the experimental approach was given to both tutors, the principal tutor and a third tutor interested to hear about the experiment. Although such 'contamination' was undesirable from a 'design' and 'statistical' point of view, it was felt that it could be permitted, as the main purpose of the experiment was to test the applicability of the approach to the teaching.

In one school the tutor teaching the control group was not going to be available for two lectures and I volunteered to teach the control group the first two lectures as no other tutor was available. Even though I took my instructions from the tutor as to how he would want to teach, I found myself pointing out relationships among the different signs and symptoms of psychiatric illness.

In school I there was no control subgroup therefore only one class was present at the time.

Each tutor applying the experimental approach to teaching was given a guideline together with a number of oral explanations and examples of application. What the tutor ultimately taught in the classroom was dependent on his own interpretation of the approach put forward. I had no direct access to the latter and felt that my knowledge of it at that stage was immaterial.

What I could offer was being available to answer queries and get the reaction of the tutor to the approach to teaching. The main principles behind the approach were:-
i) to use 'situations' from the practical field, these being the best guide to what the student needs to know and learn to 'manage'. Because tutors had not enough time to go to the ward and choose for themselves 'situations' for teaching, it was suggested that the student write about a 'situation'. In most cases this meant writing about a patient she felt interested in. The tutor could then use the information provided by the student(s) and link up the similarities between the different students' contributions;

ii) to point out the applicable psychiatric nursing principles to the different situations encountered by the students. This is achieved by showing the relatedness of variables or of knowledge imparted, as well as by indicating similarities and differences. In so doing one was helping the student to formulate general ideas from isolated incidences, as well as to apply general ideas previously acquired to instances she encountered;

iii) to vary the aspect of viewing the situation from the patient's point of view, from an administrative point of view, from the nurse's point of view, etc., in order to introduce the student to the idea of difference in perception, and develop her ability to empathize;

iv) to introduce from three to six new general ideas in the course of one lecture, depending on the complexity of the idea and context within which it is introduced in order to avoid 'overloading' of knowledge, and give the student time and 'space' to assimilate the new ideas and their relatedness to previous ones.
Course Evaluation

The psychiatric secondment period of eight weeks was divided into four weeks in an acute ward followed by four weeks in a long-term ward or vice versa. As pointed out earlier (p. 265) this was not always the case, nevertheless, in an attempt to evaluate the student's perception of what helps her to 'understand' and to 'work' on the ward, a course evaluation schedule was distributed. The same format was filled twice by the students. Four weeks seemed a natural division within the circumstances. The course evaluation schedule was given at the end of four weeks, i.e. following the first kind of experience, and at the end of seven weeks, within the questionnaire, following the other kind of experience. In both instances it was given during 'class hour'.

The schedule included all the possible activities which could have contributed to the student's understanding of psychiatric nursing knowledge and to her ability to practice on the ward.

The differentiation between 'understanding' and 'working' was made on the grounds that the student could feel that though the lectures, for instance, helped her understand what a neurosis was and how it presents in a patient's behaviour, the same lecture did not succeed in making her know what to do and what to say to the patient and how to manage the situation on the ward. It was also an attempt at identifying which activities, according to the student, were capable of relating 'theory' to 'practice'.
The Questionnaire

In the survey, the student's perception of the degree and extent of relatedness between theoretical instruction and practical experience were known mainly through the use of a questionnaire. For the sake of comparison, it was felt that the same procedure should be adopted in the experiment. It was also felt that for better evaluation of the student's perception of her psychiatric nursing experience her perception of her general nursing experience should be sought as a background, therefore the same questionnaire was used again with some modifications. Questions 14, 15 and 16 pertaining to objectives were removed, together with questions 20, 21, 22, 23, 24, 25 and 26. To let the student rank the objectives of the training fulfilled no useful purpose in that small group. The group of questions 20 to 26 pertained to psychological aspect of patient's care and to psychiatric secondment, which seemed repetitious and inappropriate, in view of the added questions pertaining to the psychiatric secondment experience.

Eight questions were introduced in place of the seven removed, asking about the psychological aspect of patient care and psychiatric secondment.

The new questions were formulated along the same lines as the ones pertaining to the general training. A copy of the added eight questions is presented in Appendix IV. Piloting of these questions was not felt to be necessary because of the similarity of working to that in the main questionnaire. The general purpose of this part of the questionnaire was to find out if the role of the
theoretical instruction was more prominent in the experimental subgroup than it has been either in their general training or for the control subgroup.

Five questions were repeated along the same lines as questions included for the general training. Table XXI shows the corresponding questions in the two parts of the questionnaire, the general nursing and the psychiatric experience.

Table XXI parallels questions used in the questionnaire given to psychiatric secondment students.

**TABLE XXI**

**PARALLEL QUESTIONS IN THE QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT</td>
<td>8 10 17 18 19</td>
</tr>
<tr>
<td>PS</td>
<td>I II VI VII VIII</td>
</tr>
</tbody>
</table>

**GT = General training.**  
**PS = Psychiatric training.**

The other three questions were attempts at evaluating the degree of relatedness as perceived by students between general training and psychiatric secondment; as well as the usefulness and applicability of the knowledge gained in psychiatric secondment to the student's general experience.

The student was also invited, at the end of the questionnaire, to comment freely about her psychiatric nursing experience. The questionnaire was given when the student's lectures had finished.
The same time allocated weekly for lectures was used for the students to complete the questionnaire in order to avoid administration upheaval. This was agreed upon before the students started their psychiatric secondment, so the administration expected and planned their off-duty accordingly.

Following the same procedure as in the survey, I distributed the questionnaire personally and stayed with the students while they filled it in. This was followed by an open discussion about their opinion of their nursing experience in the psychiatric area and, when applicable, their evaluation of the experimental teaching.

The Tests

Two tests were used at the end of the eight weeks experience, an Inferential Test to evaluate the presence and degree of development of the inferential ability of the student and a Factual Test to evaluate the student's understanding of some of the psychiatric knowledge gained during the experience. A copy of each test is included in Appendix IV. The Factual Test was usually given first.

i) Factual Test

The purpose of giving a Factual Test was to evaluate whether the students following the experimental teaching suffered any lack of 'knowledge' due to the approach used, and to evaluate the effect of the way of teaching on the acquisition of factual knowledge. The knowledge required
in this test was of the type that the student would have gained by working on a psychiatric ward, to make the test applicable to all schools.

The test consisted of four parts, in each part a choice was given between two alternatives, "Please answer either A or B section."

Part I pertained to drugs used and only required a superficial knowledge of the name of the drug and its category.

Part II pertained to definition of signs and symptoms encountered in psychiatry illustrated by examples.

Part III pertained to the student's opinion on topics, her opinion based on her observation on the ward, for example, "In your opinion, how does 'mental illness' affect the eating habits and the food intake of a person?"

Part IV pertained to more direct nursing care issues. It also was based on the 'observation' handout, an example being, "What do we usually want to know about the patient's sleep? What is the importance of such knowledge?"

The test was constructed after some consultation with the three tutors in School IV. After I had written the test the three tutors read it for approval before distribution. Every part of the test was allocated 12 points, 6 points for each Section A and B. The total number of points was 24 (4 Parts x 6 points). No time limit was set on the test.

ii) Inferential Test

The purpose of giving the inferential test was to
evaluate whether the students in the experimental subgroup had developed inferential ability more than the students in the control subgroup.

The general principle tested pertained to the ability of the student to recognize and explain relationships. This test consisted of three parts:

Part I tested the student's ability to recognize similarity between symptoms and to pointing out the fundamental relationship between them. A group of symptoms were given and the student had to decide for herself which two were related in a fundamental way and to give her reasoning for the relatedness. In other words the student had to rely entirely on her ability to recognize relationships. If the student did not know the meaning of one of the symptoms I gave her a standard definition of the symptom.

Part II tested the student's ability to recognize similarity between instances and their psychiatric principle applicable to these instances: in other words, the ability to pass from the specific to the general. The psychiatric nursing principle handout was used as the source of the group of principles the student had to choose from.

Part III tested the same ability as that tested by Part II but in the opposite direction: the ability to pass from the general to the specific.

Both Parts II and III provided the general concept
and the student had to recognize the translation of the concept into concrete behaviour. In this sense Parts II and III were easier than Part I in which the student had to find the general concept for herself. This test, as explained earlier, was constructed by myself, with some help in the use of language in testing provided by test constructors at the Godfrey Thomson Unit for Academic Assessment.

Every answer to the test was allocated one point, giving 14 points for Part I, 6 points for Part II and 3 points for Part III, making a total of 23 points.

No time limit was set on the test, but students were required to write down the time at the beginning and at the end of the test. There was usually a period of open discussion about the tests and generally the students wanted to go over the inferential test again and know the right answers. The results of the Adult I test were also given privately to those who wanted it. Names and addresses were taken of the students who requested that the results of the tests were sent to them.
CHAPTER NINE

RESULTS

Results of the experiment will be presented under four headings: (1) Opinion of tutors and students; (2) Results of Questionnaire, (3) Course evaluation results, and (4) Results of different tests used.

1. Opinions of Tutors and of Students

Tutors

The main purpose of planning the experiment was to find out the extent of applicability of teaching on the basis of a situation.

At the end of the experimental course I had a meeting with the tutors involved for their opinion of the approach used. On the whole the tutors found the approach "meaningful" and effective "it makes more sense to the students than giving them a list of signs and symptoms" said one tutor.

The merits of the approach in the opinion of the tutors were:

- the course had a plan and a purpose;
- though the nurses were in different wards, the knowledge was qualified by the student's experience;
- the information given seemed relevant to the student's experience;
- it was more akin to education by being open and free and by avoiding rote learning;
- it was a different way of looking at the teaching which was stimulating and interesting;
- its applicability in other areas like in-service education was appealing to one of the tutors who felt that experienced people would benefit from it even more. The **demerits** of the approach in the opinion of the tutors were:
  - eight weeks was too short a period to develop the approach and start using its potentials;
  - there was a danger of missing out some important facts and some knowledge which needs to be mastered by the student, if it does not occur within the situation;
  - it is time-consuming in terms of preparation and organization;
  - it requires some time for its mastery;
  - not all students would feel safe without specific knowledge.

Our conclusion was that it is possible to teach on the basis of a situation, but some modification would be desirable. Tutors thought that teaching by the use of a situation was essential all the time. This in fact was not necessary as the study and understanding of the 'situation' was an attempt at constantly drawing attention to the presence and relatedness of variables and their
implications. This could be achieved in several ways and not necessarily by the use of a 'situation' set-up. The use of the concept of a situation generally was an attempt at representing the 'reality' of practice in the classroom teaching to help the student learn how to study and manage such a situation.

Students

The students' opinion should be interpreted in perspectives of how the psychiatric secondment was viewed by them. The psychiatric secondment was a different atmosphere from what the student was used to in the general hospital. In the psychiatric hospital she did not 'rush around' doing things, she could 'sit down' and talk to patients or play cards with them. She does not wear a uniform in some wards. The relationship between Sister and staff was of a more relaxed nature. A student said,

The attitude of the staff towards each other is very relaxed and so a very easy atmosphere is created, in this kind of atmosphere it is very easy to work and learn. It is also a much better atmosphere for getting to know the patients we are working with.

The ward the student worked on, her ability to put up with the strain of working with the mentally ill, and her liking of that type of nursing as well as the amount of guidance she receives decided whether she liked or disliked the psychiatric nursing experience and this naturally flavoured her answers generally.
During the open discussions the students generally expressed the feeling that they enjoyed the psychiatric experience. The reasons given were varied. Some students felt that they "learnt so much", others thought it was "very interesting", one student felt that:

the study of the mind (is) fairly fascinating but I must admit the more you know about this the more you realise how much you are scraping the surface. I find it very difficult and exhausting understanding these abstract concepts. (student from a control group).

Some students did not enjoy it because they did not like that type of nursing, or because they felt 'left out' on the ward and did not know much about the patient illness or history.

As to the experimental group some of them felt that it was part of the different kind of experience, it "fitted well". Some students thought it made a lot of sense and helped them understand the patient better. Some students wished their tutors in "general" would know about this way of teaching. However, a group of students who did not seem very responsive in the discussion, did not know what I was talking about when I asked how they found the idea of teaching in the basis of a situation. A few students could not see that it was very much of a help. Somehow it seems that the tutors who were enthusiastic about the idea transmitted such a feeling to the students.

2. Questionnaires

All five groups of students from the four schools were considered as one group in order to follow the same line of
presentation as the survey. The control group of school I was not given the questionnaire. Some students were wasted by absenteeism. The following table shows the student distribution.

**TABLE XXII**

**STUDENTS DISTRIBUTION OVER FOUR SCHOOLS**

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental</th>
<th>Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>8</td>
<td>- *</td>
<td>8</td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>III</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>IVa</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>IVb</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>38</strong></td>
<td><strong>26</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>

As the purpose was to find the difference, if any, between experimental and control subgroups, the data for these are presented accordingly. Kendall’s coefficient of concordance ‘w’ was not used in this instance as the groups were too small. The results of the questionnaire are reported under two headings: A General Training, B Psychiatric Training, and the pattern of reporting was, First, the question: next, a table, showing the distribution of answers in the experimental and the control subgroups in terms of numbers and percentages.

* No control present.
A General Training

(Q. 8) when faced with a hospital situation requiring quick action, which helps you most?

<table>
<thead>
<tr>
<th>Source of help</th>
<th>N = 38</th>
<th>N = 26</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental subgroup</td>
<td>Control subgroup</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>a. Previous hospital experience</td>
<td>24</td>
<td>63</td>
</tr>
<tr>
<td>b. Classroom teaching</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>c. Student's own judgement</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>d. Combination of a to c</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

The general pattern was that students rely on their previous hospital experience most. The next source of help was their own judgement and the least the classroom teaching. This result is similar to the survey group with the exception that the latter group ranked 'classroom teaching' third in priority.

(Q. 9) To what extent do you feel that the anatomy and physiology you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?

<table>
<thead>
<tr>
<th>Extent of relatedness needed</th>
<th>N = 38</th>
<th>N = 25*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental subgroup</td>
<td>Control subgroup</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>a. Great</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>18</td>
<td>47</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>10</td>
<td>26</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>7</td>
<td>19</td>
</tr>
</tbody>
</table>

* 1 no answer.
The same pattern as the survey group is followed by the psychiatric secondment students. Students' comments showed that anatomy and physiology, as taught, need to be more closely related than at present, the order was b (moderate), c (minimum), d (not at all) and a (to a great extent).

(Q. 10) To what extent do you feel that the 'nursing care' you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?

<table>
<thead>
<tr>
<th>Extent of relatedness needed</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 37*</td>
<td>N = 26</td>
</tr>
<tr>
<td>a. Great</td>
<td>5 14</td>
<td>5 19</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>17 46</td>
<td>11 43</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>9 24</td>
<td>5 19</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>6 16</td>
<td>5 19</td>
</tr>
</tbody>
</table>

* 1 no answer

Students feel that there is a need for 'nursing care' as taught in the classroom to be 'more closely related' to how it is applied in practice. The order of the extent of need was b (moderate), c (minimum), d (not at all) and a (great) for the experimental and control group together. The result differs from the survey group in that in the latter the extent of need expressed was in the following order: b - moderate, a - great, c - minimum and d - not at all.

Comments under "In what ways?" were written by 70% of the students in the experimental subgroup and 69% of the students in the control subgroup.
The categories of answers are those used for the survey group. Because of the small numbers in the experimental and control subgroups and because they were similar in the order of importance given to each category, the results of both subgroups are reported together. The categories were as follows:

- 68% c) lack of practicality or consideration of 'reality' of the situation by the school, hence the need for knowing how to manage practically;
- 16% a) lack of communication between school and hospital, and tutors' lack of contact with hospital;
- 7% b) need for teaching on the wards;
- 7% e) 'other' comments;
- 2% d) lack of consideration to the 'patient' by school.

Examples of the students' comments on category (c) were:

Often ward difficulties are not thought of when 'nursing care' is being taught, e.g. very ill patient, difficult to move, it always seems easy with a model instead of a real patient,

and

In the wards when you are busy you just don't have time to do it the so called proper way of the classroom, to a happy medium should be thought of.

Examples of the students' comments in category (a) were:

The teaching staff tend to be out of touch with what happens in ward situations,...

and

We are given many procedures to carry out which we are not taught in school and on the other hand we are taught some procedures which are outdated and/or never used on the wards.
Examples of the students' comments in category (b) were:

By having more clinical instructors on the wards, and

There should be more ward visits with the tutor to put into practice what you have previously been shown.

An example of student's comments in category (e) was:

I do not think it needs any change because I think it is up to the individual person how he/she carries out nursing care.

Only one student's comment was included in category (d):

In that each patient is different and has to be approached differently, there is no specific nursing care which applies to every patient. Each patient must be treated individually.

Generally the contents of comments given by the experimental and control group were the same as the survey group.

(Q. 11) To what extent do you feel that your practical hospital experience helps you to understand what is taught in the classroom?

<table>
<thead>
<tr>
<th>Extent of help</th>
<th>N = 38</th>
<th>N = 26</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental subgroup</td>
<td>Control subgroup</td>
</tr>
<tr>
<td>a. Great</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The students seem to be unanimous whether in the experimental or control subgroup or in the survey group, that their hospital experience plays a very prominent
role in making the classroom teaching easier to understand.

(Q. 12) How often does your tutor in the classroom use your personal experience in the hospital to illustrate her/his teaching?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Often</td>
<td>4 (10)</td>
<td>3 (11)</td>
</tr>
<tr>
<td>b. Sometimes</td>
<td>17 (45)</td>
<td>15 (58)</td>
</tr>
<tr>
<td>c. Seldom</td>
<td>14 (37)</td>
<td>6 (23)</td>
</tr>
<tr>
<td>d. Never</td>
<td>3 (8)</td>
<td>2 (8)</td>
</tr>
</tbody>
</table>

The answers follow the same pattern for both subgroups. It is also the same pattern of answer given by the survey group. Tutors use the students' personal experience in hospital to illustrate their teaching to a fair extent.

(Q. 13) How often have you been faced with a discrepancy between what is taught in the classroom and what is practiced on the wards?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Often</td>
<td>21 (56)</td>
<td>17 (65)</td>
</tr>
<tr>
<td>b. Sometimes</td>
<td>14 (38)</td>
<td>9 (35)</td>
</tr>
<tr>
<td>c. Seldom</td>
<td>1 (3)</td>
<td>-</td>
</tr>
<tr>
<td>d. Never</td>
<td>1 (3)</td>
<td>-</td>
</tr>
</tbody>
</table>

Again a similar pattern between the two subgroups and the survey group is found. Students 'often' encounter
a discrepancy between what is taught and what is practised.

As explained earlier, Questions 14, 15 and 16 were excluded as they did not fulfil any useful purpose.

(Q. 17) Which of the following have you found most difficult to cope with in your present programme?

<table>
<thead>
<tr>
<th>Most difficult area</th>
<th>Experimental Subgroup</th>
<th>Control Subgroup</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 37*</td>
<td>N = 24**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N   %</td>
<td>N   %</td>
<td></td>
</tr>
<tr>
<td>a. Classroom material</td>
<td>22   59</td>
<td>12  50</td>
<td>More experimental subgroup students had difficulty with classroom material than control group.</td>
</tr>
<tr>
<td>b. Hospital training</td>
<td>4    11</td>
<td>-    -</td>
<td>More control subgroup had no difficulties than experimental subgroup.</td>
</tr>
<tr>
<td>c. Both a and b</td>
<td>8    22</td>
<td>7    29</td>
<td></td>
</tr>
<tr>
<td>d. No difficulties</td>
<td>3    8</td>
<td>5    21</td>
<td></td>
</tr>
</tbody>
</table>

\* 1 no answer \** 2 no answer

The general pattern of answer in the above table is similar to that for the survey group (p. 99). But the tendency seems to be that the students in the experimental subgroup find their training more difficult to cope with than the students in the control subgroup. 4 students out of 37 in the experimental subgroup commented on Q. 17 as opposed to 7 students out of 24 in the control subgroup. Difficulties pertained to relationships with staff in hospital or school, to 'content' of what is taught and to 'administrative' issues. One student expressed difficulty pertaining to expectations.
... changing from one ward to another. Some you are treated very junior like and others more senior. It is sometimes difficult to know what is expected of you.

Difficulties in relationships were very similar to those expressed by the students in the survey (p. 102):

Ward staff, particularly big-headed senior staff,

and

Ward staff, especially those in a superior position.

An example of difficulties pertaining to content, was:

Trying to put classroom theory into practice in the wards, Most of the time it is not possible.

The following comment was classified as 'administrative' as I was lost as to how to classify it:

The ignorance of our tutors at times to realise how things are on the ward ...  

(Q. 18) Statements describing the students' difficulties with classroom work.

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Experimental Subgroup</th>
<th>Control Subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>a. Too much material in time available</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>b. Too much 'ideal' knowledge not applicable to hospital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>c. Not enough teaching and application</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>d. 'Nursing care' as taught is different from practice</td>
<td>23</td>
<td>20*</td>
</tr>
<tr>
<td>e. Treated as though you are expected to know</td>
<td>12</td>
<td>11</td>
</tr>
</tbody>
</table>
f. Student's own decision for application of knowledge in practice

<table>
<thead>
<tr>
<th></th>
<th>11</th>
<th>10</th>
<th>10</th>
<th>14</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

TOTAL

112* 100 72* 100

* Students ticked as many difficulties as they wished.

The order of difficulties generally similar to that of the students in the survey (p. 105). The pressure of time, unrealtedness of teaching to practice and the unrealistic expectation from the student to know what she has not been prepared for, was again the general theme of the answers.

The comments included under 'other' pertained to:

(i) 'administration' (3 comments) examples were:
I feel there is too long between study blocks;
while another student in a different school said
too long blocks;

(ii) 'Content', one comment:
Nursing care cannot usefully be taught without a patient and (by) not using ward facilities, it is a meaningless pantomime in the classroom;

(iii) 'expectations', one comment:
We are treated like children in school and yet they give us responsibility of a ward on night duty, etc.

(Q. 19) Statements describing the student's difficulties with practical hospital experience.
<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Experimental Subgroup</th>
<th>Control Subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>a. In getting along with staff on ward</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>b. In applying principles of classroom to ward because of disagreement</td>
<td>26</td>
<td>20</td>
</tr>
<tr>
<td>c. Fear of being 'caught' talking to a patient</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>d. Not enough instruction for carrying out techniques</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>e. Lack of orientation to ward organization</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>f. Being expected not to argue or express opinion</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>g. Not asked point of view about patient care</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>h. No difficulties</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>i. Others</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>128*</td>
<td>100</td>
</tr>
</tbody>
</table>

Students ticked as many difficulties as they wished.

Distribution of percentages has the same characteristics as that of the survey (p.108) spread out with very small difference between percentages. The rank order between survey students and this group was slightly different. The most prominent difference was statement (c) fear of being 'caught' talking to patients, which was fourth in priority in the survey (p.108) but is first in priority for this group.
The comments included under 'other' pertained mainly to 'administration' and 'relationships', examples are:

Senior staff don't seem to realise that junior staff care about their patients too and so expect us to skive off or take unnecessary short cuts;

and

I feel in hospital you are treated as a number and not as a person.

Some comments pertained to pressure of work:

Not having enough time to read the Kardex or case notes of the patients,

and

Not having enough time to talk to patients who need to be talked to.

B Psychiatric Experience

This group of questions pertained to the student's psychiatric secondment experience.

(Q. 1) When faced with a difficult situation on the ward, which helps you most?

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Previous ward experience</td>
<td>N = 38</td>
<td>N = 26</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>a. Previous ward experience</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>b. Classroom instruction</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>c. Personal judgement and intuition</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td>d. Other</td>
<td>8</td>
<td>21</td>
</tr>
</tbody>
</table>

* Large difference of percentage between E and C groups.
Both groups agree on the ranking in relation to what helps them most. Their own intuition followed by ward experience play a major part in dealing with situations. However, several points of interest should be mentioned. The percentage distribution of answers is more spread out in the experimental group than the control group where answering concentrated mainly on (c) and (a); the difference of percentage in the use of intuition and student's judgement between experimental and control group is very large. The general tendency seems to be that the experimental subgroup relied more on their experience whether at hospital or school than the control subgroup who relied mainly on their intuition and own judgement.

(Q. 2) To what extent do you consider that your classroom instructions are related to your practical experience?

Two points need to be made for the 'correct' interpretation of the answers to this question:

i. the question asks about 'classroom instruction', without specifying whether it is nursing or doctor's lectures. In the students' answers reference was made to doctor's lectures sometimes which alerted my attention to the weakness of the question;

ii. psychiatric experience included both theory and practice within the same period of time, such a fact is likely to influence the student favourably in terms of relatedness, as this was lacking in their 'general' experience on the whole. Indications to this effect were shown by a comment of a student in the control subgroup:
We are told about a variety of illnesses and in the wards we saw most of the illnesses.

The answers were distributed as follows:

<table>
<thead>
<tr>
<th>Extent of relatedness</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 38</td>
<td>N = 26</td>
</tr>
<tr>
<td>a. Great</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>23%</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>24</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>63%</td>
<td>50%</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>27%</td>
<td>15%</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>12%</td>
</tr>
</tbody>
</table>

The percentage distribution for the control subgroup is more widely spread than that of the experimental subgroup.

On the whole, the control subgroup felt that classroom instruction was related to hospital experience more than the experimental subgroup. 58% of the experimental subgroup and 85% of the control subgroup commented under "In what ways?", examples of answers are given in the discussion.

(Q. 3) To what extent do you consider that the knowledge and experience you gained in this course is related to your general training?

<table>
<thead>
<tr>
<th>Extent of relatedness</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 38</td>
<td>N = 26</td>
</tr>
<tr>
<td>a. Great</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>55%</td>
<td>61%</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>-</td>
</tr>
</tbody>
</table>
Both groups feel that they have gained knowledge and experience which is applicable to their general training. The control group feel more strongly than the experimental subgroup that this is the case. 84% of the experimental subgroup and 85% of the control subgroup commented under "In what ways?"

(Q. 4) To what extent do you consider that psychiatric nursing is related to general nursing?

<table>
<thead>
<tr>
<th>Extent of relatedness</th>
<th>N = 36*</th>
<th>N = 24**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental subgroup</td>
<td>Control subgroup</td>
</tr>
<tr>
<td>a. Great</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>14</td>
</tr>
</tbody>
</table>

* 2 no answer ** 2 no answer

The experimental subgroup seemed to think that psychiatric nursing is more related to general nursing than does the control subgroup; 80% of the experimental subgroup and 70% of the control subgroup commented on "In what ways?"

(Q. 5) To what extent do you consider that the knowledge you gained in this course would help you deal with the general nursing situation on the whole (excluding the psychiatric disorders met in the general hospital)?
The extent of help perceived by the experimental and control subgroups is as follows:

<table>
<thead>
<tr>
<th>Extent of Help</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Great</td>
<td>5 (13%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>b. Moderate</td>
<td>23 (61%)</td>
<td>14 (56%)</td>
</tr>
<tr>
<td>c. Minimum</td>
<td>8 (21%)</td>
<td>7 (28%)</td>
</tr>
<tr>
<td>d. Not at all</td>
<td>2 (5%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

The experimental subgroup seems to feel a little more than the control subgroup that, on the whole, knowledge gained in psychiatric experience shall help in general nursing. 66% of the experimental subgroup and 72% of the control subgroup commented on "In what ways?"

(Q. 6) Which of the following have you found most difficult to cope with in your present course of psychiatric secondment?

<table>
<thead>
<tr>
<th>Source of difficulty</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Classroom instruction</td>
<td>11 (30%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>b. Ward experience</td>
<td>4 (11%)</td>
<td>7 (27%)</td>
</tr>
<tr>
<td>c. Both (a) and (b)</td>
<td>14 (38%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>d. Other</td>
<td>8 (21%)</td>
<td>9 (35%)</td>
</tr>
</tbody>
</table>

The same tendency as in (Q. 4) is present in Q. 5. 1 no answer
The general observation about the above table is that there was a fairly large difference of percentage for each category of source of difficulty between experimental and control group. They also differed in their main source of difficulty:

to the control subgroup it was classified under 'other'. Comments specified referred mainly to the difference in type of nursing specifically mentioning the difficulty of adjusting to the slower pace in psychiatry. One student found that "the feeling of always being 'sized-up' by the ward staff made her uncomfortable". Another student found that the difficulty was to be "treated as an outsider in the ward situation" while another complained of "boredom!" Some students also mentioned their difficulty in "knowing how to handle the patients", and one student said "I would have liked to have had more doctors' lectures." The doctor referred to in this last comment was very helpful to the students, as his lectures were well planned and had a distinct practical aspect. Their second source of difficulty was their ward experience which supports comments written under 'other'. Two students commented after ticking (b), one said: "It is sometimes difficult to know what to say to patients", the other, "first ward". Their third and fourth sources of difficulty have the same ranking:

to the experimental subgroup, their main source of difficulty relates to both classroom and ward. Only one
student commented after ticking (c), "It is a completely different approach both in methods and ideas of treatment." Their second source was the classroom instruction. Again, the same weakness as Question II (p. 293) is relevant here. There was no specification as to whether it is classroom instruction in nursing or doctor's lectures. Since both subgroups, experimental and control, had the same doctor's lecture it is probable that their difficulty pertained to the nursing lectures. Under 'other' their third source of difficulty, all the students' comments related to the difference of type of experience, specifically the difference in pace of work between psychiatric and general.

Their fourth source of difficulty was related to their ward experience which only few students found difficult.

(Q. 7) The student was asked to tick as many statements as she wished which would describe her difficulty with classroom teaching.
Statement of Difficulties with Classroom teaching

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Too much material for time available</td>
<td>9 (18) (3)</td>
<td>9 (25) (1)</td>
</tr>
<tr>
<td>b. 'Ideal' knowledge with no practical application</td>
<td>10 (21) (2)</td>
<td>7 (20) (2)</td>
</tr>
<tr>
<td>c. Treated as though you are 'expected to know'</td>
<td>3 (6) (6½)</td>
<td>3 (8) (6)</td>
</tr>
<tr>
<td>d. Own decision for application of knowledge</td>
<td>12 (25) (1)</td>
<td>3 (8) (6)</td>
</tr>
<tr>
<td>e. Not treated as responsible person</td>
<td>3 (6) (6½)</td>
<td>3 (8) (6)</td>
</tr>
<tr>
<td>f. No difficulties</td>
<td>7 (14) (4)</td>
<td>5 (14) (4)</td>
</tr>
<tr>
<td>g. 'Other'</td>
<td>5 (10) (5)</td>
<td>6 (17) (3)</td>
</tr>
</tbody>
</table>

TOTAL 49* 100 36** 100

* 1 no answer ** 2 no answer

Again the same weakness of the question should be pointed out regarding the lack of specificity in relation to classroom instruction. The students' main difficulty with classroom instruction was for the experimental and the control subgroups though similar in terms of percentage, 25%. The experimental subgroup's main difficulty is in deciding for themselves how to apply knowledge while the control subgroup find the amount of material taught in the time available the most difficult.

Both the experimental and control subgroups share the second order of difficulty that of being taught ideal
knowledge with no practical application. They share
the magnitude of difficulty pertaining to items (c),
(e) and (f) but differ on item (g) 'other'.

(Q. 8) The student was asked to tick as many statements
as she wished which would describe her difficulties
with ward experience.

<table>
<thead>
<tr>
<th>Statement of difficulties with ward experience</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Difficulty in relationship with staff</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>b. Feeling of worthlessness due to staff attitude</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>c. Not knowing what would happen and how to cope with it (Statement (c) badly constructed as it asked 2 questions in one)</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>d. Treated as though 'expected to know'</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>e. Lack of orientation on ward</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>f. Considered as outsider in ward</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>g. Your views not invited for patient care</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>h. No difficulties</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>i. Others</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50*</td>
<td>100</td>
</tr>
</tbody>
</table>

* 1 no answer  ** 1 no answer
The experimental subgroup expressed lack of difficulties much more than the control subgroup. 24% as opposed to 7%, which agrees with the results of Q. 6, p. 296.

The difficulties expressed by the experimental subgroup in order of magnitude are related to expectation and action on the ward, items (f), (b), (e) and (g). Item (d) was last in importance. Under 'others' three students wrote:

... adjusting to the type of nursing involved;
... adapting to a ward routine and hierarchy;
Basic nursing care on ward - was inadequate and I would prefer to see fewer patients of that type per ward.

The control subgroup had difficulties due to position as seconded students, i.e. outsiders, and in knowing what to expect and how to cope in practice together with relationships and consideration by staff, - items (b), (d), (g) and a slight percentage for item (a). Under 'others' four students wrote:

lack of communication;
lack of communication in (named hospital) between staff sometimes leading to some neglect of time occupation of the patients;
not being able to converse with patients;
the situation brought about by psychotherapy.

General Comments

In addition to the comments quoted above, at the end of the questionnaire a space was left for the student to comment more generally on her opinion of the psychiatric experience etc. Fifteen students or 39% of the experimental subgroup and ten students or 38% of the control subgroup took the opportunity to comment more
freely. On the whole the students expressed the feeling that they enjoyed their secondment and the way they have been treated by staff on the ward, except that they wanted to be more involved and not considered as outsiders. Some students expressed the feeling that the doctor's lectures were interesting and two students from the control subgroup said that the nursing lectures were boring. Some students from the experimental subgroup offered some suggestions for the secondment like:

I think the course would be more beneficial if lectures are given before starting our practical experience on the ward.

Suggestions for longer periods were also offered. Only one student in the experimental subgroup mentioned the nursing lectures specifically and said that:

I did not really find the nursing that was taught in school very useful. I have found that the charge nurses on both wards have been most helpful and useful in telling me things about the patients.

She was from School III.

3. Course Evaluation Schedules

As explained earlier, the evaluation schedule was given twice with a three week interval, first after four weeks' experience and the second time it was included with the questionnaire in the seventh week.

Several practical factors limited elaborate analysis of the schedules:

1. the small size of the groups taking part in both experimental and control subgroups did not lend itself to detailed statistical analysis;
ii. variations occurred within each group of students in each school. In some schools some tutors went to visit the student on the ward once or twice, while in other schools they did not go at all. The doctor's lectures varied considerably with the personality of the psychiatrist teaching and with the amount of preparation for and structure of the lecture;

iii. hospital experience varied considerably from hospital to hospital and from ward to ward. Some hospitals kept the students 1 - 2 weeks only in the same ward at a time making their experience very fragmented. Students' answers referred to the 'specific' ward experience therefore it was difficult to generalise;

iv. some ward sisters and staff were supportive to and taught the student and some others gave them minimum attention. The student's hospital experience, in terms of nature of work, feeling of support and security given by the staff and her relationship with the staff was the main influence which was reflected in her opinion of the whole psychiatric experience, as it occupied the major part of her experience;

v. the distribution of 'handouts' to the control subgroup was an addition, not previously included in a psychiatric secondment experience (or a student's general hospital experience). The hand-outs acted as orientation guides and a concrete source of reference. Their usefulness was re-inforced by how the tutor used them in his teaching.
Conclusion: the student's answer to the evaluation schedule was therefore influenced by a number of variables of different natures. This factor did not justify an accurate calculation of two 'course evaluation' schedules and their comparisons within an interval of three weeks, and in view of the small number of students either on the whole or per school.

It was decided therefore that only the results of the second evaluation schedule would be considered for analysis. The results of the first 'course evaluation' schedule are included in Table XXIII, page 304a, with no further analysis.
<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNDERSTAND</th>
<th>WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>b</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>1. Course objectives</td>
<td>%</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>2. Psychiatric nursing principles</td>
<td>%</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>3. Observation guide</td>
<td>%</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>4. Hospital seminar</td>
<td>%</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>5. Nursing lectures</td>
<td>%</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>6. Doctor's lectures</td>
<td>%</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>7. Ward visits by the teacher</td>
<td>%</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>8. Ward practice</td>
<td>%</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>9. Other</td>
<td>%</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
<tr>
<td>TOTAL</td>
<td>%</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>EC</td>
<td>EC</td>
</tr>
</tbody>
</table>
The results of the second 'course evaluation' schedule are reported in relation to the purpose of the schedule.

a) What helps the student 'understand' and 'work'.

b) What helps the student relate theory to practice.

a) What helps the student most to 'understand' and to 'work' on the ward. The items included in the 'course evaluation' schedule shall be grouped as follows:

i) nursing 'theory' shall include items: 1. course objectives, 2. psychiatric nursing principles, e. observation guide and 4. nursing lectures;

ii) doctor's lecture makes item 6;

iii) hospital experience shall include items: 4. hospital seminar, 8. ward practice, 9. other, which on the whole pertained to hospital;

iv) ward visits by teacher, item 7, is excluded from the analysis as it was not possible for all tutors to visit students on the ward. A general observation about item 7 was that it seemed to have a high relatedness value: the help it provided to the student was rated to a near equal extent under 'understand' and 'work' (See Table XXIV).

Table XXIV shows the distribution of extent of help offered by the different items for the experimental and control subgroup.
### TABLE XXIV

**COURSE EVALUATION RESULTS FOR E AND C SUBGROUPS**

**SEVEN WEEKS EXPERIENCE**

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNDERSTAND</th>
<th>WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>b</td>
</tr>
<tr>
<td></td>
<td>Grt. Extent</td>
<td>Mod. Extent</td>
</tr>
<tr>
<td>-------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1. Course objectives</td>
<td>E</td>
<td>C</td>
</tr>
<tr>
<td>2. Psychiatric nursing principles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Observation guide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Hospital seminar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Nursing lectures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Doctor's Lectures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ward visits by the teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ward practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What helps the student to 'understand'? 

Table XXV shows distribution of answers according to above grouping. In order to compare the help derived from theory as opposed to practice Nursing Theory and Doctor's Lectures are pooled under school. The number of students who either said 'don't know' or 'not applicable', or did not answer were grouped under 'no reply'. In arriving at percentage, the 'no reply' category has been omitted in this and succeeding tables.

**TABLE XXV**

**EXPERIMENT AND CONTROL SUBGROUPS' EVALUATION OF HELP DERIVED FROM THE 'GROUPED ITEMS' FOR 'UNDERSTANDING'**

<table>
<thead>
<tr>
<th>Grouped items</th>
<th>E N = 38</th>
<th>C N = 25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Great Extent</td>
<td>Moderate Extent</td>
</tr>
<tr>
<td></td>
<td>a</td>
<td>b</td>
</tr>
<tr>
<td></td>
<td>E C</td>
<td>E C</td>
</tr>
<tr>
<td>1. N.Th.</td>
<td>% 22 25</td>
<td>% 57 57</td>
</tr>
<tr>
<td></td>
<td>N 32 24</td>
<td>N 82 54</td>
</tr>
<tr>
<td>2. D.L.</td>
<td>% 28 50</td>
<td>% 43 46</td>
</tr>
<tr>
<td></td>
<td>N 10 12</td>
<td>N 15 11</td>
</tr>
<tr>
<td>3. Sc.(1+2)</td>
<td>% 24 30</td>
<td>% 54 55</td>
</tr>
<tr>
<td></td>
<td>N 42 36</td>
<td>N 97 65</td>
</tr>
<tr>
<td>4. H.E.</td>
<td>% 34 40</td>
<td>% 49 50</td>
</tr>
<tr>
<td></td>
<td>N 18 15</td>
<td>N 26 19</td>
</tr>
</tbody>
</table>

N.Th. = Nursing Theory.
D.L. = Doctor's Lectures.
Sc. (1+2) = School (both 1 + 2).
H.E. = Hospital experience.
Pooling percentages for 'Great Extent' and 'Moderate Extent' we find that for the experimental subgroup, hospital experience helps 'understanding' more than the school does, and so too with the control subgroup, but at a higher percentage level all round.

<table>
<thead>
<tr>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a + b</td>
<td>a + b</td>
</tr>
<tr>
<td>School</td>
<td>78%</td>
</tr>
<tr>
<td>hospital</td>
<td>83%</td>
</tr>
</tbody>
</table>

Comparing the experimental and control subgroups in relation to nursing 'theory' and doctor's lectures the following was noticed:

<table>
<thead>
<tr>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>a + b (≠ of %)</td>
<td>a + b (≠ of %)</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Nursing 'theory'</td>
<td>79 + 8</td>
</tr>
<tr>
<td>Doctor's lecture</td>
<td>71</td>
</tr>
</tbody>
</table>

A greater percentage of the control subgroup than of the experimental subgroup found nursing theory helpful, but for the experimental subgroup nursing 'theory' was more helpful than 'doctor's lecture'. For the control subgroup the reverse was the case, doctor's lecture was more helpful.
What helps the student to 'work'?  

The same pattern of reporting, as above is followed. Table XXVI shows distribution of answers.

<table>
<thead>
<tr>
<th>Grouped items</th>
<th>Great Extent</th>
<th>Moderate Extent</th>
<th>Minimum Extent</th>
<th>Not at all</th>
<th>No reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.Th.</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
</tr>
<tr>
<td>D.L.</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
</tr>
<tr>
<td>Sc. (1+2)</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
</tr>
<tr>
<td>H.E.</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
<td>E C</td>
</tr>
</tbody>
</table>

N.Th. = Nursing theory.  
D.L. = Doctor's Lectures.  
Sc. (1+2) = School (both 1 + 2)  
H.E. = Hospital experience.  

The same pattern of answers, as for 'understanding' applied for 'working'. Both the experimental and control subgroup found that the hospital experience helped more than the school in 'working' on the ward.
Comparing the experimental and control subgroups in relation to nursing 'theory' and doctor's lecture the following was noticed:

<table>
<thead>
<tr>
<th></th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b (≠ of %)</td>
<td>a + b (≠ of %)</td>
</tr>
<tr>
<td>Nursing 'theory'</td>
<td>68% + 2</td>
<td>68% - 28</td>
</tr>
<tr>
<td>Doctor's lecture</td>
<td>66%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Though 'nursing theory' was equally helpful, in terms of percentage, for both the experimental and control subgroups, the experimental subgroup found 'nursing theory' slightly more helpful than 'doctor's lecture' for working on the ward. The reverse was the case for the control subgroup who found the 'doctor's lecture' much more helpful than 'nursing theory' for working on the ward.

b) What helps the student to relate her theory to her practice?

This could be considered either by looking at what helped her work on the ward only or by comparing the percentage shift (if any) from 'understanding' to 'work' in relation to different groups. The former was dealt with above, the latter would be considered briefly.

In the experimental subgroup we note the following:
### Experimental subgroup

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Work</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>a + b</td>
<td>a + b</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Nursing 'theory'</td>
<td>79</td>
<td>68</td>
</tr>
<tr>
<td>Doctor's lecture</td>
<td>71</td>
<td>66</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>83</td>
<td>75</td>
</tr>
</tbody>
</table>

In the control group, we note the following:

### Control subgroup

<table>
<thead>
<tr>
<th>Understanding</th>
<th>Work</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>a + b</td>
<td>a + b</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Nursing 'theory'</td>
<td>82</td>
<td>68</td>
</tr>
<tr>
<td>Doctor's lecture</td>
<td>96</td>
<td>96</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>90</td>
<td>83</td>
</tr>
</tbody>
</table>

The shift of percentage does not appear to be significantly different between Experimental and Control subgroup. The rough general impression is one where 'nursing theory' was more appreciated by the experimental subgroup, while 'doctor's lecture' rate very highly for the control subgroup.

4. Tests

All tests were initially corrected by myself, and checked by each tutor of the group concerned.

**Adult I**

The main purpose of using the Adult I verbal reasoning test was for statistical control. It was used as an
independent variable in the analyses of co-variance in which the other two tests (Factual and Inferential) were the dependent variables.

The Adult I had not been standardized for groups of nurses, so that the reasoning quotient could not be calculated. However, in terms of raw scores, Table XXVII shows the school means for the experimental and control subgroups and the overall means for these two subgroups. The Table shows also the school mean difference and the overall mean difference.

### TABLE XXVII

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental</th>
<th>Control</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>$\bar{x}$</td>
<td>n</td>
</tr>
<tr>
<td>I</td>
<td>8</td>
<td>39.37</td>
<td>9</td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>47.42</td>
<td>5</td>
</tr>
<tr>
<td>III</td>
<td>7</td>
<td>50.71</td>
<td>5</td>
</tr>
<tr>
<td>IVa</td>
<td>10</td>
<td>56.40</td>
<td>11</td>
</tr>
<tr>
<td>IVb</td>
<td>6</td>
<td>52.33</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>38</td>
<td>49.47</td>
<td>36</td>
</tr>
</tbody>
</table>

The overall mean difference between the experimental and control subgroup is so trivial, that any statistical test is unnecessary. The individual school differences are large and two differ in direction from the remaining three, clearly there is need for control for this independent variable.
Factual Test

The Factual Test was used to evaluate the student's understanding of some of the psychiatric knowledge gained during the experience. Two statistical tests were carried out on the scores of this test.

i) Student's test

Table XXVIII shows the distribution of mean scores for each school, the overall means, and the corresponding differences.

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental</th>
<th>Control</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>x</td>
<td>n</td>
</tr>
<tr>
<td>I*</td>
<td>7</td>
<td>18.85</td>
<td>5</td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>15.00</td>
<td>5</td>
</tr>
<tr>
<td>III</td>
<td>7</td>
<td>12.80</td>
<td>11</td>
</tr>
<tr>
<td>IVa</td>
<td>6</td>
<td>18.00</td>
<td>6</td>
</tr>
<tr>
<td>IVb</td>
<td>30</td>
<td>15.26</td>
<td>27</td>
</tr>
</tbody>
</table>

* Control subgroup of school I did not answer Factual Test.

The control subgroup scored better than the experimental subgroup, but difference was not significant.

(t = 1.833, d.f. = 3, p < 0.05) (Raw figures in Appendix VI.)
ii) Analysis of Co-variance

Analyses of co-variance with Adult I as the independent variable, and the Factual Test scores as the dependent variable were made for the experimental and control subgroups for each school separately.

The procedure is illustrated in Table XXVIV which relates to school II.

**TABLE XXIX**
ANALYSIS OF CO-VARIANCE FOR SCHOOL II (FACTUAL TEST)

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Degree of Freedom</th>
<th>SSx</th>
<th>SSy</th>
<th>SPxy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>1</td>
<td>84.16</td>
<td>0.01</td>
<td>-0.90</td>
</tr>
<tr>
<td>Within groups</td>
<td>10</td>
<td>1660.51</td>
<td>73.66</td>
<td>-19.72</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>11</strong></td>
<td><strong>1744.67</strong></td>
<td><strong>73.67</strong></td>
<td><strong>-20.67</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjusted (y) Degree of Freedom</th>
<th>SS (adj.y)</th>
<th>M.S.</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>1</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Within groups</td>
<td>9</td>
<td>73.42</td>
<td>8.16</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10</strong></td>
<td><strong>73.43</strong></td>
<td><strong>7.34</strong></td>
</tr>
</tbody>
</table>

Table XXX shows the results of the ratio of variance (F) in the 'adjusted' analysis and its significance for the given degrees of freedom (d.f.) for all the schools involved.
TABLE XXX
RATIO OF VARIANCE (F) FOR FACTUAL TEST IN THE FIVE GROUPS

<table>
<thead>
<tr>
<th>Schools</th>
<th>F</th>
<th>d.f.</th>
<th>Significance beyond 5% level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (No return)</td>
<td>0.00</td>
<td>1,9</td>
<td>no</td>
</tr>
<tr>
<td>II</td>
<td>0.00</td>
<td>1,9</td>
<td>no</td>
</tr>
<tr>
<td>III</td>
<td>1.41</td>
<td>1,9</td>
<td>no</td>
</tr>
<tr>
<td>IVa</td>
<td>5.96</td>
<td>1,18</td>
<td>yes</td>
</tr>
<tr>
<td>IVb</td>
<td>0.42</td>
<td>1,9</td>
<td>no</td>
</tr>
<tr>
<td>Pooling across Schools</td>
<td>2.22</td>
<td>1,54</td>
<td>no</td>
</tr>
</tbody>
</table>

Thus, after co-varying out the effect of initial differences in performance on Adult I, only in one School, IVa, is their a significant difference between E and C subgroups in performance on the Factual Test. The observed within-school differences between E and C subgroups are clearly not 'explained' by initial differences in the ability measured by Adult I.

Inferential Test

To evaluate the difference (if present) between the students taught through the experimental approach and those taught in the 'usual' way in relation to inferential ability. The results of this test will be presented under three headings: (i) comparison of mean scores, (ii) detailed comparison of each part of the test, (iii) analysis of co-variance.
i) Comparison of mean scores (t test)

Table XXXI shows the mean score for each school, for the experimental and control subgroups overall, and the corresponding mean differences.

Table XXXI

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental</th>
<th>Control</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>$\bar{x}$</td>
<td>n</td>
</tr>
<tr>
<td>I</td>
<td>8</td>
<td>10.37</td>
<td>9</td>
</tr>
<tr>
<td>II</td>
<td>7</td>
<td>11.42</td>
<td>5</td>
</tr>
<tr>
<td>III</td>
<td>7</td>
<td>9.42</td>
<td>5</td>
</tr>
<tr>
<td>IVa</td>
<td>10</td>
<td>11.20</td>
<td>11</td>
</tr>
<tr>
<td>IVb</td>
<td>6</td>
<td>14.66</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>38</td>
<td>11.28</td>
<td>36</td>
</tr>
</tbody>
</table>

Overall, the experimental group is slightly superior to the control group, but the difference in means does not reach the 5 per cent level of significance.

(t = 1.55, d.f. = 4).

ii) Detailed comparison of each part of the test

It was anticipated that Part I of the test would prove to be the most difficult, requiring a more developed ability, and students' opinions confirmed this, (p. 277).

The way of marking Part I was flexible in as much as there was an 'expected' answer and a 'right' explanation for this answer, but it was left open to consider 'unexpected'
answers as right answers if the explanation given denoted a way of relating the two items on a fundamental basis rather than coincidence of occurrence of the symptoms such as occurrence in the same illness.

There were seven groups of items in Part I allocated 2 points each, one for the underlying of the two words they thought were related in a fundamental way, and one for the explanation of such relatedness. Categories* of answers and their corresponding allocated marks are included in Table XXXII.

TABLE XXXII
CATEGORIES AND MARKS OF ANSWERS TO PART I
OF THE INFERENTIAL TEST

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Answer</td>
<td>Expected Answer</td>
<td>Unexpected Answer</td>
<td>Unexpected Answer</td>
<td></td>
</tr>
<tr>
<td>+ Right Explanation</td>
<td>+ No Explanation</td>
<td>+ Right Explanation</td>
<td>+ Explanation</td>
<td></td>
</tr>
<tr>
<td>Marking Points</td>
<td>1 + 1 = 2</td>
<td>1 + 0 = 1</td>
<td>1 + 1 = 2</td>
<td>0 + 0 = 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Answer</td>
<td>Unexpected Answer</td>
<td>No Answer</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>+ Wrong Explanation</td>
<td>+ Wrong Explanation</td>
<td>Blank</td>
<td>Explanation</td>
<td></td>
</tr>
<tr>
<td>Marking Points</td>
<td>1 + 0 = 1</td>
<td>0 + 0 = 0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table XXXIII shows the distribution of answers under each category from A - G above, for experimental and control subgroups.

*Only one student out of 7½ gave an explanation without underlying, this category was disregarded.
TABLE XXXIII

DISTRIBUTION OF ANSWERS TO PART I OF THE INFERENTIAL TEST

<table>
<thead>
<tr>
<th>Categories</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exp.A</td>
<td>Exp.A</td>
<td>UnexpA</td>
<td>UnexpA</td>
<td>Exp.A</td>
<td>UnexpA</td>
<td>Blank</td>
</tr>
<tr>
<td></td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>53</td>
<td>20</td>
<td>34</td>
<td>13</td>
<td>15</td>
<td>6</td>
<td>42</td>
<td>16</td>
<td>25</td>
<td>9</td>
<td>63</td>
<td>24</td>
<td>34</td>
<td>13</td>
<td>266</td>
<td>100</td>
</tr>
<tr>
<td>Control</td>
<td>48</td>
<td>19</td>
<td>11</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>35</td>
<td>14</td>
<td>28</td>
<td>11</td>
<td>83</td>
<td>33</td>
<td>38</td>
<td>15</td>
<td>250</td>
<td>100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>20</td>
<td>45</td>
<td>9</td>
<td>22</td>
<td>4</td>
<td>77</td>
<td>15</td>
<td>53</td>
<td>10</td>
<td>146</td>
<td>28</td>
<td>72</td>
<td>14</td>
<td>526</td>
<td>100</td>
</tr>
</tbody>
</table>

It would be noticed that the largest percentage difference between E and C subgroup pertained to: Category B 'Expected answer and no explanation, (8%); Category C 'unexpected answer and right explanation', (3%). This probably was a difficult category, as presumably the 'expected answer' would have been the 'obvious' one, to have had the ability to understand and justify the connection required an ability to relate on a more fundamental basis; and Category F 'unexpected answer and wrong explanation, (9%).

In all categories the direction of the percentage difference favours the E subgroup.

Another computation was carried out to compare Part I and Part II of the test. Part III was not included because the total number of points allocated to it was 3, which was too small for computation.
Part I and Part II were believed to be testing slightly different abilities as explained earlier on p. 276.

The Pearson coefficient of correlation \( r \) was calculated to test the direction and degree of correlation between scores on Part I and Part II of the Inferential Test for the experimental and control subgroups for each school.

Table XXXIV shows the results of \( r \), and it will be seen that in all schools, with the exception of School I the E subgroup \( r \) is smaller in value than the C subgroup \( r \).

**TABLE XXXIV**

**CORRELATIONS PART I AND II OF INFERENTIAL TEST**

<table>
<thead>
<tr>
<th>School</th>
<th>Experimental subgroup</th>
<th>Control subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>+0.530</td>
<td>+0.271</td>
</tr>
<tr>
<td>II</td>
<td>-0.311</td>
<td>-0.265</td>
</tr>
<tr>
<td>III</td>
<td>+0.474</td>
<td>+0.838</td>
</tr>
<tr>
<td>IVa</td>
<td>+0.178</td>
<td>+0.390</td>
</tr>
<tr>
<td>IVb</td>
<td>-0.168</td>
<td>+0.813</td>
</tr>
</tbody>
</table>

* Pearson's \( r \).

The Pearson's coefficient of correlation \( r \) was converted into Fisher's \( z \) and the appropriate test used. None of the differences reached significance, therefore the value of \( z \) was not reported.

iii) **Analysis of Co-variance**

Table XXXV shows the results of the analysis of co-variance taking Adult I as the independent variable.
and the Inferential Test (as a whole) as the dependent variable. Calculations pertain to the five groups (10 subgroups) in the four schools involved. The procedure is illustrated for School I in Table XXXV.

**TABLE XXXV**

ANALYSIS OF CO-VARIANCE FOR SCHOOL I (INFERENTIAL TEST)

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Degree of Freedom</th>
<th>SSx</th>
<th>SSy</th>
<th>SPxy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>1</td>
<td>961.79</td>
<td>1.51</td>
<td>-38.11</td>
</tr>
<tr>
<td>Within groups</td>
<td>15</td>
<td>3784.09</td>
<td>145.43</td>
<td>125.76</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>16</td>
<td>4745.88</td>
<td>146.94</td>
<td>87.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjusted (y) Degree of Freedom</th>
<th>SS(adj.y)</th>
<th>M.S.</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>4.07</td>
<td>4.07</td>
<td></td>
</tr>
<tr>
<td>Within groups</td>
<td>141.25</td>
<td>10.09</td>
<td>0.40</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>145.32</td>
<td>9.69</td>
<td></td>
</tr>
</tbody>
</table>

Table XXXVI shows for all schools the results of the ratio of variance F and its significance for the given degrees of freedom (d.f.).
<table>
<thead>
<tr>
<th>School</th>
<th>$F$</th>
<th>d.f.</th>
<th>Significance beyond 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>0.40</td>
<td>1,14</td>
<td>No</td>
</tr>
<tr>
<td>II</td>
<td>1.78</td>
<td>1,9</td>
<td>No</td>
</tr>
<tr>
<td>III</td>
<td>0.27</td>
<td>1,9</td>
<td>No</td>
</tr>
<tr>
<td>IVa</td>
<td>0.10</td>
<td>1,18</td>
<td>No</td>
</tr>
<tr>
<td>IVb</td>
<td>0.53</td>
<td>1,9</td>
<td>No</td>
</tr>
<tr>
<td>ALL</td>
<td>0.19</td>
<td>1,71</td>
<td>No</td>
</tr>
</tbody>
</table>

These results show that after taking account of initial differences between the experimental and control subgroups in Adult I performance, there is no significant difference between these groups in any school in performance on the Inferential Test.
The statistical analyses in the preceding Chapter do not indicate any large difference between the experimental and control subgroups, either on the Factual Test or on the Inferential Test. However, the results of the experiment should be read and interpreted within perspective. The experiment was aiming mainly at two basic points: one, the applicability of an approach, the other, the development of an ability involving a different way of thinking. By necessity these two points need one important factor and that is adequate length of time. In order to arrive at the possibility of applying an idea it requires above all sufficient time for the people applying it to familiarise themselves with it as well as to understand it well enough to make maximum use of its potentials. The development of an ability is also a process which develops gradually over time. When a different way of thinking is introduced it passes through a similar
process as that of change, which was discussed in Chapter One. Time was obviously short in relation to the experiment as within the eight weeks only six hours of nursing lectures were allowed. These factors, by necessity, limited the expectations from the experiment.

Having regard to this time factor, the discussion of results will now centre on 'tendencies' and 'directions' rather than levels of significance in the light of the issues raised in the following discussion.

The accepted level of significance for the different statistical tests used in this Thesis, is the 5% level. Any result which is under 5% will be indicated by N.S., i.e. Non-significant.

A Discussion of results

From the tutors' opinion and my own experience of teaching one experimental subgroup, teaching on the basis of a situation is feasible provided certain provisions are made. Allowing more time and opportunity for such an approach does not necessitate the use of a real situation for teaching during every class hour. Preparation for such an approach, regardless of the method of teaching used
(lectures, discussions, seminars, projects etc.) could always be carried along the same lines as the approach. In other words, whenever knowledge is transmitted to the student, units of knowledge are related and implications of knowledge considered. This would help the student learn to receive knowledge through a network of communicating lines rather than a simple channel of communication. This process of pulling the connections together could be done by either tutors or students according to stage of learning.

The use of an actual situation in teaching in the classroom facilitates and builds a shared frame of reference between tutors and students which acts as a bridge in improving the communication between them and it helps its effectiveness.

The difficulty of introducing the approach of teaching on the basis of a situation was enhanced by two subtle misunderstandings: the use of the word 'approach' which was easily equated with 'method of teaching', and the use of the word 'situation' which was equated with 'case study'. I did not succeed, on the whole, in clarifying these distinctions with the tutors mainly because of shortage of time which did not allow for presentation and repeated discussion to lessen the gap of difference in interpretation of what is involved in teaching on the basis of a situation.

An approach does not entirely dictate a method of teaching but would probably disfavour some methods of teaching. As the approach included student's participation,
it consequently required the active involvement of the student and consideration of her queries in relation to variables present in a situation and their implications. This could equally be achieved through lecturing alternating with periods where the student can verbalise her queries and thoughts or through seminars, discussion, project work.

The basic differences between teaching based on a 'situation' and that based on case study are as follows:

<table>
<thead>
<tr>
<th>Patient Study</th>
<th>Situational Study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Figure</strong></td>
<td>Patient</td>
</tr>
<tr>
<td><strong>Nature of Study</strong></td>
<td>Descriptive</td>
</tr>
<tr>
<td><strong>Units of Knowledge</strong></td>
<td>Presents as lists, etc. of e.g. related signs and symptoms</td>
</tr>
<tr>
<td><strong>Purpose of Study</strong></td>
<td>Understanding</td>
</tr>
<tr>
<td><strong>Aspects Considered</strong></td>
<td>Pertain mainly to patient and his circumstances</td>
</tr>
<tr>
<td><strong>General Structure</strong></td>
<td>Undefined variable, e.g. disease centred or disease plus social background</td>
</tr>
<tr>
<td><strong>Emphasis</strong></td>
<td>Fixed</td>
</tr>
<tr>
<td><strong>Organizational Principle</strong></td>
<td>Usually follows an outline</td>
</tr>
</tbody>
</table>
One of the merits of the teaching based on the situation is that it was applicable without interference with the syllabus in terms of content, number of hours allocated to teaching or any form of reorganization either within syllabus or hospital administration.

**The Questionnaire**

The answers pertaining to the general training were generally very similar to those of the survey, and therefore will not be discussed on their own. Instead, the answers to the psychiatric nursing experience will be considered more carefully using the answers to the 'general training' part of the questionnaire as a background. Results of the Questionnaire are discussed under three headings: 1) degree of reliance of students on their own judgement, 2) the process of relating, and 3) difficulties with the psychiatric secondment experience.

1) **Degree of reliance of students on their own judgement**

Even though the question, Q. 8 (General) p. 283 and Q. 1 (Psychiatric) p. 292, were worded slightly differently and referred to different contexts, some comparison of the general tendency is possible.

Table XXXVII shows the percentage distributions of answers to Q. 8 and Q. 1 for E and C subgroups and the corresponding ranks.
TABLE XXXVII
PERCENTAGE DISTRIBUTION AND RANKS OF ANSWERS TO Q.8 AND Q.1 FOR E AND C SUBGROUP

<table>
<thead>
<tr>
<th>Category of Answers</th>
<th>Experimental n = 38</th>
<th>Control n = 26</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q.8 % Rank</td>
<td>Q.1 % Rank</td>
</tr>
<tr>
<td>a) Hospital experience</td>
<td>63 (1)</td>
<td>29 (2)</td>
</tr>
<tr>
<td>b) School</td>
<td>8 (4)</td>
<td>8 (4)</td>
</tr>
<tr>
<td>c) Intuition or own judgement</td>
<td>18 (2)</td>
<td>42 (1)</td>
</tr>
<tr>
<td>d) No difficulties/Other</td>
<td>11 (3)</td>
<td>21 (3)</td>
</tr>
</tbody>
</table>

The changes in rankings show that the most helpful source for dealing with situations has shifted, in both subgroups, from the hospital experience to the student’s intuition and own judgement. This might be explained by the fact that the ‘hospital experience’, referring to the psychiatric experience, is ‘foreign’ and recent to students in both subgroups.

While the direction of difference in percentage between E and C for (c) student’s intuition and own judgement remains the same, the actual difference is larger.

The overall picture is one where those in C subgroup seem to rely on their own judgement because other sources of help did not prove of great value. This same impression though true for E subgroup is less acute. The percentage of students choosing (d) ‘other’ as a source of help is another indication. The E subgroup found this source more helpful than the C subgroup. ‘Other’ for E subgroup
consisted of: "staff working on the ward" and a combination of classroom instruction, together with either hospital experience or with their own intuition.

Some examples of the E subgroup answers were:

The classroom instruction helped me to interpret and understand the situation, previous experience in other wards also helps

Classroom instruction helps to a great extent as you can apply it in the situation. Intuition and judgement helps because you can try and understand the patient in relation to yourself.

Examples of answers of the C subgroup were provided by three students who chose (d) 'other'. These were: a, b, and c;

advice of Psychiatric nurses;

and

a and c using common sense with personal information.

Considering the help provided by (b) 'classroom instruction' it seems that the E subgroup found it of actual use slightly more than the C subgroup bearing in mind, of course, that classroom instruction could refer to nursing as well as doctor's lectures.

2) The process of relating

It will be recalled that questions 2 to 5 (p.293 to p.295) in the 'psychiatric training' part of the Questionnaire asked about the students' perception of the relatedness (i) between theory and practice within their secondment (Q. 2), (ii) between psychiatric and general experience in terms of theory and practice (Q. 3), (iii) between psychiatric nursing and general nursing on the whole (Q.4)
and (iv) between psychiatric and general nursing experience in terms of fundamental principles. This group of questions was intended to probe into the extent of development in the E subgroup of the ability to perceive fundamental relationship as well as to help evaluate the experimental approach to the teaching.

Looking at the results in terms of percentage distribution of answers between E and C subgroup, the difference is not striking, and at times in favour of the C subgroup, e.g. Q. 2, p. 293.

However, comparison of the comments written by the E and C subgroup indicates that a difference in the nature of what they wrote was present. On the whole this difference seemed to indicate that the E subgroup started to develop certain characteristics. The E subgroup appeared more cautious and critical in their evaluation, but at the same time more 'decided' as a group. The latter was gathered mainly from the percentage distribution of the answers, the former from the choice of words in their comments, as well as the content of the comments in general.

The E students started to develop a frame of reference which is more practical in nature. They somehow used their knowledge practically. This is indicated by the expressions used in the comments and supported by the results of the 'course evaluation' schedule. The development of ability to see relationships beyond the immediate or obvious was also indicated by their answers and comments to Q. 3, 4 and 5.
The E and C subgroups' comments on Questions 2 to 5 are reported under two headings: i) favourable; where comments written by students who ticked a (great extent) and b (moderate extent) are pooled, and ii) unfavourable; where comments written by students who ticked c (minimum extent) and d (not at all) are also pooled.

The pattern of reporting for both E and C subgroups would be as follows: first the question number, next the percentage of students who commented on that question, and finally the two headings 'favourable and 'unfavourable', indicating the number of students who ticked (a), (b), (c) or (d) and commented, followed by a sample of comments.

The choice of the sample of comments was, on the whole, made for the comments which were most representative of the students' opinion. Students tended to have similar comments in each subgroup, which best illustrates a point brought up by the majority of comments.

Q. 2. Relatedness of classroom instruction to practical experience.

Comments of students in E and C subgroups.

(i) E subgroup: 58% of students commented on this question.

Favourable comments:

those who ticked (a) (only two students commented)
It was related in such a way that we knew about the types of patients and how to deal with situations aroused by them.

It taught insight into behaviour and gave a greater understanding of patients illness and needs.

those who ticked (b) (13 students commented)
It helped me to understand why the patients act as they do and how to help them.

I found myself linking the lectures with the situation which rose in the wards.
It helped me to know what was wrong with certain patients and the best way to help them.

because you learn things about the patients' illness which can be used to help you in the ward.

Unfavourable comments:

those who ticked (c) (6 students commented)

Classroom instruction is vague and hard to understand without more time spent with patients.

The situation arising in the ward cannot possibly be foreseen in the classroom.

those who ticked (d)

The two students who ticked (d) did not comment.

(ii) C subgroup: 85% of students commented on this question.

Favourable comments:

those who ticked (a) (three students commented)

I feel that in Psychiatry it is much easier to relate classwork to practical as you have time to sit and think things out while speaking to the patient.

The classroom experience has been a good guide on how to observe these patients.

those who ticked (b) (11 students commented)

Each person has to be dealt with differently and not by a set pattern although instruction in how to deal with various groups on the whole does help, and so does a knowledge of the cause of their complaint or problem.

Alcoholism was never discussed by the Doctor and the tutor's lectures were boring.

It gave you an idea of what to expect.

We are told about a variety of illnesses and in the ward we saw most of these illnesses.

Unfavourable comments:

those who ticked (c) (three students commented)

because in school it is more disease than situations being taught. (She seems to have had a friend from the E subgroup!)
The situation described in the classroom does not often apply in actual ward situations.

those who ticked (d) (two students commented)

The classroom instruction does not help the nurse to talk to patient.

The patients were so good that it was not applicable or hardly ever.

Q. 3 Relatedness of psychiatric knowledge and experience to general training.

Comments of Students in E and C subgroups.

(i) E subgroup: 84% of students commented on this question.

Favourable comments in terms of extent of relatedness:

those who ticked (a) (10 students commented)

related in that it shows that physical illness is related to mental illness.

I feel as if I have learned to cope with some of the mental worries patients have.

Quite a lot of people with physical illness develop mental states as well and we can be of greater support to them now.

those who ticked (b) (17 students commented)

It helped by showing us how to react with these kinds of patients which we find in general hospital.

We cannot really tell until we return to ... and put this knowledge into practice.

I think I will be able to see things more in perspective now.

Understanding specific behaviour and reactions to stressful situations, etc.

Unfavourable comments in terms of the extent of relatedness:

those who ticked (c) (4 students commented)

I feel that the only thing which relates is that you are still dealing with people who need your help and at all times a nurse should be able to give it.
The general nurses don't seem to have time to sit and talk to the patient which I think should be.

One student ticked (d) and she wrote:

because there is no physical treatment given to the patients.

(ii) C subgroup: 85% of students commented on this question.

Favourable comments in terms of extent of relatedness:

those who ticked (a) (7 students commented)

It has given me more insight into people as hospital patients. It has helped me to realise that all patients are people.

helps in a greater understanding of patients and their problems.

those who ticked (b) (14 students commented)

patients in general hospital are often depressed and need someone to talk to them, I think the course gives you an insight as to how they are feeling.

Understanding of psychosomatic illnesses and other psychiatric illnesses likely in general patients, greater understanding of human behaviour.

could help one probably assess a patient who has been admitted to a general hospital who is psychologically ill.

There are always psychiatric patients in a general hospital at one time or another.

Unfavourable comments in terms of extent of relatedness:

Only one student ticked (c), she commented:

Help you to understand people better.

No student in the C subgroup ticked (d).

Q. 4. Relatedness of Psychiatric nursing to general nursing:

Comments of students in E and C subgroups.

(i) E subgroup: 80% of students commented on this question.

Favourable comments in terms of relatedness:
those who ticked (a) (7 students commented)
the mind and body are so close and not as apart as once seemed.

All the patients who are sick need help no matter which type of illness and each type of patient can suffer from the other kind of illness.

those who ticked (b) (11 students commented)
Although different fields of nursing it is all to do with the benefit of our patients.
You will be able to have a nurse-patient type of relationship and will find out their problems.

Unfavourable comments in terms of extent of relatedness:
those who ticked (c) (6 students commented)
It is a different concept from general except in the case of a patient with anxiety.
not very much related because it is a completely different type of nursing and it takes a few weeks to get into the way of working in a hospital such as this as the pace is a lot slower than in a general hospital.

those who ticked (d) (5 students commented)
it is not really related because psychiatric is different from medicine in that it is the mind you are working with, whereas in general I don’t think that the patient’s mental welfare is attended to as much as it should be.
because there is a much more relaxed atmosphere in psychiatric than in general, this is why general nursing is so tiring at times.

(ii) C subgroup: 70% of students commented on this question.

Favourable comments in terms of extent of relatedness:
those who ticked (a) (two students commented)
helps to give a great insight to the patient’s disease.
I think it is greatly related because it is important to understand their mental stress as well as their physical needs.

those who ticked (b) (7 students commented)
we sometimes have to deal with psychiatric patients in the general hospital.
Psychiatric patients need care as do general patients. Psychiatric patients take physical illnesses too.

Unfavourable comments in terms of extent of relatedness:
those who ticked (c) (8 students commented)
the working atmosphere is much more free and easy there is no real 'hard slog' and there is very little basic nursing care required in a psychiatric hospital though I expect the situation is different in a geriatric ward. The nurse is given more chance to use her own initiative in this hospital.

It may help in dealing with psychosomatic illness.
those who ticked (d)
Only one student felt there was no relationship between the two fields of nursing and gave her reason as follows:
Psychiatric nursing and general nursing are not related at all. Psychiatric patients have a slow recovery whereas most general patients have a quick recovery; as well the nurse can see progress or deterioration more easily. The psychiatric patient therapy includes talking over their problems with the staff. In general hospital due to the pressure of work etc. talking and listening to patients is very rarely possible. In general hospital there is a greater turnover of patients, there is more chance to get to know psychiatric patients than there is to the general patients as they are not in hospital long enough for the nurses to get to know them.

Q. 5. Relatedness of psychiatric knowledge to the general situation. Fundamental Relatedness of knowledge in the two fields, psychiatric and general.
Comments of students in E and C subgroups.
(i) E subgroup: 66% of students commented on this question.
Favourable in terms of extent of help:
those who ticked (a) (two students commented)
talk to patients.
It would help me to understand the situation more and make me think about it more and the way I'd deal with it.
those who ticked (b) (18 students commented)

It will help us to understand the patient's behaviour and how to deal with them if they are difficult.

It would help you deal with people better by understanding them more and you may find you are able to help them quite a lot.

I'll be able to understand people better and may be able to help them more.

Unfavourable comments in terms of extent of help:
those who ticked (c) (5 students commented)

by giving an increased knowledge of what makes people tick.

It will help me understand the patient when he is demanding and attention seeking.

those who ticked (d)

None of the students who ticked (d) commented.

(ii) C subgroup: 72% of students commented on this question.

Favourable comments in terms of extent of help:
those who ticked (a)

Only one student commented by saying:

to observe patients more closely in appearance and actions and to help the patients with any emotional problems and to try to reassure them.

those who ticked (b) (13 students commented)

I feel much more at ease when talking to all sorts of people after this psychiatric course, and also in appreciating other people's problems.

understand patient's emotion and fancies better than before.

more experienced with people.

Unfavourable comments in terms of extent of help:
those who ticked (c) (two students commented)

the amount of knowledge gained would only help in a small way.
to deal with patient's anxiety.

Only one student ticked (d)

It will help me to stay cool because of the related atmosphere in a psychiatric hospital.

It was noticed from the above comments that students in both E and C subgroup are struggling to adjust to a 'strange' environment which is simply different. Both subgroups evaluate the difference within the 'general nursing' frame of reference, i.e. in terms of specifics by mentioning specific signs and symptoms or illnesses, the C subgroup tended to do so more than the E subgroup.

A student's comment in the E subgroup illustrated this point. She evaluated the relatedness of psychiatric experience to general training as non-existent because the only thing in common she could see between the two fields was that, "patients in general hospital are often depressed".

On the whole the C subgroup's comments were more descriptive in nature, while those of the E subgroup were directed towards management using words like "deal with", "know what to do" etc. Something in the experience of the E subgroup had helped them direct their knowledge to practical application. Both subgroups had the same doctor's lecture and practiced on the same wards (not concurrently) most of the time, the only difference was in their 'nursing lectures' which might have accounted for the development of this practical orientation.
A comment which directs attention to this ability to apply knowledge practically was given by a student in the E subgroup explaining how classroom was related to practical experience. She said:

because you learn things about the patients' illness which can be used to help you in the ward. (my underlying).

This ability is an important factor in the study of relatedness between theory and practice and was aimed at in the experimental teaching. Knowledge could be transmitted to the student in the form of information but it also could be transmitted in such a way that it would have an intrinsic value in making the relatedness clearer. I shall illustrate what I mean by an example.

To know that a schizophrenic patient can get: 'delusions, auditory hallucinations, visual hallucinations, thought withdrawal, thought insertion'; as part of the repertoire of signs and symptoms manifested by the illness is passing on knowledge in the form of information.

But to know that the patient's perception can be affected in schizophrenia; that perception pertains to the five senses (seeing, hearing, touching, smelling, tasting); that possibly the patient's perceptive abilities are heightened to the extent that he perceives through his senses in the absence of external stimulation like in auditory hallucinations where he hears voices which are not present in the environment, but might be derived from the heightened neutral state of the patient whose thought process is affected, making him believe that someone is
putting thoughts into his head (thought insertion) and he can hear this voice telling him things. To know that behaviour relies on our perception (p. 263) so that the patient 'hearing' these voices may behave according to the content of what he 'hears', is expected.

Knowledge in the second illustration includes understanding of the process of illness and the relatedness of 'thought', 'perception' and 'behaviour', which suggest in a subtle way how to deal with the manifested behaviour of the patient.

A support to the argument that 'something' in the E subgroups' experience made them use their knowledge and experience in a different way from the C subgroup is provided by comparing answers to Q. 10 of the general training and Q. 2 of the psychiatric training.

Though Q. 10 specifically asked about 'nursing care' and Q. 2 asked about their psychiatric experience, some similarities in the general purpose of the two questions was present.

Table XXXVIII shows the results of the two questions for E and C subgroups.
TABLE XXXVIII
PERCENTAGE DISTRIBUTION AND RANK OF ANSWERS TO Q.10 AND Q.2 FOR E AND C SUBGROUPS

<table>
<thead>
<tr>
<th>Extent of relatedness</th>
<th>Question 10 (General)</th>
<th>Question 2 (Psychiatry)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>N % Rank</td>
<td>N % Rank</td>
</tr>
<tr>
<td>a) Great</td>
<td>5 14 4</td>
<td>5 19 2</td>
</tr>
<tr>
<td>b) Moderate</td>
<td>17 46 1</td>
<td>11 43 1</td>
</tr>
<tr>
<td>c) Minimum</td>
<td>9 24 2</td>
<td>5 19 2</td>
</tr>
<tr>
<td>d) Not at all</td>
<td>6 16 3</td>
<td>5 19 2</td>
</tr>
</tbody>
</table>

Q. 10 shows a similar percentage distribution over categories (a) 'great extent' (d) 'not at all' for both E and C subgroups.

Q. 2 shows a wide difference in percentage distribution over categories (a) 'great extent' to (d) 'not at all' between the two subgroups.

For Q.10 the difference of percentage between E and C fluctuated between 3 - 5%. For Q. 2 the difference of percentage between E and C fluctuated between 7 - 18%. The rank order is also different for the two questions ten and two.

These results suggest that the nature of the students' experience (either in classroom and/or hospital) was different for E and C subgroups, even though the rank order might suggest that C subgroup found that theory and practice was more related that the E subgroup. The
content of comments on Q.2 indicated that the E subgroup seemed to have 'gained' more than the C subgroup.

These results might alternatively indicate the difficulty experienced by the E subgroup with their nursing lectures as these were 'different' in nature.

3) Difficulties with psychiatric secondment experience.

This part of the discussion deals with Q. 6 (p. 296), Q. 7 (p. 298) and Q. 8 (p. 300).

It will be recalled that Q. 6 asked the students about what they found most difficult to cope with during their secondment. The results showed a marked difference of percentage between the two subgroups for each source of difficulty (p. 296). The students in C subgroup seem to have had difficulty in 'coping' with the practice. Their first source of difficulty related to 'other' sources, which was in the main, their lack of guidance on how to manage patients, e.g. "obstreperous, aggressive, psychogeriatrics", or what to tell patients or how to "handle patients". One student expressed the need for guidance by wishing she had more doctor's lectures. Their second source of difficulty was related to their ward experience.

The students in the E subgroup, however, seemed to manage better on the practical level than the C subgroup. These results support the impression gained from students' comments to Q. 2 - 5 above. All the E students' comments under 'other' related to adjustment to the different pace of work in the psychiatric hospital. Their main
difficulty pertained to classroom instruction and to relating classroom to hospital experience.

Interpretation of these results in the light of the students' answers to Q. 17 might be more informative.

**TABLE XXXIX:**

**PERCENTAGE DISTRIBUTION AND RANKS OF ANSWERS TO Q. 17 AND Q.6 FOR E AND C SUBGROUPS**

<table>
<thead>
<tr>
<th></th>
<th>Question 17 (general)</th>
<th>Question 6 (Psychiatry)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>C</td>
</tr>
<tr>
<td>a) Classroom instruction</td>
<td>N % Rank</td>
<td>N % Rank</td>
</tr>
<tr>
<td></td>
<td>22 59 1 12 50 1</td>
<td>11 30 2 51 9 3.5</td>
</tr>
<tr>
<td>b) Ward experience</td>
<td>4 11 3 - - -</td>
<td>4 11 4 7 27 2</td>
</tr>
<tr>
<td>c) Both a &amp; b</td>
<td>8 22 2 7 29 2</td>
<td>14 38 1 5 19 3.5</td>
</tr>
<tr>
<td>d) No difficulty/Other</td>
<td>3 8 4 5 21 3</td>
<td>8 21 3 9 25 1</td>
</tr>
</tbody>
</table>

* 1 no answer  **  2 no answer

A difference occurred in both E and C subgroups as a result of their psychiatric experience, the C subgroup, seemed to have experienced more upheaval. The order of the source of difficulty they experienced shifted from being 3rd and 4th in the general training to being 1st and 2nd in the psychiatric experience; it was the practice. The change of order in the source of difficulty in the E subgroup seemed to have been reverted between 1st and 2nd, and 3rd and 4th. For a more careful comparison between
Q.17 and Q. 6, first the $x^2$ is calculated for Q.17 for the E and C subgroups, then it is calculated for Q. 6. Table XXXX shows the frequency distribution of answers to Q.17.

**TABLE XXL**

$X^2$ TEST FOR Q.17 E AND C SUBGROUPS

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Class a</th>
<th>Ward b</th>
<th>Both c</th>
<th>No difficulties d</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>22</td>
<td>4</td>
<td>8</td>
<td>3</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>(20.6)</td>
<td>(2.4)</td>
<td>(9)</td>
<td>(4.8)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>12</td>
<td>-</td>
<td>7</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>(13.3)</td>
<td>(1.5)</td>
<td>(5.9)</td>
<td>(3.1)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>34</td>
<td>4</td>
<td>15</td>
<td>8</td>
<td>61</td>
</tr>
</tbody>
</table>

The $x^2$ is not significant at the 5% level ($x^2 = 4.94$, d.f. = 3). However, as pointed out earlier (p. 321) what would be sought was the study of the 'tendencies'. From Table XXXX the E subgroup had more difficulty with class and hospital work than expectation (values of expected included between brackets). Their lack of difficulties and their difficulty with both a and b (class and ward) was however less than expectation. The C subgroup had less difficulty than expectation with class and hospital work. However their lack of difficulties and their difficulties with both a and b (class and ward) was above expectation.
Now calculating the $x^2$ for Q. 6 for the E and C subgroup, Table XXXXI shows the results.

### TABLE XXXXI

**$x^2$ TEST FOR Q. 6 E AND C SUBGROUPS**

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Class a</th>
<th>Ward b</th>
<th>Both c</th>
<th>'Other' d</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>11</td>
<td>4</td>
<td>14</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>(9.3)</td>
<td>(6.4)</td>
<td>(11.1)</td>
<td>(9.9)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>(6.6)</td>
<td>(4.5)</td>
<td>(7.8)</td>
<td>(7)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>11</td>
<td>19</td>
<td>17</td>
<td>63</td>
</tr>
</tbody>
</table>

Again the $x^2$ does not reach significance at the 5% level ($x^2 = 5.68, d.f. = 3$).

However, interpretation of the 'tendencies' in this table should be made, bearing in mind that the students' psychiatric experience was new to them and that to the E subgroup an added factor was the approach to the teaching. The E subgroup had more difficulties than expectation with their class work and with both a and b (class and ward); but they had less difficulties than expectation with their hospital experience and 'other'. Comparing these results with their answer to Q. 17 it seems that the magnitude of difference between 'observed' and 'expected' is similar for the class work but their difficulties with hospital experience decreased in the psychiatric field. The other
difference in results pertains to 'both' a and b (class and ward), the 'observed' value for Q. 6 is relatively, considerably higher than expectation when compared to the observed value for Q. 17 where it was slightly lower than expectation. It appears that the difficulties born out of the different approach to the teaching in the E subgroup is showing in relation to both classroom and hospital. Probably a reappraisal of the way of considering theoretical instruction and its relation to practice is introduced, but somehow they cope better with their hospital experience.

No comparable change occurred in the C subgroup. Instead they had less difficulties than expectation with their class work and 'both' a and b (class and ward), but had more difficulties than expectation with their hospital experience and 'other' which was mainly pertaining to management of, and coping with, patient.

The general impression from the tendencies of results and magnitude of difference comparing answers to Q. 17 and Q. 6 and $X^2$ calculations for both questions for E and C subgroup, was that the E subgroup became 'relatedness conscious' and seemed to have gained a practical ability which the C subgroup missed.

Q. 7, to remind the reader, asked about the students' difficulties with classroom work during psychiatric experience.

In order to compare the answers of E with those of C subgroup on the background of their answer to (Q. 18)
'difficulties with classroom work' in their general training, only the statements of Q. 18 and Q. 7 which relate directly to each other are included. Table XXXII gives the results.

TABLE XXXII
PERCENTAGE DISTRIBUTION AND RANKS OF ANSWERS TO Q.18 AND Q.7 FOR E AND C SUBGROUPS

<table>
<thead>
<tr>
<th>Statement of difficulties</th>
<th>Q. 18 - General</th>
<th>Q. 7 - Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E N % R N % R</td>
<td>E N % R N % R</td>
</tr>
<tr>
<td>a) Too much material in time available</td>
<td>30 39 1 18 37 1</td>
<td>9 24 3 9 36 1</td>
</tr>
<tr>
<td>b) 'Ideal' knowledge with no practical application</td>
<td>15 19 2 7 14 4</td>
<td>10 27 2 7 28 2</td>
</tr>
<tr>
<td>c) Treated as though you are expected 'to know'</td>
<td>12 16 3 7 14 4</td>
<td>3 8 4 3 12 4</td>
</tr>
<tr>
<td>f) Own decision for application of knowledge</td>
<td>9 12 4 7 14 4</td>
<td>12 33 1 3 12 4</td>
</tr>
<tr>
<td>g) Not treated as a responsible person</td>
<td>11 14 5 10 21 2</td>
<td>3 8 4 3 12 4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>77 100 49 100</td>
<td>37 100 25 100</td>
</tr>
</tbody>
</table>

From Table XXXII it was noticed that difference of percentage between E and C for Q.18 varied between 2 and 7%, while for Q.7 it varied between 1 and 21%. Marked difference in percentage occurred for statement (a) 'Too much material in time available', and statement (f) 'Own
decision for application of knowledge'. These results could be interpreted as being in favour of the experimental approach to the teaching. The E subgroup seem to have been relieved from the 'load' of knowledge received in the classroom, which remained a major problem to the C subgroup. It will be recalled that the approach to the teaching was attempting at drawing common factors and ideas, rather than emphasizing details. Relating knowledge was felt to be economical in terms of time and amount of material used in the lecture. The students in the E subgroup considerably more so than their colleagues in the C subgroup, felt that they were deciding for themselves how to relate knowledge from classroom to practical experience.

The shift which occurred from Q.18 to Q.7 in that respect for the E subgroup was considerable. The consistency of the results of the C subgroup to the same statement (f/d) was also of interest. Generally the E subgroup experienced more upheaval than the C subgroup as a result of the psychiatric secondment. From the latter presentations it seems fair to infer that the students in the E subgroup became more aware of the process of relating their knowledge to their practice, and therefore find it difficult. This interpretation supports the interpretation of results to Q.6 above. Both subgroups found that their classroom instruction included more 'ideal knowledge with no practical application' (higher percentage in Q.7). These results might be partly
because psychiatric knowledge is totally new to them. But it is of interest to notice that the E subgroup felt that they received 'ideal' knowledge with no application, when their results to the questionnaire on the whole as well as to the course evaluation schedule and tests indicate that they seemed to have 'applied' their knowledge practically more than the C subgroup. It was suspected that the change in the student of the E subgroup was so slight and at its beginning stages, that she herself was not aware of the change, but only of the effort she had to apply the knowledge in practice. It should also be remembered that 'classroom instruction' was not specified in the questions and therefore subject to the students' interpretation. Some or all students might have answered the question in relation to 'doctor's lecture' and/or 'nursing lecture'.

Following the same pattern as for Q. 6, the $X^2$ test for Q. 18 and Q. 6 was calculated. Table XXXIII shows results for Q.18.
### TABLE A.XLIII

**X² Test for Q.18 E and C Subgroups**

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Statements of difficulties</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a  b  c  d  e  f  g</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30  15  12  9  11</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>(29.3) (13.4) (11.6) (9.7) (12.8)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(18.6) (8.5) (7.3) (6.2) (8.1)</td>
<td>49</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>48  22  19  16  21</td>
<td>126</td>
</tr>
</tbody>
</table>

The $X^2$ was not significant at the 5% level ($X^2 = 1.374, d.f. = 4$).

Table XXXXIV shows the results of the $X^2$ Test for Q.7.

### TABLE A.XL.IV

**X² Test for Q. 7 E and C Subgroups**

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Statements of difficulties</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a  b  c  d  e</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9  10  3  12  3</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>(10.7) (10.1) (3.5) (8.9) (3.5)</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(7.2) (6.8) (2.4) (6.0) (2.4)</td>
<td>25</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18  17  6  15  6</td>
<td>62</td>
</tr>
</tbody>
</table>

Again $X^2$ did not reach significance at the 5% level. ($X^2 = 3.74, d.f. = 4$).
From the general tendency of the result it appears that the psychiatric experience was different from the general training for both E and C subgroup. Though for Q.18 the E and C subgroups are similar in their response their 'observed' answers were in opposite direction from 'expectation'. In the psychiatric experience their answers, though remaining opposite changed directions. Their answers to (a) 'too much material in the time available' though slightly different from expectation for Q.18 is slightly more different for Q. 7. Fewer students in E subgroup than 'expectation' found (a) to be a difficulty. The same tendency as for (a) occurred for (b) 'too much 'ideal' knowledge with no practical application', the difference between 'observed' and 'expected' is negligible. The answers to (f/d) 'having to decide for yourself how to apply knowledge' is of interest. More students in E subgroup found (f/d) to be a difficulty, while fewer students in C subgroup than 'expectation' found (f/d) to be a difficulty. The difference between 'observed' and 'expected' is greater for statement (d) of Q. 7, than for the same statement (f) of Q. 18. This result is consistent with answers to Q. 6 of psychiatric experience where more students in E subgroup found (c) both school and hospital, more difficult to cope with than students in C subgroup as well as with argument on p.327.

Comments written under 'other' in relation to Q. 7 of the psychiatric experience support the opinion that students in the E subgroup had difficulty with a 'new' and
'different' way of teaching.

In order to compare comments for E and C subgroups, written under 'other' in a better perspective they shall be presented according to schools, as every school had a different tutor.

**School II** (in both cases, comment relates to content of lectures)

E subgroup:
- not enough definite material

C subgroup:
- Memorizing types and names of medicines and their side effects.

**School III**

E subgroup:
- Coping with my own adjustment to the different type of nursing lectures.

and
- the tutorial lectures were too general and sympathetic. I would have preferred lectures on more distinct subjects.

(Both comments relate to content of nursing lectures).

C subgroup:
- Adapting from general to psychiatric, personally it took me a long time to adapt to the atmosphere in this hospital, i.e. it is not as strict as our (hospital) and therefore I found it harder to concentrate and to study.

**School IVa**

E subgroup had no ticks under 'other'.

C subgroup had three comments:
- difficulty in communicating with the tutor (nursing).
have not really had enough material to judge and I think on the whole it has been presented well. difficulty with relationship with patients at first.

School IVb

E subgroup:

too much deeper work just being skimmed over and yet we are expected to learn and understand. (doctor's lecture)

and

I am thinking of the doctor's lectures and found him quite boring as I did not feel that he was talking to us.

C subgroup:

We had to cover a great deal of material in a very short time, and so could barely touch the edges of most things. Were the time longer, a better and probably more lasting knowledge could have been gained.

It will be recalled that Q. 8 asked the students about their difficulties with hospital experience during psychiatric secondment.

As the statements of difficulties with hospital experience were different for general training and psychiatric experience, only the latter will be considered. The $X^2$ was calculated in order to compare direction of difficulties for students in both E and C subgroups. Table XXXXV shows the results.
TABLE XLIV

$X^2$ TEST FOR 0.8 FOR E AND C SUBGROUPS

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Statement of Difficulties</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>b</td>
</tr>
<tr>
<td>E</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>1.0</td>
<td>3.8</td>
</tr>
<tr>
<td>C</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>0.9</td>
<td>3.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

rel = relationship  wor = worthlessness
cop = coping  ex.k = expected to know
N.o = No orientation  out = outsider
VnC = view not considered
Ndf = No difficulties  oth = others.

Only tendencies could be considered as the $X^2$ was not significant. ($X^2 = 10.83, d.f. = 8, p < 0.05$).

Few answers have a difference between 'observed' and 'expected' worthy of comment. The value of these answers lies in the fact that they seem to be related. These answers pertain to statements c, f, h, and i.

(c) 'Not knowing what would happen and how to cope with it';
(f) 'Considered as outsider on ward'; (h) No difficulties;
(i) Others.

More students in the E subgroup than expectation did not find difficulty (h) with hospital experience, unlike
their colleagues in the C subgroup who had more difficulty with hospital experience than expectations.

The statement of 'other' (i) difficulties referred to management of patients for the C subgroup and to initial adjustment to "pace" and "routine" for the E subgroup. This source of difficulty was below expectation for E and above expectation for C subgroups.

More students in the E subgroup than expectation found difficulty coping with "not knowing what would happen and how to cope" (c). Unlike the C subgroup who had less difficulty than expectation in that respect. This result seems to support the idea that because the E subgroup became more aware of the 'relatedness' they found it difficult, as results generally indicate their developing ability to 'manage'.

Considerably less students of the E subgroup than expectation felt as outsiders to the ward (f), contrary to the students in the C subgroup who more than expectation felt as outsiders.

The general picture is one where the E subgroup are more adjustable (a characteristic not measured) and seem to cope well practically, than the C subgroup.

The Course Evaluation Schedule

The general comment on the answers to the course evaluation schedule seems to be that the students in the C subgroup were more generous and enthusiastic about their evaluation while the students in the E subgroup were more moderately critical and not so easily satisfied. The
students in the E subgroup valued the nursing lectures more than the doctor's lectures both for 'understanding' and for 'working' on the ward. The reverse was true for the students in the C subgroup who valued the doctor's lectures very highly. Table XXXVI to Table XXXIX below attempt to study more carefully the results of the 'course evaluation' schedules, using the $\chi^2$ Test for E subgroup rather than for C subgroup. In both cases (a) 'great extent' and (b) 'moderate extent' are pooled together and also (c) 'minimum extent' and (d) 'not at all' are pooled together.

**TABLE XXXVI**

$\chi^2$ Test for E subgroup. Help from 'Nursing theory' and 'Doctor's lectures' in 'Understanding'.

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>help understand</td>
<td>not help understand</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>$a + b$</td>
<td>$c + d$</td>
</tr>
<tr>
<td>$(111.9)$</td>
<td>$(33.0)$</td>
<td></td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>$25$</td>
<td>$10$</td>
</tr>
<tr>
<td>$(27.02)$</td>
<td>$(7.9)$</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$139$</td>
<td>$41$</td>
</tr>
</tbody>
</table>

$\chi^2 = 0.86$, d.f. = 1, $P < 0.50$
**TABLE XXLVII**

\(\chi^2\) TEST FOR E SUBGROUP. HELP FROM 'NURSING THEORY' AND 'DOCTOR'S LECTURES' IN 'WORKING'.

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b</td>
<td>c + d</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>97 (96.4)</td>
<td>46 (46.5)</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>23 (23.5)</td>
<td>12 (11.4)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>120</td>
<td>58</td>
</tr>
</tbody>
</table>

\(\chi^2 = 0.05, \text{d.f.} = 1, p < 0.90\)

**TABLE XXLVIII**

\(\chi^2\) TEST FOR C SUBGROUP. HELP FROM 'NURSING THEORY' AND 'DOCTOR'S LECTURE' IN 'UNDERSTANDING'.

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b</td>
<td>c + d</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>78 (80.6)</td>
<td>17 (14.3)</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>28 (20.3)</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>18</td>
</tr>
</tbody>
</table>

\(\chi^2 = 5.39, \text{d.f.} = 1, p < 0.05\)
TABLE XLIX

χ² TEST FOR C SUBGROUP. HELP FROM 'NURSING THEORY' AND 'DOCTOR'S LECTURE' IN 'WORKING'.

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b</td>
<td>c + d</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>62</td>
<td>29</td>
</tr>
<tr>
<td>(67)</td>
<td>(23.9)</td>
<td></td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>(16.9)</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>84</td>
<td>30</td>
</tr>
</tbody>
</table>

(χ² = 7.16, d.f. = 1)

From the overall tendency of the distribution of frequencies in the above tables it seems as though the students of the C subgroup deal better with factual information but students of E subgroup seem to have started to acquire something different which allows them to make more use of knowledge. This is supported by the calculation of χ² for the value of hospital experience when compared with Doctor's lectures and nursing theory for both E and C subgroups in Tables XXXXX to Table XXXXXXVII below.
TABLE XI

**X² Test for E Subgroup: Help from 'Nursing Theory' and 'Hospital Experience' in 'Understanding'**

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>help understand</td>
<td>not help understand</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>114 (115.7)</td>
<td>31 (29.2)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>44 (42.2)</td>
<td>9 (10.7)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>158</td>
<td>40</td>
</tr>
</tbody>
</table>

\( (X² = 0.48, \text{d.f.} = 1, \ p < 0.05) \)

TABLE XII

**X² Test for E Subgroup: Help from 'Nursing Theory' and 'Hospital Experience' in 'Working'**

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>help in working</td>
<td>not help in working</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>97 (99.9)</td>
<td>46 (43)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>40 (37)</td>
<td>13 (15.9)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>137</td>
<td>59</td>
</tr>
</tbody>
</table>

\( (X² = 1.06, \text{d.f.} = 1, \ p < 0.05) \)
<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b</td>
<td>c + d</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>25 (27.4)</td>
<td>10 (7.5)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>44 (41.5)</td>
<td>9 (11.4)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>69</td>
<td>19</td>
</tr>
</tbody>
</table>

\( x^2 = 1.69, \text{d.f.} = 1, \ p < 0.05 \)

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a + b</td>
<td>c + d</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>23 (25.0)</td>
<td>12 (9.9)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>40 (37.9)</td>
<td>13 (15)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>63</td>
<td>25</td>
</tr>
</tbody>
</table>

\( x^2 = 0.98, \text{d.f.} = 1, \ p < 0.05 \)
TABLE XLI: EIV

$X^2$ TEST FOR C SUBGROUP. HELP FROM 'NURSING THEORY' AND 'HOSPITAL EXPERIENCE' IN 'UNDERSTANDING.'

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$a + b$</td>
<td>$c + d$</td>
</tr>
<tr>
<td>Help understand</td>
<td>not help understand</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>78</td>
<td>17</td>
</tr>
<tr>
<td>(79.9)</td>
<td>(14.9)</td>
<td></td>
</tr>
<tr>
<td>Hospital experience</td>
<td>34</td>
<td>4</td>
</tr>
<tr>
<td>(31.9)</td>
<td>(5.9)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>112</td>
<td>21</td>
</tr>
</tbody>
</table>

($X^2 = 1.09, \text{d.f.} = 1, p < 0.05$)

TABLE XLII: EIV

$X^2$ TEST FOR C SUBGROUP. HELP FROM 'NURSING THEORY' AND 'HOSPITAL EXPERIENCE' IN 'WORKING.'

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$a + b$</td>
<td>$c + d$</td>
</tr>
<tr>
<td>Help in working</td>
<td>not help in working</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Nursing theory</td>
<td>62</td>
<td>29</td>
</tr>
<tr>
<td>(65.9)</td>
<td>(25)</td>
<td></td>
</tr>
<tr>
<td>Hospital experience</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>(26)</td>
<td>(9.9)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>92</td>
<td>35</td>
</tr>
</tbody>
</table>

($X^2 = 3.02, \text{d.f.} = 1, p < 0.05$)
### TABLE L-VI

**$X^2$ TEST FOR C SUBGROUP. HELP FROM 'DOCTOR’S LECTURE' AND 'HOSPITAL EXPERIENCE' IN 'UNDERSTANDING'**

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in understanding</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$a + b$</td>
<td>$c + d$</td>
</tr>
<tr>
<td></td>
<td>help understand</td>
<td>not help understand</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>23 (22)</td>
<td>1 (1.9)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>34 (34.9)</td>
<td>4 (3.0)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>57</td>
<td>5</td>
</tr>
</tbody>
</table>

($X^2 = 0.82, d.f. = 1, p < 0.05$)

### TABLE L-VII

**$X^2$ TEST FOR C SUBGROUP. HELP FROM 'DOCTOR'S LECTURE' AND 'HOSPITAL EXPERIENCE' IN 'WORKING'**

<table>
<thead>
<tr>
<th>Source of help</th>
<th>Extent of help in working</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$a + b$</td>
<td>$c + d$</td>
</tr>
<tr>
<td></td>
<td>help in working</td>
<td>not help in working</td>
</tr>
<tr>
<td>Dr's lecture</td>
<td>22 (20.2)</td>
<td>1 (2.7)</td>
</tr>
<tr>
<td>Hospital experience</td>
<td>30 (31.7)</td>
<td>6 (4.2)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>7</td>
</tr>
</tbody>
</table>

($X^2 = 2.09, d.f. = 1, p < 0.05$)
The inclusion of the handouts: 1) course objectives, 2) principles of psychiatric nursing, 3) observation guide, was of help to both subgroups. One student in the control subgroup expressed this explicitly:

course objectives are useful at the beginning of the 8 weeks secondment to help us understand what is expected during the short period. The observation guide is extremely helpful and covers all aspects which one should observe.

Tests

As the period of trial was short, only tendencies and directions could be discussed.

The tendencies and directions of the results of the two tests support the general impression that the students of the C subgroup deal better with factual information. The analysis of covariance showed that whatever achievement the student had, could be attributable to the student's own ability. In the analysis of covariance for the factual test, only group of students who showed a significant result, beyond 5%, was in School IVa.

It could be speculated that Adult I test was not testing the same kind of ability as the factual test. The Adult I was testing the ability to reason in the verbal medium while the factual test was testing specific knowledge.

The results of the inferential test are of special interest as noted earlier. Part I of the inferential test was perceived as the most difficult by students and by myself. The $X^2$ Test was calculated to compare
frequencies of results for E and C subgroups. This showed that overall the differences were not significant ($\chi^2 = 2.406, \text{ d.f.} = 6, \text{ p}<0.05$).

**TABLE L-VIII**

$\chi^2$ TEST FOR E AND C SUBGROUPS. INFERENTIAL TEST PART I

<table>
<thead>
<tr>
<th>Groups</th>
<th>Categories of Answers</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A B C D E F G</td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td>53 34 15 42 25 63 34</td>
<td>266</td>
</tr>
<tr>
<td></td>
<td>(52)(23)(11)(40)(27)(75)(37)</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>48 11 7 35 28 83 38</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>(49)(22)(11)(37)(26)(71)(35)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>101 45 22 77 53 146 72</td>
<td>516</td>
</tr>
</tbody>
</table>

Some particular observations are interesting. The largest difference between 'expected' and 'observed' in order of magnitude, occur in categories F, B and C: (12, 11, 4)

Category F: 'unexpected answer and wrong explanation'.

The control subgroup did considerably worse than expectation while the experimental subgroup did considerably better.

The control subgroup gave unexpected answer and wrong explanation much more frequently than experimental subgroup.

Category B: 'expected answer and no explanation'. The control subgroup did considerably less well than expectation
and the experimental subgroup considerably better. More students from experimental subgroup underlined the expected answer, but gave no explanation than students in the control subgroup. 

Category C: 'unexpected answer and right explanation' (which is comparatively the most difficult category). The control subgroup did less well than expectation while the experimental subgroup did better. (Same pattern for Category G: 'blank').

While not definitive, these observations suggest that in respect of these categories the experimental subgroup were superior to the control subgroup.

The results of the Pearson co-efficient of correlation in Table XXXIV (p.318) show that E subgroup in all schools, except School I, had a small $r$ than the C subgroup. The inference seems to be that as Park I and Part II tested two slightly different abilities, with Part I being more difficult, if an ability for Part I or Part II started to develop it would then be expected that correlation would be rather small, especially during the transition phase from one way of thinking to the next.

The Pearson correlation coefficient $r$ for the C subgroup was larger than for E subgroup, which might indicate that for the C subgroup the test as a whole was either too difficult or easy, but they were not 'sensitive' enough to the differentiation between Part I and Part II.
The first school was different in pattern, this was believed to be due to the fact that the C subgroup were not a concurrent group to E subgroup. These results of Pearson coefficient of correlation $r$, together with results of $X^2$ calculation for Part I distribution of answers in Table XXXXVIII, seem to indicate that the students in the E subgroup started to develop a different way of thinking, but such difference was not given enough chance to develop even for the students to be aware of it. The weaknesses of the inferential test related to its wordings specifically for Part III; Part II and Part III of the test would benefit from the addition on to every question of the opportunity for the student to qualify her answers.

General conclusion to discussion

What is there to be said about this series of generally non-significant differences?

It will be recalled that because of the brevity of the experiment, it was not anticipated that any spectacular differences would be observed between the E and C subgroups; and that the subsequent discussion would therefore be concerned with such 'tendencies' and 'directions' as might be observed (p. 321).

From p.342 to p.361 are displayed 12 2x2 tables; 6 2xn tables, as well as all other tables presenting results in p.283 to p.320. In none of which, individually, was there any statistically significant difference between the E and C subgroups. However, scrutiny of these tables would
show that in all cases, such differences as were observed between the two subgroups were directionally in line with the hypothesis that greater 'benefit' would accrue to the E subgroup as a result of the experimental approach in teaching, than would accrue to the C subgroup, which received a more conventional form of teaching. By 'benefit' is meant the development of an inferential ability, and an increased awareness of the variables present in a situation, which would facilitate the relatedness between theory and practice and help the student to manage on a practical level.

The cumulative effect of all these individually non-significant unidirectional differences is to be taken seriously. Statistically, it is improbable that the occurrence of a difference in the same direction in each of 18 out of 18 tables at least can be attributed to chance. The accumulated evidence, though circumstantial, suggests together with comments of students, strongly that an ability started to develop as a result of the experimental approach to teaching.

Having regard to the short period available for introducing the 'new' teaching approach and for familiarising all concerned with it, perhaps no stronger indication of its effectiveness was to be hoped for.

Summary of Results

An experimental course of teaching the psychiatric seconded students, was planned and carried out with five groups of students, with the view of;
i) relating theory of instruction to practical experience through increasing the student's awareness of the practicality of knowledge;

ii) giving the student an opportunity to re-appraise her way of thinking and develop an 'inferential ability' which will help her in the process of relating;

iii) giving to the student opportunity to think about and view the situation in terms of management.

The results of the different instruments used in the evaluation, though not statistically significant, were cumulatively and directionally strongly suggestive of the 'potential' success of the approach to the teaching.

Generally speaking, though students in the C subgroup seemed generous and enthusiastic with their rating, they did not give enough indication of the acquisition of new abilities. The introduction of the experiment, probably helped make the secondment easier for them. Both nursing and doctor's lectures were along the same lines that they had been used to during their general training. Unlike their general training, they were helped by having a 'concrete' and available source (the handouts) from which to know what to expect during the secondment and received some guidance. The lectures were also given at the same time as the practice.

The students in the E subgroup had to cope with both a new type of experience; psychiatric nursing, as well as learn about this new field through an 'unusual' way. The students were required through the approach to the teaching, to actively participate intellectually, which
some of them found hard. Some students expressed anxiety about lack of 'specific' knowledge. Even though they seem to have started to develop an intellectual ability as well as a practical frame of mind, they were not fully aware of such a change. What they did seem aware of was the effort they exercised which made them less enthusiastic than their colleagues in the C subgroup. All these factors together with the short period allocated to the experiment and lack of adequate time for the preparation of tutors, speak in favour of the approach to teaching.

For a fair appraisal of the approach a longer trial over a variety of subjects is necessary. A longer trial rather than more trials would be more useful as the approach is concerned with the development of an ability.

In such an extended trial, a pre and post test experimental design would be more appropriate and useful in avoiding uncontrolled environmental influences, as well as in dealing with the problem of assessment. This was also indicated by Williams (1965) discussing the problems involved in the experimental comparison of teaching methods.
PART FOUR

PHILOSOPHICAL ANALYSIS

Chapter XI : Literature Review of the Meaning of Nursing.

1. Identity of Nursing
2. Frame of Reference in Nursing

Chapter XII : Literature Review of the Meaning of Nursing (Continued).

1. Concepts of Nursing.
2. Theory.

Chapter XIII : Philosophical point of view.

1. Philosophical analysis
2. Organizational structure
3. Meaning of Nursing

Chapter XIV : Philosophical point of view (Continued).

1. Implications for nursing education
2. Implications for nursing practice
3. Nursing and allied professions
4. General discussion.
CHAPTER ELEVEN

LITERATURE REVIEW OF THE MEANING OF NURSING

GENERAL INTRODUCTION

All along I have argued for the need for an explicit exposition of the meaning of nursing. In this Chapter I shall review some of the literature concerned with the meaning of nursing.

My main references are North American as they have dealt more with the problems at hand than British literature.

Throughout, a considerable amount of doubt as to what nursing 'is' was expressed, in many countries. The multiplicity of interpretations of nursing in the North American literature is a fair reflection in itself of the degree of indecision present: Bennett (1970) expressing his belief that nursing may become extinct, wrote:

There are continuing controversies concerning the definition of nursing, the practice of nursing, the art of nursing, the specialties of nursing, the practical and professional sides of nursing, the clientele of nursing, the practitioners of nursing, and the philosophies of nursing, to mention a few.

Though controversies existed a fair degree of agreement was present in relation to what constitutes the problem in 'Nursing'. Walker (1970) saw the problem in the fact that the uniqueness of nursing has not been fully described:
... nursing is something, the essence of which is unique ... However, if nursing is to survive as an entity primary consideration must be given to the acquisition of tools and attitudes that will enable it to identify and describe its uniqueness ...

The Nursing Development Conference Group (1973 p.11) wondered if it was not the lack of a structured nurse's knowledge which causes the problem:

It is not lack of ability on the part of nurses to participate in a communication process in which nursing content is brought to bear in exploring or solving health-care and service problems due at least in part to the absence of structured nursing knowledge available for use in health-care situations?

They amplified the need for this structured knowledge thus:

What elements or key ideas in general concepts of nursing can be identified as reflections of the real world of nursing? What are the logical relations between the elements? Do the elements and their order reveal the reason why nursing exists, the uniqueness of nursing?

Hassenplug (1970), along the same lines, expressed the need for,

... the importance of delineating a body of nursing knowledge that would guide nursing practice...

King (1968) pleaded for a clear frame of reference in nursing:

Yet within the nursing profession a conceptual frame of reference basic to practice has not always been clearly defined.

The literature seemed to agree about the need for a frame of reference, for decision about what constitutes the identity of nursing and for clarity of concepts used in nursing. I shall proceed to discuss each of these needs separately.
The identity of Nursing

This need for making more explicit than at present what is 'unique' to nursing was expressed in terms of common core in nursing or of the Art and the Science of nursing. Sutherland (1971) in Britain asked a series of questions:

Is there a 'core' of nursing? If so, what is it? Can it be identified?

Cherescavich (1964) in America, tried to delineate Science from Art in Nursing. She perceived science as what,

... provides the nurse with specific knowledge
and art as what

enables her to convert scientific knowledge into abilities that prepare her to become a skilled clinical practitioner.

Sutherland (1971) also follows the same line of thought of dividing nursing into Art and Science components. He sees the former component as subjective and the latter as nearly non-existent. He doubts if nursing as a Science

has a core of its own at all.

He argues that what is studied by nurses is studied in greater depth by

Doctors, psychologists, dietitians, teachers, physiotherapists, occupational therapists.

Both Cherescavich (in America) and Sutherland (in Britain) perceived the Science and Art components in a similar way.

Science was illustrated as cold and uncaring, while Art was illustrated as humane and caring. Art seems to be more akin to what nursing 'is'.
Cherescavich (1964) believed that:

... when science fails ... the art of nursing, the humanistic, creative, sensitive self of the nurse make it possible for the nurse to accept the patient, and to create an environment which permits the patient to live as comfortably as he can ... when he cannot, support him to die with dignity.

Along the same lines Sutherland (1971) believed that what nursing 'is' "cannot be expressed by words alone", but that many nurses who took a second or subsequent qualification in nursing felt that their first training (irrespective of the field i.e. whether general, mental, sick children, or mental deficiency) gave them the "heart of the matter". He concluded from the latter observation that:

to recognise a common core is not to threaten the identity of special fields; on the contrary it is to set each field free to develop its own distinctive work, for which the common core is the pre-requisite.

The common core of nursing, therefore, in these authors' opinion is a human ability to care for patients irrespective of their ailments. The patient's ailment seems to decide the 'added' knowledge the nurse needs, which is provided by Science.

The view that more science does not contribute to the human element in nursing, and at times acts as a deterrent, is quite widespread among nurses. It sometimes prompts the question: How can a University Degree make you a better nurse? This view is worthy of consideration.

If the University Degree is one in nursing why is it not appreciated? It seems that the answer lies in
the meaning given to nursing if nursing is divisible into components of Art and Science with Art constituting the care, therefore it makes sense that a University Degree which will feed the other 'added' component, Science is not going to contribute in a fundamental way. However, a University Degree or higher basic educational qualification could become an asset if nursing was not perceived in compartments. The question of the use of a degree in a discipline unrelated to nursing has been discussed in Chapter One, page 21.

Our perception influences our behaviour, therefore perceiving nursing to be compartmentalised would influence the way each compartment is evaluated. The concentration would be on the individual compartment rather than on the 'whole' of nursing.

Hirst and Peters (1970) and Wilson (1972) argue for the influence of "having the concept of" and behaving accordingly. In other words what we understand by the different concepts we use influences our behaviour. Peters (1973) and Wilson (1973) discuss the connection between feelings and cognition.

Greenwald (1968), Oppenheim (1966), Audi (1973) too, point out the effect of attitudes and beliefs on behaviour.

It would be agreed therefore that a well planned educational programme taking into active consideration the development of the 'affect', could be a great asset to nursing. The establishment and development of a 'helping' or 'therapeutic' relationship is a highly skilled ability involving cognition, affection and behaviour.
The argument that what was studied by nurses in the field of science, was studied by other professions in greater depth, is responsible for the lack of a 'unique' body of knowledge in nursing.

If the concept of uniqueness is not made to refer to specifics, i.e. science component, but rather conceived as a wider frame of reference in which nursing is a coherent entity, then the latter argument about education could be used in favour of an identity in nursing.

It could be concluded, from the previous brief discussion that an identity in nursing was difficult to reach because nursing was perceived as compartmentalized and specific therefore difficult to describe adequately.

The previous discussion reveals the difficulties of identifying nursing as a "whole" because it is perceived as compartmentalized into specific skills and disciplines. Even if to describe nursing was the aim, this would be rendered inadequate because of the degree of specificity.

A frame of reference in nursing

The lack of a frame of reference was one of the identified problems in nursing. It was also argued, in A (above) that a wider frame of reference was needed to give nursing its identity.

The literature reviewed in this section is North American.

1) Sociological frame of reference

King (1968) indicated the complexity of the nursing situation and suggested a way of dealing with it.
The world of reality indicates that teachers and practitioners of nursing are faced with increasingly complex problems, specially those which deal with finding ways of applying the vast accumulation of scientific knowledge and with the new technologies resulting from research. Therefore, knowledge that is available and applicable to nursing requires some structure.

She defined nursing as:

a process of action, reaction, interaction and transaction, whereby nurses assist individuals of any age group to meet their basic human needs in coping with their health status at some point in their life cycle. Nurses perform their functions within social institutions and they interact with individuals and groups.

And therefore identified three distinct levels of operation:

(1) the individual, (2) the group, and (3) society.

Within this frame of reference five general concepts were given: perception, communication, interpersonal relationships, health and social institutions. These five concepts,

are abstract and general but related to phenomena in nursing situations (they) lend flexibility in the process of structuring knowledge for teaching, for use in practice, and for generating hypotheses for research.

I am in complete agreement with Dr. King about the following factors:

- the importance of the interaction between nurse and patient(s);
- the fact that institutions as 'organised systems', with all that implies, are an important element in nursing;
- the importance of considering the factor of time the nurse assists individuals to cope with their health needs at a particular point in time;
- the importance of perception which is expressed in terms of behaviour;
- the importance of a frame of reference which would be workable for teaching, practice and research.

My main comment though, on the presented frame of reference is that it is sociologically biased and therefore does not sufficiently focus on what is particular to nursing.

It does not give sufficient consideration to the actual activities carried out by the nurse, which constitute a great part of her daily work. It is an extensive study of one aspect of the nurse's role, namely communication. Although communication is one of the cornerstones in the nurse's role, it is, nevertheless, one cornerstone. It could be argued that one can include a great deal under the heading 'communication' and explain the different activities carried out by the nurse in 'communication' terms. I think that even though this is possible it might tend to distort reality rather than meet it. Activities might be in danger of being 'tailored to fit' the concept of 'communication', regardless of the actual situation which is likely to include variables from different sources, psychological, sociological, or biological. Such a frame of reference would then be restrictive.

2) A shifting frame of reference

Smith (1967) found that nursing was accepting the
challenge of making greater use of the sociological and anthropological studies dealing with social and cultural dynamics. She thought that:

The frame of reference for nursing action is shifting from an earlier concentration upon the medical diagnosis, the disease process, and the therapeutic regimen to the patient or individual within the context of the environment.

She introduced five papers exploring the relevance of three social and anthropological concepts to nursing practice, education and research. Three of these papers dealt with the different aspects of the sociological concept of 'role' as it related to the professional nurse, the student nurse and the patient.

Another concept, anthropological: 'culture', dealt "very convincingly" with the need for "the nurse to have scientific knowledge about people of diverse cultures."

The last concept introduced was "powerlessness" which in that instance was "related to the ability to learn". The author of this last paper, in Smith's view pointed "to the potential significance of recent social and psychological research for nursing assessment when powerlessness is a factor in patient behaviour."

I agree with Dr. Smith that the papers would "provide insights" into these issues. I believe that concepts introduced from other disciplines should be studied, and the degree and extent of their relevance and applicability to nursing investigated. Such a process is essential if we as nurses are to make use of new concepts in nursing.
What I find difficult to agree with is the feeling that this could act as a frame of reference to nursing. To make use of these concepts in nursing is one thing but to let these concepts or their related discipline 'make use' of nursing, is undesirable and detrimental to the identity of nursing.

The title of Dr. Smith's editorial is "The shifting frame of reference in nursing." To talk about a shifting frame of reference suggest that either the frame is in the process of change (or shift), or that it is in a continuous state of change. If the frame shifted from one centre "disease" to another "environment" it might be more appropriate to talk of a shifted frame of reference. The distinction in that instance is not merely linguistic in nature. Many things are changing or required to change in nursing. If the frame of reference is also continually changing the 'basic background' would completely disintegrate. A sense of security and continuity, indeed a sense of identity, needs a less changeable reference. This does not imply that nursing would be rigid. For change in nursing to be effective and help development it should occur within a context that remains consistently the same, (It is similar to the concept of freedom which needs restraints to be free from them.) The word 'refer' is always used in relation to a source. The Concise Oxford Dictionary defines reference as
referring of matter for decision or settlement or consideration to some authority ...

2. Relation, respect ... to
3. Allusion to ...

In other words a reference is always being redirected to the source; for consultation and settlement; or for the establishment of 'truth'; or for a 'goodness of fit' test; all of which imply and require that this source be a known 'constant'.

Such argument does not favour a 'shifting' frame of reference.

Another observation would be that passing from one area of concentration, "disease, its diagnosis and treatment", to another area of concentration "individual within the context of the environment" does not, in the long run, make any difference. With a change of interest, one aspect of the 'whole' is over-emphasised, at the expense of the other aspects and of the whole. Change of emphasis, within perspective could occur without loosing the central concepts or basic frame of reference of the vocation or profession. The extent and content of activities carried out by lawyers and doctors for example changed and varied through the years, but they still remained 'lawyers' and 'Drs'. To my mind what basically maintained the perpetuation of the total 'picture' are the central concepts and the frame of reference of these vocations as well as the relationship between these central concepts and their corresponding frame of reference.
Change in this instance would be considered in terms of: how much of the change is a change in essence and how much of it is a change in details (Section A, p. 17).

Going back to Dr. Smith I would say that the understanding of these concepts and their relevance to nursing is very important for a more enlightened nursing practice (whether in teaching, actual practice or research). I do not think, though, that it ought to constitute a frame of reference for nursing. These concepts might change with further investigation and study. This change would occur in a sociological or anthropological context, enriching the basis of these fields. Inman (1972) wrote:

A sociologist undertaking investigations into miners, policemen or nurses, remains a sociologist, however detailed and illuminating his knowledge of the group he may have studied for several years ...

Therefore, we as nurses should be able to make use of the concepts developed from different fields, within a nursing context, to help enrich the basis of nursing. By studying, for example, how culture and its meaning influence health practices, or how culture could be a component put into practical consideration when teaching a group of mothers about infant feeding.

The outcome of transplanting sociological or anthropological concepts in nursing without integrating them into the nursing process and translating them into nursing terms would lead to 'rejection', 'misfit',
'incompatibility' of the concepts or would confuse the meaning of nursing. King (1968) rightly pointed out that:

Concepts, principles, laws and facts are not the exclusive province of one individual or one field of study. The roles, functions, and goals of individuals and groups, however tend to determine the variations in the use of knowledge.

3) **Adaptation: a conceptual framework for nursing**

Roy (1970) presents 'Adaptation' as a conceptual framework. The conceptual model of 'Adaptation' is based on the work of Helson, a physiological psychologist, who considered adaptation responses as functions of the stimulus and of the adaptation level of the organism. The adaptation level of the organism is determined by the pooled effect of

i) focal stimuli (immediate ones)

ii) background stimuli (all others present)

iii) residual stimuli:

beliefs, attitudes, traits and other factors from past experience which are relevant to the present situation.

Sister Roy finds that the individual as a recipient of nursing care is a "bio-psychosocial being ... located at some point along the health-illness continuum" and that nursing is concerned with that individual as a patient in order to "support and promote patient adaptation, ... to bring about an adaptive state in the patient."

To achieve promotion of patient's adaptation the nurse needs to assess the adaptive state of the patient and
his position on the health-illness continuum, to be able to intervene for the purpose of adaptation.

This conceptual model was used for curriculum planning, for the teaching of science and social subjects, e.g. "courses in theories of learning and personality."

Therefore Sister Roy thought that:

The nursing courses could be introduced by an integration of these knowledges in an understanding of the healthy man and his mechanisms for responding to ordinary stresses."

The curriculum followed a 4-square matrix of adaptation problems:

<table>
<thead>
<tr>
<th>Simple Health Problems</th>
<th>Complex Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple Illness Problems</td>
<td>Complex Illness Problems</td>
</tr>
</tbody>
</table>

The course seems to be applicable to graduates.

Among the good points of such a framework are:
1) the presentation of the complexity of the situation;
2) the consideration of the human being as a totality;
3) the identification of a starting point and an aim;
4) the identification of the process through which such an aim could be reached;
5) identification of the need for integrating knowledge of understanding man, to the nursing courses.

What I believe the shortcomings of this framework to be, are:

1) the suggestion that such an approach is for a 'graduate' nurse, which limits its applicability to other types of nurses;
ii) the concentration on one way of coping with the situation, namely 'adaptation'.

When reviewing the process of change in Section A, p. 10, other mechanisms were identified namely 'absorption' which Soddy (1965) thought it implies a different notion of identity-formation; one that would enable a greater flexibility of personality development,

another mechanism presented by Schein (in Bennis 1969) was the process of change in behaviour and attitudes by "unfreezing, change and refreezing."

iii) the impression gained from the article is one where the implementation of the approach involves assessment procedures, which are not only numerous but different in nature, an example was:

the professional nurse might be responsible first, for obtaining and recording an adaptation history, that is, identifying relevant residual factors and usual coping patterns (data from health agencies in the community and from an admission interview with the patient) ... Second the nurse would evaluate the patient in regard to predominant stimuli at his position on the health-illness continuum and would diagnose adaptation failure. She would then initiate action to manipulate the appropriate stimuli to make a positive response possible. Finally, she would evaluate the effectiveness of her action by a reassessment and would insure continuity of the plan by a written care plan.

Such assessment would imply, among other things, devising criteria for measuring all these requirements. Criteria identification and measurement is a difficult, time consuming, and often unreliable field, especially if it is in the number required by this approach and the area of their application;
iv) the approach does not seem to give much attention to the respect of patient privacy. Patients are open for assessment about their present condition and past history. The multiplicity of assessment procedures give the impression that an 'object' is being put under scrutiny and somehow this lacks the human touch;

v) the suggestion that by teaching subjects like Biology, Chemistry, Psychology, Sociology, Anthropology, History, Literature and Philosophy could develop an understanding of man and his responses to life situations

is not necessarily true. This suggestion overlooks the importance of how a subject is taught, which plays a vital part in the process of transfer of learning.

î) The Venn Diagram

The main purpose of Thigpen and Drane (1967) was to use the Venn diagram to assist the nurse to develop further skill in conceptualization and as a theoretical frame of reference within which to do nursing research.

It was considered to be a tool by which to illustrate relationships, and

a frame of reference by which to check the accuracy of observations and interpretations.

Even though it was believed to be "simple and lucid as constructed" it became very complex as the number, shape and placements of sets increased:

Because of the exact analogue between the Venn diagram and set algebra one eventually resorts to the more tenable algebraic equivalent as the diagram reaches unwieldy proportions.
Thigpen and Drane add to the advantages of using the Venn diagram, referred to above, by saying that:

The analysis of the Venn diagram illustrating professional nursing provides both a framework for viewing professional nursing care and a relatively uncomplicated introduction to the process of diagram analysis.

Relationships as delineated within the diagram have served both as a check on the validity of the classification of relationships and activities and as a guide for a more adequate representation of various aspects of nursing.

(It) enables one to picture abstractly groups and individual relationships ... (and) also enables one to view relationships not just in isolated areas or aspects but as parts of a whole.

I believe that the latter advantage, referred to by Thigpen and Drane, is of prime importance. It is essential in the process of arriving at an identity of nursing.

The use of the Venn diagram seems to be mainly an illustrative technique, with the advantages and shortcomings of such a technique. It represents what we believe to be the case, but does not necessarily guide in the formation of 'what' ought to be the case. Because of its mathematical nature it would be restricted for use only by people possessing such an ability. It cannot be used as an everyday guide in nursing.

5) Nursing frame of reference

During the discussion of the pros and cons of the four 'frames of reference' reviewed above, several points of importance were referred to. These were:

a) A frame of reference is needed in order to guide thinking and action in nursing;
b) A frame of reference would help the relatedness among three important aspects of nursing, viz. Education, practice and research;

c) A frame of reference in nursing ought to be 'nursing' biased rather than 'psychologically,' 'biologically,' 'sociologically' or 'anthropologically' biased. This does not exclude the use and integration of the principles and concepts of these disciplines in nursing;

d) A frame of reference by definition requires to be stable or constant to enable development and evaluation of any progress taking place, and to ensure that such development is relevant to the frame of reference;

e) A frame of reference in nursing ought to be sufficiently simple to allow wider applicability; and at the same time sufficiently flexible to allow more than one level of complexity;

f) A frame of reference in nursing ought to ensure an easier method of direct patient care, with 'care' considered as central to nursing. It would act more as a guideline in this instance;

g) A frame of reference ought to reflect the 'whole' picture of nursing.

If such a frame of reference, as described above, could be arrived at, it would be of great benefit to the cause of 'nursing'. My contribution, of a nursing frame of reference is included in Chapter 13, along with what I understand by nursing.
In the last Chapter I reviewed and discussed literature dealing with nursing, identity and frame of references. In this Chapter I shall review some of the literature presenting a concept of nursing and theories of nursing.

**Concepts of nursing**

The Nursing Development Conference Group (N.D.C.S.) (1973) reviewed "a selected sample of concepts of Nursing published by ten nurses."

They reached the conclusion that the reviewed concepts agreed on three facts:

1. Nursing is concerned with the care of the individual patient and his/her surroundings, involving basic needs of the patient for hygiene and healthful living, as he is incapable of doing so himself due to impairment of health;

2. Nursing is different from medicine in its functions specifically illustrated by Virginia Henderson's fourteen components of basic nursing;

3. Nursing deals with "the state of health or well-being, or the absence thereof, in recipients of nursing."
There were also differences relating to ways of symbolizing recipients of nursing (the sick, the injured, dependent, experiencing needs ...). The forms of nursing as action (nursing conceptualized as: helping or assisting persons toward something or because of something ... assumption of or exercise of responsibility for another person ... 'interposition of skills and knowledge'), and the results of nursing (states of persons expressed in relation to comfort and ease of mind and body ... adjustment of individuals to unalterable situations ... freedom from assistance ... coherence and integrity of the 'human field' ... adjustments of the nurse).

It seems that there is a fair amount of agreement as to what is involved in nursing, even though interpretation and extent of a nurse's function differed.

What the N.D.C.G. defined as concept was borrowed from:
- Brownowski (1965), who states that a concept is the product of a person observing instances with their regularities and variants thinking about these real-world phenomena, and finding in them unexpected likenesses of structure, unity and intelligibility (p. 20).
- from Gibson (1968) and Arnheim (1969): who believed that concepts may be described as extensions of percepts, as a grasp of overall structure obtained by the isolation and identification of relevant factors and relationships in orderly array (p. 20).

A concept according to the above understanding, is a process of passing from the particular or specific to the general. However, Hamlyn (1970) expresses the view that: there are clearly some concepts that are not derivable from experience. Not all concepts or ideas are ... a posteriori; some are a priori, independent of experience (p. 56).
The N.D.C.G. believed that what is unique about nursing lies in the reasons for what the nurse does in society as well as in the characteristics of what she does. A description of the why and what of nursing would embody a general concept of nursing and would constitute a guide for enquiry and for the structuring of nursing knowledge. (p.21).

They also thought that this general concept has to be "static" and becomes "dynamic" only when examining specific instances of nursing (p.22). They state that reliability and validity are two opposing criteria which control the conception chosen to guide enquiry. The reasons why reliability and validity oppose each other were not made sufficiently clear. They said that reliability requires that a concept of nursing be clear and usable (and unambiguous)

while

validity requires that the substantive structure point to representative data (reflecting richness and complexity of subject matter) (p.23).

From the above quote it seemed implied that complexity is unclear and ambiguous therefore not usable.

The group seem to use the word concept as an instrument of measurement hence the concern about reliability and validity, while, according to the Encyclopaedia Britannica "abstraction" is innate in the idea of a concept. What I found inappropriate in their arguments was the reference to reliability and validity rather than to the use of criteria in the analysis of a concept.

As the N.D.C.G. proceed to discuss what they mean by concept it becomes clear that they used the word concept
to mean different things. The picture gets more confusing as they elaborate on the use of concepts:

In a practice discipline, such as nursing, a general concept is necessary to guide individuals in the production of results. (p.22),

then further on:

In a practice discipline, theory, research, and practice are interrelated and interdependent. Theory is born in practice, refined in research, and returned to practice in a continuing cycle. To theorize is to invent a conceptual framework to some purpose. A concept of nursing has concrete referents - it deals with the real world where nursing is practiced - but it frees thought and expression from the domination of that real world. If the concept is too static and over-verbalized, however, it will make inadequate reference to actual nursing situations. A static concept of nursing, then, must continue to become dynamic in the fields of research and practice. (p.23),

and

Embryos of nursing theory do exist in the literature but often without specification of the relation of small segments to the total theoretical picture. A sound general concept of nursing would be a helpful instrument for integrating segments of nursing theory and relevant theory from other disciplines toward an adequate total product. (p.24),

and again

Concepts in a discipline vary according to their degree of productivity in generating new concepts or in holding knowledge static within the discipline. Selection of more highly valued concepts, those which have a high degree of reliability and validity, as a base for scientific inquiry will result in greater productivity and should take precedence in use within the discipline. (p.24).

Their statements that theory, research and practice are interrelated though acceptable, does not include the way in which such relatedness is achieved. They believed that theory is born in practice which is not always the
case. Dickoff and James (1968) for example thought that a theory in nursing ought to be 'situation-producing' and said that it must be invented rather than discovered. The N.D.C.G. also contradict themselves as to whether a concept should be "static" or "dynamic":

A general concept of nursing is, necessarily, a static concept, then go on to say that it should not be "too static". The picture is further confused by their use of the sentence "highly valued concepts", which begs the question: How can a concept be judged as 'good' or 'bad'? They also use the word 'nursing' indiscriminately to mean sometimes the profession of nursing and sometimes the activity of 'nursing the patient'. To my mind to talk about the concept of nursing is inadequate, as nursing includes more than one concept. In my opinion the N.D.C.G. was defining nursing rather than analysing the concept 'nursing'.

Laying down criteria for the process and activities in nursing might be more beneficial than giving a definition of nursing. The finding of the N.D.C.G. about the three points of agreement among nurses as to what nursing is, seemed to support laying down criteria rather than defining nursing as it appears more operational.

I have so far discussed the concept of nursing only. In Chapters 13 and 14, I shall discuss the pros and cons of a definition as opposed to concept analysis in nursing.
Grouped and organized concepts: Theory

This was mainly discussed during a 'Symposium on theory development in Nursing' in 1968. Dickoff and James presented background knowledge about theory, Dorothy Johnston differentiated between what is borrowed and what is unique theory in nursing, Reva Rebinsea presented a 'Theory of clinical nursing' and Myrtle I. Brown discussed the role of 'Social theory in geriatric Nursing Research'.

Dickoff and James gave the definition of a theory and what a nursing theory would look like:

- a theory is a conceptual system or framework
- ... a set of elements in interrelation

number, characteristic and complexity of elements vary, as well as the kind of relation holding between or among the theory's elements or ingredients,

- at its highest level (a theory also) contain whole theories as elements.

They believed that a good theory is one that fulfilled the purpose for which it was proposed or invented. They considered Nursing theory to be of an elaborate kind:

(a theory) within which predictive theory functions as an element of the theory.

In their opinion nursing was a practice discipline therefore its theory must

provide for more than mere understanding or 'describing' or even predicting reality and must provide conceptualization specially intended to guide the shaping of reality to that profession's professional purpose.
It ought to be a theory at the fourth or highest level, i.e. "situation-producing" theory, ("prescriptive-theories") where setting one's goal would be of prime importance.

They thought that the advantages offered by nursing for such a theory are: "a non-artificial field of observation" and a "fund of practical wisdom (which is) passed on".

They also believed that such a theory must be invented rather than 'discovered' from a hidden truth or abstracted somehow from the real. But consulting empirical reality is an important way of assessing fruitfulness.

Research to them was an important tool for testing or stimulating thought toward the production of theory. Research ought to be carried out in the context of theory with the clear realization of what it is that research has to say or contribute to that theory.

But there will be a long wait if anyone waits for research to invent theory.

Dorothy Johnston defined "borrowed theory" and "unique theory" in nursing. She thought that it was hazardous to do so, as:

Knowledge does not innately "belong" to any field of science.

Nevertheless she felt that such an examination would help clarify

nursing's appropriate place and focus in theory development.
(1) Borrowed theory

She investigated what was borrowed by examining the nature of the knowledge required for nursing practice and the availability of that knowledge. She identified three types:

- Knowledge of order. She believed that in nature there are:
  
  regularities in the arrangements and sequences which underlie and govern the relations of physical, biological and social objects and events".

- Knowledge of disorder, like disease, which she defined as:

  events which pose a threat to the well-being ... of the individual or society".

- Knowledge of control which allowed

  to prescribe a course of action which, when executed, changes the sequence of events in desired ways and toward specified outcomes".

She thought that nursing was concerned with "man as an organized and integrated whole", but the knowledge of order required for man as a whole was not available at present. Until the basic sciences develop such a knowledge, nurses will have to "'make do' by collating and synthesizing ... the findings of several fields", in other words, borrow knowledge.

The knowledge of disorder produced by the basic sciences in these areas (i.e. medicine and disease) (although it) is exceedingly useful; it is and will continue to be qualitatively insufficient for a profession which must have a more holistic perspective in examining more pervasive phenoma.

Therefore she foresaw that in nursing we will probably (have to) develop our own theory.
The knowledge of control cannot be dealt with at the moment "since (it) stems from and thus is directly related to the knowledge of disorder".

In Dorothy Johnston's opinion what prevented "future professional and scientific development" was our lack of clarity in respect to

... (the) end (towards which) knowledge is to be used, ... (and what is) the area of our primary responsibility to patients.

She went on to say that, answering the question, What is nursing? ... we will find our boundaries as a professional and scientific discipline.

(ii) Unique theory

She believed that what was unique to nursing will evolve only through the study of phenomena and the asking of questions in a way that is not characteristic of any other discipline.

The phenomena with which nursing was concerned in her view came under the general class of behavioural system disorder, i.e.

the patterned and repetitive ways of behaving that characterize the life of man, ... conceived as forming an organized and integrated whole made up of interrelated and interdependent parts. This system ... is determined ... regulated and controlled ... by many factors of a biological, psychological and social nature.

She recommended that the same principles of establishing knowledge of order, disorder and control ought to be used within such a context. Professor Johnson concluded that the body of knowledge needed for nursing practice would be incomplete,
until we learn to ask ... nursing questions about events in nature of specific concern to us because we are committed to their management.

Comparing Professor Johnson's theory with Dickoff and James' the following is noted:

What she understood by theory stemmed from the 'study of phenomena' i.e. from observables. The ordering of ideas was illustrated by the division of knowledge into that of order, disorder, and control.

She did not, however, show clearly enough the relationship between and among the theory's elements or constructs as recommended by Dickoff and James or by Torgerson (in Hayman 1968). Torgerson in Hayman's view added perspective

with his statement that theory is made up of constructs and their relations to one another and that science consists of theory on the one hand and empirical evidence, that is, basic observable data, on the other. A major concern in science is the interplay between theory and empirical evidence.

Professor Johnson disagreed with Dickoff and James in respect to the role of research. They believed that research had a role to play in theory building but that it would not create theory, while Professor Johnson thought that "the way out can come through research". Another point of disagreement with Dickoff and James was her requirement for a theory that would describe and explain reality, while they thought that nursing needed a theory which would shape reality.
Reva Rubin based her 'theory of clinical nursing' on the fact that the proper study of nursing was the patient and not the nurse. Because patients are persons undergoing subjectively involved experiences of varying degrees of tension or stress in a health problem situation.

In her opinion, the definition of this situation was what distinguished one profession from another. As far as nursing is concerned its context can be illustrated by a simple conceptual model:

\[
\text{Nursing care} \quad \infty \quad \text{Patient} \quad \underline{\text{Situation}}
\]

The sign of infinity "represents an ever changing process and an interaction process".

She went on to say:

Nursing care is dependent on the best estimate available of ... the situation of the patient ... (and it) exists in a one-to-one relationship. ... Situations, within the sphere of proper nursing concern, are fluid ... (which) characterizes and distinguishes nursing care from other helping professions in three major ways: time, definition or diagnostic sets, and actions.

She thought that nursing operated in the immediate present, and that,

All nursing, because it is done in interaction within a dependency relationship, conveys a message to the patient about himself in the immediacy of the situation.

She believed that nursing diagnoses was based on the definition of capacities and limitations of the person as a patient and knowledge of these are obtainable from: (i) known source, e.g. age, sex, medical
diagnosis; and (ii) from interaction with the patient (which was considered as the primary source). She thought that such a model could be used as a research model if the nurse became "more consciously aware of making observations" and focused on the question: "How does this patient feel about himself in this situation at this time?" Sample of patients and "time-situation" was dependent on the problem.

The advantages of this research design as seen by Professor Rubin were:

- it delineates nursing spheres and nursing problems;
- it avoids an artificial laboratory situation;
- The control of variables ... is a mental operation not a structural one;
- The research tends to be descriptive. This is the intended outcome. At this stage in nursing research we are most concerned with discerning patterns, processes, and phenomena in patient situations.

She identified the following as disadvantages "inherent in the design":

- patients do not present themselves identified for a problem;
- If, as investigator, one wishes another case of some very interesting phenomena in behaviour, one must wait for that behaviour to appear which requires from the clinical nurse scientist a high tolerance for open-endedness and for delay of gratifications;
- Patients often self-refer. They see the clinical nurse scientist in action with another patient and in subtle and less subtle ways seek nursing care for themselves. Referrals of patients who came themselves or through "rejection of the staff" for a difficult patient was hardly random;
the method is in itself therapeutic (which) is a more serious disadvantage.

She concluded by saying that

Basic to this design for studying patient situations is the need for an orienting concept, a point of view so that one can observe, a frame of reference so that one can analyze what is observed.

The theory presented by Professor Rubin does not meet all the requirements of a theory as defined by Dickoff and James. A model is given which established a form of relationship between nursing care, patient and situation. But the theory did not, however, show clearly what made up each of these elements. Even though she said that the 'definition of the situation' was what made the difference between professions, she did not give a clear picture of how nursing defines the situation.

Among other theorists who presented applied theories from different disciplines were Myrtle Brown who applied socialisation theory to nursing research. She began,

... to use the concept of socialization in a gerontological research project. In this effort, socialization theory applied to older persons ... provided the classes for categorizing and ranking nurse and aged patient behaviours in the nursing process and the conceptual framework for hypothesis formulation.

She found however that the concept of socialization failed to provide criteria of social health.

Other contributions to a theory of nursing were offered by Walker (1971) who followed Maccia's analysis of an educational theory; by Vaillot (1968) who used general system theory and self-actualization concepts.
On a slightly different line Abdellah and Others (1969) in a "Conference on the nature of science in Nursing" criticized existing theories and offered their own.

Discussion of the reviewed concepts and theories in nursing

My general comment about the reviewed Concepts and Theories is that words like concept and theory are used indiscriminately. The terminology used on the whole is not clearly defined. The use of words in a context like clarification of the meaning of nursing plays a vital role.

Professor Johnson and Professor Robinson both brought to light important points.

Professor Johnson recommended that "nursing questions" should be asked in order to help the cause of nursing.

Professor Robinson pays special attention to the subjective feelings of the patient. She also mentions the influence of the situation on patient care as well as that of time and interaction between the nurse and patient.

In all the theories presented emphasis is put on the aspect which is applied from the lending discipline. Somehow, while most of the theories recommend a "holistic" approach, the picture conveyed is an incomplete one.

What to my mind, confuses the issue in the reviewed literature about the meaning of nursing are several points:
(i) the concern with "uniqueness" whether of nursing, frame of reference, concept of nursing or theory of nursing;

(ii) The emphasis put on the fact that nursing is "practical" and functional and therefore not theoretical, in other words making a clear distinction between practice and theory;

(iii) The pre-occupation with wanting to prove that nursing is a respectable profession in its own right. This pre-occupation at times becomes a hinderance rather than a help in the development of nursing. Development occurs outwith nursing rather than in nursing, because efforts are not channelled toward a given purpose. For example, a nurse carried along by her enthusiasm for some psychological/sociological theories will spend a great deal of time and energy to model nursing, its interpretation and activities on these theories. So that 'nursing' in the long run is 'torn apart' rather than 'brought together' for development.

As pointed out earlier psychological, sociological or any other discipline's concepts could be advantageously integrated to nursing, rather than considering as "borrowed" and waiting until the "basic sciences develop this knowledge (of) man as an organised and integrated whole", in Professor Johnson's (1968) terminology. If and when the basic sciences reach such perfection we still
shall have to translate this into nursing terms. Professor Johnson herself pointed out that knowledge was not the property of any one discipline (p. 391).

In the following two Chapters the points raised here are studied further. Having set such severe boundaries (through criticism) of what is required for the development of nursing, I put myself under scrutiny by presenting in Chapter 13 my own interpretation of nursing.
CHAPTER THIRTEEN

PHILOSOPHICAL POINT OF VIEW

General Introduction

From the previous Two Chapters, there was a need for tidying up the relevant issues raised when discussing the meaning of nursing.

How to approach the discussion of the meaning of nursing? What needs to be clarified? What are the elements involved? What relationship do they have to each other? Is there a principle which organizes the relationships?

These are a few of the questions which require answers. In this present Chapter I shall first plead the case for a philosophical analysis of nursing as opposed to a definition of nursing. Then I shall proceed to offer a suggestion for organizing nursing in such a way that would enable its effective analysis and study, as well as an interpretation of nursing.

Philosophical analysis

1. What does philosophy entail?

Hirst and Peters (1970) presented what they meant by philosophy. They considered that philosophy was concerned with reflective inquiry into what was a going concern. They thought (in Tibble (ed) 1966) that it was concerned with questions of meaning, truth and categories of thought at the most general level (p.60) and
... with questions about the analysis of concepts and with questions about the grounds of knowledge, belief, actions and activities. (in Hirst and Peters 1970, p.3).

They defined conceptual analysis as the ability to understand and relate words to each other, as well as the ability to recognize cases to which the word applied. An example would be: in exposing our understanding of the concept 'nursing care' we use and imply many words, these words in turn have to be explained and clarified and their relation to the words 'nursing care' put forward.

Hirst and Peters (1970) were of the opinion that to explain what a concept is, was a difficult task; to have a concept covers both the experience of grasping a principle and the ability to discriminate and use words correctly. This was believed by them to be a necessary criterion to identify having a concept, but having a concept was not identical with the criterion. They thought that Locke was as close as one could get to explaining what a concept was when he said that an idea was "the object of the understanding when a man thinks." (p.5)

Along the same lines, and in agreement with Hirst and Peters (1970), Wilson (1972) discussed the use and misuse of the word concept. He considered the notion of "having, acquiring and using concept," and argued that:

1. Having the concept (to be in possession of a principle of unity according to which a number of things may all be regarded as being the same, or as being of one kind)

   la. wanting to use it

   lb. being able to use it
2. Having the ability to 'recognise' (full understanding requires both the ability to give a formal account of redness (for example) and the ability to recognise instances)

2a. wanting to use it
2b. being able to use it,

are all required for the concept to be actually operative in a person's everyday thinking.

In other words it seems that concepts include certain characteristics or components, pertaining to an object X, as well as the operation of recognising and applying this understanding.

Hirst and Peters (1970) said that in analysing a concept the use of the word was examined as well as the principle(s) which governed its use, and this principle made explicit. They identified two categories of words: those which call for a weak sense of definition and those which call for a strong sense of definition. The latter involves conditions where it was logically both necessary and sufficient for a word to be what it is. The former involves picking out characteristics which are logically necessary for using the word.

An example of the strong sense of definition would be to use a word like triangle, where one can say 'if and only if' characteristics x, y, z are present, then it is a triangle. Words used in ordinary language are not easily defined in that sense.

An example of the weak sense of definition would be to use a word like punishment where it is logically necessary to use the word if something unpleasant should
be done to someone. This condition of something unpleasant is inseparable from our understanding of what it is to punish someone. However, logically necessary conditions are not obvious and easy to identify in most cases.

Peters (1966 p.25) considers 'Education' to be a word that could be best defined in the weak sense, as it does not pick out specific activities, "it lays down criteria to which activities or processes must conform."

Dealing with the questions of concept first and isolating them from other considerations of 'facts' and 'morality' was perceived as an important step in the techniques of concept analysis by Wilson (1963) because he thought

considerations of fact and morality cannot be relevantly applied at all until one has worked out just what they are supposed to be applied to. (p.25).

Peters and Hirst (1970) suggest that one should not look for defining characteristics in any simple stereotyped way in relation to one word. Concepts, they said, can only be understood in relation to other concepts, hence the use and need for conceptual analysis.

This opinion was also supported by Wittgenstein who stated that words form

a 'family' united by a complicated network of similarities overlapping and criss-crossing sometimes overall similarities, sometimes similarity of details. (in Peters 1966 p.23).
Wittgenstein further drew attention to the error of assuming that

all words have meaning on the model of names which are associated with some typical referent.

2. Nursing: definition or philosophy?

**Definition**

Nursing, whether one talks about the profession of nursing, or whether about the activity of nursing a patient, is a very complex process. Giving a definition of nursing which would be concise, short, clear and comprehensive would be a near impossible task; it is not likely that it will be effective in providing guidelines as to what knowledge, beliefs, values, action and activities pertain to nursing. It might provide a general idea of what it involves, but will certainly fail to provide a deeper understanding of what it entails, for the guidance of our action and behaviour as nurses.

A definition of nursing has limited potentialities, mainly because of the fact that it needs to be short. It could only cover some aspects of what is meant by nursing. Virginia Henderson's (1960, p.3) definition of nursing, which came to be recognised by the International Council of Nurses, is a good illustration:
the unique function of the nurse is to assist the individual sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

The first comment on the definition is that it picked out one aspect viz. the 'unique function' of the nurse. While it provided information, in general terms, about 'what' is to be done and to whom, for what reason, it missed out some important aspects.

These aspects were: other functions of the nurse than her 'unique' function; the specification of 'those activities' which contribute to "health, its recovery or peaceful death"; as well as the characteristics of these activities. It did not say how this unique function fits into the general picture of nursing or what role did it play in relation to allied professions.

The definition did not indicate the desirable values and abilities needed in the nurse or the type of knowledge required for the condition of the patient at the time. Peters' (1966, p.46) view in this context, talking about education, seems appropriate:

some of the models of the educational situation so far considered have proved inadequate because they tend to emphasize one criterion to the exclusion of others.

A criticism of Henderson's definition and its discussion (p. 5 - 7) would be that no justification of the uniqueness of the function of the nurse was identified.
If one were to list the implications of Henderson's definition, the justification for performing these activities by the nurse to the 'individual' is that he lacks "the strength, will or knowledge". This somehow implies that knowledge pertaining to nursing is not in any way a 'specialised' knowledge. It is a knowledge that everybody has. It gives the impression that preparation of the nurse through a formal programme, does not make her knowledge 'special', but rather common.

No indication is given as to the manner in which these activities are to be performed, by Virginia Henderson. For instance, how can activities be performed with the least amount of discomfort and maximum measures for safety, or what would they be centred around. The definition gives the impression of a sum total of activities to be accomplished in as short a period as possible, but does not indicate any 'care' or coherence pertaining to the activities.

In short, one can say that though a definition has a role it is a restricted one. A definition gives information, but this information is limited as it does not help/guide the application either in planning an educational programme or in planning practice on an every day basis. It tells us something, but misses out on a great deal that could be important, both conceptually and in terms of practice.
Philosophy

What can a philosophical analysis of nursing achieve? As pointed out earlier philosophy is concerned with concepts and their analysis. O'Connor (1957) wrote that philosophy was

... an activity of criticism or clarification, (p.4).

Peters (in Tibble 1966, p.61) described philosophy as:

... critical and constructive and, like science, represents an autonomous type of inquiry that is not imprisoned completely within the presuppositions of a particular period.

The consideration of philosophy as a type of inquiry should not undermine its vital role, as pointed out by Hirst (in Tibble 1966 p.38). Peters (in Tibble 1966) considered the question, "What is his (a person's) philosophy of education?" inappropriate, as it was like asking the person "What is your logic of politics?", both entail formulating principles which are considered "logical hybrids". Such principles would be

distillations of complex empirical generalizations and of value-judgements. So their validity will depend partly upon matters about which the philosopher is not an authority qua philosopher. (p.63).

What I advocate is not to present a philosophy of nursing but to analyse conceptually and in terms of implications what is understood by nursing. Such extensive, and explicit exposition would help direct our action in both education and practice. It would also help through the establishment of the relatedness among the different aspects to give a frame of reference, and a coherent picture of the meaning held of nursing.
Organizational Structure

Nursing over the years has accumulated a certain fund of knowledge, beliefs, values and skills and has assumed different functions. But a great deal of doubt is still being expressed as to what nursing is as discussed in the previous two chapters. Some reasons for this confusion and lack of certainty were given in Chapter Twelve p. 399, to which I would like to add another two:

i) nurses have mostly been orientated to 'specifics'.
   During her hours of duty for instance, the nurse thinks about the "4 hourly T.P.R. (Temperature, Pulse, Respiration), the two more "back rubs" to finish and to make sure Mr. Smith's "2 hourly mouth care" is done. With the advancement in technology and increased specialisation in science this tendency to be pre-occupied with the 'specific' has grown even more. For example a physiotherapist helps the patient with breathing exercises, a technician does his E.C.G. (electro-cardiogramme) another technician gets a blood sample from him, etc.

ii) lack of an organizational structure and principle for the arrangement and co-ordination of this fund of knowledge, beliefs values and functions to form a coherent whole.

Orientation is the domain and responsibility of an educational programme, and therefore will be discussed under education.
Certain requirements are needed to make use of the potentials of organization. For a group of activities, for instance, to be effectively organized, it is essential to know (i) what are these activities (I shall call them elements), (ii) how many of them need to be involved, and (iii) in what sequence they are to be carried out (relationship between the elements), (iv) what is the context in which they are to occur (frame of reference) and (v) what is the purpose to be achieved (general idea).

To illustrate the point let us suppose that we were given twelve pieces of cardboard different in shape: eight ovals, (element A), two lozenges, (element B), a long narrow rectangle, (element C) and a circle (element D). If we do not know anything about what they are and what they are supposed to form at the end, but we are given a circle to arrange the elements within, we could spend an interesting time arranging them in different combinations and perhaps investigating our creative ability and imagination. One example of the arrangement could be like Fig. 1, on page 410a. We could make as many arrangements as we wish. But if we know that these twelve pieces constitute a flower which is painted on a plate, then we have a frame of reference (plate) and a purpose. By a process of inference we would be able to differentiate between the elements, collecting the petals together, the leaves together, the stem and the centre of the flower, hence Fig. 2 on page 410a.
RANDOM ORGANIZATION

FIG. 1

ORGANIZATION ON THE BASIS OF KNOWLEDGE

PRINCIPLE:: RELATEDNESS

FIG. 2

ORGANIZATION ON THE BASIS OF KNOWLEDGE

PRINCIPLE:: INTEGRATION

FIG. 3
Our arrangement of the flower would be enhanced by our added knowledge. This knowledge could be, type of plate, type of flower (a spray or rose), the idea to be conveyed. In other words, the more knowledge we have the better our organization.

What would make such organization effective, would be the knowledge of the principle to be used to guide action. The principle could be relatedness, which would decide the type of relationships between and among the elements. It would be expected that the elements would remain identifiable as: petals, leaves, stem, centre, and the connection between them made clear. The outcome also is influenced by the principle. Fig. 2, page 410a, could be considered as an illustration of organization on the basis of knowledge with relatedness as the principle.

The principle could be integration, which would again decide the type of relationships between and among the elements. It would be expected that the element would become fused together, and less easily identifiable. The greater the integration the lesser the differentiation between the elements. The outcome is consequently influenced by integration as the principle. Fig. 3, page 410a, illustrates the idea of organization on the basis of knowledge when integration is the principle.

A number of points need to be emphasised, from the above illustrations.

(1) I draw a distinction between integration and relatedness as organizational principles.
(ii) I conceive of organization as a complex set of factors.

(iii) I believe that for organization to be effective, a structural frame of reference is needed along with knowledge about the elements, the principle which governs their relationship within the given structure, and the outcome to be attained.

The illustrations used on page 410a above, were too concrete and limited in scope when applied to the more abstract idea of organization.

To help develop this abstract aspect of my argument about organization based on knowledge, I shall refer to an argument used by Hospers (1967 p.167). Hospers in discussing analytic propositions, stated that:

everything we know about X is embodied in the concept of X, the more we know, the richer the concept of X becomes, and we would have a complete concept of X only if we know everything there is to be known about X.

He went on arguing that there are certain characteristics by which we identify X, and others that add to our knowledge about the concept used. For example, one may have the concept of 'gold' or 'nursing' without knowing everything there is to know about gold or nursing. But a certain amount of knowledge is necessary and essential before we can say that we have the concept of 'gold' or 'nursing'. Hospers called what is necessary and essential the 'defining characteristics' and the extras he called 'accompanying characteristics'.
Therefore to be able to organise what we mean by nursing in an effective way we need to study what constitutes the 'elements' in nursing, i.e. what concepts are involved.

The principle chosen for the study, would play a decisive role in the type of relationships between and among the elements. To guide the choice of the principle, an ultimate aim in nursing should be set, and a structure or frame of reference clarified. This approach to organization does not necessitate that nursing would mean one thing to everyone. It only allows for what Hospers called 'defining characteristics'. In other words there is need for agreement among nurses about a general line of thought for nursing, i.e. an agreement about the 'defining characteristics' in nursing.

It is inevitable because of varying circumstances within each country and each situation, that a certain amount of difference would exist. This is by no means detrimental to the identity of nursing. Variety could exist within a given structure, without changing it. Change in the structure would occur if variety is not contained within the frame of reference of the given structure, and guided by the purpose to be reached. In my opinion it is expected and acceptable that there will be disagreement about the 'accompanying characteristics' of nursing.
Relatedness versus Integration as organizational principles.

Even though 'Relating' and 'Integrating' have been used interchangeably in the literature, I believe that a distinction between the two processes is necessary for organization as illumination. In a previous article to the Nursing Mirror Journal, I discussed the distinction between the two processes (Abdel-Al 1974). To revise briefly, the decision as to whether relating or integrating was best suited to the task at hand, depended upon:

(i) nature of the elements involved. To give an example, units of knowledge could be integrated like regulation of pressure of fluid in a tube and tube feeding, the former stems from physics the latter from nursing. Two fields of study could be related, like 'education' and 'practice', each has its 'individuality' and characteristics. Losing these characteristics is not likely to be beneficial to either of them.

(ii) purpose of the process: what is to be achieved as an outcome. If fusion and undifferentiation is required then integration achieves this better. If a clear picture has more potential for tracing and planning development then relating achieves this better.

(iii) the nature of each process involved. In integration the elements are brought together to form a whole, losing most of their identity, in other words, out of integration a new (different/bigger) element is formed.

Appendix VIII.
In relating the elements keep their identity and connections between/among them are established in the form of similarities and differences. The process of relating can generate development in the elements and widens the connections among them.

Generally complex elements would benefit more from relatedness than from integration. The former process would require 'clarification' of the elements to allow the study of their similarities and differences, and of the type of relatedness they stand to each other within the given context and purpose. 'Education' and 'practice' are believed to be complex elements. To integrate them would magnify the already existing problems. To my mind a great deal of the problems between 'education' and 'practice' is that they have never been 'clarified' enough. To relate them would help their clarification and would direct attention to the connection between them. To go a step further, the study of their relatedness would be further improved if the context in which they occur was identified and explicitly expressed, i.e. nursing. Identifying what the meaning of nursing involves helps relate such meaning to both 'education' and 'practice', as well as help their relatedness.

A frame of reference in nursing

The characteristics of a nursing frame of reference were discussed in Chapter 11 on p. 383-384.
I would like to emphasise that what would constitute a 'Nursing' frame of reference is not the frame of reference itself, but rather the relationship which exists among the concepts (embodied in the elements), the structure of the frame of reference and the expressed purpose to be achieved.

In Chapter 7, the concept of a situation was introduced. In this Chapter I propose that the same concept be used as a frame of reference for Nursing. The concept of a 'situation' has the advantage of meeting the requirements referred to on p. 383-384.

The structure of a situation included four elements. I shall now try to show how these elements could usefully be used as a structural frame in 'nursing'.

(i) Human element: In nursing this element is a very prominent one. Nurses as human beings, by virtue of their role come in contact with each other, patients, clients, doctors, other professionals, like the social workers, technicians and physiotherapists, and the relatives of patients/clients. Each individual plays a part within the situation. To emphasise the importance of one group of people to the exclusion of other groups leads to frustration and disappointment as a result of unrealistic expectations. The patient or client is the individual for whose benefit the health service basically exists. This is an important factor which nonetheless needs to be kept in perspective. To advocate a patient-centred
organization of care would be short-sighted as it would overlook the nature of the situation as a whole. Patient care depends on several professional groups, as well as upon the orientation and education of these groups. Patients in hospitals or in the community are not cared for one individual at a time, therefore some consideration ought to be reserved for the availability of resources and the given factors within a situation. The fact that hospitals are built for the sake of patients may seem ipso facto, but reality is different. The patient is part of a 'situation' which is complex in nature. Overlooking such a reality will not help achieve the aim of nurses in 'caring' for the patient as a person in a given situation. Titmus (1963, Chap. 7) discussed the dangers to the patient's welfare caused by the complexity of the hospital as an institution. He believed that:

Complex institutions and society carry within themselves a strong tendency to make and multiply new complexities, and each one in itself represents another possibility of waste, misdirected effort and the growth of organizational fetishes. (p.120).

Titmus argued that while the introduction of the National Health Service led to an enlargement of professional freedom it created new problems, one of these being the danger that

... the hospital may tend increasingly to be run in the interests of those working in and for the hospital rather than in the interests of the patients. (p.122).
Revans (1964) in a study about "the Morale and Effectiveness of General Hospitals" drew attention to the influence of 'environmental' factors on job satisfaction and consequently on effectiveness of patient care.

To care for patients as individuals, would be influenced by how the different professional groups are organised and 'who' is involved in such organization. The greater the number and variety of people involved in patient care the more compartmentalized the care becomes. This observation seems to hold whether one considered the composition of the 'nursing team' or that of the 'health team' in general.

In conclusion to place the patient into the right perspective within the situation would be more beneficial in terms of his care, than placing him as the centre of the situation, under false pretence. To place the patient 'within' the situation would be more dynamic and would ensure his involvement. But to place the patient 'out' of the activities occurring within the situation (like in the centre) would be potentially dangerous as he could be more easily forgotten in the 'hustle and bustle' of these activities. Therefore, the organization of the human elements whether patients, nurses or other professionals, is influenced by our purpose and understanding of nursing.
(ii) Geographical element: Different geographical areas, whether nations, towns or villages, have different health needs. These health needs and provisions for meeting them are influenced by the place of their existence. Some areas because of their climate or their location, are more prone to some health problems than others. These factors together with the general economy of the country and the education of the professional groups involved in planning health care, would decide the distribution of care between 'hospital' and 'community'. This decision would consequently influence the preparation of the nurse in terms of priority of care. Whether the majority of the population suffered from 'disease' or whether it would be threatened to become 'ill', would decide the amount of effort to be directed towards 'care' or towards 'prevention'.

It would be recalled that the concept of the situation as introduced on p. 224, included a shift of emphasis keeping, all the time, the variables in perspective within the situation as a whole. This would allow nursing to include both 'care' and 'prevention' at the same time.

Organization of patient care would also be influenced by the hospital structure, or the location and area covered in the case of community work. Subsequently, the type of care offered would influence
the requirements for certain architectural structure of a hospital, and the planning of community work to enable its function to meet the intended purpose.

The effect of architectural structure on the care of incontinent patients was investigated by Reid (1975). Other factors which would influence the place where nursing was carried out, are the policies, rules and regulations held by the people responsible for planning and organization in this 'place'. The culture and traditions of the place are also a very influential factor. It will be recalled that in the open discussion with students, p. 153, they expressed the need for feeling of belonging and of loyalty to a hospital. I believe that this factor strengthens in an indirect way, a feeling of belonging to 'nursing'. In other words, it seems that this abstract need for belonging to 'nursing' becomes materialised in relation to a 'place'. The nurse then becomes referred to as a 'Pelican', or a 'Nightingale' for instance, which are denominations given to nurses trained at The Royal Infirmary of Edinburgh and St. Thomas' Hospital in London, respectively. These hospitals carry certain traditions. In conclusion, 'nursing' is influenced by the characteristics and structure of the 'place';
and what is meant by nursing influences decisions as to 'where' nursing would be carried out.

(iii) Temporal element: Because of the nature of nursing, it needs to be carried out over the 24 hours, in some institutions like hospitals. This time factor requires that enough nurses (human resources) with certain qualifications would be available to cover patient care twenty-four hours of the day, all year round, year after year. What is meant by nursing and the variation, if present, of requirement of care over this period of time; would decide future plans about the type and number of nurses needed. The available human resources, their qualifications and the variables of the hospital situation, for example, over a period of time would influence the way these human resources were organized. Even though nurses are required for patient care in hospitals over twenty-four hours, they are not the only group of people who are needed within that period. Therefore organization of nurses would also be influenced to a certain extent by the other related groups needed over the twenty-four hours.

What is included in a meaning of nursing would decide the kind of activities carried out by nurses. It would decide what would be considered nursing and what would not be considered nursing. Such
decisions would establish the type of relationship established between nurses and other professional groups and would therefore influence the presence and organization of these groups over the twenty-four hours. To give an example, if intravenous treatment is needed during the night, if such an activity is considered beyond the nurse's scope of activities, then a doctor would need to be available at night to carry out the treatment. If such treatment is expected to be frequently needed during the night then a doctor would need to be present on the ward. It would follow then that the extent and frequency of the need for the presence of a doctor, would decide whether doctors, in a given area, would have to be 'on call' or whether they would have to be 'on duty', i.e. on the ward.

(iv) Environmental element: All that nursing would involve in terms of meaning and relationships among nurses and between nurses and other professional groups would constitute the environmental element. The type of preparation needed for nursing and the standards of care to be aimed at, would also be part of the environmental element. Because the environmental element is almost synonymous with the exposition of the meaning of nursing, together with what it implies in terms of values, standards, knowledge, tradition and culture.
This is developed further on p. 424 where I present my interpretation of 'Nursing'.

In summary, the suggested frame of reference in nursing, would help guide decisions about the organization of human resources and what role they are to play. It would also help decide distribution of resources among areas, and fields of nursing. All this is guided by what is involved in the meaning of nursing.

It was apparent from my presentation above that 'elements' were interrelated, where the relatedness depended upon the meaning of nursing held, together with other variables within the situation.

In the presentation, nursing practice in the hospital was mainly referred to. But it is believed that nursing practice in the community is equally applicable as it represents a 'situation' where variables relate in a different way. Nursing education shall be discussed further in Part V.

The main function of the suggested frame of reference is guidance. The suggested frame of reference is not prescriptive or specifically applicable to one discipline. Its main function is one of guidance and orientation. It increases and maintains awareness to the basic elements and their variables within a situation, as well as to the implications of the relatedness present among the elements and their variables.

The suggested frame of reference invites questions
How would variables a, b and c of the element 'Individual' influence variables e, f and g of the element 'place'? How would the depth of involvement of variable h influence the decision I am to take?

Meaning of Nursing

I shall first present an abstract of what I understand by nursing then carry out a conceptual analysis of the words used in the abstract. I would like to point out that I attempt the technique of concept analysis as an amateur.

Abstract

I take nursing to involve a pattern of related activities of different kinds, whose unity consist in their being directed towards continuous care of people whose health is impaired, or threatened. This involves personal contact with them, with the intention of helping them regain or maintain a harmonious state of health within the given situation.

Concept analysis

Words or groups of words are presented for analysis and the relatedness between and among them established. (1) Activities of different kinds

What is meant by an activity? One way of answering this question is asking a further question: what is the difference between an activity and a skill?
A skill is specific. One talks of 'motor' skills and 'mental' skills, e.g. walking, talking, moving objects, driving a car. These are specific occurrences and processes, even though the process can be complex requiring perceptual and muscular co-ordination.

An activity encompasses more than one skill, and has the added dimension of making a number of specifics into a whole or unit. An example from nursing practice is:

A surgical dressing procedure is made up of a number of motor skills, e.g. handling the forceps, taking them out of a container without touching the sides, picking up a swab, bandaging the area, handling sterile material. The carrying out of the dressing to the patient is an activity, as it includes more than these skills. It also includes preparing the patient for the procedure, relating the steps of the procedure to the condition of the patient and that of the wound, finishing the activity and leaving the patient. The activity, therefore, includes: (i) knowledge of different sciences: bacteriology, physiology, anatomy, ergonomics, psychology, (ii) an ability to apply this knowledge practically, (iii) certain norms and standards of performing the activity, (iv) certain values as to where priorities lie and how to deal with the whole situation. In short, an activity is multidimensional while a skill is basically uni-dimensional.

The distinction between an activity and a skill, raises the further question of: What then is the difference
between a procedure and an activity? To my way of thinking, a procedure is a set of steps to carry out an activity or an aspect of an activity. The procedure of carrying out the surgical dressing, for example, includes steps that could be grouped under preparing the patient, changing the dressing, tidying up the patient and the equipment used. The activity involved is more than the sum total of all these. It embraces the approach to the patient, the knowledge used, the values held which all influence the behaviour of the nurse. Again, a procedure, though more complex in extent and number of variables than a skill, remains uni-dimensional while an activity is multi-dimensional.

An activity is the outcome of interaction between what I know about the patient and his condition, what I know about the condition the patient suffers from, what I know about the rules and regulations of the place where the patient is treated, what I know about the doctor's evaluation of the patient's condition, what I know about the usual measures taken in such a case. It is the nurse's judgement of how these different aspects/dimensions influence each other that is going to decide what the nurse shall plan to include in the care of the patient. It is such judgement that will determine how activities pertaining to different spheres are going to be related to one another in order to achieve what is meant by care. What are the spheres to which activities pertain?
When a patient is admitted to a hospital, or to the nurse's care in the community, it is within the realm of the nurse's responsibility to see to a multiplicity of details. The patient must know where he is (if that is possible), the location of his bed and the course of action which will be taken. The nurse must see that he is comfortable, has a place to put his belongings, has things he will need within his reach, and knows what to do in case he requires help. It must be seen that the patient's physiological functions are maintained. The patient's condition is then assessed in order to plan his care, help or guidance. What is involved in such assessment is:

How are his 'normal' physiological functions affected by his present condition?
What is the care needed which specifically pertains to the condition he suffers from?
What are the doctor's prescriptions which are within the nursing domain? and are the prescriptions which are the doctor's responsibility?
Who from any allied professional group is to be involved with the patient? Like, for instance: contact to be made with X-ray department or social worker.

I would like to discuss briefly a distinction which is frequently raised when patient care is mentioned.
Literature and hospitals usually divide care into, basic and technical care. Basic care includes personal hygiene. Technical care includes more specialised procedures like surgical dressings, or intravenous infusion for example. This division leads to the following argument. Personal hygiene is something that all of us carry out for ourselves, which means that whoever carries it out does not need any training, therefore a nursing auxiliary or a first year pupil or student nurse can do it.

I would like to argue that such a way of thinking and reasoning misses many important factors.

'Personal hygiene' is not something which is apart from the 'illness' the patient may suffer, it is influenced by the patient's condition and is not therefore always the same, i.e. pre-determined. 'Personal hygiene' of the patient could vary to a considerable extent according to his condition generally.

The physiological functions of the body act in unison, therefore a disturbance in one system or function would influence the function of other systems to varying degrees, depending upon the extent and relatedness of the affected system to the others.

For this reason I feel that the division between 'personal hygiene' and the 'illness' condition of the patient, is artificial and misleading.
(2) Related pattern

Such a variety and complexity of activities by necessity calls for some sort of organisation to make the fulfilment of such activities possible and effective. The extent and depth of the nurse's involvement vary according to the variables of the situation. The whole process of organisation is not simply one of ordering of activities but also of judgement as to the extent and depth of actual help or of guidance needed. On the basis of her assessment, the nurse could assist the patient, guide the patient, teach the patient or family, supervise the patient or family to carry out certain activities, or carry them out herself for the patient. She needs to do this on the individual level and also on the group level, in the event she is in charge of a number of patients or clients or, for example, is responsible for classes to educate mothers-to-be.

Such organisation is complex and needs a guideline, capable of catering for complexity, multi-dimensionality, and variability. The frame of reference introduced on p. 226, and discussed on p. 415, could usefully be used in this instance.

It is important to stress here that the situation will influence how and if a certain activity is going to be carried out. It is by working out the relatedness between and among the different variables that activity A rather than activity B is to be carried out and in what way.
For example, the patient is to have restricted movement and has difficulty in defecating on a bed pan or on a commode. It is therefore arranged that what he is allowed in terms of movement will be used to get him up and to the toilet where he is more comfortable.

(3) Care

What does the concept of care entail? I shall answer the question by considering the different ways the word care is used. What is the difference between telling someone 'I care for you a great deal' and saying 'I took care of Mary while her mother was away' and 'She is the one who takes care of me'.

The first implies that I am interested in the person I am addressing, it matters to me what happens to that person, how he feels, what he does, I am keen to do all that I can to make this person happy. In other words, there is an emphasis on my emotions or feelings toward that person.

The second implies that I took charge of Mary, seeing to what her mother would usually have done for her. If Mary is a child I probably would have been feeding her, washing her, making sure to keep her warm enough and prevent any harm from occurring to her. In other words, there is an emphasis on activities that Mary requires for the fulfilment of her needs.

The third implies that a person has made it her concern to make sure that I am all right, I have what I require
in terms of concrete commodities. This person makes me feel important, wanted and loved. In other words, there is a balance, in terms of emphasis, as to the emotions involved and the activities required.

In what sense would we be using the word care in nursing?

When patients are admitted to hospital part of our responsibility as nurses is to carry out certain activities for them dictated by their condition. We make it our concern to see that they have what they require and that no added harm is to happen to them. But what about the emotional involvement? Sometimes nurses are warned that they should not get emotionally involved with the patient, that if one lets one's feelings intervene one may not be able to cope with the situation. But how realistic or even how desirable would such a warning be?

It is difficult to divide between one's feelings, one's behaviour and one's way of thinking. We behave according to our perceptions of the situation, which are based/influenced by our feeling and cognition of what the situation means. Consciously minimising the 'feeling' aspect is a very difficult and energy consuming activity and not a desirable activity in many ways in my opinion. The patient who is a stranger to the environment of a hospital has to adjust to the 'hospital' as a different environment, and to a great number of other things which are part of the situation of being 'ill'. Among these are: his own feelings, his illness, the isolation from his family,
cessation of his work, the bodily sensations which he experiences and which might be enigmatic to him. He also has to adjust to other people, to that which is supplied by the people around him and to activities that are carried to him. He has to adjust to the doctors' or nurses' facial expressions about his conditions, the 'jargon' used by the staff, the machinery he is subjected to. If on the top of all this he has to adjust to having nurses around him who carry out activities 'dispassionately', this would be a very dehumanizing experience which would add to the patient's difficulty and no doubt may be most unsatisfactory to the nurse herself as a human being. For a patient in hospital, it is essential that he feels that someone is 'concerned' and 'cares' whether he is in pain or whether he is unhappy, even if the nurse does not actively do something about his unhappiness. It is easier to bear with one's difficulties if one does not feel emotionally isolated from those who are around one. This does not, however, mean either that nurses should show concern and do nothing about the patient's difficulty, nor does it mean that nurses should show concern to the extent of adding to the patient's upset. Through a gradual process of learning how to recognise patient's feelings as well as of one's own feelings, one learns to channel such concern and care into explicit behaviour of helping the patient in the way which is best suited to the situation as a whole. How the nurse plans and shows her care depends
on the whole 'situation' and could mean anything from lending a sympathetic ear to discussing the whole thing with the patient and suggesting some steps to be taken. Such decisions are made according to the nurse's judgement of what needs to be done, based on the 'situation'.

So the concept of care in nursing to my mind is one which involves an interaction of cognition, feeling and behaviour/action.

Caring for the patient then, as pointed out earlier, has to include personal contact with the patient in order to evaluate and judge what needs to be done in the given 'situation'. It also has to include prevention of unnecessary worries. The patient's needs as dictated by his condition and the situation he finds himself in are by necessity varied in nature. A patient with paralysis of part of his body has a restricted degree of movement, therefore needs a certain degree of help. Some activities because of his condition would need to be done for him like passive exercises of his paralysed limbs, care of his pressure areas, special care of his circulation. Because the activities are different in kind, the characteristics of these varied activities are the fact that they are directed towards the care of the patient as an individual within the hospital 'situation'. The whole 'situation' is influenced by the degree of health impairment the patient suffered which will dictate the extent and intensity of the care.
needed by the patient. The patient is admitted to a hospital, this care would have to be continuously (time factor) provided over the twenty-four hours of the length of period the patient is in hospital. Therefore continuity is an integral part of care. Continuity of care is also needed by patients who attend the clinic or are visited at home.

(4) Continuity

The concept of continuity of care includes a temporal/chronological dimension as well as an environmental/content dimension. It involves decisions like: How much help is to be given by the nurse when, where and for how long, and how much help is to be provided by the patient to himself or by relatives. It also includes a human dimension.

Nurses work on hospital wards for twenty-four hours all the year round; it is not the same nurse who attends to the same patient for that length of time, so can one call the care continuous if this is the case?

The care would be continuous in relation to a group of nurses who act in a relay. What would increase the effectiveness of continuity would be a well thought and clear plan which would be followed by the different nurses. Organization of nurses in terms of patient care is another factor. The same group of nurses could care for the patient.

Continuity of care in relation to out-patient clinics or in the community, emphasise the nurse (individual) more than the time factor. The nurse carries out the activities
the client/patient requires over a period of time until it is completed or achieved. The nature of the activities needed by patients and clients on an out-patient clinic/home visit basis is different which requires a different organization for its execution.

Continuity of care is related to what happened before, what is taking place now and what is to happen in the future. The overall purpose of an activity contributes to the concept of continuity. An activity might require the involvement of medical attention, or social worker's service. The co-ordination of these other services would also contribute to 'continuity'.

Continuity of care given by nurses to patients is a process which is perpetuated regardless of the effect or outcome of the doctor's attention or the social worker's service. An example would be the care of the terminally ill patient. I would like to stress that consistency in terms of the nurse caring for the patient/client, and of an ultimate goal to be reached by 'nursing' this patient or client, is an important factor in the concept of continuity.

Therefore continuity involves the following factors: time, perpetuity, content, an ultimate aim, and consistency.

(5) Health

The contact between nurses and those they care for takes place in the context of health.

W.H.O. defines health as a state of physical, mental, social and spiritual well-being and not merely the absence
of disease or infirmity.

The shortcomings of such a definition are that (i) it is ideal to the point that it is humanly unreachable and this renders work pertaining to achieving such a standard frustrating and unproductive (ii) it does not take into account individual differences as well as differences brought about by cultures and beliefs, e.g. what is considered a sign of mental illness in one community might be an acceptable behaviour in another (iii) it excludes more people than it includes, like the well adjusted physically-handicapped person.

In my opinion, health is a state of harmony within the individual, between the different aspects of his personality and the outside world, whether physical or sociological. This state of harmony is relative to the person and the community in which he lives and its geographical set-up.

It is difficult to separate the different aspects of personality into physical, mental, social and spiritual as the individual is an integrated unit. Because of this it is, for example, difficult to say that a person is physically ill, or mentally ill. To my mind it is more appropriate to talk about the emphasis of the impairment of health (see p. 230, situation). For example, a person with a gall bladder trouble is mainly affected physically, This does not exclude the psychological worry it is causing him or the fact that his social engagements have been
affected by not accepting as many invitations for dinners as he would have done otherwise.

I shall use the concept of the situation and the argument that one can talk about emphasis and keep the rest of the variables of the situation in perspective, as my frame of reference. Within this frame of reference I would say that nursing occurs when patients'/clients' health is impaired from a physical-psychological somatopsychic aspect. The cause of the impairment might have been a social factor but the patient does not come "into" care except when the psychosomatic/somatopsychic aspect of him as an individual cannot cope unaided.

The emphasis of the nursing concern is then psychosomatic or somatopsychic. Within these two aspects when the emphasis is somatic patients are admitted to General hospitals, when it is psychic they are admitted to psychiatric hospitals.

Nursing is also concerned when health is threatened to be impaired. This would cover people like pregnant mothers, growing children and ageing persons.

Prevention is part of the nurse's responsibility in dealing with the threat on health impairment.

(6) Personal contact

In order for the nurse to carry out activities as part of the process of caring for the patient or client, she has to use her judgement and evaluation as far as what needs to be done within the given 'situation'. Intrinsic
to the concept of care and carrying out of an activity, as well as continuity, is the contact of the nurse with the patient or client. In order to evaluate the adjustment needed in the activity, the types of activities appropriate and necessary as well as the planning of those in relation to the variables of the situation, contact is essential. All these decisions depend on the nurse's 'immediate' contact with the patient. This is an important and crucial characteristic. The process of nursing the patient or client is mainly one that happens through personal contact, rather than through the directions of the nurse 'in charge', though such directions are valuable, they do not substitute for personal contact. The nurse 'in charge' can help direct the nurse's perception and judgement, but 'nursing' is mainly an immediate process. The nurse in charge acts as a guide to what the hospital and ward policies are in order to prevent conflict.

The innumerable number of cues the patient may give of a worry he has, or to a rather depressive mood that would be missed by the nurse immediately in contact with the patient if she is not 'orientated' to recognizing and understanding these cues.

An important aspect of the personal contact of the nurse with the patient is the opportunity provided to the nurse to teach the patient at a 'psychological moment' during her interaction with the patient. Most of the time this cannot be planned ahead.
The type of care that would be provided by the nurse and the relationship that is formed between her and the patient is in itself therapeutic, in terms of comfort and prevention of unnecessary worry. It also helps build her image and identity as a nurse, as argued earlier on p. 16.

From the above presentation it could be said that the care of people whose health is impaired consists of a unit of related activities, that this care is mainly ministered through personal contact for the purpose of regaining or maintaining health within the given situation.

It would be noticed that all along in the process of concept analysis I used the concept of a situation as my frame of reference. Such an exposition of what I mean by nursing is by no means as clear, ordered or comprehensive as it should be. It nevertheless, gives some guidance as to who would be eligible to 'nurse', what a 'nursing' activity involves, therefore what qualities and abilities are needed in the nurse, and it also gives some directions as to the broad lines of organization for the practice of nursing.

None of the above concepts in isolation is what I understand by nursing. The relatedness among these concepts together with the frame of reference I used, constitutes what I mean by nursing.
CHAPTER FOURTEEN

PHILOSOPHICAL POINT OF VIEW (CONTINUED)

1) Implications of the meaning of nursing

Nursing education

According to Professor Peters, the concept of education includes breadth and depth of understanding. It is non-instrumental in that enjoyment of an activity, is for its own sake and this does not necessarily reflect lack of practicality. The concept includes various aspects of the activities considered, which indicates a critical power and imagination. It entails judgement which is regarded as the application of understanding in particular cases. Peters (1966 p. 32) describes the difference between education and training:

'Trained' suggests the development of competence in a limited skill or mode of thought whereas 'educated' suggests a linkage with a wider system of beliefs.

He goes on saying that in the case of training it is appropriate to ask the questions "to do what?", "for what?", "as what?", "in what?" (p. 34). While in the case of education the person is not described as "educated" in relation to any specific end, function, or mode of thought, "Education is of the whole man". (p. 35).

The understanding of nursing presented in the previous Chapter calls for the development of competence in carrying out certain skills and it also calls for an
ability to assess, infer and make decisions.

Using Peters' distinction between education and training, I shall examine briefly the points raised by the understanding in relation to Peters distinction.

In nursing it is inevitable that the nurse would be required to develop certain skills like observation, and manual skills. But from the understanding presented skills are part of a nursing activity. The activity, however, includes the nurse's judgement to decide action in terms of how and why given the situation. Caring for the patient was not thought to be extraneous to either the nurse or the patient, they both interact as individuals using the 'self' in the interaction. The nurse's 'self' has to have room and opportunity to develop and get enriched by her experience of nursing, as this would enable her to grow and develop on the one hand, and enjoy her work on the other. She is bound to get more satisfaction through involvement and the feeling (based on facts) that 'she' is contributing to the care of the patient. The work she would be carrying out will cease to be viewed as 'tasks' which are repetitive and boring but as activities which are 'individual' and satisfying. The importance of the development of emotions for effective nursing was also pointed out (p. 214).

Peters (1966) believes that

we talk more naturally of educating the emotions ... because the different emotions are differentiated by their cognitive core, by the different beliefs that go with them. (p.32).
The frame of reference presented, to guide the nurse's thinking, is meant to increase her awareness of reality. It is one which, by its specification, directs her towards flexibility and critical appraisal of the situation. It allows for the development of her imagination, e.g. how the patient could feel, what would it be like if instead of A she did B to the patient, would that help more? The nurse needs to be imaginative in order to anticipate patient's needs. It also requires a kind of knowledge that is based on certain beliefs. The belief that the individual is a totality, that he reacts to his feelings and thoughts and the outside world in toto and not with part of his personality. That illness is not merely an affliction of one of his organs, giving rise to certain signs and symptoms, but it is an experience which he passes through as a person which affects him as a whole. An illness means more than signs and symptoms, it might mean cessation of work with all its consequences to the person and the work condition; it might mean family upheaval and reorganisation, e.g. having the wife go out to work and finding someone to stay with the children. Depending on the type of illness this could mean more immediate menace on life or a period of separation from the family. The belief that there is more to knowledge than the memorization of 'facts', that knowledge could be made more interesting by seeking and grasping the general ideas behind facts, and how facts relate to each other.
The realisation that our beliefs influence our way of thinking, feeling and perceiving the situation and hence our reaction to this situation.

With a broader understanding of nursing the nurse ceases to perceive the 'bed bath' for instance, as a procedure for personal hygiene, but rather as an activity aimed at helping the 'normal' physiological function of the skin, and introduces modification in the procedure as necessary, according to the patient's condition. She would also learn to use the opportunity of 'patient contact', through the carrying out of the bed bath, for getting to 'know' the patient as a person which is an intrinsic aspect of building a relationship with the patient.

The idea of understanding in a broader and deeper sense through the presented frame of reference, tallies with Peters' (1966) discussion about the cognitive aspect of 'education', who thought that an 'educated' man needed to understand principles for the organization of disjointed facts into a coherent body of knowledge, (p.30).

In the brief discussion that preceded there were arguments for training and for education, according to the presented understanding of nursing. Peters (1966, and in Hirst and Peters 1970) argues that education could include training but training does not include education, as education is a wider concept. On such basis I would suggest that the programme should aim at educating the nurse. This does not preclude the fact that she should/
could be trained in a given number of skills.

Nursing practice

In the exposition of my understanding of nursing above, special attention was given to the fact that a person was a totality. This then means that it is not acceptable to divide the person into aspects or parts for care. At the same time it is humanly impossible for one person to be prepared in such a way that he/she will be solely responsible for everything to do with the patient, whether medical, social or nursing. What is possible, is making sure that whoever comes in contact with the patient is contributing something that cannot be contributed by someone else already present and functioning within the situation. The doctor comes in contact with the patient and has a distinctive function of diagnosis and treatment of the patient. The nurse comes in contact with the patient and has a distinctive function of caring for the patient generally and specifically. The social worker comes in contact with the patient and has a distinctive function of seeing to the patient's problems in relation to finance, work or family affairs, in the patient's absence. The chaplain comes in contact with the patient and has the distinctive function of attending to the patient's religious and spiritual needs. A number of technicians come in contact with the patient for

* This would depend on what is meant by 'contribution' and requires judgement as to who is most able to carry out such contribution. This of course calls for identification of roles of the people involved.
the purpose of 'investigation' or treatment; this number varies according to hospitals and the amount of technological advances made for investigation or treatment. In the field of medicine there is a tendency for increased specialisation which means increased numbers of referrals of the patient to the different specialists. The latter was one of Titmus' concerns (1963, p.124) for the patient's welfare:

These advances of science into the hospital have made it harder to treat the patient as a person. As nurses we should stop and think about all the people the patient has to put up with, he might wish not to have contact with a social worker or a priest/chaplain, and this might be within his power to decide, but he is left powerless in front of all the other contacts. It is the responsibility of the nurse in collaboration with the doctor to think about what could be done to reduce the number of people rather than passively accept it as inevitable. If the nurse's belief is that the patient as an individual is a totality and acts accordingly, and that one cannot behave towards him in the way described above without threatening his welfare, then she will feel that it is within her responsibility to play a more active role in the situation.

The main sphere of the nurse's responsibility is nursing itself. Her role as a nurse and the time factor involved, makes her the one who has the greatest number and range of contact with the patient during his stay in hospital.
I shall now discuss the present state of nursing practice and show how a lack of an understanding of nurses influences the situation.

Two factors need further consideration in relation to the number of nurses caring for the patient:

(i) the number of nurses caring for any one patient,
(ii) the different kinds of nurses caring for any one patient,

(i) Other than the number of nurses available and employed, two factors decide the number of nurses caring for any one patient.

(a) to be able to cover the 24 hours, nurses need to work shifts. There has been a tendency to make shifts shorter in duration and consequently more in frequency. This is not meant as a criticism but as a statement of fact of the reality of the situation.

(b) the organisation of nursing care on the ward. If task allocation is practised, which is the case in the main, then probably all or most of the nurse's on the ward will have a contact with the patient for the purpose of carrying out a task for him. Let us suppose a hospital is running on three shifts basis and five nurses work in the morning shift, three nurses in the evening shift and two nurses at night. This means that over the 24 hours, the patient would have been in contact with at least 8 - 9 nurses. One or two (may be more) of
these 10 nurses working over the 24 hours might be replaced by different nurses the next day, due to days off, holidays or 'pool'/'floating' nursing system.

Some implications of such a situation affect 'continuity' of care. This would mean that continuity refers mainly to the 'time' factor, i.e. over the 24 hours the patient receives some kind of care given by a group of nurses. The element of consistency in the concept of continuity of care will stem from the list of tasks required to be 'done' in relation to the patient, rather than from the judgement of the nurse as to what is needed, given the situation. It is in a sense an imposed or artificial consistency.

The patient does not recognise 'one' or two of the nurses as the one to refer to if and when he has any queries or requires help in any way. If the patient can ask any nurse he will be less dependent on the one nurse. On the other hand, if 'one' nurse knows about him and his condition then he might feel more confident about the answers he receives. It might be argued that he will choose the nurse he gets along best with, but this can be the least qualified and we run into the difficulty of the nurse coming in direct contact with him missing cues from the patient. The organisation of care in that way forces the patient to resort to the authority figure for confident information, e.g. Sister in charge, but this
will be limited to knowledge of facts like date of operation, discharge etc. The whole range of subtle anxiety producing events that the patient might feel too self-conscious/inhibited to ask about, will be lost. In other words, nursing becomes a service rendered on 'demand' mainly. Relationship between the nurse and the patient, becomes rather difficult to achieve as the patient comes in contact with many people, like the doctor, technicians, physiotherapists, occupational therapists, etc., he also has to cope with his own condition and how he is reacting to it, all of which makes it difficult for him to also establish a relationship with eight or nine nurses. Even if the patient succeeds, what quality of relationship would that be and of what benefit would it be to him? It might be argued that because the patient tends to have a shorter period of hospitalization a relationship can hardly be established in two or three days anyway. I think that all the more reason for having fewer numbers of persons caring for the patient, as the sheer movement/turnover of staff is liable to cause anxiety to the patient and there is not enough time to explain to him or for him to assimilate why he needs all these people to care for him.

From the nurse's point of view, if each nurse is carrying out tasks or part of the care of every patient on the ward, she can hardly 'know' any one patient in the sense discussed in Chapter IV. The fewer the number of
patients. She has to care for the better the chance of her knowing the patient as a person. The frequent shift of nurses among patients allows for a great deal of loss in the potential quality of the care that could be given to the patient. The nurse's 'activity' is reduced to the carrying out of a series of skills or procedures and the patient is reduced to a 'disease', a 'condition', or a 'task consumer' and definitely lacks the consideration due to his integrity.

(ii) The different kinds of nurses caring for any one patient. In Britain three kinds of nurses care for the patient, the R.G.N. (Registered nurse), the S.E.N. (Enrolled nurse) and the nursing auxiliary. The first gets three years preparation or a University degree along with her nurse training, the second two years and the third no formal preparation. Why does the patient need three kinds of nurse to care for him? How does each kind of nurse contribute to the care of the patient?

What is the relationship of the nurse's qualification (or lack of it) to her contribution to the patient's care? Does a range of qualification, from none to a University degree, mean different levels of excellence or different aspects of patient care? Is the most qualified the one who comes most in direct contact with the patient? Does different levels of excellence tally with different levels of patients' needs? How can needs be divided and
distributed to the different levels? Referring to what actually happens on the ward, as investigated by the Nuffield Hospital Trust (1953) and McNaught (1967, S.H.H.D.) these different kinds of nurses to not necessarily carry out different tasks. Though the R.G.N. and S.E.N. do carry out certain tasks which the nursing auxiliary is not allowed to carry out, policies change from hospital to hospital. An 'experienced' auxiliary could be carrying out tasks recognised as the R.G.N.'s domain. The main difference distinctly lies in the salary scale and the possibility of promotion for each of the three kinds of nurses. Authority cannot be included among one of the differences, as some auxiliary nurses have a degree of informal or indirect authority that is not to be undermined.

In the understanding of nursing presented in the previous Chapter, it was argued that the main source for decision making and assessment of the patient's care, is the patient himself. The nurse, to be able to assess and plan the patient care effectively, has to have a wide understanding of the patient as a person and of his ailment and how he reacts to it. She should have received an orientation that sharpened her awareness and sensitivity to all the cues given by the patient. These cues might be bodily or psychological, verbal or non-verbal. Getting to know the patient is a process which spreads over a period of time and a variety of
activities, it requires a certain degree of continuity and consistency and is achieved through personal contact. This understanding of nursing, the belief that the patient is an individual/undividable person; the judgements to be done on the basis of perception, knowledge and abilities, the preparation of the nurse and the actual carrying out of care and the personal contact with patient; all these are closely related, conceptually and within the real situation and they all form a unit.

Therefore this implies direct personal contact between the nurse and the patient as well as a certain degree of preparation of the nurse. It therefore excludes the non-qualified from being called a nurse or to be 'nursing', which is more to the point here. Having accepted that qualifications, i.e. formal preparation, is needed the next question would be: is there a need for more than one 'level' of qualification? Having more than one level reflects a belief that the patient is dividable and that care is of different quality. The first implication disagrees with the understanding presented so far; the second implication raises the practical and ethical issue of how to decide about the distribution of the quality of care among patients. Do some patients need better care than others and where are they to be cared for? Who is to make such a decision? What is certain is that both the R.G.N. and the S.E.N. work on the same ward with the same patient. According to the 'Tutor's Working Party'
Raven (1960), the S.E.N. knows the 'how' but the R.G.N. knows the 'why'. It is difficult to divide nursing in such a way.

Besides, one can know in great detail 'why' a certain activity is done but lack the ability to apply this knowledge in the 'how' sense. Knowing 'why' is not only designed to broaden the nurse's information, it is to refine her performance in terms of quality as well. In other words it is not a matter of either 'how' or 'why' but of the relatedness of the two. This argument does not exclude 'aids' to nurses but it draws the line as to what is within the limits of what is called nursing. Nurses could be helped in the performance of their duty as long as this help is within the realm of non-nursing duties.

I would like to add here that this analysis is mainly concerned with 'nursing' and that the label 'nurse' qualifies the person who is authorised by licence to be called so. A 'nurse' could do other activities than nursing, e.g. teach nursing, carry out a research. She acquires the label 'nurse' through a programme of training of some kind, or according to the rules of the country.*

Summary

The exposed understanding of nursing could be used as a guide as to the preparation needed, the knowledge required, values to be fostered and abilities to be

* I would like to acknowledge my colleague, Miss N. Grant's contribution in this instance by pointing out this distinction to my notice.
developed. It also helps in guiding organisation of patient care and what is considered nursing activities. It does not, however, advocate one way or method of doing nursing, it rather draws the boundaries necessary for the identity and hence the development of nursing.

**Nursing and allied professions**

Medicine and social work are two professions which are often quoted for their similarities or differences to nursing.

It is important to note two factors, one is that it is expected because of their proximity to nursing that their similarities and differences be quoted; the other being that if nursing was identical to any of these it would have been extinguished long ago.

It is important at this point to discuss the concept of 'uniqueness'. Whenever a group of people work in close proximity to each other they learn a great deal about each others work and sometimes carry out some aspects of each others work. Increased knowledge and specialisation as well as availability and applicability of such knowledge increases the proximity among different professions. The concept of 'uniqueness' therefore could no longer refer to specific knowledge, it has to change emphasis because of such factors. It would be inaccurate to talk of a unique body of knowledge to a certain profession, or a unique activity. It is more accurate to talk of an 'emphasis' on a group of related activities
pertaining mainly to a certain field. With such increased complexity and details, it is becoming more and more difficult to give a short definition of what a certain profession is or deals with, without having comments like 'but such and such other profession also does this'. 'Uniqueness' ought to be applied to the relationship between the central concepts and the frame of reference of context within which a profession functions. A profession is unique in its totality rather than in its specificity.

(1) Nursing and Medicine

Millis (1970) suggested that one basic difference between nursing and medicine is that the latter is primarily concerned with cure, while the former is primarily concerned with care. Cure is episodic while care is a process. Cure, comprises two distinct but related aspects, viz. diagnosis and treatment. By their own nature diagnosis or treatment need to be precise and specific, e.g. throbbing pain in the left lateral quadrant of .... or 2 mg. of valium 3 times daily.

So far the difference is that in nursing the emphasis is on care and by its own nature nursing care is non-specific; it is varied and complex including different kinds of activities.

Medicine is trying to 'spot' the signs and symptoms and investigations which would help diagnosis and define treatment. Nursing is trying to cover all the unattended
areas, other than those 'spotted' by the doctor as part of the disease condition the patient suffers from. This is one reason why the process of thought in nursing is mainly one of inference, i.e. relies more on the individual judgement and imagination of the nurse.

Both medicine and nursing take place in the same geographical area most of the time and their consumer, the patient or client, is the same. Within the context of health impairment they are both introduced when the emphasis is on physical or psychological or mental affliction.

Using the concept of a situation as a frame of reference, the difference between nursing and medicine is, on the whole, one of extent and depth. Also the relatedness of variables is different together with the content of what nursing involves in terms of activities.

Activities in medicine are varied but center around the individual patient/client as a whole within the given 'situation'. Some nursing activities are related to diagnosis, e.g. collection of urine specimen, observation of effect of drug, pattern of temperature; and to treatment, e.g. giving injections, intravenous fluids, medications, token economy schemes in psychiatry. Some activities pertain to the care of the patient as a person, e.g. care of normal body functioning, reaction of the patient to his condition. Some activities are related to the running of the ward or service in the
community to ensure safety and comfort to the patient or client. Some activities are related to supervision of the creation of a healthy environment whether in hospital or at home, e.g. cleanliness, prevention of infection spread, reporting to health board about sanitary facilities at home. Some activities pertain to coordinating the service to the patient or client, e.g. ordering and receiving food from the main kitchen, seeing to the patient receiving the help of the social worker, getting a home help in the community or receiving meals on wheels.

Doctors and patients need to establish some sort of relationship. Doctors also need to get in contact with relatives. The relationship between the nurse and the patient is of a more 'intimate' nature because of the types of activities involved, e.g. assisting in elimination, bathing and vomiting, and is more extensive in terms of time and variety of contacts. The relationship with relatives is of a stronger nature as the nurse would teach the relative/s how to care for the patient on discharge if need be; she is the one around during visiting hours and therefore has more opportunity to get to know the relatives than the doctor.

Prevention is an aspect of medical care; it relates mostly to cure therefore is more specific. The doctor is interested in preventing the spread of disease, or the complications of a disease or those related to administration of a certain type of treatment, e.g. side effects of a drug.
In the case of nursing prevention spreads over a whole range of activities and includes the different aspects of personality. Nursing care is directed towards prevention of imbalance of normal body function, of mental strain and psychological unrest, family worries or trouble by getting the patient or family in contact with a social worker. An example here would be: a patient is to have complete bed rest. This would be prescribed by the doctor along with some drugs. Some other measures or drugs might be used to prevent side effects of the condition or treatment used. Prevention in nursing terms would include preventing bed sores, keeping the skin clean and well hydrated, keeping the usual or normal (to the patient) bowel function and bladder function, keeping the muscles from wasting or getting damaged (foot drop), observing the effect of treatment on the patient's condition, planning to meet the expected or unexpected effect the treatment of the patient is having on him or her, e.g. drug causing dryness of mouth, then need more frequent mouth care, and may be something to suck to keep mouth moistened or to provide fluids according to what causes the dryness of the mouth. The patient would need a great deal of reassurance about how he is getting along, how long he will have to 'lie still', what are the things he is allowed to do and why, and what are the things he is to avoid and why. He needs some sort of mental diversion, according to his condition, background and preference, to prevent him from lying doing nothing and worrying about himself.
The doctor's contact with the patient is episodic, i.e. when needed. The nurse's contact with the patient is more continuous, it is more persistent and predictable in the sense that there will always be a nurse for immediate reference. This is more so the case in hospital than in the community.

Medical care and nursing care have each a part to play in the care of the person whose health is impaired or threatened to be. The boundaries between them get crossed sometimes because of their proximity in terms of knowledge/skill and place. The distinction is clearer when one considers each on a different scale and in more general terms of emphasis.

(2) Nursing and social work

The same frame of reference for comparison could be applied for comparison of social workers. The place where nursing and social work meet is either the hospital or the community. In the latter the overlap of functions or activities is more pronounced as both nursing and social care involve the whole family. The place is smaller and the 'rules and regulations', unlike the hospital, are not external to the family but are formulated and executed by the family itself. The family reacts to the nurse or social worker as 'a person offering care'; they do not necessarily tell the nurse what is more appropriate to her domain and the social worker what is appropriate to hers. The family talks about their problems and look for help.
They do not divide their problems, they perceive it as theirs, as a whole. It is the nurse or the social worker who concentrates and guides the family along the lines they are most competent in. From the point of view of health impairment, the social worker's interest or area of competence occurs when impairment has a social emphasis. It is therefore not necessary that the client be 'ill', i.e. have physical impairment as well to be entitled to social care. The field of social work, differs from country to country and relies on the evaluation of health impairment in terms of emphasis, e.g. if mental subnormalities are viewed in terms of illness they fall within the realms of hospital care mainly, with the help of social workers. If they are viewed as mainly a social problem then they fall within the realms of social care, be it in institutions, centres or schools. The activities involved in nursing are basically different than those involved in social work, because of the context within which each of them functions. Social work starts from the family as the unit of care, while nursing starts from the individual as the unit of care. In both, more is included and is of importance. Prevention in social work is more of a relationship type, like prevention of family disharmony and relates to livelihood, e.g. work, or finance.

Continuity of social care is more akin to the type of nursing continuity when social service and nursing care occur within the hospital set up. The extent and depth of continuity is greater in nursing care, due to the
situation in which the patient is in. This varies when it occurs within the community set up as it depends on the emphasis of the problems experienced by the family, whether it is social and emotional (social worker's domain) or physical and emotional (nurse's domain).

Again, each type of care contributes to the restoration or maintenance of health, but some areas along the boundaries are blurred and if effort and study is concentrated on this area alone rather than the general picture of each, a great deal of conflict and confusion is bound to occur.

Summary

It is advisable to accept as expected and inevitable that a certain number of functions are going to be shared among professions working in close proximity. Rather than concentrate on such an area to demarcate the difference between them, it is more effective to look at each profession in a synoptic view and identifying its general emphasis. It might be beneficial to direct attention to the area of overlap as an asset for increased insight by each profession to the other working in conjunction with it.

2) General Discussion

From the variety of literature reviewed in Part I, the meaning of nursing inferred was one where Nursing was considered a sum total of prescribed tasks, mainly procedures. These tasks were predetermined and had a
limited potential of expansion or adjustment. This explained why unqualified staff like nursing auxiliaries and beginning students could carry out these tasks. Because tasks were ends in themselves, this made the qualification of the person carrying them out redundant.

The fact that tasks were specific and that an understanding of nursing had not been explicitly expressed made the number of tasks carried out by the nurse prone to increase with advances in technology and with doctors referring tasks to nurses. The more the tasks increased in number and variety, the greater the concern about the nature of nursing. A vicious circle was then created. Tasks get added and subtracted from the nurse's work, and confusion grows as to the nurse's role. Lack of clarity about the nurse's role, in its turn, makes it more liable to change in a haphazard and uncontrolled way.

This inconsistency and variety of nursing does not allow for the measurement of quality of care. For such measurement standards of achievement would be required. But compartmentalization of nursing did not allow for the establishment of standards. Compartmentalization was also reflected on the programme of training which added to the students' and tutors' load of work.

From the above presentation the need for an explicit expression of the meaning of nursing, and for a recognisable purpose becomes apparent.

The function fulfilled by explicitness is important. As it has been shown in Chapter 1 and Chapter 6, the meaning of nursing was reflected on the way education was
planned and practice was organised, even in the absence of the explicit presentation of such a meaning. Making the meaning explicit would act as an enlightenment. It consequently makes one more aware of the implications of what is meant by the use of words, and brings matters into perspective. It also helps establish the connection between 'education' and 'practice'.

To say that nursing was inferred to mean a sum total of tasks, is not a short-coming in itself, but rather the fact that this was not realised to be the case. To hold such understanding of nursing would be considered restrictive but could be made more effective by making it explicit and working out its implications for programme organization and practice. The realisation would help direct effort towards the better fulfillment of what is meant by nursing. Effort would be channelled to develop the skills of the nurse in relation to these tasks.

Regardless of content of understanding certain factors are essential to make the application of the meaning of nursing to 'education' and 'practice' effective:

The understanding should be set within a frame of reference. It ought to have a body of content which would be developed to provide information as to what knowledge is needed for practice, what abilities need to be developed and what are the values to be fostered. The standard of care would also be specified. All this is best achieved if an organizational principle is chosen according to the desired aim.
Each country and situation has its own variables which decide the most suited understanding within the given limitations. This would also decide, according to resources whether 'training' or 'education' is to be the purpose of the programme of preparation. The argument for or against education does not necessarily mean that a University is the only place to conduct a nurse's 'education'. Even though a 'University' by virtue of its function is supposed to foster abilities that are more akin to education, it does not follow that nursing ought to be taught at University level for it to be an education.

The 'place' is one element which could encourage or discourage a certain quality of thinking but is not on its own decisive of the outcome. Decisions made ought to take into consideration, health needs, culture, human resources and the country's policies and economy.

The meaning held will also decide the variety of nurses needed.

The concept of a situation presented in Chapter 7, could be usefully used to guide thinking. The principle of relatedness also seems more suited to the study of the relationship between 'education' and 'practice'.

For the sake of effective communication it might be advisable that the structure and central concepts of what is referred to as nursing, be shared by all concerned, on national and international level.
PART FIVE

THE NURSING CURRICULUM

Chapter XV : Candidates and their Teachers.
   1. Personality development of candidates
   2. Academic ability of candidates
   3. Teachers' preparation and role.

Chapter XVI : Context and Design of the Curriculum.
   1. Context
   2. Design
   3. Design of the nursing curriculum

Chapter XVII : Development of the curriculum.
   1. General introduction
   2. Change needed
   3. Relatedness of Theory to Practice
   4. General discussion of the nursing curriculum.
CHAPTER FIFTEEN
CANDIDATES AND THEIR TEACHERS

GENERAL INTRODUCTION

The main interest of this Thesis being education, the whole of Part V is concerned with the study and discussion of the nursing curriculum.

The general plan of Part V includes discussions about
- The candidates as receiver of the educational programme and their teachers,
- The context of the curriculum which is nursing and the importance of the establishment and clarification of such context,
- The design of the curriculum which is mainly influenced by the context,
- The development of the curriculum which is mainly concerned with the relatedness of 'theory' to 'practice', where both theory and practice are studied at the different levels possible.

Finally a general discussion brings these different aspects of the nursing curriculum together by laying down the required criteria for an effective curriculum.

CANDIDATES AND THEIR TEACHERS
A. Candidates

In Chapter I, p.18, the characteristics needed by the nurse were investigated and discussed. These could be
broadly divided into characteristics which refer to the student's personality and those which refer to her academic qualification. In the discussion which follows reference is made to both the R.G.N. training programme and to the understanding of nursing presented in Chapter XIII. I shall discuss each group of characteristics separately.

1) **Interest in and provision for personality development within the nursing programme**

The GNC in its guide to the syllabus of subjects for general nurses states that:

> the entire programme of nurse training as outlined should present to the student nurse a challenge and inspiration to acquire knowledge, practical ability and development of personality.

Development of personality is therefore an outcome the GNC hopes the student will achieve. From the sentence quoted it seems that the onus is put on the student to be "challenged" and "inspired" in order for her to "acquire" development of personality. To use the verb 'acquire' in that context gives the impression that "development of personality" is static and that it is 'given' so that one can 'come into possession' of it.

The GNC states what should be done but does not indicate or give any guidelines as to how such goals are to be achieved.

Rée (1967) talking about teacher training points out the role of the teachers' preparation and programme organisation in the development of personality thus:
... salvation for our schools can only come from well trained teachers who are lively, self-confident and questioning, open-minded and fully human; but the training process in the colleges, through which the majority of teachers pass, is all too often a deadener, equipped to turn out answerers rather than questioners, insecure convergers rather than ranging explorers, who emerge after their training - to use Edward Blishen's sympathetic phrase "expurgated and abridged human beings". The fact that there do emerge from the end of this production line some lively exceptions who are noticeably different, says much for the occasional fighters on the staffs of colleges, as well as for the resilience and resistance of the students themselves. But most of the courses, and, above all, the day-to-day and term-by-term experience of students normally does little to encourage these exceptions and nothing to expand their numbers so that they become the rule.

This illustrates how uninspired teaching in the college can inhibit and damage a desirable development in the personality of the student teacher. While guidance and active provision for the development of the student teacher's personality would make use of the potentials present.

The role and influence played by the teacher who is the transmitter of theory into classroom practice is vital. Such influence has been pointed out in different spheres of education, curriculum innovation and evaluation. Its role has been demonstrated by Shipman's (1973) study:

This (result) confirm the now common finding that any innovation, means of organization or teaching method depends for success on the attitudes of the teachers, regardless of the intrinsic merits of the scheme.

How do nurse tutors consider the importance of developing the student's personality? Results show that tutors ranked 'developing the student's personality as a nurse' (Objective B) second in importance ($W = 0.7$). But during the rest of the interview and from the discussion it was not very clear what provisions were made
for the fulfilment of such an objective. Both students and tutors thought that the qualified hospital staff would rank this objective B as of least importance. From the results of the survey it was argued that students during training develop a nurse's role by 'copying' the qualified nursing staff. Therefore qualified staff play an important role in developing the student's personality.

The little anecdote that follows highlights the influence of the nursing staff's behaviour on the student. During the 'back round' I noticed that all bottoms were rubbed with soap indiscriminately. One day as I was working with a third year student, with six months to go before registration, I asked her, "Why do you use soap?" She replied, "I don't know." I expressed surprise and mild disappointment which she countered with, "I suppose because the first time I worked on a ward they told me to do it this way."

This was not the only incident nor the only student who displayed such behaviour during my period of work. Such incidence is a reflection not on the student's intelligence, but rather on the culture and tradition of the place and the people working there. It also reflects on the system as a whole where students are forced to work without questioning the methods or procedures being taught.

It has been pointed out frequently in this study that the student is not encouraged to think for herself, that she is led to accept uncritically the lecturing she receives at school or the tasks she is given to carry out
in the hospital. There is generally very little room for 'give and take' and tasks or activities are on the whole pre-determined. Development of personality in these circumstances can only lead to a rigid and passive type of personality. This begs two questions, (i) What is involved generally in developing personality?, and (ii) what is specific to developing the personality of the student as a nurse? I will deal with each question in turn.

(i) **What is involved in developing personality?**

One provision which needs to be made is to allow the person to grow as an individual. This consequently means freedom of expression, interchange of opinions, use of judgement, provision for doubt, questioning, and argument in order for her to reach conviction, beliefs and values which are essential to an identifiable personality. This, according to Jourard (1971 p.204) will also make the nurse free to care about others:

> this openness to herself makes it possible for her to establish empathic contact with the patients as they come and go. She realises that each patient is unique, and there is no automatic, easy way to take care of individual patients - only of people who fall into a category and who have thus lost all vestiges of individuality. Consequently, she never assumes that she knows a patient before she has taken steps to become acquainted and reacquainted with the reality of his self, his inner experience.

This process of self development and of 'becoming' a nurse has also been introduced as a way to 'commitment to nursing' by Sister Clemence Vaillot (1962). It is based on the existentialistic philosophy of self-realisation or
self-actualization.

The value of personality development then fulfils a dual purpose, one for the student's benefit and the other for the patient's benefit by caring for him as an individual.*

Another aspect for personality development would be the development of self-confidence. The concept of self-confidence is closely related to those of self-image, self-esteem, level of aspiration, and a sense of dignity. Therefore it is dependent on many factors and influences many factors.

Developing self-confidence within the nursing context would mean
- providing the student with knowledge, skills and abilities which would help her function safely and comfortably;
- help her respect and recognise herself for what she is and what she is capable of: develop what is desirable, help what needs improvement and accept limitations.

Some of the tutors interviewed referred to the importance of knowledge in that context. In response to the question

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* Students, during the pre-pilot open discussions, referred often to the lack of respect for their individuality by the 'administration', e.g. "treated like a number". This made me ask the students (having no commitment to answer) whether this consequently made them treat patients as numbers. In response some smiled, some abstained, some said, "Quite honestly, yes."

Abel-Smith (1960 p.141) wrote, "How often did junior nurses, themselves the victims of authoritarianism, unconsciously take their revenge on the patients? Was the nurse placed in the appropriate setting to encourage her to 'sun the sweet flower of our work into beneficence'?"
on the aim of classroom teaching, one tutor said it was
(for the students) to be safe and enjoy what they
are doing.

Another tutor said, it is

necessary to equip her (the student) with a certain
amount of confidence before going into the wards.

Marston (1968), dealing with low self-confidence in
relation to achievement, pointed out some very interesting
and important points. He found that progress depended
on the 'credibility gap' between the subject's self-
evaluation and the experimenter feedback of success.
"The greater the gap, the less effect success experience
will have on raising self-confidence." Emphasising that,

it is the interpretation of rewards and punishments
by humans which must be seriously considered,

he concludes that,

a systematic concentration on more objective self-
evaluation and encouragement for more frequent and
less stringent self-praise can increase self-confidence,
improve actual performance and allay the secondary
symptom of experienced anxiety.

In other words, to develop self-confidence requires
individual attention from the teacher rather than an
automatic or artificial type of praise, unrelated to the
actual student's performance and her own self-evaluation.
In other words, the teacher needs to 'know' the student as
a person.

Leith and Davis (1969) studying the influence of social
reinforcement on achievement also point out the importance
of face to face relationship between the teacher and the
student. An illustration of the importance and influence
of self-confidence in dealing with patients was given by a student nurse in the Survey. She found the hospital experience the most difficult thing to cope with (Q.17 of questionnaire). This was due to a large extent to a natural uncertainty in dealing with patients who are themselves anxious and look to the nurse for confident reassurance and optimism.

The student would be better able to give 'confident reassurance' were she herself self-confident.

Tutors, nursing staff and administrative personnel can all play an important part in building the student's self-confidence by respecting her dignity. The consideration of the student as a person was among the issues of 'difficulties' both of school and at hospital as illustrated by the questionnaire (e.g. p.105 and p.108). Not allowing the student free expression of her opinions as well as ignoring them could make a student feel that her opinions are not worthwhile or important. Because opinions are bound to the "self", if 'my opinions are not worthwhile then 'I am not worthwhile'. The feeling of being an unimportant person does not contribute to the development of the student as a person.

There is a basic truth in what Ernst Papanek said (in Bruce, 1970) though there is more to the point than

Punishing teaches the child only how to punish, scolding him teaches him how to scold. By showing him that we understand we teach him to understand,

* To listen to the student's opinion and argue with her about them does not necessitate accepting them. What is important is the process of actually considering her opinions.
by helping him we teach him to help, by co-operating we teach him to co-operate.

These are some of the aspects which are fundamental to personality development which ought to be the responsibility of any educational programme.

(ii) What is peculiar to developing the student's personality as a nurse?

In Chapters IV to VI it was argued that there is a common understanding that a nurse is 'born and not made'. This implied that there are certain characteristics which are compatible with being a nurse. It seems that another area where nurse training and teacher training share a common ground is in relation to the personality of the nurse or teacher. Fluck (1967), presenting a critique of how the teachers we need are "trained", says,

... if you wish to fail a student you are just as likely as he to end up in the doghouse, particularly if you are complaining on academic grounds only. There is little point in objecting that a girl cannot spell if she is college javelin champion. I have been told that "mere facts" are unimportant and that the "rapport" between teacher and class is vital. Hence one concludes that excitingly taught inaccuracies are acceptable. I have witnessed a French lesson being assessed by an Education tutor who knew not a syllable of that language. We live in challenging times.

This piece of savage irony brings out a point of vital educational importance: What ought to be the acceptable degree of interplay between personality and academic achievement or indeed professional safety in the case of the nurse? There is surely no need to argue as to which is the more important, personality or accuracy and safe
use of knowledge. Dealing with human beings, especially in the fields of teaching and nursing, compels one to discuss the interplay of both rather than their relative importances. There is another important yet elusive and subtle point: if one's attitude of mind is rather neglectful or lax about certain aspects of an integrated whole, e.g. it does not matter if the teacher cannot spell correctly; or it does not matter if the nurse is not intelligent; then such neglect or laxity may infiltrate many other aspects of more crucial importance. I suppose this is congruous with the character of attitudes, which are "pervasive abstractions" (Oppenheim 1966) influencing a wide variety of cognitive, affective and conative manifestations.

Such attitude of mind if present in a teacher would be directly and indirectly transmitted to the students.

To determine the acceptable degree of interplay of academic and personality factors would help decide the requirements for entrance to a nursing programme. It would also help in the study of recruitment and success of nurses joining the educational programme. I shall first review some of the relevant literature dealing with personal characteristics, study their implications, and then discuss the interplay of personality to academic ability.

According to Bailey (1969) traits like 'nurturance, order, abasement and succorance' would facilitate
effectiveness in the professional nursing role.

Schultz (1964 in Gunter 1969 Part II) found that the ideal image of the nurse as ranked by a faculty of nursing is one where the nurse is seen to be:

sympathetic, outgoing with strong interest in the feeling and behaviour of others. Her well-planned activities should be carried out to detailed perfection. She should be desirous of success in even the most difficult tasks. She should not defy conventions, seek sympathy from others or insist on being the centre of attention. She should be tolerant, in control of her emotions and devoid of inferiority feelings.

A number of British studies have looked at the characteristics of entrants to training using personality measurements, examples being those of Grygier (1957), Lee (1959), and Petrie and Powell (1951) who concluded that selection tests... which depended only on measures of intellectual capacity were ignoring a vital component of the make-up of a 'good nurse' namely personality variables including education.

Cordiner (1968) studying the personality characteristics of nurses using the Cattell's Sixteen Personality Factor Questionnaire, form C (I.P.A.T.) and tutors' Assessments felt that

If independent criteria for adjustment (in nursing) could be set up the I.P.A.T. might make a useful instrument in a selection test battery for student nurses and help to reduce withdrawal.

Birch (1972) studied the personality of 'leavers' and 'stayers' in nursing.

In America, Krall (1970) and Thurston et al (1969) studied the relationship of personality to success and
failure in Nursing School. Smith (1968) was concerned with the role played by the educational programme in enhancing some characteristics, which lead to more success than others. Bullock (1954 in Smith 1968) found that what nurses disliked about the profession was that it tended to promote undesirable characteristics such as hardness, strictness and grouchiness which were believed to be due to the teaching-learning process rather than to the profession as such. Gunter (1969) pointed to the fact that nursing students are developing; hence the important role played by the practices during training in influencing the self-actualizing values of the student. She also points out that

it is widely recognised that professionals with distorted and immature personalities are in position to inflict damage on those whom they would serve.

The effect of the training on the personality of the nurse was also studied by George and Stephens (1968) and by Psathas and Plapp (1968).

Outside nursing, Kassargian (1963) studied success and failure in relation to personality on a two-dimensional continuum. His results indicated a moderate correlation (0.51) between two dimensions: a "societal" dimension (objective measures of achievement); and an "individual" dimension aspirations of the individual and his self-perception of success and failure (subjective measures). McCloud and Kidd (1963) used the Rokeach's dogmatism scale to select appropriate psychiatric nursing personnel.
Shadbolt (1968) studied the interaction of personality with strategies of teaching in terms of degree of 'structure' in the teaching. Several points of interest were brought up in his study; for example, in his review of literature he reported that Vernon (1964) wondered about how far Eysenck was justified in fitting other workers' factors into his two-dimensional system. Vernon quoted the variety of terms used and asserted that there is little evidence that the tests on which these factors are based measure the same thing as extraversion-introversion and neuroticism stability.

Shadbolt also reports that Cronbach (1966 p.91-92 in Shadbolt 1968 p.23), states that

there will need to be more complex experiments ... to explore a five-fold interaction-subject matter, with type of instruction, with timing of instruction, with type of pupil, with outcome.

This lead Shadbolt (1968 p.193) to conclude at the end of his study that

the results add to a small but growing body of evidence indicating the importance of personality variables in relation to learning and teaching and that one method of teaching is not suited to all subjects.

Cronbach (1967 p.36 in Shadbolt 1968) raises a further point. He argues that if anxious children learn best under conditions of dependency then a structured situation will help them achieve success but that we should not restrict these pupils so that they remain anxious.

Cronbach then suggested that part of the teaching programme
should aim to increase the pupils' self-assurance. Shadbolt (1968 p.193) then suggested that teaching for individual differences implied two complementary processes: capitalising on the existing aptitude patterns as a short-term aim; and varying teaching strategy to achieve independence and adaptability as a long-term aim.

Evans (1967) evaluated the effect of a teacher-training course on the attitudes and values of students using the Study of Values and the Minnesota Teacher Attitude Inventory. She suggested that the rule should be "select according to what cannot be changed and then train what is changeable". She recommended further research to identify the qualities which are more or less changeable and these may not be the same with students of different sexes and greatly differing ages.

In summary, the important points raised in this review are:

- the personality of the student nurse is an important factor in her success as a nurse as well as her influence on her patient;
- certain personal qualities are needed in nursing, some of which are trainable or amenable to development, and others not;
- curriculum organization generally, and in terms of teaching specifically, plays a decisive role in the development of the student personality.
All these factors enhance what Vernon (1969 p.28) defines as the potentialities of the person, in this case the student.

Any nursing programme should therefore decide what are the personal qualities needed in a nurse. These should then be divided into those which the candidate should possess initially and those which the programme is responsible to develop; the means of achieving such a development comes next. The source from which decisions are made about the personal qualities needed by a nurse would be the understanding of nursing held. Such understanding would be consistent even though ways of achieving it might be different to accommodate change and progress and therefore, provide a standard background. This view is supported by Wilson (1969) who, discussing the difficulties and possibilities of justification in the curriculum, says:

the notion of justification is heavily context-dependent and it seems dangerous to attempt to 'justify science' or 'justify philosophy' without spelling out the context in some detail.

He goes on to say that

it is hard to imagine what it would mean to 'justify fiddling' per se, just as it is hard to imagine a person asking the question 'What should I do?' apart from a particular context.

This becomes apparent when one is required to decide about the personal qualities needed by the nurse. Details of the context in which the nurse is working viz. nursing, then become obviously necessary. To take an example
from my understanding of nursing (p. 424). I took nursing to involve activities directed towards "continuous care of people" and that such care involves "personal contact with them". This then implies that to give continuous care to people the nurse ought to be tolerant, and genuinely interested in people's welfare and comfort, whether physical or psychological. These qualities could then be translated in terms of measurement. Examples are 'succorance' and 'nurturance' which the Edwards personal preference scale measures. The 'social type' of individual (who values people for themselves, and is kind, sympathetic and unselfish) might be picked out by Allport's 'Study of Values'. These are qualities needed to be present in the candidate applying to become a nurse.

The programme could enhance these qualities by increasing the student nurse's awareness, by sharpening her sensitivity and by developing her understanding of other people's inner experience and their meaning.

Among the writers who advocated the education of emotions are Peters (1973), Wilson (1973), Schrag (1972) and Bantock (1967). Kalisch (1971), Dimock (1971) and on a more philosophical level Harris (1974) investigated the development of 'empathy'.

Mischel ed. (1969 and 1974) studied on psychological and philosophical grounds what is involved in human behaviour and in understanding other persons.

To summarise, psychologists have already developed tools for the measurement of personality attributes.
These could be used in recruiting the desired types of personality into nursing. The decision as to what personality attributes are needed (active interest in people's welfare, ability to empathize) could come from an explicit exposition of the meaning of nursing. Psychologists would help by providing tests for measurements of these qualities by information about which attributes are relatively fixed and which are capable of development by a suitable form of education.

2) Academic ability

Owen and Feldrmhusen (1970) studying the effectiveness of three models of multivariate prediction of academic success in nursing education found that:

there is a tremendous amount of evidence which points to past intellectual and achievement indices as the most powerful predictors of future school performance not only in public schools, but also in higher education including technical and specialised schools. This, however, has been attributed to the fact that there "are more similarities than differences between high school and college environments." Moreover, Guola (in Owen and Feldrmhusen 1970) found that cumulative previous grades in the college of nursing were better predictors of future success than previous high school performance. The National Foundation for educational research (1972) in their school to University research, also found that:

For most courses the best predictors of first-year performance as assessed by the University and of final degree results were G.C.E.A.-level grades. (Choppin et al. 1972)

These findings lead us to consider the relationship
between general education and nursing education.

Such relationship could be illustrated as follows:

i) Nursing is a specialised area of activity which requires preparation for its fulfilment;

ii) To 'become a nurse' is a stage in the educational scale which occurs after a period of general education and starts from a given age (17½ years for Scotland);

iii) The general education of the person applying to become a nurse is influenced by the culture, ideas and educational outlook of the country in which that education takes place.

All these factors also influence the 'specialised' education, in that instance nursing. Therefore nursing is closely linked to general education.

There have been some complaints among tutors about the student's lack of conception of 'sciences' subjects. Logically, if these are needed and if emphasis is on biological sciences (as shown on p. 199) why not require one of the 'O' levels to be a science subject. The answer to this came from some tutors who said that not all schools have facilities to teach science subjects; therefore there would be a loss of recruitment if the GNC made it a requirement. The question is then, would wastage from such a source exceed wastage during nurse training caused by student's dissatisfaction with the programme and their inability to cope with it? We note that this dissatisfaction is partly due to the mixed
'ability' nature of the class as well as to the educational backgrounds of students. Educational background was not specifically studied in terms of subjects, in this research, so no clues could be had. The following comment from McGuire (1969 p.61) seems indicative of the nature of the difficulties encountered:

It has been suggested that the 'common course' nature of much of the teaching in the introductory block provokes boredom among entrants who already have some nursing experience or who have passed examinations in human biology.

Another indication was that students with more 'O' levels and 'A' levels or Highers were less likely to withdraw from training. This might be explained by the fact that more subjects mean a greater probability of science subjects being included. This however, is only speculative; more research is needed in this area.

The Brigg's Committee (1972 p.82) indicated the links between nursing recruits and general education:

We conclude from projections of the Department of Education and Science that it is likely that there will be a sharp fall between 1972 and 1982 in the number of girls (and boys) leaving school with no 'O' levels of their equivalent (55.4 (56.1) per cent of total female (male) school leavers in 1971/2 to 41.3 (42.2) per cent in 1981/82) and that the number of girls (boys) with five 'O' levels or more or their equivalent will rise from 24.0 (23.6) per cent of total female (male) school leavers in 1971/72 to 34.5 (33.8) per cent in 1981/2.

From the figures it seems that the GNC could safely require more 'O' levels in the future. The Brigg's Report seems to contradict itself in relation to the educational requirement needed. On the one hand it emphasises the importance of continuing education, University degrees and
further education for the development of professional knowledge and the satisfaction of the need of recruits who should be people capable of initiating ideas (and) carrying heavy responsibilities. (p.96)

On the other hand the Committee thinks that the relationship between secondary school performance and success in nursing and midwifery is still uncertain. (p.82).

This presumably means that the Committee is not clearly for or against academic qualification, but prefers to keep options open. While it states its belief that the profession needs to recruit "candidates" who have "done well" at school, it also holds that nursing often appeals strongly to late developers and to people with average intelligence or more who, though they may have few formal academic qualifications have a high degree of motivation, (p.82).

Suitability should not be determined by 'O' levels along, (p.83).

This opinion, expressed by the Brigg's Committee raises a point of educational concern. That of recruiting people with average intelligence to start with, then expecting them to go on for further education and University degrees. Briggs' answer to this is to recommend that applicants with different initial academic qualifications ranging from average intelligence to the highest, should be accepted. However, such mixed abilities would be difficult for the tutors to handle. Vickers (1973),
discussing the scope of the educator, says,

... the more egalitarian the educational system, the more these inequalities (students' diversities) complicate his (educator) task of communication.

From the Survey and the study of the GMC syllabus, it was apparent that the educational system was "egalitarian", therefore the Brigg's recommendation would complicate matters within such a system. But the Brigg's Committee recommends too, that the more flexible the system the better. (p.90).

The latter recommendation might answer the problem, but the Committee did not give any practical suggestions as to how with a limited number of tutors and a large number of students can the system be flexible within the 18 months duration of the certificate. This flexibility will also need to apply to the further 18 months required for registration and that 6 months course for the Higher Certificate. This, keeping in mind that probably some tutors in some schools would be involved in teaching the three courses.

The issue of standards is raised by the Brigg's Committee's recommendation for flexibility and by their statement that:

The different elements in the Higher Certificate course would be studied in greater depth than subjects either in the Certificate in nursing practice or the modules leading to Registration.

together with their advocation that:

While all students will be following a common programme, they will be following it at different rates of progress and with different degrees of understanding and assimilation. (p.88).
The function of the GNC is to certify/register students who have all the aptitudes needed to be a nurse and a given level of understanding and assimilation of the knowledge imparted in the programme. It should therefore insist that teaching for individual difference does not and should not mean teaching below a required professional standard. Such required standard is crucial both for organising the education programme and for working with patients or clients. Without such standard, there is no provision for a base from which to evaluate the effectiveness of education or that of patient/client care. Without such standard as a background, the teaching of nursing and its application would be variable to a pointless extent. The aim should be to set a standard above which individual differences are to be catered for - a very different thing from catering for individual differences without setting any standards. The first would develop identifiable individual nurses; the second would develop chaos.

One tutor during the Survey concerned about standards said,

I think in general now ... I feel that there is an atmosphere of laissez-faire, if the student wants to study or not it is up to her, but ... we are dealing with life and death and I think we should have the right to ensure that she studies and know what she can give in return, we are responsible to produce a certain standard. I think there should be more of a policy to it, it should come from the top. She went on to give instances where lack of a certain standard would be dangerous. She also felt that students
needed more time to perfect a skill before going to practice it on the ward. Along the same lines of the safety of a nurse as a practitioner she talked about examiner's attitude:

I attended refresher course about oral examination... now they give different instruction about the attitude of the examiner and how to examine. I used to know that you had to ask the student in depth and width, but now they tell you to ask her what she knows and leave it to her to tell you what she knows. But a lot she has to know.

From the above discussion about academic ability it becomes apparent that a source which would guide the requirement of types of subjects needed as part of the educational background of students is necessary. Such a source should also help in co-ordinating the purpose set for the programme with the available resources whether human, material or immaterial. It will provide guidance as to the level at which standards are to be set.

In my opinion all this would be provided by the elaborate exposition of an understanding of nursing. To take the example of the interpretation of nursing I offered in Chapter XIII; The elaboration of what is included in a nursing activity, what abilities are required like an ability to observe, or infer, and what values are to be fostered, would provide guidance for decisions about the issues raised.
3) The interplay between personality and academic factors.

The study of an understanding of nursing ought to decide what personality factors in relation to what academic abilities would achieve the standard of nursing advocated.

The principle of relatedness would usefully guide such a study. Given the country's 'situation' and the understanding of nursing held by those responsible what should be the requirements at entrance to the training and what is to be achieved by the programme itself? By working out the implications of the relatedness between the variables of the situation, decisions should be arrived at for recruitment and for programme organisation.

B. Teachers

All along, the different arguments presented, referred invariably to the role played by the tutors in the students' learning or development of personality. The teacher's influence is an important factor which has been investigated by several researchers. Adams (1970) felt that

Although the teacher is central in the educational transaction, we do not really know what he does when educating, and we know little about his satisfactions and dissatisfactions.

Adams analysed the teacher's role in the belief that explanations for behaviour permit more accurate predictions about the consequences of that behaviour.
He differentiated between: "Role clarity" which
specifies the extent to which agreement on role
exists in a given group;
"Role diffusion" which
indicates the extent and range of relevant
behaviours.
This concept is useful for drawing distinctions between
primary and secondary teachers, urban or rural teachers,
for instance; "Role consensus" which would provide "a
variety of leads". It will prevent "disjunctions
between teachers' intentions and pupils' perception of
their intentions" which is believed to militate against
successful teaching.

Taking this last remark by Adams I would like to add
that communication between the students and tutors could
be enhanced if they came to know about each other's frame
of reference. This was pointed out on p. 322. To use
the concept of the situation as a frame of reference
for teaching has the added advantage of unifying the
tutor's and the students' effort toward the same purpose:
that of developing the same frame of reference.
Knowledge given by the tutor would be incorporated within
the frame of reference of the student (so to speak) with
the double merit of becoming related to a whole and
possessing more potential for application and development.

Along these lines of making knowledge (theory) and
application (practice) meet, Shipman (1967), discussing
theory and practice in the education of teachers,
considered that two sets of factors were involved in the
interaction between theory and practice. These were "material" factors and "motivational" factors. He found that:

Motivational factors proved more important. For the interaction of theory and practice to be beneficial the attitudes of college and school staffs must reinforce.

This issue of communication between tutors and hospital staff has been pointed out several times during the presentation and discussion of the Survey results. Tutors and qualified staff did not seem to share the same values or purpose. Their attitude on the whole seemed contradictory. The general impression gained was one where tutors cared about the "proper way of carrying out a procedure", while qualified staff cared about "getting all the work done". Probably if tutors and qualified staff in hospital were to get to communicate with each other more, they might find out that they shared more "role consensus" than "role dissensus" to use Adams' terminology. Hutty (1965) investigating the problems faced by first year student nurses argued that better communication between tutors and ward sisters with some elementary instruction in teaching methods for the latter, would help to bridge the gap between the school and the ward situation (in McGuire 1969 p.177). The role played by a shared frame of reference in nursing among tutors, qualified staff and students would be invaluably beneficial for all concerned. The patient though not directly involved,
is bound to gain considerably in the long run. Sharing of such a frame of reference could be achieved through increased communication on a more personal and deeper level, or through teaching.

If pressure and load of details in the tutor's teaching was to decrease through concentration on development of 'abilities'; and by studying a group of skills and determining the common factors present; if the GNC syllabus would 'behave' more like a syllabus and take the form of an outline rather than a list of 'prescriptions'; the tutor would then be freed from these restrictions, and able to invite students' participation. Woolford (1969) was of the opinion that:

Students preferred patterns of teacher influence encouraging participation, regardless of their ability, sociometric status and personality traits. Students' participation as argued in Chapter 6, was viewed to be essential for the development in the students of critical thinking. Participation of students would also ensure 'teaching' of the student by the tutor. In this instance the concept of teaching would be closer to that of Hirst (1971). Hirst believed that being clear of what teaching is matters vitally because how teachers understand teaching very much affects what they actually do in the classroom.

In Hirst's concept of teaching three criteria are

(1) the intention of teaching is learning.
(ii) the presentation of teaching follows certain "observable conditions" which characterise it and includes "achievement".

(iii) teaching involves teaching something to somebody where what is taught should be adjusted to the conceptual ability and level of understanding of those who are taught.

Penfold and Meldon (1969) investigated the relationship between teaching efficiency and a personality trait, "social sensitivity". Among the characteristics of a socially sensitive individual were understanding and support of others, tolerance for complexity and ambiguity. Teachers possessing these characteristics tended to emphasise courage and independent thinking in their pupils and offer them the chance to develop as adaptable, autonomous persons which promote maturity in the students. They concluded that

Teaching efficiency is in fact related to social sensitivity.

All the above arguments converge to the teacher's own preparation and training. The teacher's orientation is going to influence her perception and interpretation of her values, her beliefs and her role. The same kind of arguments used for students' preparation could be repeated here.

A study of a tutor's course and a clinical instructor's course revealed that the general nature of these courses was the same as that of the general nurse training course. The reader is invited to study the syllabuses of these
two courses along the lines followed in this thesis. A copy of each syllabus is included in Appendix VII.
I. Context

The importance of clarifying the context of the curriculum becomes prominently needed when the definition and evaluation of the curriculum are considered. To illustrate, first curriculum definitions are presented and their relation to the context examined; then what is involved in evaluation is considered and the connection between evaluation of the curriculum and its context examined.

1) Definitions of curriculum and its relation to context.

Lawton (1973) reviewed some definitions of the word curriculum. He found that past definitions emphasised 'content' of the teaching programme like Maccia (1965 in Lawton 1973) who defined curriculum as "presented instructional content"; and that contemporary writers "are much more likely to define it in terms of the whole learning situation".

Kerr (1968 p.16) defined curriculum as:

all the learning which is planned and guided by the school, whether it is carried on in groups or individually, inside or outside the school.

The definition was modified from Herrick and Tyler (eds.) (1950 in Kerr 1962 p.37).
Hirst (in Kerr 1968 p.40) interpreted the term curriculum to mean:

a programme of activities designed so that pupils will attain, as far as possible, certain educational ends or objectives.

The activities referred to by Hirst are concerned with both pupils and teachers. He goes on to clarify the role of each:

activities on the part of the child are essential if there is to be any significant learning at all, and activities on the part of the teacher are necessary to produce the learning with which education is concerned.

Rudd (in Butcher and Pont eds. 1970 p.120) was of the opinion that the term curriculum had acquired a different connotations;

On the one hand it is commonly used, for example, in respect of both of the 'O' level teaching programmes developed by the Nuffield Foundation for each science separately and also for the joint Nuffield Foundation/Schools Council project in the humanities. On the other hand, it is customary also to argue that the products of all such national efforts are merely curriculum materials, to be adapted by each teacher according to his own purposes in the circumstances of his classroom.

Stake (1967 p.4) introduced the curriculum as:

an educational programme,

which could be:

informally (apprenticeship) or formally organised. A curriculum defined in this way, could be a mere lesson, or it could be the curriculum programme of a comprehensive high school, or the entire educational programme of a nation. A curriculum may be specified in terms of what the teacher will do, in terms of what the student will be exposed to, or - as Gagne does ... in terms of student achievement.

The characteristics of an educational programme as perceived by Stake are:
... their purposes, their content, their environments, their methods, and the changes they bring about. Usually there are messages to be conveyed, relationships to be demonstrated, concepts to be symbolized, understanding and skills to be acquired.

The common factors from the above definitions are that the curriculum is based on a certain structure which decides the relationship between the individuals involved. Their interactions include a certain kind of 'material' or content, and their endeavour is to reach a certain purpose.

What then is going to decide the form of structure, the kind of content and the purpose to be reached? Are curricula uniform in their structure, content and purpose?

By necessity curricula could not be all alike as they usually refer to different context. A science curriculum could have the same structure and purpose as one in the humanities, but their content would be different.

This difference of context between curricula becomes prominent when a general education curriculum is compared to a vocational education curriculum. The role played by context in decisions about curriculum design and development has been discussed by several writers in Part I of Hooper ed. (1971). The points I would like to emphasise from this review are that:—

- the curriculum is:
  
  socially and historically located and culturally determined. (Hooper 1971 p.2).

- it does not develop in a vacuum but proceeds on the basis of beliefs - seldom made explicit - about how people learn, what human beings should be like, what society is.
the knowledge carried by the curriculum is "highly value-laden and relative".

thinking about the curriculum ought to be guided by the belief, which Harold Benjamin (in Hooper 1971 p.15) satirizes in the 'Saber-tooth curriculum' as follows:

the essence of true education is timelessness. It is something that endures through changing conditions like a solid rock standing squarely and firmly in the middle of a raging torrent.

These points though referring to general education are also applicable to a vocational education.

Clarification of the context within which the curriculum is to be designed and developed is a difficult and complex task which is comparatively made easier when referring to a vocational curriculum as the field of study is relatively more limited.

The importance of clarifying the context of a nursing curriculum could be illustrated as follows:

(1) The influence of an attitude of mind on thinking and behaviour has been referred to on p.10. This same kind of relationship between attitude of mind and thinking and behaviour also applies to the relationship between 'context' and 'design' in the curriculum. Attitude of mind would be paralleled with context, and thinking and behaviour with design and development in the curriculum. This relationship has also been pointed out by Lawton (1973 p.11)

The recent research by Mrs. Barker-Lunn (1970) has shown quite clearly that when most schools are classified as streamed or non-streamed, this turns out to be not simply a method of organising classes but represents a different philosophy of education which will show itself in the curriculum of the school as well as in the groupings of children in classes.
This relationship between the abstract and applied level or between the understanding of Nursing, Education and Practice as illustrated repeatedly through the present study, is considered of crucial importance.

(ii) The importance of defining one's objectives has been emphasised by almost every writer discussing the curriculum. Hirst (1974) discussing the role of philosophy in curriculum planning said:

... for curriculum planning to be rational, it must start with clear and specific objectives, and then, and only then, address itself to discovering the plan of means, the content and methods in terms which these objectives are to be obtained.

I share the opinion of Hirst and many other writers about the importance of objectives, but I would like to go a step further and say that for curriculum planning to be rational, effective and relevant, one ought to start with clarifying the 'context' of the curriculum in order to formulate objectives on the basis of the given 'context'. Objectives cannot exist without a source and a frame of reference, i.e. a context. This point is crucial for planning vocational curricula.

It is from the context that objectives or aims are formulated and consequently means of achieving them defined.

(iii) The belief that language carries meaning and influences our thought, concept formation and action, has been illustrated by writers like Vygotsky (1962), Hayakawa (1964), Barnes et al. (1971) and by a group of writers for the Open University (1972). Therefore the clarification of the words and concepts making up the 'context' of the
nursing curriculum and their relatedness would guide decisions pertaining to the design and development of the curriculum. Such exposition of concepts was offered in Chapter 13. The lack of a clear understanding making up the 'context' within which the nursing curriculum could be planned and organised would influence the educational programme and the practice of nursing. This latter point has been demonstrated through the study of the GNC Syllabus and its implementation in schools of nursing. The consideration of language in the definition of the context would allow for clarification about the knowledge, skills, abilities, and values which are needed at a fundamental level and those which are needed on higher and more specialised levels. Partly because of lack of sufficient clarity about the understanding of nursing, and partly because of unguarded use of language, courses developed for nurse education on more specialised level are multiplying. These courses lack a unifying context which would make their purpose and design clearer and hence more effective. An example of these specialised courses are those offered by the Joint Board of Clinical Nursing Studies. To illustrate, I shall take an example from one of the syllabuses. In the General Intensive Care Nursing Syllabus, 1972, two of the attitudes to be developed in the nurse are:

Respects the human dignity of every patient and his relatives.

and

Accepts responsibility.
If one expanded the meaning of these attitudes, one would wonder why are they to be developed at a higher and more specialised level? Ought they not constitute part of the fundamental values of what is involved in our understanding of nursing?

In the twenty-four weeks duration of the above mentioned course there are fifteen attitudes to be developed. This begs the question: What is meant by attitude in that context?

(iv) The role played by expectation from the educational programme has been studied and referred to mainly in Part II, the Survey. Disappointment and frustrations on the part of tutors, students and qualified staff was shown and inferred to be present.

One way of helping expectations to be met is to provide a clearer picture of what could be realistically expected from a given educational programme. The fact that:

If you don't know where you are going then you will reach nowhere in particular,

though a tautology, illustrates an important point. To clarify the purpose to be reached by the educational programme, within a given context, will help direct expectations of teachers as to what needs to be developed, how and in what distribution of students as to what needs to be learned, and of qualified staff as to what needs to be reinforced and what to expect from the student at different stages of her development as a nurse. If the
purpose is the development of the inferential ability of the student for example, then one does not expect her to develop it in one lecture or 'study block'. One would expect her to be taught knowledge in a certain way, and to provide opportunities for the student to exercise this ability.

2) Evaluation and its connection to context.

Evaluation as a measure of assessment applies to different levels of the educational programme.

It could apply to students' achievements, to the effect of a course, to the effectiveness of a method of teaching, to the curriculum as a whole, and to the comparison of one curriculum with another. On the students' achievement level Pilliner (1973 p.13) defined assessment procedure as:

instruments to help make decisions about people - outward-looking decisions when we award a student this mark or that grade, inward-looking when we assess our own success in teaching and working with him. The decisions we make are value judgements which, even if we would, we cannot escape.

Regardless of the level at which assessment is taking place, it is basically a technique whereby information is gathered as to whether what was intended to be achieved was in fact achieved.

Pilliner (1974) distinguishes two forms of assessment norm-reference and criterion reference, these are mostly applicable to student's achievement. On a curriculum level Parlett and Hamilton (1972) differentiate between: (1) traditional evaluation or the agricultural-botany paradigm which assess the effectiveness of an innovation
for example, by examining whether or not it has reached required standards on pre-specified criteria. The general form would be pre-test - treatment - post-test. (ii) illuminative evaluation or the social-anthropology paradigm, which is mainly concerned with description and interpretation rather than measurement and prediction. They favoured the second type of evaluation. Along the same line of a comprehensive approach to evaluation Miller and Parlett (1974) studied

the whole system of University assessment as experienced and perceived by staff and students. They too valued their approach to the research as

by focusing on a small number of departments we became increasingly aware of the connections between issues and phenomena of assessment which at first sight might have appeared to be in separate areas. Among the interesting points in their study, of relevance here is their finding that:

This basic difference, between assessment of a more bureaucratic type and that of a more personalized form is based on a contextual difference ...

Stake (1967) discussing perspectives of curriculum evaluation, recommends that for a complete evaluation of a programme two main kinds of data should be collected:

(1) objective descriptions of goals, environments, personnel methods and content, and outcomes; and
(2) personal judgements as to the quality and appropriateness of those goals, environments, etc. ...

Dubois and Mayo (1970) introducing research strategies for evaluating training, support Stake (1967) in his opinion that there is a hierarchy of dependency in educational evaluation. They write:
At the functional level, standard operating procedures are needed, but the criteria for adequate procedures require rationales, which ultimately depend upon theories. Thus, the basic issues are theoretical and rational in nature and normally precede the criterion and procedural aspects of training research.

Taylor (1967 in Hooper 1971 p.167) discussing curriculum evaluation was of the opinion that the question 'Is curriculum A better than curriculum B?'... can refer to any one of the three dimensions of curriculum (objectives, teaching methods and subject matter) or to all three at once.

He finds that:

In a period of radical curriculum change new curricula are likely to be different in more than one major respect from old curricula, in which case things are likely to be very unequal indeed and there is not much to be gained from comparisons. (p.168)

Curriculum evaluation, on the whole, is discussed in connection to innovation or change. Wiseman and Pidgeon (1970 p.26) distinguish between 'formative evaluation' i.e. "on-going evaluation during the development process" of an innovation, and 'summative evaluation' i.e. evaluation of the new curriculum "once (it) has been developed, and the materials published in their final form for use in the schools".

Davies (1969, p.5) discussing the role of curriculum theory wrote:

Educators can deal effectively and efficiently with the problems of curriculum planning, development and evaluation only in so far as there is a theory that gives meaning, direction and justification to such work.

The issue of justification and worthwhileness of curriculum content has been discussed by several educationists, examples are Peters (1966 Chap.3), Hirst (in Kerr 1968), Wilson (1969). The latter is of the opinion that
justification of curriculum is "context-dependent". I would like to emphasise two points from the above brief review about evaluation,

(a) curriculum evaluation ought to apply not only to innovation or comparisons between curricula, but also to already existing curricula. In nursing, evaluation of curricula ought to be guided ultimately by the degree of effectiveness reached by the curriculum in representing what is understood by nursing. The clarification of the context, i.e. understanding of nursing would be a more reliable and useful guide in evaluating a curriculum or in comparing two or more curricula.

(b) Evaluation was considered as one of the elements of the curriculum by most writers. To my mind this confuses both the role of curriculum and of evaluation. Evaluation is a technique by which a curriculum is guided through its different stages of planning, organization and execution. Evaluation also operates mainly on two levels: the implicit level which is an integral part of each of the processes of planning, organization, execution and teaching; and the explicit level which is identifiable in terms of procedures and techniques like examinations, assessment techniques, objective descriptions. These two levels of evaluation take place at different stages of the educational process.
II. Design

Hooper (1971 p.116) wrote that the way we set about designing curriculum follows logically from what we think curriculum is.

He found that most writers about the curriculum put forward a model which basically comprises four interrelated elements: objectives, content, methods and evaluation.

The value of this model in Kerr's opinion (in Hooper ed. 1971 p.181) is that:

... it suggests four basic questions for use in the construction of a new curriculum: What is its purpose? What subject matter is to be used? What learning experiences and school organization are to be provided? How are the results to be assessed? The model itself gives no guidance about choice of objectives, content, or methods of teaching.

I would like to add to the foregoing opinion that in the case of nursing as in the case of any vocation, what we understand by nursing is what would influence our design of the curriculum. Unlike general education, in nursing a model used as a frame of reference influences to some extent the choice of objectives, content and methods, as it is a frame of reference for what is understood by nursing.

As suggested earlier when discussing the concept of the situation in Chapter 7, this same concept could be usefully used as a frame of reference for curriculum design.

With such background and using the four elements proposed by Kerr I shall proceed to discuss each in turn.

A. Objectives:

Wheeler (1967 p.22) drew a distinction, for the sake of clarity, between "aims" as referring to "the broad generalities which describe what the school is trying to do."
"Purposes" as referring to "the ends of planned individual activities"; and "Objectives" as referring to "the ends of planned activities in the school or classroom".

From the present study it appears that what the nursing programme as a whole was aiming at was to teach the student a number of procedures and a certain amount of knowledge. Bendall (1971) discussing 'student states' and whether control of students' training should be vested in the Department of Health or the Department of Education wrote:

In educational terms it is a question of finding the most effective way of learning to take place - for this surely is what training is all about.

I would like to add here that though the effective way for learning to take place is of supreme importance, it is an incomplete question. The question of identifying the ultimate aim of the programme and its relatedness to 'how', 'what' and 'when' given the reality of the situation, is what needs to be studied. The questions which need to be answered are:

- What is it that we want the student to learn? Is it a number of specifics like knowledge or skills? Or is it some more general abilities like the ability to think critically, the ability to apply knowledge and skills in different situations?

- How could such aims be best fulfilled?

- What is the purpose of this learning? Is it to equip the student to cope with the variables presented by the situation one at a time? Or is it to equip the
student to cope with the situation as it occurs in toto?

Answers to such questions would provide direction to the more specific objectives to be achieved.

Objectives have been referred to as instructional, educational, and behavioural. These adjectives have sometimes been used interchangeably. What type of objectives are needed to be developed in nursing? The appeal for behavioural objectives has been apparent in the syllabuses planned by the Joint Board of Clinical Nursing Studies.

Behavioural objectives as introduced by Bloom (1956), Mager (1962) and Krathwohl (1964) usually begin with a verb stated in terms of the learner terminal behaviour. Each objective covers one outcome only. The objectives are conventionally identified in relation to three areas or domains, the cognitive, affective and psychomotor, referring respectively to knowledge, attitudes and skills. Usually a list of typical verbs used for each domain is supplied. Among the merits attributed to identifying behavioural objectives are: that it requires the teachers to rethink the approach they have been using in course design; and that it helps both teachers and students to see what the course is about. Behavioural objectives are described as being systematic, realistic and appropriate, as they have to relate to the product rather than process and be defined in terms of the learner rather than the teacher.
Among the critiques of behavioural objectives are:

Hogben (1972) who pointed out some of the problems and dangers relating to the specification of behavioural objectives:

There is a considerable bias toward low-level cognitive performance and simple skill and

the vast number of statements required.

He none-the-less believed that though Bloom's Taxonomy has weaknesses as it refers mainly to "student's performance" only, the

search for more acceptable classifications and systems should continue in the same general direction.

Both Sockett (1971) and Pring (1971) criticised Bloom's Taxonomy on philosophical grounds. Sockett (1971) wrote that:

The overriding criticism is that the taxonomy operates with a naive theory of knowledge which cannot be ignored however classificatory and neutral its intention.

Among his criticism of the taxonomy is the fact that we need to be sure that the way words are used within this internally consistent system, relates in fact to the way in which the terms operate. He takes the example where Bloom talks about knowledge of specific facts including 'Knowledge of dates, events, persons, places'. Sockett criticises such approach on the ground that knowledge of these different events is not on the same logical or even psychological plane, as knowing a person is different from knowing an event, different criteria of knowledge apply to each 'event'.
This opinion agrees with Mischel ed. (1974), who felt that what is involved in person perception is different from what is involved in object perception.

Sockett summarises his criticisms as follows:

... The taxonomy rests on the possible distinction between behavioural and substantive elements in statements of educational objectives. This conception is incoherent ... in persisting with the division the attempt to specify i.e. delineate criteria for different behaviours, runs into difficulties, not merely because it cannot be done without specifying a content, but simply because there are non. ... the organizing principles boil down to a psychological principle: Philosophy is emasculated via logic to mean internal consistency and education is merely a label. The result is that philosophical work in the theory of knowledge which has a prima facie claim for inclusion is ignored ...

Pring (1971) criticised Bloom's Taxonomy mainly on two points: the first was that the entire taxonomy depends upon the distinction between the cognitive and the affective domains of objectives.

But Pring believed that ...

... the whole enterprise would seem to be misconceived. For this simply is not how the practical mind works, nor indeed is this account based upon any acceptable analysis of the moral judgement made or of the moral attitudes adopted.

The second criticism was that

Within the cognitive domain, one is asked to distinguish between knowledge and intellectual abilities which themselves are differentiated into comprehension, application, analysis, synthesis and evaluation.

Pring's criticism in this instance was:

Underlying Bloom's analysis of knowledge seems to be the model of a computer controlled filing cabinet. ... Through lack of any epistemological analysis of cognitive process, the taxonomy makes false distinctions and thereby provides a nonsensical classification...

Pring goes further in his criticism of the Taxonomy by saying that:
In so far as this dissection (of mental process into isolated and identifiable behaviours) is not possible without a total misrepresentation of what is going on ... it cannot be the basis for describing educational objectives. The importance of this criticism extends beyond the taxonomy itself. It embraces all those schemes which adopt the rational curriculum plan, ... in which the curriculum planner identifies his behavioural objectives and then chooses those learning experiences which enable him to achieve those objectives.

Pring is of the opinion that the failure of the taxonomy to provide an adequate description because of epistemological reasons, casts doubt "upon the relevance of such a model to educational processes."

Doll (1972) offered an alternative to behavioural objectives, based on Dewey's concept of personal experiences. He advocated an educational structure where in each individual can develop his own experiences. Where goals, activities and behaviours of the student are not determined for him but rather by him. In this model it is the process of experiencing in the sense of both doing and receiving the results of doing, which becomes focal.

Page (1974) offers a different direction for working out educational objectives. He is mainly concerned with measurement of behavioural objectives. He suggested an alternative to the "bottom-up" approach of specifying objectives which is detailed and cumbersome to overcome such uncontrolled details, he suggested a "top-down" value tree. He offers a technical procedure which would give a unit for measuring the level of education of the student. Such unit he calls the "bentee score" which is:

An ideal, overall appraisal of an individual or of some subgroup, compared with that norm population.

What then of the tendency in nursing which favours behavioural objectives in view of the presented criticism of such
objectives? In my opinion, the ultimate aim we decide upon for a nursing programme is going to decide the types of objectives we choose. None-the-less I see the dangers of the specification of behavioural objectives as follows:

(i) In nursing the tendency has been to compartmentalise, and fragment what is meant by nursing and emphasise details. Specifying behavioural objectives is going to magnify such a tendency to a considerable extent, which is hard to conceive as being of value.

(ii) Specifying behavioural objectives has the tendency to predetermine the type of behaviour to be expected from the student. Such a process is more akin to 'moulding', and does not allow for personality development. Personality development could occur within a frame of reference, but this is different from being 'moulded into' a given frame of reference.

(iii) Nursing includes a variety of activities of different kind. Though activities are varied and complex, common characteristics bring them together. To specify behavioural objectives for every activity would mean preparing an unmanageable number of lists, which would literally be unending.

(iv) Behavioural objectives distinguish between affective and cognitive domain, therefore would help orient the student nurse toward such division, which is believed to be detrimental to the idea of 'respect of individuality' of the patient and of care of the patient as a 'whole'.
(v) Behavioural objectives tend to concentrate on the measurable types of behaviour, a great deal of what happens in the nurse-patient interactions is not amenable to measurement, but is none-the-less very important. To ignore such an area would encourage the technical aspect of nursing to take priority over the human interaction aspect.

In conclusion it could be said that the direction of aims and objectives in nursing ought to encourage holistic orientation rather than basically specific orientation. This does not mean that the nurse ought to be orientated towards perceiving the situation as a whole and neglect details or specifics. It means that the nurse ought to be orientated toward a coherent frame of reference which will allow specifics to constitute a whole and that her thinking would be towards establishing the connection between the specific and the whole. In that case the order of going from specific to general or vice versa is not of prime importance. It is the process of relating one to the other which is the key process in that context. Such understanding would also favour the development of abilities.

B. Content:

As the content, methods and organizational principle within the curriculum are interrelated, I shall first review the literature pertaining to each separately, then discuss them all together within the nursing context.
Hooper (1971) wrote that:

Decisions about ... content or subject matter - derive from an analysis of the characteristics of the knowledge represented by school knowledge and of the characteristics of the learning process.

Taba (in Hooper ed. 1971 p.136) talks about the importance of a rationale for the design of the curriculum which will influence content. She says:

Designs with no rationale, or a confusing one, result in a curriculum framework with a higher overtone of prescription because the requirements regarding content or the nature of learning experiences are difficult to explain and seem to demand a docile acceptance of directives by those who implement the curriculum in the classroom. ... Such a curriculum also tends to remain inflexible.

This comment seems to agree with the analysis and interpretation of the GNC Syllabus in Chapter 6.

In Hooper's (1971) view

the organization of content stems from the structure of the disciplines and the ways of thinking these disciplines embody.

Lawton (1973) examining the structure and organization of knowledge referred to two views:

The classical view of curriculum stresses knowledge in terms of disciplines and ultimately of school subjects, and sees the curriculum as the induction of young members of society into the established forms of thought and understanding.

and

The romantic view of curriculum, ..., sees education as an integral part of life rather than preparation for the adult world and stresses experience, awareness and creativity and sometimes, but not always, the 'unity of knowledge'.

Hirst (in Hirst and Peters 1970) distinguished seven forms of knowledge: formal logic and mathematics, the physical sciences, our awareness and understanding of our own and
other people's minds, moral judgement and awareness, aesthetic experience, religious, philosophical.

When applying his theory of the structure and organization of knowledge to the selection of curriculum objectives, Hirst suggests that general education should include all the distinct forms of knowledge, and that distinction should be made between general and specialised understanding in any of the seven forms of knowledge.

Phenix (1964) identified six reals of meaning and suggested the organization of the curriculum along these lines, to provide a comprehensive pattern within which the constituent parts are located. He expressed concern about the meaning which would be "... lost in an abyss of meaninglessness". His six fundamental patterns of the possible distinctive modes of human understanding are:

Symbolics comprises ordinary language, mathematics and ... nondiscursive symbolic forms such as gestures ... empirics, includes the sciences of the physical world of living things, and of man... esthetics, contains the various arts, such as music ... literature ... synnoetics, embraces what Michael Polanyi calls "personal knowledge" and Martin Buber the "I-Thou" relation. The novel term "synnoetics" ... derives from the Greek synnoesis, meaning "meditative thought" ... ethics, includes moral meanings that express obligation rather than fact, perceptual form, or awareness of relation ... synoptics, refers to meanings that are comprehensively integrative. It includes history, religion and philosophy...

Kerr (in Hooper ed. 1971) and Pring (in Hooper ed. 1971) examine theories of knowledge which justify interdisciplinary curricula.
Meredith (1949) organised curriculum content on the basis of "topic analysis".

The point illustrated by this quick review is that content within the curriculum could be organised on the basis of different principles, what seems to be common is that the content forms a whole and is centred around a rationale. The purpose and context of the curriculum would influence the content and its organization to a considerable extent.

C. Methods:

Both Hirst (in Kerr 1968) and Peters (in Tibble ed. 1966) felt that methods are inseparable from content. Hooper (1971) perceived the methods of achieving curriculum objectives to be connected to how the student learns. He pointed out the difficulty raised by individual differences in learning in relation to:

pace, learning strategy, attention span, interest in given subject matter, preference for learning by one medium rather than another.

These differences raise the question of effectiveness of teaching when these differences are disregarded. A point discussed in Part I and Part II of this study.

Individualised system of learning were introduced to meet individual differences in learning. Such system depends considerably on resources. To my mind it also
depends on the ultimate aim of the programme and the subject matter. Decisions about the use of such a system should not only include criteria like does learning take place, but should be seen in much wider perspective.

Methods are also influenced by the architecture of the school and availability of rooms for teaching, given the school population and timetable distribution.

D. Evaluation:

As pointed out earlier under Context, Evaluation could occur at different stages of curriculum planning and at different levels.

The issue of evaluation or assessment of student performance in nursing is an important one as the student performance refer to demonstrable skills, knowledge and abilities. The greater part of the student nurse's training takes place in the practical area, while her final evaluation mainly depends on a written assessment. This leads a number of schools of nursing to start thinking about continuous assessment.

E. Organizational principle:

As pointed out earlier in Chapter 13, integration and relatedness are used indiscriminately. In relation to the curriculum it appears more customary to refer to an 'integrated curriculum' and to integration of knowledge.

Bernstein (in Hamilton 1973) studied the social
organization and transmission of educational knowledge, with particular reference to "education of knowledge codes" of the "collection" and "integrated" type.

He qualified the "collection curricula" as "closed" and compartmentalised and the "integrated curricula" as "open". Bernstein thought that for integration to be successful four conditions are necessary:

... (i) high ideological consensus among the staff... (ii) linkage between the integrating idea and the knowledge to be co-ordinated must also be coherently spelled out ... (iii) close face to face liaison, discussion and feed-back between staff and students (as evaluation criteria are less likely to be as explicit and measurable as in the case of collection) ... (iv) clear criteria of evaluation.

Hamilton (1973) applied Bernstein's proposed model to study two organizational forms taken by the Scottish Integrated Science Scheme, which represent both types of curriculum, the "collection" and the "integrated" curricula. He concluded that Bernstein's curriculum model only applied to clear-cut situations. Hamilton was of the opinion that the two curricula "exist side by side". He went on to say that:

Although it is logically possible for the 'organizational' problems to be reduced in a situation of mixed curricula, it is more often the case that they are heightened. This may be for the reason that certain features of the curriculum types outlined by Bernstein are in direct opposition to each other.

Hamilton (1973) discussed further the implications of the integrated curriculum in terms of teacher's role, interaction and organization of the school. He concluded that (p.14):

The introduction of integrated studies is not merely equivalent to introducing a new syllabus but implies a radical change of emphasis in the organizational context and thinking of secondary education.
He suggested that the coexistence of integrated and collection curricula in secondary education points, to a fundamental dilemma, if not a crisis for the comprehensive school.

The implications in terms of expectations from teachers in such a set up, create tensions as the teachers are expected to be

'inter disciplinary' and subject-specialists; to be concerned with teaching sixth-formers and 'slow-learners'; and to be responsible for both the academic and social welfare of their pupils.

This study by Hamilton even though it applies to general education, has a great deal of relevance in nurse education. As pointed out in Chapter 15, the system of education of a country whether general or special, is influenced by the country's policy, way of thinking about education, culture, etc. In nursing the idea of a comprehensive training has also been introduced (Chapter 2). In that training, 'comprehensive' means that the subjects taught by the different programmes (general, psychiatric, mental deficiency and sick children) are pooled. All students from different programmes start with the same subjects and are taught in the same classroom. During phase one of the comprehensive programme implementation, the students of the different programmes practice in their respective areas. In Bernstein's model integration refers to a more fundamental type of pooling of subjects.

To my mind the difficulties caused by 'integration' in the curriculum are caused by the nature of 'integration' as a process. This was discussed in Chapter 13, where integration involved fusion. Fusion in turn makes it
difficult to delineate the role of each teacher taking part, the distribution of hours of teaching, the implications in terms of teacher's responsibility. These implications were mentioned by Hamilton (1973), but to my mind he did not perceive them as caused by the process of integration itself.

I believe that if the nursing programme development toward comprehensive training is a step in the right direction, which needs to be guarded against the type of organizational principle used in the curriculum. In Britain the tendency towards integration was apparent in nursing in relation to the re-organization of the Health Services and in what some of the nursing literature refer to as the integration of theory to practice or education to service. I have suggested in Chapter 13 that relatedness as an organizational principle would be effective in the study of nursing. I would like to emphasise here that it is even more vital in relation to curriculum organization because of the nature of subject matter. Integration has a role to play but I would consider this role to pertain to the level of units of knowledge rather than to curriculum organization.

F. Design of the Nursing Curriculum:

I shall now illustrate the implications of what was reviewed, in A - E above, in terms of the nursing curriculum, using the understanding of nursing presented
in Chapter 13. To remind the reader the abstract of such understanding was that I took nursing to involve a pattern of related activities of different kinds, whose unity consist in their being directed towards continuous care of people whose health is impaired, or threatened. This involves personal contact with them, with the intention of helping them regain or maintain a harmonious state of health within the given situation.

Such understanding implies that what we want to prepare the student for is ultimately for her to be able to cope with the situation as a totality.

Among the abilities which need to be developed are: the ability to infer relatedness between and among variables, a heightened sensitivity to patient's behaviour, an acuity of observation, an ability to establish a relationship with other people, the application of knowledge and skills to varying situations.

Certain points need to be emphasised in relation to the curriculum:

1. The type of knowledge to be included:

   Knowledge in the nursing curriculum refers to a variety of disciplines. Examples: knowledge of physics, knowledge of chemistry, knowledge of physiology, knowledge of psychology, knowledge of sociology.

   Two points are important in this instance: the first is related to the language used. It is apparent that a student would be subjected to a number of specialised 'jargon' used by the different disciplines. The way the
student is introduced to jargon is important. It was argued earlier that language or words carry meaning, that the meaning of language also relates to the context in which it is used. The introduction of a new terminology draws the attention and memory of the student. She would want to remember it because that is a new addition in her repertoire. If she did not understand what it meant or did not grasp the meaning sufficiently, she might use the word without really understanding what is meant by it. She will most probably hear it again used by other people, maybe during her practice. She will start to gather its meaning slowly as she goes along. This process has its risks, because she would be trying to remember words rather than understand them on the one hand, on the other hand there is no guarantee that what she will 'pick up' about the word illustrates its meaning. The dangers of jargon are specifically apparent in the psychiatric nursing field. Words make up concepts, therefore the words we use represent the concept we have of them. The major part of the therapeutic relationship between the nurse and the patient in the psychiatric field, relies on language.

Examples of the relationship of language to concepts could be inferred from the Roger Brook's collection of mistakes nurses make in examination papers. I would therefore suggest that the idea behind the new terminology ought to precede the introduction of the terminology itself.

The second important point about knowledge in nursing
is the fact that again a great deal of information and knowledge is involved. If this knowledge is taught to the student in terms of specifics, her memory would be overburdened by details, and not enough is made of the potential of 'understanding'.

Pole (1971) presents a philosophical analysis about understanding. He compares it to perception and argues that it involves breadth and depth.

Along the same lines, I believe that what nursing involves in terms of knowledge and abilities, develops over time and that one can make use of repeated exposure to a situation to deepen the student's understanding.

Lawton (1973 p.16) illustrated the point that understanding can occur after the exposure to the situation where knowledge was presented, thus

I read some of Shelley's poetry at school, when I was sixteen, which I did not really appreciate until I read some Plato some years later (and possibly I understood Plato better having read the Shelley).

Bruner (1960) suggested a curriculum design based on the idea of depth of understanding.

Because of the nature of what is involved in nursing, a general idea would be more beneficial to introduce the student to. It also would be helpful if she was given a frame of reference within which the knowledge gained is related to. This would lessen the burden on 'memory' and encourage the potentials of 'understanding'.

A related point in this instance is the idea of
teaching on the basis of principles. I would argue that to concentrate teaching on the basis of 'principles' alone without relating them to a frame of reference would be incomplete and would not necessarily develop understanding.

2. Skills in nursing:

That a certain number of skills are an essential component of the nurses work is undoubtable. I am here referring mainly to psychomotor skills. To introduce the teaching of skills as part of a wider function, for example procedure, is to my mind confusing. Most of the introduced skills are novel to the student, therefore would require a great deal of her energy and attention to grasp all the necessary movements involved. I would then suggest that skills which are common to different procedures are taught and practiced separately, then the student could be allowed to apply this skill to different situations. If she has mastered the basic skill required then the greater part of her energy is directed toward a different aspect of the activity she is learning. In a sense she would be 'freer' to learn about the procedure, for example. This becomes specifically important when the issue of 'where' would she be introduced to the skills arises. Should students be taught procedures on the ward or at school? The answer ought to be decided on the basis of the facts that: learning is energy consuming (it involves attention, understanding, mental practice), the introduction of a new
skill draws most of the energy towards it, leading the
student to concentrate on the acquisition of the skill
to the exclusion of anything introduced concomittantly
with it.

The answer to the question then would also rely on
the purpose of teaching the skill on the ward or
at school. If the purpose is to teach her how to carry
out the procedure, then she ought to be taught that outside
the ward. If the purpose is to teach her how to adapt the
procedure to the condition of the patient, then she ought
to be taught the procedure first outside the ward and
master the skills involved before she is allowed to carry
it out to the patient. She ought to be helped to be
'free' to nurse the patient, and not concentrate on her
skills. She ought to be 'free' to receive the patient's
cues which would help guide the application of the
procedure to the patient's condition. She would also be
free to interact with the patient and the situation as a
whole.

Another related point in this instance is the fact
that psychomotor skills have a cognitive aspect which
would also be needed to be introduced along the introduction
of the motor skill. This might take the form of
explanation as to why a forcep is held pointing down, or
why not touch the edge of the container with a sterile
instrument, or why thin the skin out for an intramuscular
injection and collect it for a subcutaneous injection.
Another important skill in nursing is that of observation. This skill could also be developed by other means than by a lecture about 'what to observe'. The student's sensitivity to cues might be developed by different means. Some exercises could be: developing her ability to memorize by showing her a number of items (possibly used in nursing), then decreasing the time, then finding out how much she can remember of them. Asking her to remember how many doors there were in the corridor she just passed through, for instance. Showing her a film about an interaction between two people, cutting out the sound and letting her pick up the non-verbal cues which would help her know what the interaction was about. Letting her listen to a recording and pick up the intonations of voice, etc. All these exercises would also help develop her inferential ability.

3. Nature of learning:

It was pointed out above that understanding develops over time. I would like to add here that time is an essential factor in learning. The student experiences different situations at varying levels, but somehow the cumulative effect of exposure to situations helps knowledge, understanding and abilities to 'mature' through time. The student should be allowed time to assimilate new knowledge specially since the type of knowledge she deals with in nursing is complex and pertains to several aspects of the situation.
The student's experience ought to be planned bearing in mind that learning does not take place merely through 'exposure' to the situation, nor does it take place as a result of one exposure, i.e. one lecture for instance. The student also learns more than what she is 'told' or 'taught' explicitly. Learning takes place within a context. Let me illustrate by an example:

On a hospital ward a bell rings and Sister tells the student nurse

Sister: "better attend to bed 5 nurse, or else she will cause more trouble".

What the student could possibly learn from this situation is that when the red light of a bell flashes she ought to answer it, that 'trouble' is to be avoided on this ward, that order and quiet are values of higher priority. That the bed number is what she is required to remember.

An alternative example would be the same situation but where Sister says:

"better attend to Mrs. Jones, Nurse Smith, she will get upset by being kept waiting".

What the student could possibly learn from this situation is that she ought to answer the patient's requests, that emphasis is on 'caring' for the patient as a person, that the patient's comfort is a value of high priority, that avoiding patient's stress is also a value of high priority. That patients are referred to by their names which denotes a more personal interest.
In other words the nurse learns a great deal from one incidence, and she learns it in more than one dimension. She gains information or knowledge, a way of behaving and the values attached to the knowledge or behaviour. What she would have learned ultimately would not depend on single incidences. It is not necessary that because she witnessed 'impersonal care' that she would have 'learned' it. It is her experience over a period of time which will teach her.

To summarise, learning could be said to be multidimensional in a related sense, i.e. the relatedness between language used, content of speech, way of expressing the language, the context in which it takes place.

On the basis of all the previous discussions, I believe that the concept of a situation could usefully be used as a frame of reference for designing the nursing curriculum. It will direct thought about each element in the curriculum as well as the relatedness of one element to the other, together with the implication of such a relatedness in terms of the whole curriculum.
CHAPTER SEVENTEEN
DEVELOPMENT OF THE CURRICULUM

GENERAL INTRODUCTION

The topic of curriculum development includes issues like: Change or innovation needed, strategies and structure in the curriculum, resources, and general aim towards which change is to be directed. These issues are all interrelated and as recommended by Hooper (1971 p.371) to be successful a strategy of innovation must take a comprehensive, not piecemeal, approach.

Even though looking at what a comprehensive approach entails in terms of complexity and details might seem enormous, Lawton (in Hooper 1971 p.463-14) still believed that while taken together these (issues) may even be seen as more manageable than if attempted one at a time. Piecemeal reform almost inevitably results in fragmentation of the curriculum, whereas the indications are that what is really required ... is far-sighted, long-term planning which would give the curriculum some kind of logical structure and unity.

As discussed in Chapter 1, change was a difficult mechanism, it depended upon the area involved, the purpose for change and its implications. Before innovation or change could be planned for the curriculum, it seems essential that two points be established: first the existing state of affairs in order to know what needs to change and in what way; second the context within which the process of change as a whole is to occur.
The Thesis presented in this study emphasised the role played by the context, which was mainly defined in terms of a frame of reference for nursing. The review of literature and the survey were investigating the validity of the mutual relatedness between Nursing Education and Practice.

It is difficult to conceive of a nursing curriculum which does not include practice. The relationship between Education and Practice is not only one where education is the source which provides nurses, and practice is the purpose for which education exists. The relationship is more fundamental and closer. Its closeness becomes apparent when issues like quality of nursing care are discussed.

Simpson (in W.H.O. 1969) reviewed some of the research in nursing practice. She believed that:

fundamentally, nursing education programmes must be assessed in terms of the number and competence of the nurses they produce and the problem for the assessor lies in determining measures of the quantity and quality of nursing care needed to make the nursing contribution to total patient care and the competence of the nurses in providing it.

All along her review a lack of 'reference' was noticed.
Some examples were

Good nursing practice is appropriate nursing practice.

The question is then 'appropriate' to what?

... the need is for measures which will differentiate between the excellence of the products of one type of educational programme and another.

The question is then 'excellence' in what terms?
There is as yet no wholly satisfactory way of measuring "good" nursing care.

The question is then 'good' in what way?

This last quotation raises a more fundamental issue. Nursing care ought to be first defined in terms of content and acceptable standards before one can place it on a scale of measurement. Content would be easily identified, but it is the relatedness of content to standards within a wider perspective which has been lacking.

Figure 4 on page 529a, illustrates in an abstract form the thesis presented so far. It is against such background that I shall now proceed to discuss some of the issues raised in the context of curriculum development.

Change needed.

In relation to the GNC Syllabus and its implementation in schools, the picture conveyed was one where the programme was causing difficulties and a great deal of potential was lost. What was tangent did not meet the reality of the situation. This state of affairs was partly caused by the organization of the syllabus, and partly by its execution. The fundamental reason for such lack of direction in organization and execution was believed to be caused by the lack of clarity and explicitness of what was understood by nursing. The fundamental issue referred to the relatedness of theory to practice.

All along I used the words theory and education interchangeably. Now I shall use the two words more discriminately. I shall use theory as a cognitive system
Explicit exposition of the meaning of nursing providing a frame of reference for the education and practice of nursing. Guidance to values, abilities, skills, knowledge and standards to be developed and means of developing them.

Curriculum planning, organisation and execution in the light of the 'understanding' of nursing held. To reach the general purpose of an effective practice in relation to receiver, provider and profession within the given 'situation'.

Work planning, organisation and execution in the light of the 'understanding' of nursing held as a result of the education provided for the development of the attributes desirable to deal with a given 'situation' effectively.
of organization, and education to refer to the curriculum. Practice is used in the sense of application in terms of action.

The relationship between theory and practice can be studied on different levels. Using the Fig.4 p.529a, theory could refer to the abstract level including the conceptual system which qualify nursing, and practice in that case would then refer to the concrete level including both education and practice (as it occurs in a clinical area). This level was prominent in Chapters 11 to 14. Theory would refer to the curriculum including the concepts of knowledge to be taught, and practice in that case would then refer to the application of such knowledge in the clinical area. This level was prominent in Chapters 3 to 10.

Relatedness between theory and practice could simply be illustrated as

\[ \text{Th.} \leftarrow \rightarrow \text{Pr.} \]

This illustration includes three elements; Th. = theory, Pr. = practice and \( \leftarrow \rightarrow \) the nature of the relatedness. I shall consider each in turn.

1) Theory: has to be studied in order to know what and how can it relate to practice.

Concepts and knowledge form the body of theory. Within theory the constituent elements are related, such relatedness needs to be clarified for the better understanding of 'theory'. Within theory different levels
could be identified, like the general conceptual level and the more specific conceptual level. An example of the general conceptual level would be the abstract of the understanding of nursing presented in Chapter 13. An example of the specific conceptual level would be the 'pattern of related activities' which are part of the abstract in the understanding of nursing in Chapter 13.

The elements of theory and their relatedness could be applied to the curriculum as follows: units of knowledge could be identified, a 'subject' could be considered as made up of several units of knowledge related by a common frame of reference. The curriculum content in that instance would refer to a group of subjects related within a given frame of reference. The implications of such considerations is that given a certain frame of reference I investigate how and in what way a subject contributes to that frame of reference. In a nursing curriculum for instance, I might plan to teach psychology on two levels: one as a subject in its own right, the other as units of knowledge within a nursing subject. This would be based on my belief that a knowledge of psychology would widen the student's horizon as to the meaning of behaviour. To include units of knowledge of psychology while teaching the student the requirement of care of Mr. Smith, for instance, would reflect my belief that I would not expect the student to automatically relate the knowledge from the psychology lectures to her practice of nursing, but that relatedness is an active process which needs to be made explicit and integrated within the approach to the teaching. Through
a similar process of what is believed to be of value as background knowledge and what is believed to be of value as an integral part of nursing, knowledge in the curriculum is decided upon.

The study of the relatedness within theory can then be carried across the same level and between the different levels.

2) Practice: the elements which constitute practice are also studied and their relatedness considered. This has been already introduced while discussing the presented understanding of nursing (Chapter 13). A single activity could be considered, or a group of activities of the same kind, or several kinds of activities. This way of considering activities might be used to study the relatedness between fields of nursing. It will also help direct decisions as to what groups of activities are basic to nursing, this would orientate the nurse towards similarities and hence give her greater opportunity of applying her basic skills to a variety of situations.

3) Relatedness ←→: the study of the relatedness of elements within theory to elements within practice, would be made clearer against such background. The relatedness of a unit of knowledge to one aspect of an activity could be studied to see how knowledge could be made more applicable to the reality of the practice. The knowledge gained
about micro-organism, their behaviour and way of transmission would decide the wearing of a certain thickness of 'mask' while dressing a patient's open wound, for instance.

Relatedness between theory and practice could then be studied in relation to different elements and on different levels. One essential factor for the effectiveness of such study is keeping it within the context of the whole situation, i.e. avoid studying the direct relatedness of one element in theory to one element in practice without the consideration of other variables present and influencing either 'theory' or 'practice' or both. This warning applies to the immediate situation and to the more fundamental context of the meaning of nursing. The immediate situation in that instance would mean teaching about a way of bed bathing a patient which is not practical because the patient could be too fat, or too ill.

In conclusion the study of relatedness between theory and practice could be more effective if what is involved in theory and what is involved in practice is explicitly recognised. This relatedness is enhanced if their shared frame of reference is clarified. This also indicates the need for a more comprehensive study when the problem of the relatedness of theory to practice is investigated.

**Relatedness of Theory to Practice**

In this part I shall review some of the literature which dealt with the relationship of theory to practice in education.
Gowin (1963) reviewed some definitions of theory and noticed that some writers placed a logical accent, and some an empirical accent upon the definition of theory. He then said that:

The exact relation between the logical and the empirical is a perennial issue among philosophers of science.

He argued for the difference in educational theory, which involves an educator "trying to do something to, with and for another person", and carries a component of moral responsibility. He points out the difference between educational theory and scientific theory:

An educational theory will differ from scientific theories in that, although they both guide practice, the referent for the guidance is a person-being-educated in one theory, and a thing-being-studied or manipulated in the other theory.

The recognition of such characteristics implies that an educational theory must specify "the nature of the moral responsibility so entailed by the nature of educational theory itself" in order for it to guide practice.

Perkinson (1963) though in agreement with Gowin above, believes that the use of the term 'educational theory' adds to the confusion, and should be abandoned. Instead he suggests "strategies of education" which he believes guide practice. He also believes that the decision to adopt an educational strategy is, in part, a moral decision.

Newsome (1964) reviewed the meaning of theory and that of practice. He noted that
It appears that there are both points of agreement and disagreement about theory and the theory-practice relationship. It seems likely that some of these differences arise from semantic problems while others reflect different conceptions of theory and practice.

He analysed the meaning and conception of theory and concluded that

Knowing a theory (of mathematics for example) as a necessary condition for teaching it does not mean that theory implies practice, or that knowledge of the theory is a sufficient condition for successful practice.

He goes on to say that:

Theory, primarily scientific theory, is a guide to action or practice only in the sense that relatively reliable, systematic, and perhaps somewhat esoteric knowledge affords a basis for understanding phenomena, serves as a criterion of reasonableness, and affords a heuristic device for conceptualization ... It is only by scientific research, not by philosophical analysis and speculation, that the practical usefulness of theory can be substantiated.

Beck (1964) examined the "nature of the relation, if any, between descriptive statements and value judgements". He was of the opinion that it was important to know if such relation exists, what it is in order to determine what studies are relevant to educational practice, and in what way. He considered two aspects to the problem: (i) the general nature of the relation between theory and practice within the context of human thought and activity and (ii) the particular sets of the theoretical statements and particular practical problems in education.

Clive Beck gave an account of the theory/practice relation in education and concluded that:

There is no general problem about the relation between theory and practice in education. Psychological theory, sociological theory, and so on, can be applied in a perfectly intelligible way to educational theory; and
educational theory, being about how education should be carried on, has obvious implications for judgements and hence decisions in particular educational situations. He consequently, having resolved the problem on the general level, could not see any reason in principle why the particular problems could not be solved.

Russell (1970) examined the logic of the statement 'the gap between theory and practice'. She thought that the word 'gap' was used vaguely in such context because the limits within which it applies are not known, if compared for instance with the use of the word in the context of the 'generation gap'. After a lengthy analysis she concluded that:

... gap-talk is an inadequate way of debating the topic and that 'theory' and 'practice' are overworked and under-defined. If we dislike employing 'strategies' and 'change agents' we might usefully talk in terms of exploring relationships between specified entities which we clearly show for what they are, whether objects, ideas or persons.

Powell (1973) called for the consideration of issues which are primarily of educational concern rather than be diverted to issues of psychological or sociological concern. This 'outside' influence on educational matter lead the state of affairs where:

The relationship between educational theory and practice is poorly understood and has received surprisingly scant attention from theorists. This has tended to encourage a regrettable lack of contact and co-operation between teachers and educational research workers.

He discerned three kinds of theory associated with education, each with a different function in relation to the practical activity of teaching and the formulation of educational policy. These were the "theory of teaching", "theory of educational policy" and "theory of educational ideas" which
he thought was commonly criticised by students and teachers as being irrelevant to the practical problems of the classroom. Powell emphasised that that was an internal relationship between these three kinds of theory and between all of them and educational practice.

This brief review indicates the types of issue which are of educational concern when the relationship of theory to practice is discussed. Such relationship is a key issue in education as it represents what education is all about. The difficulties encountered in the study of the relationship between theory and practice, are minimized when they occur within an identifiable context; provided such a context is comprehensively and explicitly clarified.

Responsibility for Change

Who is to initiate change? What is the source from which decisions for change are made?

Source of decisions for change: This is an area where research could usefully be directed. The type of content and strategies within the nursing curriculum relate to the type of clientele to be served by their needs.

Research could provide information about the community's health needs. It could also indicate where nurses work mostly, in the hospital or in the community, whether such distribution of nurses is meeting the needs or whether there is a lack of nursing service in any given area. Research within the hospital can provide information about the percentage of severely ill, how and where patients are
distributed, in order to balance the student allocation according to the reality of what is needed.

Who is to initiate change?: I believe that one cannot prescribe who should initiate change. In Chapter 1 change in nursing was observed to have occurred from within and from outside nursing. I think that whoever initiates change, for it to be effective, all concerned ought to participate.

From the survey it was apparent that the tutors were restricted by the syllabus. On the other hand Shipman (1973) reached the same conclusion as many other studies, that if change is introduced from above, its success or failure depended on the teachers. Because the curriculum is a closely knit system, its innovation necessitates the combined efforts of the curriculum planners, teachers, students and the people responsible for the clinical area.

General discussion of the nursing curriculum

Discussions about the nursing curriculum include topics relating to the organization and study of the curriculum generally and to the organization and study of the curriculum within a nursing context.

The importance of context was illustrated using general education literature. Most of the literature referring to the nursing curriculum are North American. I shall here briefly illustrate how the lack of context for the nursing curriculum was responsible for a lack of purpose in the literature discussing the curriculum.
Longway (1972) analysed the curriculum content in nursing and examined the connection between such content and the contemporary social scene. From the Florence Nightingale era till the present. She wrote that:

Every knowledge area can be organized in some way. A logical and inclusive system of relating the sub-areas within the field facilitates transmission of knowledge to others and serves as a guide to practice and research ... Ways of organizing content which have served well in the past have become inadequate as needs of society have changed and the knowledge base in nursing and its cognate sciences have increased.

This quotation suggests that the content of the curriculum was relating to 'specifics' which were peculiar to a certain period (further specification). This then suggests one of the criteria which characterise a non-viable curriculum.

Longway (1972) forecasted after her review that:

The areas in which change will most likely be accommodated may be in a redefinition of nursing or in early specialisation in the educational process.

Commenting on Ina Longway's forecast I would say that we have never defined nursing clearly enough, or in such a way that it would direct thought and action in terms of education and practice. The tendency to early specialisation is one that is likely to increase the problem of non-viability rather than meet it.

In Britain the training is divided into four registers, as explained in Chapter 2, but the need for a more 'general' outlook was translated in the requirement for and introduction of a comprehensive training.

Stevens (1971) analysed the structural forms used in nursing curricula. She was of the opinion that the first
step in analysing any existing programme is to differentiate content from methodological structure. She identified four methods. (i) The logistic method which is built upon the parts, but does not focus upon the whole process as such. This method is best known as the disease-centred or teaching by 'body systems' approach. (ii) The dialectical method which has a global view, and where the parts are seen as they function in the whole. The organising principle is "a concept of man from birth through growth, to maturity". (iii) The operational method which is based on the nursing student's needs.

No prestructured curriculum exists, students select from their environment the activities and observations which will best meet their own learning needs. The "operational thought" move by a process of differentiation and discrimination. It is a matter of "either study Mr. X or Mr. Y." (iv) The problematic method where the focus is an identified problem situation. This was based on John Dewey's process of inquiry.

Stevens concluded that two trends could be identified. One is that the problematic approach is persisting, the other that the logistic approach is coming back with some modification.

My comment on this review is that Stevens starts by differentiating content from methods; this division as discussed earlier is conceptually and practically inaccurate. The curriculum organization in this instance does not relate to any identifiable context which raises the question: What is it that an operational method of
curriculum organization is trying to achieve? No purpose, standards, core content or values are given. The student is being self-centred for the duration of the programme, then at the end of it she is required presumably to 'care' for all patients. The argument about how much of the curriculum should be pre-determined and how much open to individual needs/choice of students was discussed by Claydon (1974). The method used in curriculum organization somehow decides the purpose of the curriculum rather than the other way round. This obviously leads to a variable outcome and reflects vagueness about the understanding of nursing.

Dolores (1971) considered some theoretical questions in relation to programme development in nursing. She asked questions like:

What constitutes professional nursing? What is nursing education? What are the sets of ideas that distinguish Medical-Surgical nursing from Maternal and Pediatric nursing? How can the sets of ideas that establish the uniqueness of a given area be organised?

After comparing educational perspectives based on Dewey's approach and Bruner's approach she concludes that:

A range of diversity is possible and that criteria for ordering of options within subject matter can be generated ... The emphasis must be on experimentation (which would establish) a community committed to a continuously evolving approach to problem solving that is based in knowledge.

My comment on Dolores' article is that it raises some important questions but again the lack of a frame of reference is prominent. The impression is that knowledge is good for its own sake.
In summary the findings and arguments about the nursing curriculum could be pointed out as follows:

(i) the Survey study and literature review indicate that a curriculum based on specifics, is fragmented and non-viable as it would not be up to date.

(ii) the clarification of the context within which the curriculum is to be organised acts as a unifying factor for the purpose, content and methods.

(iii) the clarification of context in terms of a frame of reference allows for more effective relatedness between theory and practice, as the relationship is of a more fundamental nature.

(iv) the organising principle within a curriculum depends on the context and purpose plays an active part in the effectiveness of the curriculum organization.

On the basis of the above discussions and summary, I would like to suggest that the criteria for an effective nursing curriculum are:

(i) Consistency: which refers to different levels. Internal consistency within the curriculum, consistency of the general idea behind the curriculum and means of organising the curriculum, consistency of intentions and strategies of the curriculum.

(ii) Relevance: of curriculum to the interpretation of nursing; to the practical situation and to the abilities and background of the people concerned, i.e. students and tutors.
(iii) Relatedness: Among elements within the curriculum. Relatedness between frame of reference and the knowledge, standards, values and abilities to be developed and applied, relatedness between theory and practice at the levels identified - the general and the more specific. (iv) Reality based: this involves the community health needs, the student's ability and background, and the practical situation.

These criteria would guide the planning, organization and implementation of the curriculum at all levels.
PART SIX

THE CONCLUSION

Chapter XVIII : Summary and concluding discussion.

1. Overall summary
2. Concluding discussion.
CHAPTER EIGHTEEN
OVERALL SUMMARY AND CONCLUDING DISCUSSION

GENERAL INTRODUCTION

To help relate the different issues raised in this Thesis I shall first give an overall summary, then discuss the relatedness of the issues raised and their implications.

OVERALL SUMMARY

The literature review revealed the presence of a problem in finding satisfactory answers to the question of what is involved in the nurse's role and how to prepare her for this role.

This problem was estimated to be caused by the lack of explicitness about the 'meaning' of Nursing. The meaning of Nursing was believed to be related to the organization of Education and Practice and consequently influenced by them. The organization involved purpose, content and structure.

The main emphasis of the present study was on the Education aspect of the triad. More specifically it was investigating the relatedness of Education to Practice. The field of the study was the three years general nurse training programme in Scotland. The investigation included (i) a survey of tutors' and student nurses' perception of the relatedness, (ii) an analysis of the
GNC syllabus and (iii) an experimental course of teaching for the purpose of enhancing and improving relatedness between theory and practice.

An interpretation of nursing and its implication to Education and Practice was presented, and the Nursing curriculum was studied on a wider educational basis.

The main findings and the points raised through the study were:

(1) The meaning of nursing inferred from the literature reflected an image of nursing which was a sum total of procedures and tasks, characterised by over-emphasis on details, vagueness and fragmentation.

(2) Theory and practice within the registered nurse training programme were unrelated in terms of administration; time sequence and distribution; of content; and sometimes of principles.

(3) The student was loaded with work both at school and at hospital. A great deal was expected of her without the corresponding preparation.

(4) The GNC syllabus was concerned with details, biased toward the biological sciences and fragmented. It was unrealistic in what it required within the time available.

(5) More prestige status was given to non-nursing subjects than to nursing. This seemed to be the case whether in the clinical area, understanding of nursing, or within the curriculum.

(6) The meaning of nursing inferred through the survey results agrees with that inferred from the literature (1).
(7) The survey results explicitly denote that theory and practice are not related. A more critical analysis shows that they are related implicitly in nature and structure.

(8) Asking questions within a given frame of reference helps arriving at a more satisfactory answer. The problem was defined more fundamentally as: lack of representation of the reality of the practical situation in teaching, rather than in terms of sequence of theory to practice.

(9) Such approach to question asking offers a change of more satisfactory answers and helps direct ones action.

(10) The hospital situation was complex and multidimensional. The school teaching was greatly simplified and unidimensional.

(11) From 9 and 10 above the suggested solution was to
- teach on the basis of a 'situation' representing reality,
- increase the student's awareness to the multiplicity and relatedness of the variables within a situation,
- develop the student's inferential ability.

(12) The relatedness of the variables involved in teaching ought to be represented in the offered solution.

(13) Content of teaching reality is complex, which necessitated an approach capable of representing such complexity in a clear and explicit way, for the student to be able to make use of such teaching she ought to be
helped to develop a corresponding ability hence the development of her inferential ability.

(14) The results of the experimental course of teaching supported the idea behind the solution.

(15) The approach to teaching corresponded to the way of examination. The principle sheet for instance was used as a guide to the student, it was used in teaching and in the examination.

(16) Meeting problems does not necessarily mean a radical change of system. The approach to the teaching suggested was applied to the same content, and schedule of lectures, yet it seemed more beneficial.

(17) The importance of the clarification and explicitness of the context of nursing in relating theory to practice and in planning, organizing, implementing and evaluating curriculum and practice was illustrated.

(18) The importance of a frame of reference, which is used as a guide to orientation was emphasised.

(19) The importance of an organization based on knowledge and the relevant principle (of organization) to the purpose and nature of both the elements to be organised and the principle, was demonstrated.

(20) The value of analysing the concepts involved in an understanding of nursing was indicated, together with how such analysis guided the implications in terms of education and practice.
The definition of a nursing frame of reference, serving as background, is important whether the study is descriptive, experimental or analytical. The role played by such a frame of reference is one of guidance to the asking of questions which would add knowledge to, and allow the development of nursing. To fulfil its function effectively the frame of reference should not be biased toward or based upon a given discipline, it should rather be neutral. What makes this frame of reference nursing is the relatedness of the concepts and the elements of such frame of reference. The suggested frame of reference was found to be applicable to the study of nursing, the curriculum and everyday practical nursing situations.

It was suggested that the concept of uniqueness of nursing in terms of activity be abandoned. The growth and sharing of knowledge by the different disciplines and the proximity of work between nurses and other professionals, makes such concept misleading.

The concept of uniqueness was extended in the literature to refer to a concept of nursing and a theory of nursing. It was felt that it would be more effective if an understanding of nursing was developed and made explicit, rather than defining nursing concisely. This would necessitate the inclusion of several concepts and their relatedness.
The value of explicitness of the understanding of nursing is in guiding the expectations from planning, organization and evaluation in nursing, whether within an educational programme or in practice.

Such understanding of nursing should include some areas of agreement with all other presented understandings of nursing, but because of varying circumstances between countries and within the same country, a certain area of disagreement about the meaning of nursing would be expected and ought to be accepted.

The Thesis presented by the study that Nursing Education and Practice are mutually related, was found to be true regardless of the content of what is meant by nursing. The potential of this Thesis could be used not only to study the meaning of nursing and the relatedness between theory and practice, but also through the clarification of what nursing involves. What is important in such a process is the working out of the implications in terms of knowledge, standards, values and abilities.

In conclusion, I would like to emphasise that the study was an attempt at finding a way of unravelling the puzzle of the relatedness of theory to practice within nursing. The Thesis needs to be refined, developed further and polished.
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APPENDIX I.

1. Summary of Results.

2. Questionnaire.

3. Interview Schedule.
Dear Colleagues,

The attached is the summary I promised to send at the end of the Survey. It is late and I apologise for the delay.

I would like to express my deepest gratitude to all the students who participated in either the preparation or the filling-in of the Questionnaire. Without the help of all of you this study would have been either non-existent or irrelevant. I thoroughly enjoyed meeting you all and discussing points of interest to us both. Meeting you was a good experience which will be a most pleasant souvenir for me to take back home with me.

My gratitude is also to all the Tutors and Clinical Instructors, who helped me so very much by their interesting talks and opinions. Giving me the privilege of sharing their 'Hobby Horses' with them made the interviews friendly and I hope as pleasant for you all as they were for me.

My deepest thanks are offered to the Principal Tutors and the Directors of the Nursing Schools who kindly granted their permission and arranged meetings and sometimes accommodation for me.

I cannot express in enough words my gratitude to everyone who helped me so very willingly, and always made me feel acceptable. One thing I am sure of is that I enjoyed every minute of my visits and meetings. A difficult task was made easy by everybody's friendly approach.

Thanking you all most sincerely, I send you my best wishes and kindest regards,

Yours sincerely,

Hend Abdel-Al.
PRELIMINARY SUMMARY OF RESULTS OF QUESTIONNAIRES AND INTERVIEWS

The following is a preliminary summary of the results of the survey. The seven schools involved are considered as one group of students and one group of tutors.

I THE DESIGN OF THE SURVEY

Seven schools of General Nurse Training, covering five Scottish Regions are involved.

In each school:

1) Questionnaires were given to three groups of students:
   a. one group in their first year of training;
   b. one group in their second year of training;
   c. one group in their third year of training;
   while they were in a 'study block'. The filling-in of the questionnaires was usually followed by an open discussion with the group.

2) Interviews were tape-recorded, with all the available tutors and clinical instructors (both Registered and unregistered), who were involved in teaching the General Nurse Training Programme.

II THE PURPOSE OF THE SURVEY

The purpose is to help the investigator to become familiar with the system of training as prescribed by the GNC and implemented in different schools of nursing. The survey is based on the specific points of interest brought up by students and tutors in the pre-pilot and pilot periods as well as on queries of the investigator. The main object of the survey is to study the nature and degree of agreement between theoretical instruction given in the classroom and the practical hospital experience in terms of the:

1) Administrative aspect: Time sequence of instruction at school and at hospital; Nursing techniques as taught and as practiced; as well as school administration or hospital administration, e.g. night duties.

2) Content aspect: Information and knowledge pertaining to a specific subject or procedure, at school and at hospital.

3) Work-load: Amount of knowledge and work, e.g. projects, reading given to student at school, and amount of responsibility and work done on the hospital wards.

4) Expectations versus preparation: Do the Teaching Staff at the school equip the students with the knowledge that they expect them to have? Do the Training Staff in hospital prepare the students for the different duties they expect them to know and to carry out?
Basically the questions in the questionnaire and the topics in the interviews (referred to in I) deal with the same matters.

III GENERAL STRUCTURE OF THIS SUMMARY

A THE TABLE
showing the distribution of students and tutors over the seven schools.

B THE RESULTS OF THE QUESTIONNAIRES
The main points are presented with reference to the different questions.
(A copy of the questionnaire will be found in the Appendix.)

C THE RESULTS OF THE INTERVIEWS
The main points are presented with reference to the different topics.
Percentages or rough generalisations are given as the group of Tutors and Clinical Instructors from the different schools are considered as one group.
(A copy of the interview schedule will be found in the Appendix.)

One statistical measure is used at this stage: the Kendall coefficient of concordance $'w'$, which is an index of the degree of agreement among members of a group (or groups) of people when they rank a set of objects or items in order of importance. The value of $'w'$ ranges from 0 to +1. On this scale $w = 0$ means no agreement at all among members of a group (or among the groups); $w = 1$ means complete agreement among members of a group (or among the group). Normally, the degree of agreement is somewhere between these two extremes, thus $w = 0.4$ denotes a moderate degree of agreement and $w = 0.9$ a much closer agreement. $'w'$ is used mostly in connection with the questionnaire to test the agreement among groups of the first, second and third year students, followed by the ranking of the different items in the given question. Percentages are also reported to indicate relative magnitudes.
**THE SUMMARY**

A **THE TABLE**

**TUTORS' & STUDENTS' SAMPLE DISTRIBUTION OVER THE SEVEN SCHOOLS INVOLVED IN THE SURVEY**

<table>
<thead>
<tr>
<th>Students' Sample n = 521</th>
<th>Tutors' Sample n = 59</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schools</strong></td>
<td>1st yr.</td>
</tr>
<tr>
<td>I</td>
<td>44</td>
</tr>
<tr>
<td>II</td>
<td>47</td>
</tr>
<tr>
<td>III</td>
<td>23</td>
</tr>
<tr>
<td>IV</td>
<td>25</td>
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<td>V</td>
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</tr>
<tr>
<td>VII</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>196</td>
</tr>
</tbody>
</table>

B **THE RESULTS OF THE QUESTIONNAIRES**

I **Help derived by students from hospital experience**

1. (Q.8) When faced with a hospital situation requiring quick action, which helps you most?

(i) \( w = 0.8 \)

(ii) Ranking:

1 = a)* previous hospital experience in the same or similar circumstances. (47%)

2 = c) Student's own judgement of the situation. (31%)

*The responses to the questions in the questionnaire were designated a), b), c) etc.

**The term 'Tutors' refers to both Tutors and Clinical Instructors whether Registered or unregistered.
1. (Q.11) To what extent do you feel that your practical hospital experience helps you to understand what is taught in the classroom?

1. (Q.9) To what extent do you feel that the Anatomy and Physiology you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?

2. (Q.10) To what extent do you feel that the 'nursing care' you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?

This was supported by comments written under "In what ways?" by 66% of the total number of students who answered this part.

Answers were under 5 categories.

1. (Q.11) Rank: 
1 = a) it helps to a great extent. (66%)
2 = b) it helps to a moderate extent. (30%)
3 = c) it helps to a minimum extent. (4%)

2. (Q.9) Rank: 
1 = b) it needs to be more closely related than at present. (38%)
2 = c) it needs to be a little more closely related than at present. (28%)
3 = d) it does not need any change from the way it is taught at present. (23%)
4 = a) it needs to be much more closely related than at present. (9%)

2. (Q.10) Rank: 
1 = b) it needs to be more closely related than at present. (33%)
2 = a) it needs to be much more closely related than at present. (24%)
3 = c) it needs to be a little more closely related than at present. (24%)
4 = d) it does not need any change from the way it is taught at present. (18%)

This was supported by comments written under "In what ways?" by 66% of the total number of students who answered this part.

Answers were under 5 categories.

1 = a) it needs to be more closely related than at present. (38%)
2 = b) it helps to a great extent. (66%)
3 = c) it helps to a moderate extent. (30%)
4 = d) it does not need any change from the way it is taught at present. (4%)

This was supported by comments written under "In what ways?" by 66% of the total number of students who answered this part.

Answers were under 5 categories.

1 = c) Lack of practicality or consideration of 'reality' of a situation by the school, hence the need for knowing how to manage practically. (43%)

This was supported by comments written under "In what ways?" by 66% of the total number of students who answered this part.

Answers were under 5 categories.
2 = a) Lack of communication between school and hospital, and, tutors’ lack of contact with hospital, (20%)
3 = b) Need for teaching on the wards, (17%)
4 = d) Lack of consideration to the ‘patient’ by school, (7%)
5 = c)* ‘Other’ comments, e.g. rigidity of school teaching; difference between preparation and expectations; Sister’s own way of doing things hindering the application of principles taught by the school.

* These were small separate categories summed together for convenience.

3. (Q.13) How often have you been faced with a discrepancy between what is taught in the classroom and what is practiced on the wards?

(1) \( w = 1.0 \)

(ii) Ranking:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Often</td>
<td>(62%)</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes</td>
<td>(32%)</td>
</tr>
<tr>
<td>3</td>
<td>Seldom</td>
<td>(6%)</td>
</tr>
<tr>
<td>4</td>
<td>Never</td>
<td>(1%)</td>
</tr>
</tbody>
</table>

III Educational objectives as perceived by students

Questions 14, 15 and 16 dealt with the ranking, in order of importance, of four educational objectives inferred by the investigator from the Introduction to the Syllabus for General Nurse 1963 (GNC). The students were asked to rank these in order of importance for (i) themselves, (ii) as they thought their tutors would rank them, and (iii) as they thought the qualified nursing staff on the ward would rank them.

7% of the total number of students either did not answer or gave incomplete responses.

The four objectives were:

A To prepare the student for her final examination;
B To develop the student’s personality as a nurse;
C To increase the student’s knowledge about nursing;
D To prepare the student to deal with any practical problem which may arise in the wards.

<table>
<thead>
<tr>
<th>Ranking for:</th>
<th>Objectives</th>
<th>( w )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A B C D</td>
<td></td>
</tr>
<tr>
<td>Themselves</td>
<td>3 4 1 2</td>
<td>1.0</td>
</tr>
<tr>
<td>Tutor</td>
<td>2 4 1 3</td>
<td>0.8</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>3 4 2 1</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Areas of difficulty for the students

1. General
   (Q.17) Which of the following have you found most difficult to cope with in your present programme?

   (i) \( w = 1.0 \)

   (ii) Ranking:
   1 = a) classroom material, (54%)
   2 = c) both classroom material and practical hospital training in some respect, (34%)
   3 = b) practical hospital training, (12%)
   4 = d) no difficulties, (1%)

   The nature of the difficulties (assessed from Q.17 where the student could specify her difficulties fully) pertaining to school is mainly to do with 'administration' and 'content'. (See "II Purpose of the Survey", page 1.)

   The nature of the difficulties pertaining to both hospital and school are, in order of severity: (i) 'content', (ii) work-load, and (iii) 'administration'.

   The nature of the difficulties pertaining to hospital training is mainly to do with 'administration'.

2. Specific
   A School
   (Q.18) Statements describing the students' difficulties with classroom work.

   (i) \( w = 0.8 \)

   (ii) Ranking:
   1 = a) too much material to study in the time available, (27%)
   2 = d) 'nursing car.' as taught in the school is different from its practice on the hospital wards, (23%)
   3 = b) too much 'ideal' knowledge that the student feels has no practical application in the hospital situation, (16%)
   4 = e) being treated as though you are 'expected to know', (13%)
   5 = g) not being treated as a responsible person, (9%)
   6 = c) not enough 'teaching' about different subjects and their use in practice, (6%)
   7 = f) having to decide for yourself (the student) how to apply knowledge gained in the classroom to the practical hospital situation.

* The percentages in the above Ranking are of the total statements, as the students were allowed to tick as many statements as were applicable to themselves.
Comments on 'other difficulties' given by 11% of the total number of students are, in order of severity: (i) content (55%)*
(ii) relationship (20%)**
(iii) work-load (17%)*
and (iv) administration (9%)*

*See "II Purpose of the Survey", page 1.
**Relationship refers to the way students feel about interaction with members of the teaching or hospital staff and the way they were treated by the staff.

B Hospital
(Q.19) Statements describing the students' difficulties with practical hospital experience.

(i) w = 0.7
(11) Ranking:
1 = b) difficulty of applying principles taught in the classroom because some of the qualified nursing staff disagree with them. (19%*)
2 = d) not enough instruction as to how to carry out different nursing techniques on the different wards. (19%*)
3 = f) being expected not to argue with the qualified nursing staff or not to express their (the students) own opinion. (17%*)
4 = c) fear of being 'caught' by the responsible nursing staff while talking to a patient who the student felt needed to be talked to. (15%*)
5 = g) not being asked your (the student's) point of view in discussion about ward organization or patient care requirements although you feel that you are close to the patient and know a lot about him/her. (13%*)
6 = e) lack of orientation to ward management and policies, procedures and personnel. (12%*)
7 = a) difficulty in getting along with the qualified nursing staff on the ward. (4%*)

*The percentages in the above Ranking are of the total statements, as the students were allowed to tick as many statements as were applicable to themselves.
Comments on 'other difficulties' given by 9% of the total number of students are, in order of severity: (i) relationship (55%)* 
(ii) administration (40%)* 
(iii) work-load (7%)* 
*See notes on previous page.

V Patients emotional needs and behaviour
1. (Q.20) Extent of difficulty felt by students in understanding these needs and behaviour.

(i) w = 1.0 
(ii) Ranking:
   1 = c) minimum extent  (61%) 
   2 = d) not at all  (22%) 
   3 = b) moderate extent  (16%) 
   4 = a) great extent  (1%)

2. (Q.21) The frequency with which students are faced with the situation where they feel that a patient is upset although not showing it.

(i) w = 0.9 
(ii) Ranking:
   1 = b) sometimes  (63%) 
   2 = a) often  (18%) 
   3 = c) seldom  (16%) 
   4 = d) never  (2%)

3. (Q.22) The behaviour of students when faced with the situation where a patient is upset although not showing it.

(i) w = 1.0 
(ii) Ranking:
   1 = c) After finding out the cause of the patient's upset the student would consult another person she/he believes could best help in dealing with the situation. (55%) 
      (* 75% of those who ticked this item would consult 'Sister'.) 
   2 = b) The student would talk to the patient and try to find out about his troubles and do what she/he could to soothe him/her. (28%) 
   3 = d) Before talking to the patient whom the student feels to be upset, she/he would consult another person on the ward. (12%) 
      (* 68% of those who ticked this item would consult 'Sister'.) 
   4 = c) 'Other' alternative behaviour is chosen. (3%)
4. (Q.23) Elements/factors helping students most in understanding situations related to patients' emotions and behaviour.

(i) \( w = 1.0 \)

(ii) Ranking:

1 = a) student's own intuition and personal experience outside the hospital or school. (60%)

2 = d) a combination of items (a) to (c) of the question. (22%)

(The large majority thought it was a combination of (a) their own intuition and personal experience outside the hospital or school, together with (c) the manner in which qualified people on the ward tackle the situation.)

3 = c) the manner in which qualified people on the ward tackle the situation. (8%)

(The large majority of those who ticked this item said it was the Sister or nursing staff.)

4 = b) specific subjects taught during study blocks (the commonest subjects: e.g. psychiatric experience and psychology lectures). (6%)

5 = e) 'Other' factors were mentioned. (2%)

5. (Q.24) Elements/factors which help students most in dealing with situations related to patients' emotions and behaviour.

(i) \( w = 0.9 \)

(ii) Ranking:

1 = a) student's own intuition and personal experience outside the hospital or school. (39%)

2 = d) a combination of items (a) to (c) of the question. (27%)

(The large majority thought it was a combination of (a) their own intuition and personal experience and (c) the manner in which qualified people on the ward tackle the situation.)

3 = c) the manner in which qualified people on the ward tackle the situation. (25%)

(The large majority of those who ticked this item said it was the Sister or nursing staff.)

4 = b) specific subject taught during study blocks. (5%)

(Again the commonest subjects being psychiatric experience and psychology lectures.)

5 = e) 'Other' factors were mentioned. (2%)
VI  Psychiatric Secondment

Psychiatric Secondment does not usually start before the 2nd year of training, so only those 2nd year students who had completed their secondment and third year students were included.
Registered Mental Nurses doing their General Training were excluded from the group for this part of the questionnaire.

1. (Q.25) The extent to which students felt that Psychiatric Secondment helped them in their General Training.
   i) Moderate extent 35%
   ii) Great extent 28%
   iii) Minimum extent 14%
   iv) Not at all 6%
Comments on this question in general did not seem in favour of an 'actual' gain.

2. (Q.26) The extent to which students felt that Psychiatric Secondment helped them understand themselves.
   i) Moderate extent 25%
   ii) Minimum extent 24%
   iii) Not at all 23%
   iv) Great extent 13%
Comments on this question did not seem to be in favour of the 'good effect' of Secondment on students.

C  THE RESULTS OF THE INTERVIEWS
I  Educational Objectives

1. (Q.1) The aims of classroom teaching as expressed by the Tutors.
   * 54% Mainly the aims are dealing with background theoretical knowledge and the correct methods of procedures and their principles.
Other aims mentioned were:
   12% Integrating theory to practice.
   10% Stimulating students to go on with knowledge.
   9% Teaching students about their role.
   - Teaching the student the concept of Nursing.
   - Developing her attitudes.
   - Showing the student that teaching is necessary.
   - Giving her confidence, letting her be safe and enjoy her training.
   (*The percentages above refer to the stated aims and not to the number of Tutors,)

The majority of Tutors (79%) expressed their aims as short term goals, laying
emphasis on theory. The remaining Tutors (21%) expressed their aims as long term goals, again laying emphasis on theory.

2. The Tutors ranked in order of importance the four educational objectives as inferred from the GNC Syllabus. (See page 5, III.) The ranking by tutors was for:

(i) themselves,
(ii) as they thought the GNC would rank them,
(iii) as they thought the students would rank them, and
(iv) as they thought the qualified staff of wards would rank them.

The four objectives were:
A To prepare the student for her final examination;
B To develop the student's personality as a nurse;
C To increase the student's knowledge about nursing;
D To prepare the student to deal with any practical problem which may arise on the wards.

<table>
<thead>
<tr>
<th>Ranking for:</th>
<th>Objectives</th>
<th>w</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Themselves</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>GNC</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Students</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

II The preparation of the student in the classroom to deal with an emergency situation on the hospital wards.

(Q.3) 73% of tutors felt it was part of their job to do so. 21% of tutors felt it was probably part of their job, but had their doubts. 5% of tutors did not think it was part of their job to do so.

The way to go about preparing the student in the classroom for hospital emergency

is:
48% through increasing the student's awareness that emergencies occur and the discussion of related issues, e.g. religious, policies, etc.
32% through teaching procedures, e.g. First Aid.
20% through leaving the responsibility to the hospital staff to carry it out.
The relationship of classroom teaching to practical hospital experience

1. (Q.4.) Regarding students' experience on hospital wards:

68% of tutors did not think that classroom teaching was related to students' experience on hospital wards, or that it was related only to a limited extent.

27% of tutors thought that it was related mainly, on the whole, but not specifically.

5% of tutors said that it does not apply to them.

The reasons given in this question for unsatisfactory relatedness are:

33% of tutors blamed the school for the lack of relation in terms of educational system, syllabus or tutors (including themselves as well).

23% of tutors blamed the hospital administration or the relationship problem with hospital.

23% blamed the lack of liaison between the school and the hospital.

20% blamed the ability, personality or attitude of students.

2. (Q.5.) Regarding the training of students:

The tutors were asked whether they would consider that for effective training of the student classroom teaching and practical hospital experience should be separate entities.

79% thought that they should be together and related.

14% of tutors gave 'other' answers, e.g. continuity between the two (classroom and hospital) or should be, on alternate periods separate followed by together, etc., or 'don't know'.

5% thought that they are separate now.

3% thought it would be good if they were separate.

The majority of tutors thought that a director of education was an important element in the effectiveness of the training programme of student nurses.

3. (Q.6) The sequence of relationship between classroom teaching and practical hospital experience. The question of whose responsibility it is to relate classroom teaching to practical hospital experience.

On the whole the tutors wanted the students to relate what they get in classroom to what they practice or vice versa. There is no clear-cut favouring for relating first from the one and then to the other, but the general feeling is that it is the student's responsibility; students need help, which is mostly seen to be due from the hospital staff.
4. The effect of sequence of experience to teaching, and tutors' preference.

66% Previous hospital experience of student helps her to understand the related topic taught. (6% thought that this helped 'only sometime'.)

11% Previous hospital experience of student was not favoured when relating to the subject taught.

19% of tutors said that it was not applicable to them for various reasons.

Tutors' preference of sequence:
46% would like theory to come first.
40% would like to have alternatively, sometimes the theory taught first followed by the practice, and sometimes the practice first followed by the theory.
7% would like the practice first.
7% would like different 'other' things, e.g. if enough Clinical Instructors were available as well as the time then they would like practice first.

IV The GNC Syllabus
(Q.8)

1. Is it possible to teach the whole of the syllabus in the time available?

The general feeling was that either it was not possible or that there is no choice but one had to do it - roughly this constituted 66% of the tutors, while 24% said yes, it was possible. For 11% of tutors the question was not applicable.

2. Is the syllabus too academic, about right or not sufficiently academic?

42% of tutors thought it was about right for different reasons, e.g. because of present qualification entrance requirements or because of a mixture of requirements relating to the standards set down for entrance.

28% of tutors could not really decide about its academic standard for different reasons, e.g. 'it is vague', 'hospital biased', or 'you can do what you like with it'.

20% of tutors said it depends upon how one interprets the syllabus.

3% of tutors said that it depends on the students qualification.

5% of tutors thought it too academic.

1% of tutors thought the syllabus unrealistic.
V Areas of difficulty for the students
(Q.8)
1. Discrepancy between procedure techniques taught at school and those used on the ward.
   97% of tutors recognised this as a problem.
   3% of tutors did not regard this as a problem.

2. Students inability to understand patient's behaviour.
   42% of tutors recognise this as a topic of difficulty saying that students bring this up eventually without realising that it is to do with emotions and behaviour.
   33% of tutors said that they did not meet this problem.
   25% of tutors said other things, although the majority considered that it was not applicable in their case.

3. Personal problems of the patient mentioned to the tutors by the students.
   60% of tutors said that it would not be mentioned to them as these problems are usually taken to the sister on the ward.
   23% of tutors said this was not applicable to them.
   19% of tutors said that the students do mention patients' personal problems.
   As for the student's personal problems, this does seem to be the tutor's domain as 78% of the tutors said that students come to them with personal problems. The remaining 22% said that it was not applicable in their case for a variety of reasons.

VI Expectations of tutors in relation to the Psychiatric Secondement of students
(Q.10)
   a) 53% of expectations are in the form of gain for use in the general hospital (psychological aspect of patient care)
   b) 14% of expectations are a combination of expectations, all of which include those set out in (a).
   c) 11% of expectations are gains for psychiatric hospital experience for its own sake.
   d) 8% said that the question was not applicable to them.
   e) 8% of expectations were rather broad.
   f) 7% of expectations are for the student's own sake -- e.g. to improve self-understanding and colleagues understanding.
VII Teaching
(Q.11)

1. Books

48% of tutors prefer to use British books, especially medical ones.
16% would prefer to use American books, especially nursing ones.
20% of tutors would use both American and British books, according to their needs.
16% of tutors said that the question did not apply to them.

60% of tutors would give references to students.
12% would not give references.
29% said that the question was either not applicable or that it depends on the situation.

(Q.12)

2. Discussions

The majority of tutors found that the acceptability of the tutor/student discussions varied from one group to another and depended on the educational ability of the students and also on the time available as even though tutors would prefer discussion they were pushed for time and had to lecture instead.

As regards the students bringing in the patient as an 'individual' or as 'signs and symptoms' during discussions, the tutors thought that on the whole the students during training are worrying about signs and symptoms, and that the stage of training would also decide how they would introduce the patient. It was felt that students, usually when in school, think about signs and symptoms because they are thinking about examinations, but that they do not lose sight of the 'individual' when nursing on the wards.

...
Dear Colleague

The following is a questionnaire i.e. a procedure used when a person is carrying out a research project for the purpose of finding out the realities of a situation known to the people involved, in this case you.

Your opinion and help, in this matter, would be greatly appreciated.

As you will have read in the Introduction to your Guide to the Syllabus of Subjects for General Nurses, published by the General Nursing Council for Scotland, there is great concern and interest in integrating theory and practice. One of the main purposes of my research is to study the present relationship between theory and practice. I need your help in filling in the attached questionnaire.

The questionnaire can be of value only if you answer the questions honestly, the way you see things. I am only interested in the actual situation and not in what ought to be. Your answers will be dealt with confidentially, and you are not required to put your name on the questionnaire.

I am asking you to be good enough to fill in the attached questionnaire. Most of the answers require one tick on the dotted line against the item, which you personally think most appropriate. Where a different way of answering is required, this will be indicated.

Thank you for your cooperation. I wish you all success in your future career.

Yours sincerely

Hend Abdel-Al
In the following questions please put one tick, on the dotted line, against the appropriate answer:

1. When did you join the present nursing programme?
   a. January
   b. April
   c. June
   d. September
   e. November
   f. Other (please specify)

2. What year of study are you now in?
   a. First
   b. Second
   c. Third

3. How many study blocks (including the present one) have you had?
   a. 1
   b. 4
   c. 7
   d. 2
   e. 5
   f. 3
   g. 6

4. Please tick the specialities below in which you have had experience:
   a. General medicine
   b. General surgery
   c. Orthopaedics
   d. Medical or surgical speciality (e.g. cardiology, neurosurgery, E.N.T., etc. . . .)
   e. Theatre
   f. Casualties
   g. Public health nursing
   h. Psychiatric nursing
   i. Gynecology and obstetrics
   j. Sick children
   k. Geriatrics
   l. Infectious diseases
   m. Other (please specify)

5. Have you had any previous nursing experience in hospitals before joining the present programme?
   a. Yes
   b. No

If No, please skip question 6
If Yes, please complete question 6 a or b.
6. If you had previous nursing experience:
   a. What qualification did you get before joining the present programme?
      - State enrolled nurse
      - Registered sick children nurse
      - Registered fever nurse
      - State certified midwife
      - Registered mental nurse
      - Other qualification (please specify)

   b. If you have not obtained a qualification, please specify below your previous nursing experience:

7. What is your present age?
   - 17½ - 20
   - 21 - 23
   - 24 and over

Please note that for each of the questions that follow there is no single answer which is 'right' or 'wrong' for everyone completing the questionnaire. I am interested only in your honest opinion about what actually happens and not what ought to happen. Please put a tick against the answer which describes best your opinion about what actually happens.

Before attempting to answer a question, you would be well advised to read the whole of it.

8. When faced with a hospital situation requiring quick action, which helps you most?
   a. Your previous hospital experience in the same or similar circumstances.
   b. Your classroom teaching in relation to the situation.
   c. Your own judgement of the situation.
   d. If none of the above, please specify what:

9. To what extent do you feel that the Anatomy and Physiology you are taught in the classroom needs to be more closely related to how you apply it in the practical hospital situation?
   a. It needs to be much more closely related than at present.
   b. It needs to be more closely related than at present.
   c. It needs a little change to become more closely related than at present.
   d. It does not need any change from the way it is taught at present.
10. To what extent do you feel that the 'nursing care' you are taught in the classroom, needs to be more closely related to how you apply it in the practical hospital situation?
   a. It needs to be much more closely related than at present. ....
   b. It needs to be more closely related than at present. ....
   c. It needs a little change to become more closely related than at present. ....
   d. It does not need any change from the way it is taught at present. ....

In what ways? ................................................................................
................................................................................
................................................................................

11. To what extent do you feel that your practical hospital experience helps you understand what is taught in the classroom?
   a. It helps me to a great extent. ....
   b. It helps me to a moderate extent. ....
   c. It helps me to a minimum extent. ....
   d. It does not help me at all. ....

12. How often does your tutor in the classroom use your personal experience in the hospital to illustrate her/his teaching?
   a. It is often used. ....
   b. It is sometimes used. ....
   c. It is seldom used. ....
   d. It is never used. ....

13. How often have you been faced with a discrepancy between what is taught in the classroom and what is practiced on the wards?
   a. Often. ....
   b. Sometimes. ....
   c. Seldom. ....
   d. Never. ....
14. Please rank the following statements a,b,c,d in their order of importance to you as a student nurse, by putting, against each statement, either 1 (most important), or 2 (not quite so important), or 3 (less important) or 4 (least important):

Classroom teaching aims:
a. to prepare you for your final examination. ....
b. to develop your personality as a nurse. ....
c. to increase your knowledge about nursing. ....
d. to prepare you to deal with any practical problem which may arise in the wards. ....

15. Next, please rank the following statements a,b,c,d in what you consider their order of importance to be to your tutor, by putting, against each statement, either 1, or 2, or 3, or 4:

Classroom teaching aims:
a. to prepare you for your final examination. ....
b. to develop your personality as a nurse. ....
c. to increase your knowledge about nursing. ....
d. to prepare you to deal with any practical problem which may arise in the wards. ....

16. Now, please rank the following statements a,b,c,d in what you consider their order of importance to be to the qualified nursing staff on the hospital wards where you have worked, by putting, against each statement, either 1, or 2, or 3, or 4:

Classroom teaching aims:
a. to prepare you for your final examination. ....
b. to develop your personality as a nurse. ....
c. to increase your knowledge about nursing. ....
d. to prepare you to deal with any practical problem which may arise in the wards. ....

Please put one tick, on the dotted line, against the answer that best describes your honest opinion, of what actually happens in the following questions.

17. Which of the following have you found most difficult to cope with in your present programme?
   a. Your classroom material. ....
   b. Your practical hospital training. ....
   c. Both a and b in some respect. ....
   d. If none of the above, please specify the most difficult thing to cope with: ........................................

.................................................................
18. In this question, please tick those statements a to h, which you feel describe your difficulties with classroom work. You may tick as many as you wish.

a. too much material to study in the time available.

b. too much 'ideal' knowledge that you feel has no practical application in the hospital situation.

c. not enough 'teaching' about different subjects and their use in practice.

d. 'nursing care' as taught in the school is different from its practice on the hospital wards.

e. being treated as though you are 'expected to know'.

f. having to decide for yourself how to apply knowledge gained in the classroom to the practical hospital situation.

g. not being treated as a responsible person.

h. I do not have difficulties with my classroom work.

If you have other difficulties, not mentioned above, please specify them below:

---------------------------------------------

19. In this question, please tick those statements a to h, which you feel describe your difficulties with practical hospital experience. You may tick as many as you wish.

a. difficulty in getting along with the qualified nursing staff on the ward.

b. difficulty of applying principles taught in the classroom because some of the qualified nursing staff disagree with them.

c. fear of being 'caught' by the responsible nursing staff talking to patients, you feel need to be talked to.

d. not enough instruction as to how to carry out different nursing techniques on the different wards.

e. lack of orientation to ward management and policies, procedures and personnel.

f. being expected not to argue with the qualified nursing staff, or not to express your own opinion.

g. not being asked your point of view in discussion about ward organization, or patient care requirements, although you feel that you are close to the patient and know a lot about him/her.

h. I do not have difficulties with pract. hosp. experience.

If you have other difficulties not mentioned above, please specify them below:

---------------------------------------------

---
20. To what extent, recently, are you having some difficulty in understanding
your patients' emotional needs and general behavior?
  a. To a great extent.
  b. To a moderate extent.
  c. To a slight extent.
  d. No difficulty at all.

21. How often have you been faced with a situation in which you felt that the
patient was upset though he/she did not show it?
  a. Often.
  b. Sometimes.
  c. Seldom.
  d. Never.

22. If faced with a situation in which you felt the patient was showing it, which of
the following best describes what you would do?
  a. Avoid asking the patient about his troubles as I know that
nothing would be done.
  b. I would talk to the patient and try to find out about his
troubles and do what I could to soothe him/her.
  c. After finding out the cause of the patient upset, I would consult
another person I believe could best help me in dealing with
this situation (please specify the position of the person).
  d. Before talking to the patient, whom I feel is upset, I would consult
another person on the ward (please specify position of person).
  e. If none of the above, please say what you would do.

23. When faced with a situation that has to do with the patient's emotions
or behavior, what helps you most in understanding the situation?
  a. Your own intuition and personal experience outside the
hospital or school.
  b. Specific subject taught during your study blocks. Please
specify which:
  c. The manner in which qualified people on the ward tackle the
situation. Please specify position of person:
  d. A mixture of a to c above. If so please specify which:
  e. Other factors. Please specify what:

24. When faced with a situation that has to do with the patient's emotions
or behavior, what helps you most in dealing with the situation?
  a. Your own intuition and personal experience outside the
hospital or school.
  b. Specific subject taught during your study blocks. Please
specify which:
  c. The manner in which qualified people on the ward tackle the
situation. Please specify position of person:
  d. A mixture of a to c above. If so please specify which:
  e. Other factors. Please specify what:
Questions 25 and 26 below should be answered only by students who already have had Psychiatric Nursing Secondment.

25. To what extent has your psychiatric nursing secondment helped you concretely in your general hospital training?
   a. It helped me to a great extent.
   b. It helped me to a moderate extent.
   c. It helped me to a slight extent.
   d. It did not help me at all.

   In what ways?

26. To what extent has your psychiatric nursing secondment helped you concretely in understanding yourself?
   a. It helped me to a great extent.
   b. It helped me to a moderate extent.
   c. It helped me to a slight extent.
   d. It did not help me at all.

   In what ways?
MEETING WITH THE TUTOR

1. What is in your opinion, the aim of classroom teaching?
2. Ranking of the four educational objectives, as inferred from the GNC syllabus.
3. Do you see it as part of your job to prepare the student in the classroom to deal with emergency situations on the hospital wards?
4. Do you think that classroom teaching, on the whole, is closely related to the student's experience on the hospital wards?
5. Do you consider that for effective training of the student, classroom teaching and practical hospital experience should be separate entities? (if school is separated from the Matron's authority, what is its effect on student's education?)
6. In the GNC syllabus for General Nurses there is a sentence that says: "The student nurse must learn to observe and appreciate what is seen and taught in the wards and relate it to the theoretical instruction she receives." What is your opinion about this sentence? What about if it was the other way round, i.e. that it is up to the student to relate classroom knowledge to practical hospital experience? In what ways?
7. If a student already has had experience of say, nursing a cardiac patient, do you feel it is easier to teach her/him the signs and symptoms and nursing care of such patients? As a tutor do you prefer: that the student should be taught beforehand in the classroom about situations she will encounter in the hospital; or that she should first encounter these situations on the hospital wards, then be taught about them in the classroom? Why do you prefer this?
8. Is it possible to teach the whole of the GNC syllabus in the time available? Do you think the syllabus is too academic, about right, or not sufficiently academic?
9. Do students come to you with problems such as:
   - Discrepancies between procedures techniques you have taught them and those used on the wards?
   - Inability to understand the patient's behaviour?
   - A patient's personal problem he/she found difficulty to talk about to anyone on the ward?
10. What do you expect the student to gain from her psychiatric nursing secondement?
11. Which do you find more helpful, British or American books? Do you give references to students?
12. Do students welcome Discussion when it is possible to have one?
   - Do students refer to patient as an individual or do they bring the patient for illustration of Signs and Symptoms and how to manage those?

Thank you very much indeed,

Hend Abdel-Al
APPENDIX II.

1. Syllabus for General Nursing and Record of practical instruction and experience.


Syllabus for General Nurses

INTRODUCTION

The training of the modern nurse is long and complex and the syllabus sets out in general terms the subjects which have to be studied.

The initial stages are concerned with the basic subjects although even from the beginning the student nurse will be introduced to practical work. A knowledge of how the human body is constructed and how it works is necessary if we are to understand what can go wrong, since it is on this knowledge that we are able to understand how we can best treat and prevent disease. This is why certain subjects which may be difficult for the young student to appreciate as of immediate interest or of obvious relevance, have first to be mastered.

Our knowledge to-day of disease is vast and in the period of training it is impossible to be complete and comprehensive. The syllabus is to be regarded as a guide to the main principles and to those matters of greatest importance. Subjects must be studied both from text books and by lectures, but of equal importance is what is learned by working in the hospital wards and theatres. The student nurse must learn to observe and appreciate what is seen and taught in the wards and relate it to the theoretical instruction she receives. Much she sees may be difficult to appreciate and understand, but under these circumstances she should ask, and by so doing, learn.

In the syllabus only the skeleton of the programme of study is set forth, and it would be wrong to take this as either complete or final. Nonetheless it indicates the general scope and character of what should be studied, a minimum rather than the maximum.

Normally this course of study extends over a period of three years, at the end of which comes the professional examination—the portal for registration.

The General Nursing Council, charged with the responsibility for the adequate training of all nurses requires that not only should a full course of formal training have been undertaken but that there should have been adequate practical experience, and accordingly demands that a full record of all ward and theatre work for each individual student nurse must be kept. The personal record is found at the end of the syllabus.

NURSING

PRINCIPLES AND PRACTICE OF NURSING

The Hospital: Its aims and functions.

Hospital etiquette.

The Nurse: Essential qualities and general duties.

National Health Service—the place of the nurse in this structure.

Nursing: Historical survey; Nurse/Patient relationship.

Ethics of Nursing; the International Code of Nursing Ethics.

The Patient: The patient as an individual.

The confidential nature of the work.

Reception and observation of the patients and orientation to the unit.

Approach and attitude to patient's relatives and other visitors.

Some of the legal aspects as they affect patients and nursing staff.
The Hospital as a Therapeutic Community

Ward Management
Care and use of hospital equipment.
Economy in use of hospital supplies and property.
Ward reports.
Ordering stores.
Inventories.
Responsibility to the Junior Nurse.
Responsibilities of the Staff Nurse.
Fire; death of the patient; accidents involving patients, visitors and staff.
Hospital regulations in such emergencies.

General Care of the Patient
(a) Basic nursing care of the patient—
   Bed-making.
   Admission of the patient.
   Positions used in nursing care, including special positions.
   Bathing.
   Observations.
   Oral hygiene.
   Prevention of pressure sores.
   Care of the bowel and bladder.
   Feeding.
   Temperature, pulse, respirations and blood pressure.

(b) Special care of the patient—
   The safety of the patient in hospital.
   Pre-operative preparation.
   Post-operative care.
   The care of the dying.
   Last offices.

(c) Nursing procedures—
   Administration of medicines and drugs.
   Injections.
   Inhalations.
   Oxygen administration.
   Enemata.
   Passage of a flatus tube.
   Application of kaolin and starch pottices.
   The conduct of surgical dressings.
   Urine testing.

(d) Preparation for and method of executing undernoted procedures—
   Artificial feeding.
   Gastric lavage and aspiration.
   Catheterisation; syringing, irrigation and drainage of urinary bladder.

Vaginal douching and perineal care, for female nurses only.
Insertion of medicated vaginal pessaries.
Treatment of mouth and throat:
   Irrigation, gargling, painting.
Treatment of the nose:
   Spraying, instillation of drops, application of ointment.
Treatment of the ear:
   Swabbing, syringing, insufflation, instillation of drops, application of dressings.
Treatment of the eye:
   Bathing, irrigation, instillation of drops, application of ointments and dressings.
Medicated baths in common use.
Methods of reducing temperature.
Pre- and post-operative nursing care.

Specimens for Examination
Nurses' duties in relation to collection of:
   Body fluids, sputum, urine, faeces, smears and cultures.
Adequate rest and sleep.
Ambulation.
Discharge.

Preparation of Apparatus. Preparation and Care of Patient
In examination of:
   Ear, nose, mouth, throat, eye, respiratory tract, alimentary tract, genital tract, urinary tract.
   Neurological examination.

Treatments:
   Exploring and aspirating pleural cavity.
   Removal of fluid from abdominal cavity and subcutaneous tissues.
   Lumbar puncture.
   Marrow biopsy.
   Venepuncture.
   Venesection.
   Intravenous injections.
   Infusions of fluid by various routes.
   Insertion and removal of supporting pessaries (for female nurses only).
   Adhesive plasters, skin traction.
   Application of plaster of Paris.
   Application of splints.
Diagnostic Tests:
Renal function tests, gastric analysis, estimations of basal metabolic rate, X-ray examinations, blood tests.

OPERATING THEATRE

Situation and construction of theatre unit.
Preparation and use of theatre.
Preparation, sterilisation, use and care of instruments, apparatus, lotions and equipment.
Instruments in common use.

Position of the patient for various operations.
Observation and care of the patient during anaesthesia and operation.
The use of recovery room.

THE NURSE AND THE LAW

ELEMENTARY PSYCHOLOGY

The Development of Personality
(a) Normal development: childhood, adolescence, adulthood, old age.
(b) Psychological problems associated with stages of development.
(c) Individual's reaction to illness.

INTRODUCTION TO PERSONAL AND COMMUNITY HEALTH

The Physical Health of the Individual from Infancy to Old Age
Personal Hygiene
Importance of: nutrition, cleanliness, clothing and footwear, fresh air and sunshine, work, exercise and recreation, rest and sleep, body mechanism and posture, habit formation, prevention of fatigue.
The living cell as the unit of life.
Characteristics of living organisms.
Man as a complex organism—with differing structure of cells in relation to function. Simple outline of tissues of body.

Brief explanation of man’s requirements for successful life
E.g.:
Protection.
Movement.
Nutrition, fluids and oxygen and their transference to the tissues.
Control of activity and awareness of environment.
Elimination.
Reproduction.

How these requirements are met anatomically and physiologically
(1) General structure of the body—
Anatomical parts of body as a whole.
Body cavities.
Position and relation of main organs.
Skin as protecting organ.

(2) How the body moves—
Skeleton, joints, muscles and their relationship to movement (no detailed anatomy to be given).

(3) Transport—fluids and oxygen
The heart; circulation, composition and functions of blood and lymph (no detailed anatomy of heart).

(4) Food
(Basic requirements given in section on Nutrition.)
Simple outline of digestive system; digestion; absorption.

(5) Respiration
How and why it is carried out.
Simple outline of air passages; lungs; muscles of respiration and action.

(6) Elimination
General outline of urinary system; functions of kidneys; micturition; composition of urine; colon and elimination.
Lungs and elimination.
Skin and effect of its function on elimination.
Fluid balance.

(7) Control of activity and awareness of environment
General arrangements and outline of function of nervous system and special senses.
Simple description of hormonal activity.

General Principles of First Aid.—Basic essentials of first-aid treatment.

Haemorrhage.—Types and methods of arrest.
Wounds and Contusions.
Cut Throat.
Shock.—Signs, symptoms, treatment.
Burns and Scalds.—Causes and treatment. Special burns—eye, mouth, throat.
Fractures, Dislocations, Sprains.—Types, signs, symptoms and treatment.
Asphyxia.—Causes, signs and symptoms, treatment; artificial respiration.
Loss of Consciousness.—Causes and general principles of treatment; fainting; fits and convulsion; head injuries; heat stroke; diabetes.


Bites and Insect Stings.—Types and treatment.
Frost Bite.—Appearance and treatment.

Foreign Bodies.—Treatment.

Equipment used in First-Aid Treatment.—Standard and improvised; application; including roller and triangular bandaging.

Methods of lifting and carrying the injured.

Reception of Accident Cases.

THE NURSING OF THE PATIENT SUFFERING FROM MEDICAL, SURGICAL OR GYNAECOLOGICAL DISORDERS

In the study of all diseases and disorders the under-noted should be included where relevant:

Symptoms and signs.
Aids to diagnosis.
Treatment and nursing care.
Observations and records to be made by the nurse.

Regulation of body temperature.

Reproduction
Outline of organs and function.
Normal course of the disease—signs of the onset of complications.
Rehabilitation.
Planned convalescence.

MEDICAL AND SURGICAL NURSING

Inflammation
Causes—micro-organisms.
Character of reaction—local and general.
Spread of infection—toxaemia, septicaemia, pyaemia.

Wounds
Character—clean and infected; healing; tetanus; burns and scalds.

Haemorrhage
General Effects of Injury
Shock: causation; fluid balance; metabolic changes.

Tumours
Nature and course—innocent and malignant.

Treatment: operative; radiotherapy; chemotherapy.

Operative Treatment
Introduction; purpose; pre-operative care; general and local; anaesthetics—effects; pre-anaesthetic medication; post-operative care and complications.

Follow up and after care.
Resettlement in suitable work.
Measures used in prevention of disease.

SURGICAL NURSING

Systemic Diseases
Under each system are noted some of the common diseases and disorders which should receive special study: (a) medical, (b) surgical.

Digestive Tract and Abdomen
General:
Abnormalities of appetite, swallowing, digestion and absorption.
Vomiting, diarrhoea and constipation.
Abnormalities of faeces.

Specific Conditions:
(a) Peptic ulcer.
Inflammatory diseases of the alimentary tract.
Cholecystitis.
Hepatitis and jaundice.
Pancreatitis.
(b) Appendicitis and peritonitis.
Peptic ulcer.
Intestinal obstruction.

Tumours.
Congenital abnormalities.
Gall-stones.
Hernia.

Respiratory System and Thorax
General:
Abnormalities of respiration.
Types of cough and sputum.
Respiratory function tests; respiratory failure; atelectasis.

Specific Conditions:
(a) Acute and chronic bronchitis.
Pneumonia.
Pulmonary oedema.
Bronchiectasis.
Industrial lung diseases.
Asthma.
Tuberculosis.
Tumours.
(b) Tumours of lungs, bronchi and pleura.
Tuberculosis—collapse and resection surgery.

Cardio-vascular System
General:
Abnormalities of pulse.
General symptoms of heart disease.
Abnormalities of blood pressure.

Genito-urinary System
General:
Abnormalities of urine and micturition.
Renal failure.
Haematuria.
Anuria.

Retention of urine.

Specific Conditions:
(a) Nephritis, acute and chronic.
Cystitis.
Uraemia.
Tuberculosis.
(b) Calculi.
Prostatic enlargement.
Tumours.

Breast
(a) Mastitis. (b) Tumours.

Bones and Joints
General:
Immobilisation.
Physiotherapy.
Specific Conditions:
(a) Metabolic disorders.
(b) Fractures and dislocations.
Deformities.
Infections.
Tumours.

Brain, Spinal Cord and Nervous System
General:
Abnormalities of:
Power of Movement.
Sensation.
Consciousness.
Management of comatose and paralysed patients.

Specific Conditions:
(a) Neuritis.
Parkinsonism.
Disseminated sclerosis.
Meningitis.
Cerebro-vascular disease.
Epilepsy.
(b) Injuries to brain and nerves.
Spinal fractures—paraplegia.
Tumours.
Concussion.
Compression.

Ear, Nose and Throat
Infections; injuries; tumours.

Eyes
Infections; injuries; tumours.
Use of corrective lenses.

Endocrine Glands
Abnormalities resulting from faulty endocrine secretion.

Deficiency Diseases
Malnutrition and starvation.
Diseases due to dietary deficiencies.

Rheumatic Diseases
Sub-acute and chronic rheumatic and rheumatoid conditions.

GYNAECOLOGICAL NURSING
Anatomy and physiology of the female reproductive organs.
The sex hormones—menstruation.
Puberty—fertility and infertility—disorders of sexual function—menopause.
Disorders of menstruation—irregular bleeding—
dysmenorrhoea, primary and secondary—amenorrhoea, primary and secondary.

Benign and malignant tumours of the uterus—
prognosis and treatment.
Infections of the reproductive tract—vulvitis, vaginitis, cervicitis, endometritis, acute and chronic salpingitis, acute and chronic pyosalpinx.
Displacements of the uterus—supports of the uterus—
retroversion—inversion—prolapse.

CONTROL OF INFECTION
Communicable Disease and its control.

PAEDIATRIC NURSING
caring for sick children with special reference to—
Drugs—action and dosage.
Anaesthesia—nursing care of child before, during and after anaesthetic.
Administration of parenteral fluids and fluid balance.

PSYCHIATRIC NURSING
Psychiatric nursing.
Psychiatric social work.
PHARMACOLOGY

The general principles of Pharmacology including absorption, excretion, cumulative action, idiosyncrasy, Action, dosage and toxic effects of selected drugs in common use.

Dangerous Drugs Act and Pharmacy and Poisons Act—regulations governing the control, storage and distribution of dangerous drugs and poisons.

THE HEALTH SERVICES

The Scope of the National Health Service

(a) National Health Service (Scotland) Act, 1947.

General Survey: Three-fold structure of the Health Service—
(1) Hospital and specialist services.
(2) Local Health Authority Services.
(3) General medical and supplementary services.

(b) Local Health Authority Services

Introduction to social and preventive medicine.

(c) The Place of the Nurse in the Health Programme

Community Health Services

The Nature and Objects of the Public Health and Medical Services they administer

(a) Local Authority Services (Relevant Public Health Acts).

(b) Local Health Authority Services (National Health Service (Scotland) Act, 1947).

The Influence on Physical and Mental Health of environment, including housing, occupation, economic circumstances, nutrition and personal hygiene.

Statistics.—The nature and source of information bearing on the health of the people.

The Causal Agents of Infection.—Their sources and control.

Social Security and the Agencies for the relief of poverty and the promotion of social welfare.

The Principles of Health Education.

International Health Organisation.

Importance of Co-operation of all statutory and voluntary services.

13

REST

General and local rest.

Use in treatment of medical and surgical conditions.

Value of mental rest.

Dangers of prolonged local or general immobilisation.

REHABILITATION AND RESETTLEMENT

Rehabilitation—definitions and stages.

Physiotherapy in treatment and recovery.

Occupational therapy—Diversional, remedial, training.

Almoner—social and economic assistance during and after illness, re-employment, advice and help.

Re-employment—

Disabled Persons Register

Ministry of Labour powers

Disablement Resettlement Officer

Re-training—Special workshops and home industries for severely disabled.
Record of Practical Instruction and Experience

GENERAL INSTRUCTIONS

All items included in this Record of Practical Instruction and Experience must be covered before entry to the Final Examination.

Space is left at the back of the Record for any special experience the student nurse may have had in addition to the items listed.

The Sister, Charge Nurse, or Clinical Instructor who teaches the nursing points in the left-hand column is kindly requested to insert his or her signature in first available column.

It is the responsibility of the student nurse to ensure that this Record is kept accurately. It must be produced at the Final Examination by the student nurse.

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<td>Commenced training</td>
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CERTIFICATE OF THEORETICAL INSTRUCTION

PERIODS SPENT IN

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Theoretical Instruction has been completed in all subjects specified in the Syllabus of Training.

Signature

Nurse Tutor/Registered Nurse Tutor
### WARD MANAGEMENT

- General cleanliness
- Ventilation
- Care and economy in the use of
  - Food
  - Gas and electricity
  - Water
- Cleaning materials
- Drugs
- Lotions
- Dressings
- Linen
- Bedding
- Bed appliances
- Disposal and disinfection of
  - Contaminated linen
  - Contaminated bedding
  - Contaminated dressings

### GENERAL CARE OF THE PATIENT

- Basic nursing care
- General bed-making

### Principles and Practice of Nursing

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<th>General cot-making</th>
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<td>Changing of bed linen</td>
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<td>Special beds</td>
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<th>Use of bed appliances</th>
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<td>Bed elevators</td>
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<td>Electric blankets</td>
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<td>Heat cradles</td>
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<td>Filling and placing of hot-water bottles</td>
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<th>Admission of patients</th>
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<td>Checking and care of clothing and valuables</td>
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<td>Positions used in nursing care</td>
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<td>Lifting and turning of patients</td>
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<td>Bathing</td>
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<td>Observation</td>
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<td>Observation, disinfection and disposal of</td>
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<td>Maintenance of fluid balance charts</td>
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<td>Care of the hair</td>
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<td>Giving of bedpans and urinals</td>
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<td>Serving of meals</td>
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<td>Feeding of helpless patients</td>
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<td>Feeding of infants</td>
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<td>Taking and charting of temperature, pulse and respirations</td>
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<td>Giving and receiving reports</td>
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# Principles and Practice of Nursing

## NURSING PROCEDURES

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<td>Dangerous Drugs Act</td>
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<tr>
<td>Enemata</td>
<td></td>
</tr>
<tr>
<td>Insertion of suppositories</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passage of a flatus tube</td>
<td></td>
</tr>
<tr>
<td>Preparation and Application of</td>
<td></td>
</tr>
<tr>
<td>Kaolin poultice</td>
<td></td>
</tr>
<tr>
<td>Starch poultice</td>
<td></td>
</tr>
<tr>
<td>Cold applications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward dressings</td>
<td></td>
</tr>
<tr>
<td>Preparation of dressing trolley</td>
<td></td>
</tr>
<tr>
<td>Conduct of ward dressings</td>
<td></td>
</tr>
<tr>
<td>Application and retention of dressings</td>
<td></td>
</tr>
<tr>
<td>Urine testing</td>
<td></td>
</tr>
</tbody>
</table>

## NURSING PROCEDURES

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial feeding</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric lavage</td>
<td></td>
</tr>
</tbody>
</table>
## Principles and Practice of Nursing

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Signature of the Ward Sister/Charge Nurse/Clinical Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric aspiration</td>
<td></td>
</tr>
<tr>
<td>Catheterisation</td>
<td></td>
</tr>
<tr>
<td>Bladder irrigation</td>
<td></td>
</tr>
<tr>
<td>Bladder drainage</td>
<td></td>
</tr>
<tr>
<td>Vulval toilet (female nurses only)</td>
<td></td>
</tr>
<tr>
<td>Vaginal douching (female nurses only)</td>
<td></td>
</tr>
<tr>
<td>Perineal care (female nurses only)</td>
<td></td>
</tr>
<tr>
<td>Insertion of medicated pessaries (female nurses only)</td>
<td></td>
</tr>
<tr>
<td>Treatment of the mouth</td>
<td></td>
</tr>
<tr>
<td>Treatment of the throat</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
</tr>
<tr>
<td>Spraying</td>
<td></td>
</tr>
<tr>
<td>Instillation of drops</td>
<td></td>
</tr>
<tr>
<td>Application of dressings</td>
<td></td>
</tr>
<tr>
<td>Treatment of the ear</td>
<td></td>
</tr>
<tr>
<td>Swabbing</td>
<td></td>
</tr>
<tr>
<td>Syringing</td>
<td></td>
</tr>
<tr>
<td>Insufflation</td>
<td></td>
</tr>
<tr>
<td>Instillation of drops</td>
<td></td>
</tr>
<tr>
<td>Application of dressings</td>
<td></td>
</tr>
<tr>
<td>Treatment of the eye</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
</tr>
<tr>
<td>Irrigation</td>
<td></td>
</tr>
<tr>
<td>Instillation of drops</td>
<td></td>
</tr>
<tr>
<td>Application of ointment</td>
<td></td>
</tr>
<tr>
<td>Application of dressings</td>
<td></td>
</tr>
<tr>
<td>Application of adhesive dressings and plasters</td>
<td></td>
</tr>
<tr>
<td>Application of medicated bandages</td>
<td></td>
</tr>
<tr>
<td>Medi cated baths</td>
<td></td>
</tr>
<tr>
<td>Treatments for reduction of body temperature</td>
<td></td>
</tr>
</tbody>
</table>
### Ward dressings
- Removal of stitches and clips
- Removal of packing
- Removal of drains

### Positions used in carrying out nursing procedures
- Recumbent
- Prone
- Semi-prone
- Lateral
- Upright

### Nurse's duties in relation to collection and dispatch of specimens
- Body fluids
- Smears
- Cultures

### Taking and recording the blood pressure
<table>
<thead>
<tr>
<th>Principles and Practice of Nursing</th>
<th>Signature of the Ward Sister/Charge Nurse/Clinical Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary tract</td>
<td></td>
</tr>
<tr>
<td>Nervous system</td>
<td></td>
</tr>
<tr>
<td><strong>Treatments</strong></td>
<td></td>
</tr>
<tr>
<td>Aspiration of the pleural cavity</td>
<td></td>
</tr>
<tr>
<td>Removal of fluid from abdominal</td>
<td></td>
</tr>
<tr>
<td>cavity</td>
<td></td>
</tr>
<tr>
<td>Removal of fluid from subcutaneous tissues</td>
<td></td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td></td>
</tr>
<tr>
<td>Marrow puncture</td>
<td></td>
</tr>
<tr>
<td>Venipuncture</td>
<td></td>
</tr>
<tr>
<td>Venesection</td>
<td></td>
</tr>
<tr>
<td>Intravenous injection</td>
<td></td>
</tr>
<tr>
<td>Blood infusion</td>
<td></td>
</tr>
<tr>
<td>Infusion of fluids</td>
<td></td>
</tr>
<tr>
<td>intravenous</td>
<td></td>
</tr>
<tr>
<td>subcutaneous</td>
<td></td>
</tr>
<tr>
<td>rectal</td>
<td></td>
</tr>
<tr>
<td>Insertion and removal of supporting pessaries (female nurses only)</td>
<td></td>
</tr>
<tr>
<td>Application of</td>
<td></td>
</tr>
<tr>
<td>plaster of Paris</td>
<td></td>
</tr>
<tr>
<td>skin traction</td>
<td></td>
</tr>
<tr>
<td>skeletal traction</td>
<td></td>
</tr>
<tr>
<td>splints</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td></td>
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<tr>
<td>Gastric analysis</td>
<td></td>
</tr>
<tr>
<td>Renal function</td>
<td></td>
</tr>
<tr>
<td>Basal metabolic rate</td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
</tr>
<tr>
<td>Principles and Practice of Nursing</td>
<td>Signature of the Ward Sister/Charge Nurse/Clinical Instructor</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Blood tests</td>
<td></td>
</tr>
<tr>
<td>Diet therapy</td>
<td></td>
</tr>
<tr>
<td>Infant nutrition and feeding</td>
<td></td>
</tr>
<tr>
<td>Nutrition and feeding of young children</td>
<td></td>
</tr>
<tr>
<td>Recording and reporting observations on the patient's condition</td>
<td></td>
</tr>
<tr>
<td>OPERATING THEATRE</td>
<td></td>
</tr>
<tr>
<td>Preparation of theatre</td>
<td></td>
</tr>
<tr>
<td>Sterilisation and care of</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
</tr>
<tr>
<td>Instruments</td>
<td></td>
</tr>
<tr>
<td>Lotions</td>
<td></td>
</tr>
<tr>
<td>Apparatus</td>
<td></td>
</tr>
<tr>
<td>Positions used for operations</td>
<td></td>
</tr>
<tr>
<td>Attendance at operations</td>
<td></td>
</tr>
<tr>
<td>WARD MANAGEMENT</td>
<td></td>
</tr>
<tr>
<td>Writing of reports</td>
<td></td>
</tr>
<tr>
<td>Maintenance of equipment</td>
<td></td>
</tr>
<tr>
<td>Ordering of stores</td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td></td>
</tr>
<tr>
<td>Preparation of schedules</td>
<td></td>
</tr>
<tr>
<td>Off-duty</td>
<td></td>
</tr>
<tr>
<td>Work routine</td>
<td></td>
</tr>
<tr>
<td>SPECIAL WORK</td>
<td></td>
</tr>
</tbody>
</table>
PRACTICAL INSTRUCTION AND EXPERIENCE HAS BEEN GAINED IN THE FOLLOWING WARDS AND DEPARTMENTS

<table>
<thead>
<tr>
<th>WARDS</th>
<th>HOSPITAL</th>
<th>PERIOD (IN WEEKS)</th>
</tr>
</thead>
</table>

Signature

Matron/Principal of Nurse Training
INTRODUCTION

The changing needs of the community and country, and the shortening of distance between nations, has demanded a new approach to the training of the student nurse.

The General Nursing Council for Scotland, after much careful thought and co-operative effort of its Education Committee, and other interested Medical and Nursing Bodies, have prepared a new syllabus in the belief that the student nurse will be better equipped to meet changing needs, both national and international.

The Council has sought to make the syllabus practical and flexible, suggesting that theory and practice should be thoroughly integrated, and the learning process made realistic through contact with the patient; therefore, the Syllabus and Practical Record have been compiled together. The entire programme of nurse training as outlined should present to the student nurse a challenge and inspiration to acquire knowledge, practical ability, and development of personality as she proceeds in training.

ELEMENTARY PSYCHOLOGY

At the beginning of training the student nurse should be introduced to the important subject of human development and behaviour within the family and society. The main object in teaching this subject is to interest her in her own mental development and in her own behaviour. After completing a brief survey of the psychological complications of human development and behaviour, the student should be taught the forces that motivate human behaviour and so cause human beings to act in specific ways. Knowledge of these underlying motives will not only aid her in appreciating the true meaning and significance of her own actions, but also increase her understanding of the conduct of others both in health and in ill-health.

PERSONAL AND COMMUNITY HEALTH

It is intended that this section should serve to introduce the nurse to the field of personal and communal health in a general manner so that an overall understanding may be achieved. It is hoped that in this way, interest may be aroused in preventive medicine, and the recognition of unnecessary detail avoided.

Every effort should be made to give practical experience of the various aspects of the subject by arranging suitable visits to implement the classroom teaching.

FIRST AID

This subject should be dealt with in the same manner as that for a first-aid class to members of the lay public.

The practical aspect should be fully covered by giving students the opportunity to participate in practical demonstrations.

PRINCIPLES AND PRACTICE OF NURSING

This first week of the student nurse's training should be regarded as a period of orientation. During this week formal teaching should be minimal. Time should be taken at this stage to help the student to settle in her new surroundings and to prepare for the new situations which she may soon be faced. The history of the hospital should be outlined and also its geography. A tour of the hospital should be made during this first week.

Standards of ethical conduct should be introduced early and form a student-nurse relationship. Inevitably this teaching will continue throughout the period of training.

A historical survey of nursing should be presented to enable the student to appreciate the growth and development of nursing in Britain and other countries; to give her an understanding of the profession in the past, and to awaken in her a personal responsibility for nursing in the future.

It is recommended that no teaching should proceed, as far as is possible, before it has been taught by a clinical instructor. Where student nurses are placed as staff in wards, Ward Sisters should be advised by means of teaching charts what material has been taught, so that student nurses will only be given responsibility for nursing practice in which they have had instruction.

Lectures in Operating Theatre technique should be given by Theatre Superintendents or Theatre Sister. Lectures in Ward Management should be given by a Senior Sister.

Students should be encouraged to prepare case histories and submit projects.

HUMAN BIOLOGY

During the first year the student should be given a simple outline of the Human Body and its functions, so that this knowledge can be applied to the actual nursing care of patients in the ward and to the other subjects studied in that year. The depth of knowledge required in the first year should be only sufficient to enable the student to understand the situation, and the basic principles behind the action taken, e.g. in First Aid, in matters of hygiene or in a practical nursing procedure. No detailed material should be taught, but rather an outline of the different components, while the concept of the body as an integrated living whole should be stressed.

At a later period more detail will be required to give understanding of matters such as medical and surgical conditions, the action of medicines and the carrying out of certain nursing procedures. Many aspects of First Aid, Personal and Communal Hygiene, and Nursing, can be linked with Human Biology to make it more meaningful and interesting. Briefly the aim should be to give a gradually increasing knowledge of Human Biology in each stage of training, instead of crowding it into the first three months to be quickly forgotten. This gradual increase, the practical application of the material and the integration with related subjects, should lead to a greater understanding and greater retention of the subject itself by making it meaningful, useful and interesting.

Man's Requirements for Successful Life

This should be a simple summary in non-technical language of man's physiological needs, designed to lead up to the sections which follow on the structure and functions of the body which meet these needs.

The Skeleton, Joints, Muscles

Detailed knowledge of the bones and joints should not be given, and the anatomy of the skeletal muscles given
simply and in groups. Individual muscles and points of origin and insertion are not required. Various aspects of this section of the subject are important in relation to First Aid, nursing procedures and care of patients.

The Blood and Circulation
No detailed anatomy of the heart should be given at this stage. That will be required later, e.g. in conjunction with Cardiac Disease. More important at this stage should be an understanding of the functions of the blood and its composition, as this enhances wide fields as the transport of food, oxygen and fluids and the natural defence of the body. Again there is the connection between this subject and First Aid, e.g. Haemorrhage and Pressure Points and the nursing procedure of observing the pulse.

Nutrition
The basic nutritional requirements will be given in Elementary Health and Nutrition. A simple outline should be given of the Digestive System including digestion and absorption. The colon should be dealt with briefly at this stage, with perhaps a little more detail under Elimination.

Respiration
Little need be added here to what is said in the syllabus except to stress the need for simplicity to give a basic understanding of the physical principles involved. Again the integration of subjects is important, e.g. in First Aid—Artificial Respiration, and in nursing, the observing of the Respiration. Greater detail will be required when dealing with diseases affecting the respiratory tract, both physical and psychological at a later date.

Elimination
A simple outline of the Urinary Tract, sufficient to give understanding of elimination by this route is required. The level should be assessed by this requirement. Elimination by other routes should be dealt with briefly at this time, to give a better overall picture. The body's loss of fluid in effecting elimination could lead on to the important subject of Fluid Balance. Many aspects of this subject are important in relation to nursing procedures, e.g. observation of urine, maintaining Fluid Balance Charts and the care of incontinent patients.

Control of Activity
Detailed anatomy should be avoided, but an outline of the peripheral nervous system is advisable. The student should be aware of major motor and sensory functions of nerves, but no detail of nerves and nerveplexuses is required at this stage. The functions of the Autonomic Nervous System and Hormone activity should be outlined, again in a simple manner. It would be advisable to go very slowly with the subject to begin with, sacrificing detail in order to give a sound basic knowledge which can be built upon later when dealing with disorders of the nervous system.

Reproduction
A simple outline of the organs concerned and their functions should be given. An important subject relationship here is that of heredity and its effect on the individual.

MEDICAL, SURGICAL AND GYNAECOLOGICAL DISORDERS
In this section of the Syllabus the opportunity should be taken to revise and to apply Anatomy and Physiology as considered necessary for a full and efficient understanding of the subjects being taught. It is recommended that in the introduction to any disease or abnormality, the clinical features should be discussed and the effects and likely prognosis. Measures of rehabilitation and of prevention are of great importance.

Under the heading "Systemic Diseases" an attempt has been made to integrate to some extent the teaching of diseases which are mainly treated by medical or by surgical means. It is impossible to make a clear-cut distinction in many cases for there must be considerable overlap. However, in discussion between Lecturers and Nurse Tutors, duplication and repetition could be avoided. No attempt has been made to compile an exhaustive list of the diseases the nurse should know. It is intended to serve only as a general guide. From time to time, some conditions may assume major importance and others become less common than at the present time. It will, therefore, be necessary for those lecturing on the subject in this Syllabus to be prepared to adjust their teaching programme to suit the existing need. It should be noted that it is the policy of the Council, wherever possible, that lectures should be given by specialists in each field.

PEDIATRIC NURSING
Lectures should as far as possible be arranged during secondment to a Children's Hospital or to a Sick Children's Unit. In order that adaptation of general nursing measures in caring for the sick child can be given, the timing of the lectures and the secondment of the nurse is important. The basic nursing measures in general nursing must already have been given. The six-week's experience given in Children's Hospitals or Units should be in medical or surgical wards with some time devoted to Milk Kitchen and Clinics.

CONTROL OF INFECTION
It is considered desirable that nurses should receive practical experience in the control of infection in an Infe¬
should be presented in the form of general principles rather than in detail. At the same time, the interest and imagination of the student should be constantly stimulated and enlarged by general reference, where appropriate, to current advances in treatment and research, and to the social aspects of the problem.

Careful planning of the content and conduct of the course should ensure that the basic aim is achieved—namely, the imparting to the student of such insights and skills as will help her to become a good general nurse.

**PHARMACOLOGY**

While individual drugs cannot be listed, it would be considered advisable to mention groups or classes of drugs, for example, antibiotics, chemotherapeutic agents, steroids, fluids and electrolytes. Economy in the use of drugs, and the cost to the National Health Service.

**THE HEALTH SERVICES**

This part of the Syllabus is designed to give a greater appreciation of the community health services concerned with the promotion of health and the prevention of disease.

Services in relation to community health, including all those factors which influence the well-being of the individual, are the responsibility of the Public Health Department under the local authority.

Comprehensive care of the individual can only be achieved by co-operation of all services under National Health. The nurse in training must be made aware of those personal health services under Part III of the National Health Service Act and the Mental Health (Scotland) Act which support the care given by hospital and general practitioners in maintaining the health of the individual and preventing the incidence of relapse.

Knowledge regarding social security and welfare services cannot be divorced from a comprehensive scheme of medical care.

During the early part of training some insight has been gained into communal health care and this will be supplemented by lectures from those closely concerned with the personal and environmental services in the public health field. In association with lectures a carefully planned programme of practical experience would be arranged to make this three-weeks' period as beneficial as possible.

Where practicable "follow-up" visits to patients who have been discharged from hospital should be arranged. Lectures to be given, as far as possible in the Public Health Department, and time allowed for discussion and evaluation.

Wherever possible films and visual aids, etc., should be used in the teaching programme.

**REHABILITATION AND RESETTLEMENT**

The suggested lectures should have as their aim the presentation of the correct place, timing and extent of rehabilitation.

Lectures by the Almoner, Physiotherapist and Occupational Therapist should be used, where possible, to describe their functions, but the importance of medical, nursing and other staff in the team-work of rehabilitation should be emphasised.
The Training Period to be 144 weeks exclusive of Annual Leave and Sick/Special Leave.

<table>
<thead>
<tr>
<th>Periods to be spent in:</th>
<th>Female Student Nurses</th>
<th>Male Student Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introductory Course</td>
<td>12 weeks</td>
<td>12 weeks</td>
</tr>
<tr>
<td>To include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Basic Sciences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Principles and Practice of Nursing</td>
<td>Introduction to Hospital Wards</td>
<td></td>
</tr>
<tr>
<td>(c) Educational Visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanatory Note - These twelve weeks need not be consecutive, the initial four weeks of the training period must be spent in the School and it is suggested that during this period a course of instruction be given in the Principles and Practice of Nursing and the Student Nurses introduced to the Hospital Wards and Departments. This Course to integrate theory and practice and the Student Nurses to have supervised practice in the Wards.

The remaining eight weeks allocated to the Introductory Course to be spent in the School at a later period or periods suitable to the needs of the Student Nurses and the Teaching Programme of the Training School.

2. Study Blocks or Equivalent Study Days (To be interspersed throughout the three year course.)

3. General Medical Nursing

General Medicine
(To include 4 weeks in a Geriatric Assessment Unit where this experience is available.)

4. General
II

<table>
<thead>
<tr>
<th></th>
<th>Female Student Nurses</th>
<th>Male Student Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Allocation</td>
<td>Total Allocation</td>
</tr>
<tr>
<td>4.</td>
<td>General Surgical Nursing</td>
<td>24 weeks</td>
</tr>
<tr>
<td>5.</td>
<td>Special Departments</td>
<td>12 weeks</td>
</tr>
<tr>
<td></td>
<td>Experience to be given in at least three of the following special departments.</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Ear, Nose &amp; Throat</td>
<td>)</td>
</tr>
<tr>
<td>2.</td>
<td>Ophthalmic</td>
<td>)</td>
</tr>
<tr>
<td>3.</td>
<td>Orthopaedic</td>
<td>)</td>
</tr>
<tr>
<td>4.</td>
<td>Neurosurgery</td>
<td>)</td>
</tr>
<tr>
<td>5.</td>
<td>Plastic Surgery</td>
<td>)</td>
</tr>
<tr>
<td>6.</td>
<td>Genito-Urinary</td>
<td>)</td>
</tr>
<tr>
<td>7.</td>
<td>Dental Surgery</td>
<td>)</td>
</tr>
<tr>
<td>8.</td>
<td>Cardiac Surgery</td>
<td>)</td>
</tr>
<tr>
<td>9.</td>
<td>Thoracic Surgery</td>
<td>)</td>
</tr>
<tr>
<td>10.</td>
<td>Burns</td>
<td>)</td>
</tr>
<tr>
<td>6.</td>
<td>Paediatric Nursing</td>
<td>)</td>
</tr>
<tr>
<td>7.</td>
<td>Control of Infection</td>
<td>)</td>
</tr>
<tr>
<td>8.</td>
<td>Gynaecology</td>
<td>6 weeks</td>
</tr>
<tr>
<td>9.</td>
<td>Out-Patients/Casualty Department</td>
<td>4 weeks</td>
</tr>
<tr>
<td>10.</td>
<td>Operating Theatre</td>
<td>4 weeks</td>
</tr>
<tr>
<td>11.</td>
<td>Psychiatric Nursing</td>
<td>8 weeks</td>
</tr>
<tr>
<td>12.</td>
<td>Public Health Services</td>
<td>3 weeks</td>
</tr>
<tr>
<td>13.</td>
<td>Obstetric Nursing</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>WEEKS ALLOCATED</td>
<td>124 weeks</td>
</tr>
</tbody>
</table>

Where the Training Scheme includes experience in the nursing of sick children, and not in the control of infection in an Infectious Diseases Hospital, six of the unallocated twenty weeks must be used for this purpose in all Regions where this experience is available. The remainder of the unallocated time may be used at the discretion of the Matron of the Training School.
### APPENDIX III.

#### TABLE A

**X² TEST FOR Q. 18 (SURVEY)**

FREQUENCY OF TICKED DIFFICULTIES FOR THE DIFFERENT YEARS OF TRAINING.

<table>
<thead>
<tr>
<th>Year of training</th>
<th>Frequency of Ticks</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
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<tr>
<td>First year</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>(24.97)</td>
</tr>
<tr>
<td>Second year</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>(25.10)</td>
</tr>
<tr>
<td>Third year</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>(19.93)</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
</tr>
</tbody>
</table>

**X² = 25.254, d.f. = 12, p < 0.02.**

#### TABLE B

**X² TEST FOR Q. 19 (SURVEY)**

FREQUENCY OF TICKED DIFFICULTIES FOR THE DIFFERENT YEARS OF TRAINING.

<table>
<thead>
<tr>
<th>Year of training</th>
<th>Frequency of ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
</tr>
<tr>
<td>First year</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>(28.64)</td>
</tr>
<tr>
<td>Second year</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>(28.79)</td>
</tr>
<tr>
<td>Third year</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
</tr>
</tbody>
</table>

**X² = 7.2720, d.f. = 12, p < 0.05 (N.S.)**
TABLE C

KOLMOGOROV-SMIRNOV TEST FOR Q. 22 (SURVEY)
PROPORTION OF STUDENTS CHOOSING STATEMENTS
a - c ACCORDING TO YEAR OF TRAINING.

<table>
<thead>
<tr>
<th>Year of training</th>
<th>a: Avoid patient</th>
<th>b: Deal with patient</th>
<th>c: Report to Sister</th>
<th>d: Consult Sister first</th>
<th>e: Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>-</td>
<td>0.33</td>
<td>0.47</td>
<td>0.15</td>
<td>0.03</td>
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<tr>
<td>2nd year</td>
<td>-</td>
<td>0.31</td>
<td>0.57</td>
<td>0.09</td>
<td>0.04</td>
</tr>
<tr>
<td>3rd year</td>
<td>-</td>
<td>0.19</td>
<td>0.65</td>
<td>0.13</td>
<td>0.02</td>
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</table>

Some of the Differences in proportions between 1st and 3rd year students were significant.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Year of Training</th>
<th>Difference in proportions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
<td>Third</td>
</tr>
<tr>
<td>b</td>
<td>0.33</td>
<td>0.19</td>
</tr>
<tr>
<td>c</td>
<td>0.47</td>
<td>0.65</td>
</tr>
<tr>
<td>d</td>
<td>0.15</td>
<td>0.13</td>
</tr>
<tr>
<td>e</td>
<td>0.03</td>
<td>0.02</td>
</tr>
</tbody>
</table>

** Largest difference D

Second largest difference.

Applying the formula
\[ X^2 = 4D^2 \frac{n_1 n_2}{n_1 + n_2} \]

Where \( D = \) largest differences 0.18 and 0.14

\[ n_1 = 196 \]
\[ n_2 = 127 \]
\[ X^2 = 4(0.18)^2 \frac{24892}{323} = 9.25 \]

\[ X^2 = 9.25, \text{ d.f.} = 2, p < 0.05. \]
Significant beyond 5% level.

\[ X^2 = 4(0.14)^2 77.07 = 6.17 \]
\[ X^2 = 6.17, \text{ d.f.} = 2, p < 0.05. \]
Significant at the 5% level.
APPENDIX IV.

1. Handouts:
   a) Objectives of course and Psychiatric Nursing.
   b) Observation guide.
   c) Legal notes.

2. Experimental subgroup guide to teaching.

3. Course evaluation schedule.

4. Questionnaire, the added 8 questions.

5. Inferential Test.

6. Factual Test.
OBJECTIVES
To help the student:
1- to recognize the meaning of behaviour in different situations.
2- to know how, given the limitations of her/his abilities, she/he can go about meeting a situation.
   Meeting a situation could be done on one's own or with help from others, or by referring the situation to next person responsible, or a combination of these alternatives.
3- to obtain information about different methods of treatment used in Psychiatric Care.

PRINCIPLES OF PSYCHIATRIC NURSING
I. Patients come to hospital for help, because they found it difficult to cope with the community outside the hospital. They need to be:
a- accepted and respected as they are.
b- permitted to express their feelings, whether pleasant or unpleasant.
c- taken at their own pace in working out their problems.
d- helped to control their behaviour, if they are unable to do so by themselves.
II. As a nurse helping in the care of the patient, one needs to remember that:
a- the patient is an individual in a difficult situation who needs, above all, to be cared for as a person.
b- the patient's behaviour is meaningful. It is the way in which he/she expresses himself/herself.
c- when patients are trying to "tell you something" by their behaviour, they expect a response from the people caring for them.
d- it is important to take into account one's own feelings about a situation, since these feelings might influence that situation.
e- the same situation might be interpreted differently by different people (whether patient or nurse).
f- even though some situations are difficult to cope with, it is more beneficial for the patient if one gets help to face the situation, rather than avoid it.
PSYCHIATRIC SECONDMENT COURSE

OBSERVATION GUIDE

I. General appearance:
   person's built
   Posture
   grooming

II. General behaviour:
   a- with others: e.g. likes to talk or sit with others (whom ?), prefers to
      sit on his/her own, attacks others in words or with
      objects (insults, throws an object), etc...
   b- with staff: e.g. likes to talk to nurses, wouldn't talk to nurse or do
      what they ask for, expresses dislikes of staff (of
      doctor, of nurse, etc.);
   c- activity: general level of activity and its form: e.g. moves all the
      time, prefers to sit, repeats same movements, etc...
      - how does the person feel about activity: e.g. welcomes it,
      needs to be encouraged to participate, etc...
   d- eating and drinking: state of appetite; way of eating or drinking; e.g.
      quickly, messing with food, etc...
   e- sleeping: state of sleep during the night; e.g. takes a long while to
      settle, sleeps easily, wakes early, etc...
      - state of sleep during the day: e.g. sleepy and drowsy, alert, etc
   f- speaking: rate: e.g. quick, very slow, mute, stops in the middle of a
      sentence, etc...
      - content: e.g. apparently meaningless sentences, always talks
      about the same thing, talks about seeing things the
      listener cannot see, carries a usual conversation, etc...
   g- mood: form: e.g. good, irritable, preoccupied, disinterested, etc...
      - stability: e.g. changes quickly, always the same regardless of
      anything, keeps being different from one moment to
      the next, etc...
   h- memory: e.g. easily forgets, needs reminding, good, forgets recent events,
      remembers only past events, etc...
   i- attention: e.g. cannot be sustained for a period of time on the same
      subject or thing, good concentration, disoriented...
      i.e. cannot recognize: person, place or time (could
      not tell the difference between morning and night)
   j- judgement: e.g. grasp meaning of what is said, realizes the fact that
      he/she is ill, denies being in hospital or being ill
      when they are, etc...
   k- facial expression: e.g. fixed expression, an expression of happiness
      when talking about a sad instance (death of a loved
      one), etc....
MENTAL HEALTH ACT (SCOTLAND) 1961

The main principles on which the Acts are based are:

1. That patients suffering from mental disorders should as far as possible be treated in or outside hospital on the same basis as patients suffering from any other disorder. They should be able to enter any hospital capable of offering treatment. They should enter hospital and leave hospital with no more formality or restrictions than any other patients.

2. That outside hospital, provisions should be made for treatment and care comparable to those offered to people suffering from other disorders.

3. That hospitals which offer psychiatric treatment should be free to refuse admission if they feel unable to help the patient or for any other reason just as other hospitals are.

4. That the provisions made for the fairly small number of patients who must be detained against their will should entail only a minimal amount of legal restriction.

INFORMAL ADMISSION

Patient admitted in the same way as they are admitted into the General Hospital.

EMERGENCY ADMISSION (Section 31)

It is established that a patient is either a danger to himself or the community.

This order is signed by the Social worker or by the patient's G.P. The patient must have been seen that day by the person signing the order. The relatives must be told. The person can be compulsorily detained for 7 days (Scotland); at the end of this time the patient is treated as an Informal patient or will have been certified.

FULL CERTIFICATION (Section 24 (Scotland)).

The Social Worker petition the Sheriff. The Sheriff appoints two doctors to examine the patient—one is a G.P., the other should have extensive experience in psychiatry. These doctors can either (a) see the patient together, or (b) if the relatives disagree, they will see patient separately and submit their reports within seven days of each other. This report must state the patient is suffering from mental disorder (diagnosis), that the patient's treatment should be carried out in hospital and that the patient is a danger to himself and others. After reading medical report, the Sheriff then signs the Certificate. The Sheriff does, however, have the right to interview relatives and patient himself before signing. Once the patient is in hospital, the patient is reviewed after 28 days and Certificate renewed, after first year and subsequent two-yearly intervals.

Any Certified patient has the right for appeal.

SECTION 54. (the Secretary of State has authority of release)

Where a person in prison awaiting trial is transferred to a psychiatric hospital because it has been found he is suffering from mental illness. This type of person rarely comes up for sentence.

SECTION 55 (the Secretary of State has authority of release)

This person has been "sentenced" to a term of psychiatric treatment, because it was felt that this crime was committed while mentally ill.

SECTION 65

Person detained "during Her Majesty's Pleasure". These people have committed more serious crimes, e.g. murder, rape, while mentally unbalanced and are classed as the Criminally Insane, sent to special State Hospitals for Security and treatment.
PSYCHIATRIC SECONDMENT COURSE

EXPERIMENTAL

GROUP

I. General outline : logical sequence of the general ideas of the course
A. A situation :
   1. has a structure:
      Individual/s  Place  Environment
      it happens at a moment in time
      environment means: policies, social rules, culture, values, climate, etc....
   2. has dynamics:
      different influences and connections between and among the
      elements in a structure; and their working forces ; i.e.
      relation or connection between individual/s and place,
      place and environment, environment and individual/s, etc..
   3. has volumes:
      - extent of situation: who does it include, and what does it
        include e.g. patient, nurse and husband or hospital, work, and home.
      - depth of situation: degree of involvement of each element
        and its relation to other e.g. degree of involvement of husband in wife's
        illness, degree of depression in relation to understood cause/s.

B. Individual/s :
   Personality: how does it develop
   three main spheres of ability (cognitive, connative, affective)
   levels of consciousness
   what does it constitute of (id, ego, superego)
   what influence it
   what identifies it (behaviour)

C. Behaviour :
   it is a response to a stimulus, so it is meaningful
   types: observable and inferred
   how to know its meaning? by trying to identify stimulus and under-
   stand the relation of the response to the stimulus, identify its
   purpose as well.
   how to identify the stimulus (or more exactly try to) and discover
   the purpose? (observation)

D. Observation:
   it is an instrument of recognizing behaviour
   how: (perception)
      a. by the use of the sense organs: visual, auditory, tactile,
gustatory, olfactory.

b. by the use of judgement, knowledge and inference from the observable behaviour, and one's own 'feeling' about the behaviour.

what to look for: what are the ways used by the person to meet the situation?

ego defences

psychiatric signs and symptoms relating to the different spheres of ability and composites of the personality

how to intervene according to the knowledge gained from the observation and from theoretical knowledge about a situation.

(treatment, and therapeutic communication)

E. Communication (therapeutic):

i.e. intervening behaviour for the purpose of adjustment

\[
\begin{align*}
stimulus & \rightarrow \text{response} \\
\uparrow & \downarrow \\
\text{response} & \leftarrow \text{stimulus}
\end{align*}
\]

at least two individuals are involved in a communication

how to intervene for the purpose of treatment, by influencing stimulus and response.

METHOD:

Giving the student the assignment of writing with the help of observation sheet and psychiatric nursing principles sheet; about a situation which took place in the ward, including:

what she knows about persons involved (patient, nurse, herself etc..)

what she knows about the ward

what she knows about her 'feeling' and 'impression' of the ward

handing this in, at most a day before the lecture time; to enable the teacher to inquire about the situation she/he intends to use for teaching.

How to use the student's illustration of a situation:

1. by presenting, at least two of these and let the students conclude the general idea.

2. another time give the general idea and let students draw on their illustration.

Lecture time distribution:

Begin by quickly (5 minutes) revising the knowledge given the last lecture

Present the illustration/s

End by summarizing the knowledge given during the current lecture; let students try to do so by themselves and teacher would either repeat or supplement summary. (not more than from 3 to 6 ideas introduced and related at a time, depending on simplicity or complexity of idea).
APPROACH TO TEACHING:

Following the general outline, one would use the illustration of a situation, prepared by the student. In so doing one would try and include the knowledge pertaining to: behaviour, personality, how to observe, and how to communicate therapeutically (therapeutically i.e. based on our knowledge, our information about the patient, our observations of the situation and how to modify the stimulus and response during communication).

Writing the general ideas or principles pertaining to each topic i.e. personality, behaviour, observation, etc...; and try to include it gradually into each illustration. At the end of each lecture one finds out how much of that has been used, how often, and how much is left.

Try and vary the angle from which one perceives a situation; in order to help the student understand that there is more than one way of doing or of studying any given situation. e.g. explaining communication in terms of 'situation' or in terms of behaviour, or in terms of stimulus response; and then let the student compare the three explanations and find out the similarities and differences if any. Another way of doing this is by viewing the situation from the nurse's point of view, then from the patient's point of view, and again help the student to find out similarities and differences.

Making sure to introduce an example from the general hospital situation, or let the student supply the example herself, again helping them find out similarities and differences.

Ask them at the end of every other lecture to summarize the knowledge they gained.

Try whenever possible to show them that what is more useful, and what usually decides action is the relation between elements in a situation, or between the elements and the whole, rather than the element as such.

FIRST LECTURE:

Revise the objectives of the course with them.
Give what we mean by a situation
Introduce the topics to be taught as outlined
Introduce behaviour
Introduce communication how they relate
Indicate their role in the teaching-learning process
Give some guidance as to how to start by giving in their illustration of a situation a description of the situation (later in the course one would ask them to analyze a situation i.e. giving relations between elements and trying to understand the situation as a whole)
Please place not more than one tick alongside each item under 'understand', and not more than one tick under 'work'. If any of the items are not applicable to you; e.g., if there are no hospital seminars; please draw a line through the description of the item.

To what extent does each of the following help you understand and work on the wards?

<table>
<thead>
<tr>
<th>Items</th>
<th>Understand</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych, nursing principles</td>
<td></td>
<td></td>
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<tr>
<td>Observation guide</td>
<td></td>
<td></td>
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<tr>
<td>Hospital seminar</td>
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<td></td>
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<tr>
<td>Nursing lectures</td>
<td></td>
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<tr>
<td>Doctor's lectures</td>
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<tr>
<td>Ward visits by teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

M.E. Grt. = great  Mod. = moderate  Min. = minimum  ext. = extent

Comments:
Keeping your psychiatric nursing experience in mind, please put one tick on the dotted line against the answer that best describes your honest opinion of the following questions.

I. When faced with a difficult situation on the ward, which helps you most?
   a. your previous ward experience in the same or similar situation.
   b. your classroom instruction.
   c. your own intuition and judgement.
   d. other: please specify..............................................................
   In what ways did this help you? ...................................................
   .................................................................................................
   .................................................................................................

II. To what extent do you consider that your classroom instructions is related to your practical experience?
   a. great extent.
   b. moderate extent.
   c. minimum extent.
   d. not at all.
   In what ways was it related/not related? ...........................................
   .................................................................................................
   .................................................................................................

III. To what extent do you consider that the knowledge and experience you gained in this course is related to your general training?
   a. great extent.
   b. moderate extent.
   c. minimum extent.
   d. not at all.
   In what ways is it related/not related? .............................................
   .................................................................................................
   .................................................................................................

IV. To what extent do you consider that psychiatric nursing is related to general nursing?
   a. great extent.
   b. moderate extent.
   c. minimum extent.
   d. not at all.
   In what ways is it related/not related? .............................................
   .................................................................................................
V. To what extent do you consider that the knowledge you gained in this course would help you deal with the general nursing situation on the whole (excluding the psychiatric disorders not in the general hospital)?
   a. great extent.
   b. moderate extent.
   c. minimum extent.
   d. not at all.

   In what ways would it help .................................................................
   .................................................................................................

VI. Which of the following have you found most difficult to cope with in your present course of psychiatric secondment?
   a. your classroom instruction.
   b. your ward experience.
   c. both a and b in some respect.
   d. if none of the above, please specify the most difficult thing to cope with: .................................................................
   .................................................................................................

VII. Please tick any of the statement a to f, which you consider describe your difficulties with classroom instruction. You may tick as many as you wish.
   a. too much material in the time available.
   b. too much 'ideal' knowledge that you feel has no practical application in the ward.
   c. being treated as though you are expected to know.
   d. having to decide for yourself how to apply knowledge gained in the classroom to the practical situation.
   e. not being treated as a responsible person.
   f. I did not have difficulties with my classroom instruction.

   If you had other difficulties, not mentioned above, please specify them here:
   .................................................................................................
   .................................................................................................
VIII. Please tick those statement a to h, which you consider describe your difficulties with ward experience. You may tick as many as you wish.

a. difficulty in getting along with the qualified nursing staff on the ward.

b. ward staff made you feel that you are worthless. as far as work is concerned.

c. not knowing what would happen and how to cope with it.

d. being treated as though you are expected to know.

e. lack of orientation to ward management, policies, procedures and personnel.

f. the ward staff consider you an outsider.

g. your views not invited in discussion about patient care and management, although you feel that you are close to the patient and know a lot about him/her.

h. I did not have difficulties with ward experience.

If you had other difficulties not mentioned above, please specify them here:

..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

If you now wish to do so, please comment more freely about the course (teaching ward experience, relationship with staff or teacher, etc...)
READ THE FOLLOWING INSTRUCTIONS CAREFULLY:
1. When you are told to begin, answer the questions as quickly and as carefully as you can.
2. If you try a question and find you cannot answer it, leave it and go on to the next.
3. Make sure any changes are clear.
4. Put up your hand, if you find that you never came across one of the items in Part I.
5. Ask no questions at all, other than what is specified in nr 4
6. When you are told to begin, write down the time (by your watch) in the space provided below.
7. When you have finished answering the test, write down the time (by your watch) in the space provided on the last page.

Time began (by your watch): ___ hr. ___ min. ___

This part not to be filled by candidate

<table>
<thead>
<tr>
<th>Question Score</th>
<th>Question Score</th>
<th>Question Score</th>
<th>Grand total</th>
</tr>
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<tr>
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<td>Part III</td>
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</tr>
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<td>1.</td>
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<td>5.</td>
<td>5.</td>
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<td>6.</td>
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<tr>
<td>7.</td>
<td>T.(14)</td>
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</tbody>
</table>
PART I

In each of the following groups of items, two items are related in a fundamental way i.e. stemming from the same origin:

1. underline the two items that you think are related in a fundamental way
2. state briefly the fundamental relatedness between them

Here is an example to guide you:

Hypersomnia, Waxy flexibility, Paramnesia, Narcolepsy.
Both are disorders of sleep


2. Reaction formation, Flight of Ideas, Stupor, Obsession.

3. Aphonia, Irritability, Depression, Negativism.


5. Sublimation, Euphoria, Displacement, Phobia.

6. Amnesia, Fixation, Anxiety, Confabulation.

7. Regression, Disorientation, Elation, Confusion.
PART II

In the following, you will be given situations illustrating the same principle; using the psychiatric nursing principles sheet attached, find the principle that best fits each group of situation. Do not use the same principle twice.

I. Situations:
   a. John: "what a bored look on their faces"
      Tom: "what a relaxed look on their faces"
   b. Allan: "What a crowded place"
      Roy: "people seem easy here"

The principle that best fits those situations is: (Please write down the number of the principle):_________

II. Situations:
   a. Mrs. Smith had been refusing to eat. She thought that if she ate, the other patients would starve and she would be responsible.
   b. Mr. McKenzie would suddenly get up and open the window, bow then sit down. He heard a 'voice' telling him to do so.

The principle that best fits these situations is: (Please write down the number of the principle):_________

III. Situations:
   a. Miss McDonald always reminded Nurse Reid of an old aunt of hers, who was a trouble maker. One afternoon a group of patients went out for a walk with Nurse Reid. Miss McDonald was walking on her own. Nurse Reid failing to understand Miss McDonald need for attention, told her to stop acting oddly and be with the group.
   b. Nurse Robert never liked old Mr. McKenzie as he always was the first to volunteer to do anything like setting the table, making beds etc... Because of her dislike of Mr. McKenzie, she missed his eager need to belong.

The principle that best fits these situations is: (Please write down the number of the principle):_________

IV. Situations:
   a. Mr. White, 50 years old, has always been used to reading before going to sleep. In hospital Sister wanted all patients in bed and lights out at 9 p.m.
   b. Mrs. Black, 70 years old, suffers from dementia. She is frequently incontinent. The nurses saw no point in changing her frequently as she would soil herself again.

The principle that best fits these situations is: (Please write down the number of the principle):_________
V. Situations:

a. Mrs. Armstrong was admitted to hospital, because she was depressed. She was very slow in her movement and would sit for hours staring into space. Nurse Brown was always at Mrs. Armstrong trying to get her to do things and sit with the group. Two days later Mrs. Armstrong was more depressed and took to her bed.

b. Mr. Johnston, when first admitted was very depressed. After some treatment his depression seemed to improve and he showed a slight interest in going to occupational therapy. The occupational therapist included Mr. Johnston in two group projects. Within three days Mr. Johnston gradually sank back into a deeper depression.

The principle that best fits these situations is: (Please write down the number of the principle) ________

VI. Situations:

a. Miss McDonald was admitted for Surgery. The night before her operation she was ringing the bell practically every half hour for "a glass of water" or a "pain in the back", or complaining that "the patient next door is snoring and I can't sleep" etc... The nurse, exasperated, told her to stop all this nonsense and go to sleep as she had other things to do.

b. Miss Robert, 60 years old, lost her husband 2 years ago. She usually feeds herself, but at times she drops the spoon and complains that she cannot cope with feeding herself. The nurse always ignores her remarks and tells her that she is old enough to feed herself.

The principle that best fits these situations is: (Please write down the number of the principle) ________
PSYCHIATRIC NURSING PRINCIPLES

Patients come to hospital for help, because they found it difficult to cope with the community outside the hospital. As a nurse helping in the care of the patient one needs to remember that:

1. the patient is an individual in a difficult situation who needs, above all, to be cared for as a person.
2. the patient's behaviour is meaningful. It is the way in which he/she expresses himself/herself.
3. when patients are trying to "tell you something" by their behaviour, they expect a response from the people caring for them.
4. it is important to take into account one's own feelings about a situation, since these feelings might influence that situation.
5. the same situation might be interpreted differently by different people (whether patient or nurse).
6. even though some situations are difficult to cope with, it is more beneficial for the patient if one gets help to face the situation, rather than avoid it.
7. patients need to be taken at their own pace in working out their problems.

NB: Please do not write on this paper.
PART III

In the following, you are given a psychiatric nursing principle, followed by 3 different situations. After a careful reading these situations, find the one that you think is an appropriate application of the principle, and place a tick in the box opposite this situation.

I. Patients are to be accepted and respected as they are:
   a. Mr. Henderson, 50 years old, came to hospital after being caught shoplifting, while he was drunk. He is an alcoholic. A good ward policy would be to allow him one drink every night.
   b. Mr. McDonald 20 years old, strongly disliked changing his clothes and bathing; he would do every thing else asked of him, but not those two things; so he was permitted to do as he wished during his 30 days of hospitalization.
   c. Mr. Ronald 40 years old, had always had difficulty in taking initiatives. The nurses asked him to tidy up the cupboards on the ward.

II. Patients should be permitted the expression of both pleasant and unpleasant feelings.
   a. Mr. Henderson had a strong dislike for dark people. Dr. John was a dark man. Mr. Henderson always insulted Dr. John everytime he saw him, and no one reprimanded Mr. Henderson.
   b. Mr. McDonald liked blonde girls, Nurse Reid was a beautiful blonde. It was an accepted thing for Mr. McDonald to kiss Nurse Reid and hug her whenever he felt like it.
   c. Mr. Robert could not stand the look of glass, so he was permitted to smash the glass cups and the glass flower pots in the ward.

III. Patient's behaviour should be controlled, if they are unable to do so themselves.
   a. Miss Thomson, when she gets in an excessively elated mood, will go on dancing for hours nonstop. Sister appointed 2 nurses to sit by her side to pull her down to her chair.
   b. Mr. Brown has difficulty getting ready and dressed in the morning. When all the patients are washing and going to the toilet in the morning, he gets very agitated and fights with anyone who tries to get to the toilet or the shower before him. Nurse White had to stay by his side and hold his arms to stop him fighting.
   c. Mrs. Reid when the lunch hour is due, she gets very upset and worried about queuing and taking a tray to fetch her lunch. She gets tremors and looks frightened. Nurse Ronald goes with her and holds the tray for her.

End of test

Time finished (by your watch) : -----hr. -----m.
FACTUAL TEST

Would you please write your full name, your school's name, and today's date on the answer sheet provided. Please answer the following questions as briefly as possible.

PART I
Please answer either A or B section:
A. What are the drugs given before an electro-convulsive therapy? Please write them down in the order in which they are given to the patient. (6)
B. 1. What are 2 main drugs used in the treatment of Schizophrenia? (2)
   2. What are 2 drugs used in the treatment of depression? (2)
   3. What is one important side-effect of major tranquilizers? (2)

PART II
Please answer either A or B section:
A. What do you understand by each of the following: a) hallucination b) delusion c) illusion? Illustrate your meaning by one example for each item. (6)
B. 1. What do you understand by 'Psychosomatic illness'? Illustrate your meaning by giving 2 examples of a psychosomatic illness. (4)
   2. What do you understand by the term 'Anxiety'? (2)

PART III
Please answer either A or B section:
A. In your opinion, how does 'mental illness' affect the eating habits and the food intake of a person? (6)
B. In your opinion, how much does Occupational Therapy play a part in the treatment of mental illness? (6)

PART IV
Please answer either A or B section:
A. 1. From your experience with a depressed patient, what do you think are some of the important points in the nursing care of a depressed patient? (4)
   2. Give 2 conditions in which B.C.T. is indicated. (2)
B. 1. What do we look for when observing the appearance of a patient? Give at least 3 different points. (3)
   2. What do we usually want to know about the patient's sleep? What is the importance of such a knowledge? (3)

N.B.: Please do not write or mark on this paper. Thank you.
APPENDIX V.

1. Original Tutors' Objectives.

2. Tutors' notes for lectures.

3. Original list of Psychiatric Nursing Principles.
APPENDIX V.

OBJECTIVES AS WRITTEN BY THE TUTORS

1st Tutor

To give the nurse the basis for a better understanding of herself, colleagues, and most important the behaviour of the patients that she cares for.

(a) By understanding the social, intellectual and emotional needs of the person and how to respond;

(b) By understanding and recognising the patient's need for psychiatric help and trying to diminish prejudice inside and outside the hospital;

(c) By knowing the value of nurse/patient relationship and also value of the ward team;

(d) By understanding the effect that their own behaviour can have on actions.

2nd Tutor

Recognising patient's emotional needs.

Recognising patient's social needs.

Recognising patient's intellectual needs.

Recognising patient's need for psychiatric help.

Recognising nurse/patient relationship.

Understanding meaning of anxiety, aggression, withdrawal, confusion, delusions and hallucinations.

Evaluating own responses in situations of stress.
3rd Tutor

To help the student in applying principles of psychiatric nursing in the clinical area.
To increase the possibility of self-awareness.
To enhance the students' abilities to care for patients generally in relation to their experience in wider basic training.

PLANS OF LECTURES FOR SECONDED STUDENTS AS WRITTEN BY TUTORS.

1st Tutor

Relationship of child and parents.

Need for warmth and security.
Need to allow child to fulfil potentialities.
Need to allow child to grow up at own speed, and to have the right to discard the attitudes and ideas of parents if they don't fit in with the child's idea of self - e.g. allowing the child to break the mould made by parents.

Overprotective and Rejective parents.

Oral - Anal and Phallic stage (briefly), uses of peer groups, Identification and learning ones own limits.

Adolescence - ½ child, ½ adult., e.g. allowed to "police Belfast" and yet at home parents often say "be in by midnight", Make decisions as to career (often for life). Beginning to understand the troubled world. Getting married/experiencing a depth of emotion and dealing with it.

Conflict cannot be kept out of a growing child's life - help in developing person to deal with it.
Expressions of conflict.

Temper Tantrums - School phobia - Child in hospital.

Drugs

Promiscuity

Adolescent Crisis

Above only briefly mentioned.

Behaviour.

Ego - id and superego.

Motivation - attractiveness and consequence of activity.

Same motive - unlike behaviour

Unlike motive - same behaviour

Unconscious activity

- Purpose

Cognitive Theory - Plans

- Achievement

Emotions

Learned behaviour - conditioning.

Dealing with behaviour problems by interrupting the pattern and replacing it with more realistic patterns.

Communication

Direct - speaking - writing - touching.

Indirect - Facial expression - gestures.

Abnormal - Double messages.

Learning - conditioning, social responses.

Effects of Mass Media - e.g. news, Open University.

Methods of Treatment.

Electroconvulsive Therapy.

Ab-reactive techniques.

Group psychotherapy.

Drugs.
Human behaviour.
1) Child - growing up, child hospital, children's neuroses, child in home.
2) Adolescence - adolescent problems.
3) Adulthood and old age.
4) Different types of personality that emerge.
Observation and Reporting.
A) Physical appearance.
   1) Facial expression
   2) Gait
   3) Scars and lumps, etc.
   4) Sleep
   5) Appetite.
B) Psychological.
   1) Speech and Thought
   2) Behaviour
   3) Mood
   4) Perceptual and conceptual difficulties
   5) Insight and Judgement.
C) Patient acceptance of hospital and people in it.
D) Confidentiality - including not getting caught by person saying "I'll tell you if you promise not to tell anyone else".

2ndTutor
1. Human behaviour - normal patterns, i.e. development - child, physique - emotion - intelligence - character.
   - abnormal, i.e. temper tantrums - tics - thumb sucking - nail biting - stammering - nocturnal enuresis - over eating - habit forming - impaired judgement - faulty tongue.
2. Behaviour and Personality.

Contributory factors, i.e. Heredity - bio-chemical - function - injury - epilepsy - syphilis - mental retardation.


Ego defence mechanisms, etc.

Influencing factors:

- Intelligence
- Initiative
- Sex-role
- Culture
- Values
- Roles of own choosing, i.e. nursing.
- Training - home - school - religion.

3. Observation.

Overt symptoms - mannerisms, speech, gait, dress, food, habits, toilet function, concern over details, i.e. clothing, bed, etc., sleep patterns.

Group observation.
- Inter personal dialogue
- Inter personal reaction
- Inter personal identification
- Cliques - formation
- Staff/patient relationships - nurse, doctor.

Development of senses, e.g. "Helen Keller".

Normal approaches - verbal and non-verbal
- written
- sign language
- T.V. and Radio.

Abnormal signs - emotion
- mood
- temperament
- ego defence mechanisms
- rage and anger
- passivity.

Objective and Subjective - awareness
- recognition
- understanding
- application.

5. Methods of Treatment.

Conservative care - Geriatrics.
Chemotherapy - drugs used - history.
Motivation - long term
- O. Therapy
- Industrial therapy.
Rehabilitation - Hostel function
- community care
- I.R.U.

Physical/Chemical - drugs
- E.C.T.
- Behaviour - "Token reinforcement" -
  awards - rewards.

Group - Social, Family, Individual.
Observation

Objective
subjective
awareness
understanding
observation
general appearance
activity
behavioural patterns
speech
mood
memory
attention
intelligence
judgement and insight
Group - observation.

Oral Anal Phalic stages.

id infancy
ego childhood
super-ego Juvenile
mechanisms Pre-adolescence
Symptomatology Adolescence
Maturity
Old age.

Methods of treatment.

Communication.

Development of senses
normal channels/verbal written non-verbal Radio T.V.
abnormal - symptomatology, thumb sucking, obsessional
neurosis, etc. ego-defence mechanisms.

3rd Tutor.
Introduction to psychiatric nursing.
The meaning of psychiatric nursing.
Students' first reactions.
Preconceptions.
First experiences with psychiatric patients.

Personality.
The nurse as a therapeutic agent.
Introduction to personality development.
Personal adjustments.
Mental mechanisms and the formation of symptoms.

Communications.
Aspects of communication
The meaning of behaviour.
Verbal and non-verbal communication.
self-awareness.

Treatment of Mental Illness.
Physical methods.
drugs.
Psychotherapies.
(The role of the nurse in augmenting these).
The Community.
   Using community resources.
   Effects of environment.
   Legal aspects.
   Rehabilitation programmes.

Perspectives.
   Origins.
   Present trends.
   Psychiatric nursing tomorrow.
Principles of Psychiatric Nursing

1. Accepting and respecting patients exactly as they are.
2. Allowing patients to express both negative and positive feelings.
3. Realising that patients need to set their own pace in working with problems.
4. Concentrating on the care of the patient as a person and not on the control of symptoms.
5. Observation directed towards understanding why patients behave as they do.
6. Attempting, through communication, to understand what patients are trying to express and responding to their communication.
7. Recognising the need for Nurses to understand their own feelings towards patients.
8. Recognising that patients respond to situations according to whatever or whoever is in them - real or otherwise.
9. Learning to deal with issues in a relationship rather than avoiding them.
10. Being able to set limits for patients who are unable to exercise control.
**APPENDIX VI.**

**SCHOOL I.**

Sample: 17 students.

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<th>Fact. Inf. Adult I Time on Inf. (min.)</th>
<th>Time on Inf. (min.)</th>
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**SCHOOL II.**

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**SCHOOL IVb.**

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APPENDIX VII.

1. Edinburgh University 2 years Tutor's course.

2. The Royal College of Nursing 6 months clinical Instructor's course.
These notes are intended to help you with an overview of the courses you are going to take in the first year:

A. Your courses will be arranged with you by your DIRECTOR OF STUDIES, who will see you personally.

B. Details concerning the arrangements of your teaching practice and your field work during vacation will be attended to by and Miss who will, from time to time, arrange to see the group of students in this connection.

C. You will have a personal tutor allocated to you. Your tutor will take an interest in your activities and will be available to help and advise you in connection with your studies and for personal matters.

You will discuss your dissertation with your tutor.

D. COURSES

1. Biological Sciences in Nursing (928K)
   (a) Anatomy and Physiology
   (b) Biology and General Science.

2. Bacteriology and Pathology (928J)
   These courses will occupy a considerable amount of your time (approximately 8 hours per week plus tutorials). It is, of course, necessary for a teacher to know in greater depth the subjects he/she has to teach. These courses are designed to take your studies to a more advanced level than is usually possible in a basic nursing programme. will arrange tutorials to help you with these subjects.

3. Community Nursing and Social Medicine (928H)
   1 hour per week plus tutorials. It is important that tutors should have knowledge of these subjects to enable them to teach students to give total nursing care.

   This course is taken jointly with students in the Nursing Administration and International School Programme.

   There will be a few Seminars at times other than lecture times. Please watch the Notice Board. Watch also for visits related to the subject.

   During the Easter vacation, you will spend one week observing the work of a Local Health Authority.
4. Psychology, Research Methods and Statistics (92SL)

5 hours per week plus tutorials. As a teacher you will need to know certain aspects of educational psychology. You will need to understand the personality of the students you teach and of the people with whom you work. These topics will be dealt with in the Autumn and Spring terms.

You will also need a deeper understanding of those aspects of psychology which relate to the nursing care of patients and which you may have to teach to student nurses. This will be dealt with in the Summer term.

Throughout the year, practice of teaching will form part of this course and the psychological principles underlying various methods of teaching will be analysed. Practice of various teaching techniques will take place in tutorial time.

During the Easter vacation, you will spend one week, and during the Summer vacation, two weeks, of teaching practice in schools of nursing outside Edinburgh.

You will also, in the Summer vacation, spend two weeks observing in a school of nursing in preparation for the course in Nursing School Administration in the second year.

It will be part of the course in Psychology to deal with methods of conducting research in order to understand the basic statistics in research reports and in the use of educational tests. One hour per week in the Autumn and Summer terms, two hours per week in the Spring term will be devoted to this aspect.

You will be joined for part of the course and for tutorials by the students for the Diploma in Adult Education. Statistics and research methods will also be studied by students taking the Nursing Administration programme. During the Spring term, one lecture per week will be given by Mr. Lecturer, Department of Adult Education.

K. Assignments

Assignments will be set in each of the courses. These should be handed to the lecturer who has given the assignment. A list of the numbers of assignments in each subject in each term will be available.

F. Dissertation: Two Year Project

A dissertation of not less than 7,000 words must be handed to your tutor by Friday, 23rd April 1973. (Two copies are required. The first copy, in a hard backed binder not larger than 11\(\times\)8\(\frac{1}{2}\), will be retained in the Department; the second copy will be returned to the student). The subject and plan of the dissertation should be discussed with your tutor in the Autumn term. An essay related to your dissertation should be submitted to your tutor during the first week of the Spring term.
All correspondence regarding the collection of material for your dissertation must be approved by your tutor before it is sent out. For detailed instructions see separate hand out.

In the Spring term, you will have the opportunity of hearing reports from the second year students about their dissertations.

G. Examinations

Class examinations will be held in most subjects; dates to be announced. It is necessary for you to have performed all required written work and to have taken class examinations before you are eligible to take final examinations. A notice will be on the Notice Board in the Summer term indicating those who are eligible to take the final examinations. During the first year's course class-work marks are not counted towards the final examination results.

H. Merit Certificates

These are awarded on the basis of class-work, class examinations and final examinations.

I. Please inform the Secretary of any change of address. If you have a telephone, please let her know the number.
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<td>1 week Public Health Observation</td>
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<tr>
<td>Tutorials</td>
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<tr>
<td>Psychology (with Adult Educ.)</td>
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<td>1.5</td>
<td>Class Exam.</td>
<td>Class Exam.</td>
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<tr>
<td>Psychology (with Teach. Practica)</td>
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<td>1.5</td>
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<tr>
<td>Research Methods and Statistics</td>
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<td>Tutorials</td>
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</table>

DNS 9/71
UNIVERSITY OF EDINBURGH - DEPARTMENT OF NURSING STUDIES

Notes for Students taking the Programme in Nursing Education - Second Year

Session 1971-72

A. Your Director of Studies.

B. Arrangements with regard to teaching practice will continue to be made by

C. You will continue to have a personal tutor. Please see your tutor early in the Autumn term with the draft of your dissertation.

D. COURSES

1. Nursing Education (928P)

Ideas about the purpose of education and assumptions on which they appear to be based will be examined. Nursing education will be considered in the wider context of general education.

Different approaches to the study of educational ideas will be through the works of some important writers and by means of a comparison of different systems.

Some of the lectures will be taken with students from the Department of Adult Education.

Final Assessment is based on students' marks in

(a) Course work: class examinations, and other work, such as essays, to be discussed and decided with students.

(b) Final examinations: two papers.

Merit Certificates are awarded when a sufficiently high overall standard is reached in the work included in final assessment.

2. Nursing Administration (928M)

This consists of the following:

(a) Administrative theory.

(b) Administration of Nursing Education.

Students' reports on Summer observation, lectures on practical topics, and case studies.

Curriculum planning.

Final Assessment: one paper in June.

3. Elective Subject

E. Dissertations /
E. Dissertations of not less than 7,000 words should be completed by the end of the Spring Term. Your tutor will assist and advise you. Dissertations should be handed in by Friday, 21st April 1972. In the Summer Term you will present a summary of your dissertation to your colleagues for discussion.

Dissertation assessment forms part of the final examination, and if the required standard is not reached, dissertations must be re-submitted in September.

F. Teaching Practice will be arranged during the Autumn and Spring Terms in schools of nursing in Edinburgh. It is suggested that you should go in pairs for half a day, and that you should listen to each other’s lessons and help each other with constructive criticism.

During the Easter vacation you will spend one week’s teaching practice in a school of nursing outside Edinburgh. You should keep a record of all the lessons you are giving, together with any comment you may wish to make about the success of your lesson or any criticisms you may wish to make of it. The record of your teaching should be available at the time of your teaching assessment.

G. Examinations and Assignments

Assignments will be given by the lecturers in each of the courses. Class examinations will be held. It is necessary for you to have performed all written work required and taken the class examination before you are eligible to take the final examination.

Your final teaching assessment will take place early in the Summer Term.

A notice will be on the notice board in the Summer Term indicating those who are eligible to take the final examination.

H. Please inform the Secretary of any change of address. If you have a telephone, please let her know the number.
<table>
<thead>
<tr>
<th>Semester</th>
<th>Hours per week</th>
<th>Course Details</th>
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<tbody>
<tr>
<td>Autumn Term</td>
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<td>2^{\frac{3}{4}}</td>
<td>Concepts of Education</td>
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<td>Tutorial</td>
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<td>Spring Term</td>
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<td>Nursing Education</td>
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<td></td>
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<td>Curriculum Planning</td>
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<td></td>
<td>1</td>
<td>Administrative Theory</td>
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<td></td>
<td>1</td>
<td>Reports of Vacation Experience</td>
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<tr>
<td>Easter Vacation</td>
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<td>Teaching Practice</td>
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<tr>
<td></td>
<td>1</td>
<td>Elective Subject</td>
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<tr>
<td></td>
<td></td>
<td>+ Tutorial</td>
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<td></td>
<td></td>
<td>+ Tutorials</td>
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<td>Summer Term</td>
<td></td>
<td>Presentation of Dissertions</td>
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<tr>
<td></td>
<td>1</td>
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<td>+ Tutorial</td>
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<td>+ Tutorials</td>
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<td>Total</td>
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<td>12 approx.</td>
<td>11 approx.</td>
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THE ROYAL COLLEGE OF NURSING AND NATIONAL COUNCIL OF NURSES OF THE UNITED KINGDOM

Institute of Advanced Nursing Education (Scotland)

CLINICAL TEACHERS COURSE
Institute of Advanced Nursing Education (Scotland)

CLINICAL TEACHERS COURSE: General information

DATES OF COURSE  From the third week of September to the end of March in the following year.

CONDITIONS OF ADMISSION TO THE COURSE

1 Candidates must be registered general nurses and have had a minimum of two years' experience in a post of responsibility in a recognised teaching school since registration. This experience must be exclusive of any further training but may have been taken in any field of nursing or midwifery. Part-time experience may be considered in special circumstances.

2 Preference will be given to those who have had charge of a ward (or who have held a charge nurse's post on night duty) for at least one year.

3 Nurses working in Scotland who are making application for this course must have an application on their behalf submitted by their Board of Management to the appropriate Regional Nurse Training Committee for onward transmission to the Registrar of the General Nursing Council for Scotland.

A candidate who is not registered in Scotland, and who intends to seek registration as a clinical teacher on successful completion of the course, is advised to apply to the General Nursing Council for Scotland for registration as a general nurse before commencement of the course, thus avoiding delay in registering as a clinical teacher assuming that Council's requirements have been met.

(over)
CONDITIONS OF ADMISSION TO THE COURSE (contd.)

4 Midwives working in Scotland should inform the Central Midwives Board for Scotland of their intention to apply for the course in order to ensure that their experience will meet the Central Midwives Board requirements regarding midwifery enrolment and practice for the award of the Midwife Clinical Instructors certificate on successful completion of the course.

5 Candidates must possess a Scottish Certificate of Education (or its equivalent) in two subjects at "Ordinary" grade, one of which should be English.

6 All applicants should be prepared to sit the College entrance test.

7 Professional references and a personal interview are necessary before an application can be completed.

FEES

Course fee (including examination fee) -

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>British students</td>
<td>£100</td>
</tr>
<tr>
<td>Overseas students</td>
<td>£160</td>
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</tbody>
</table>

Fees are payable in advance or on arrival to take the course. Guidance on financial assistance may be found in SHM 73/1971 (Scotland), HMC (54)28 (England and Wales, Northern Ireland).

43/44 Heriot Row
Edinburgh EH3 6EY
031-225 7231/2
The course is specially designed to give experienced nurses the opportunity to improve their methods of bedside teaching.

Students are prepared for the CLINICAL TEACHERS CERTIFICATE of the Royal College of Nursing and National Council of Nurses of the United Kingdom.

On successful completion of the course (provided requirements of the respective bodies have been met) nurses may apply for -

registration as clinical teachers by the General Nursing Council for Scotland

the Midwife Clinical Instructors Certificate of the Central Midwives Board for Scotland.

SYLLABUS

NORMAL AND DISORDERED BODY FUNCTION The topics include -

Blood. Anaemia, response to infection and disorders of clotting.

Heart and vascular system. Heart failure and hypertension.

Body fluids. Acidosis and alkalosis, dehydration and oedema.

Respiration. Dyspnoea, carbon dioxide retention, cyanosis.

Renal function. Renal failure.

Endocrines and disorders of function.

Liver. Hepatic failure and jaundice.

Nervous system. Paralysis and sensory loss, coma, disorder of speech.

Reproduction.

Regulation of body temperature.
SYLLABUS (contd.)

PRACTICAL PHYSIOLOGY AND SCIENCE
These lectures run concurrently with those on normal and disordered body function.

PSYCHOLOGY
The learning process.
Intelligence and methods of testing.
Memory: observation, understanding, recall, recognition, forgetting.
Conditioning. Problem solving.
Learning of skills. Fatigue.
Personality. Freudian theory.
Attitudes: positive and negative.
Needs of patients, effects of hospitalisation.
Needs of students.

NURSING EDUCATION
Methods of teaching. Audio-visual aids.
Training for the Register. Training for the Roll.
Systems of nursing education.
Examination and assessment.
Recruitment and selection of nurses.
Curriculum planning.
Current trends in nursing education.
Post-registration education.

continued
SYLLABUS (contd.)

NURSING EDUCATION (contd.)

Clinical Teaching. - The role of the clinical teacher.
Principles of patient-centred teaching.
Organisation of the clinical teacher's work.

Two weeks' visits of observation in schools of nursing.

ETHICS
Ethics and codes of morality.
Basic ethical concepts. Selected ethical theories.
Specific medico-ethical issues: birth and death; drugs;
clinical experimentation; biological research; patients' rights; uses and abuses of authority; current issues.

HISTORY OF NURSING
The Nightingale system of training.
Developments in nurse education.
Statutory bodies. Professional associations.
Some recent reports in nursing.
Experiments and advances in nursing.
SYLLABUS (contd.)

CONTEMPORARY SOCIAL BACKGROUND


PSYCHIATRY


EXAMINATION SUBJECTS

Three written papers of three hours each -
1 Normal and Disordered Body Function
2 Psychology
3 Clinical Teaching

Selective oral examination in 1 and 2.

Each student is asked to undertake a project which will be taken into consideration in the final results.
(Teaching to be geared to the level of the Clinical Teachers course. Time allowed: 20 minutes. Each lecturer is expected to provide a list of teachers' objectives for the lesson and a tool to measure achievement. Each member of the group should be given an opportunity to introduce the lecturer and accord a vote of thanks.)

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Lecturer</th>
<th>Date</th>
<th>Topic</th>
<th>Lecturer</th>
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</thead>
<tbody>
<tr>
<td>16.2.73</td>
<td>Intelligence and how it is measured.</td>
<td></td>
<td></td>
<td>The role of water and sodium in extracellular fluid.</td>
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<tr>
<td></td>
<td>Group A</td>
<td></td>
<td></td>
<td>How oedema results from a reduction in plasma albumen.</td>
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<tr>
<td>16.2.73</td>
<td>Heredity and environment in relation to the Intelligence quotient.</td>
<td></td>
<td></td>
<td>Restoration of the circulating blood volume following a donation of blood.</td>
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<tr>
<td></td>
<td>Group B</td>
<td></td>
<td></td>
<td>How the body re-establishes its constant fluid balance following an intravenous infusion of 2 litres of isotonic saline.</td>
<td></td>
</tr>
<tr>
<td>23.2.73</td>
<td>Knowledge of the criteria of maturity can influence methods of teaching.</td>
<td></td>
<td></td>
<td>Why blood refuses to clot in haemophilia.</td>
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<tr>
<td></td>
<td>Group A</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>23.2.73</td>
<td>Motivation in adult student learning.</td>
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<tr>
<td></td>
<td>Group B</td>
<td></td>
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<tr>
<td>2.3.73</td>
<td>Effects of authoritarian and permissive teaching in adult education.</td>
<td></td>
<td></td>
<td>Mitral incompetence and its effect on the systolic blood pressure.</td>
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<td>Group A</td>
<td></td>
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<tr>
<td>2.3.73</td>
<td>The effects of reward and punishment on the process of learning.</td>
<td></td>
<td></td>
<td>Renal hypertension explained.</td>
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<tr>
<td></td>
<td>Group B</td>
<td></td>
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<tr>
<td>Date</td>
<td>Group</td>
<td>Topic</td>
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<tr>
<td>9.3.73</td>
<td>Group B</td>
<td>Learning experiments on animals and their relevance to human learning.</td>
<td></td>
<td>Acetone may present in the urine of a fasting patient. Why does coma not ensue?</td>
<td></td>
</tr>
<tr>
<td>13.3.73</td>
<td>Group A</td>
<td>Factors influencing the steepness in the curve of forgetting.</td>
<td></td>
<td>Protein metabolism and its relevance to the dietary management of uraemia.</td>
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<tr>
<td>13.3.73</td>
<td>Group B</td>
<td>Gestalt theory on learning with examples of its application to teaching.</td>
<td></td>
<td>Thyroid function in the maintenance of body temperature.</td>
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<tr>
<td>14.3.73</td>
<td>Group A</td>
<td>Behaviourist theory on learning with examples of its application to teaching.</td>
<td></td>
<td>Ov-secreton of the three zones of the adrenal cortex results in Cushing's syndrome.</td>
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<tr>
<td>14.3.73</td>
<td>Group B</td>
<td>Identification.</td>
<td></td>
<td>Paralysis can be spastic or flaccid depending on the motor neurone affected.</td>
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<tr>
<td>15.3.73</td>
<td>Group A</td>
<td>Teaching and learning motor skills.</td>
<td></td>
<td>The value of oxygen therapy in hypoxia.</td>
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</tr>
<tr>
<td>15.3.73</td>
<td>Group B</td>
<td>Curriculum planning based on the principles of educational psychology.</td>
<td></td>
<td>Cautions to be observed in the administration of oxygen to patients with chronic chest disease.</td>
<td></td>
</tr>
<tr>
<td>16.3.73</td>
<td>Group A</td>
<td>Knowledge of the laws of learning can improve personal study.</td>
<td></td>
<td>How tracheotomy and the administration of oxygen minimize the risks associated with intermittent positive pressure respirators.</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td>Interpretation of electrocardiograms.</td>
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OVER the past four years I have been studying the relatedness of theory to practice in nurse education. My field of investigation was the three-year Registered General Nurse training programme in Scotland.

First, I conducted a survey to elicit the nature and extent of agreement between theoretical instruction and hospital practice. For the survey the sample consisted of 521 students in their first, second, and third years of training, and 59 tutors (the word tutor in this instance is used to include both tators and clinical teachers, registered and unregistered).

The sample was drawn from seven schools, representing the five Scottish regions. After giving a questionnaire to the students, I engaged them in open discussion and interviewed their tutors. The general conclusions from the survey were:

(a) in the opinion of the students and tutors, theory and practice need to be related more closely;

(b) relating theoretical instruction to practice was expected to be, in the main, the students' own responsibility;

(c) theoretical instruction did not sufficiently reflect the complexity and variability of the real situation;

(d) theoretical instruction in the classroom cannot prepare the student for the range and diversity of the situations encountered on the wards.

These conclusions, reached on the basis of the survey results, suggested the lines I should take in planning the experiment which followed.

The purpose of the experiment was to explore the possibility that teaching on the basis of a real "situation" (this concept will be clarified later) would help:

(i) to relate theory to practice on a closer and deeper basis;

(ii) to develop the inferential ability of the student, so as to make more effective use of the relatedness.

Five schools of psychiatric nursing tried out the experimental course of teaching with five groups of students during their psychiatric nursing secondment. Each group was divided into an experimental and a control group. The total student sample was 74 (38 students in the experimental group and 36 students in the control group). Both groups (experimental and control) were taught for the same number of hours, at the same time of day and week; the subject matter also was the same. The only difference was in the organisation and presentation of the subject matter. The control group was taught as before, and the experimental group in the way I suggested (Figure 1).

The results of the experiment suggested the need for a longer period of trial, but the overall tendency favoured the experimental group.

**CLARIFICATION**

"Relate" versus "integrating"

I make a distinction between relating and integrating because I see the processes involved to be different. An understanding of the nature of these processes is essential if an effective interaction between theory and practice is to be achieved. Several factors would decide which of the two processes, one leading to relating and the other to integrating, is the more appropriate and hence, probably, the more effective. The distinction between the two processes is based on the following factors.

1. The nature of each of the elements which are involved, such as theory and practice; in other words, the distinction between education and service. To illustrate what is meant, one can talk of relating two individuals through a common interest, but not of integrating them, however extensive the common ground.

2. The purpose of the process. In what different circumstances are integrating and relating needed?

If I have two elements, A and B, which I wish to integrate, the outcome is a third element, C, which, though still including characteristics from both A and B, also acquires new characteristics. For example: let A = 2 and B = 5. I could integrate them by multiplying them: 2 × 5 = 10. Then 10 would represent C. Or, let A = 4oz flour, B = 2oz butter. F = 1 egg. I could integrate them by mixing and baking them in an oven to produce a cake. The outcome "cake" would represent C.

If, however, I have two elements, A and B, which I relate, the outcome is a series of links. A number of links that I would be able to establish depends on the nature of the study or knowledge of the elements A and B. Take, for example, A = 2 and B = 5. I could relate them by identifying some links between them. Both 2 and 5 are numbers, both are numbers of the set of whole numbers less than 10, 2 is an even number while 5 is odd. Links can be either via similarities or via differences. Or, again, take A = 4oz flour, B = 2oz butter. F = 1 egg. I could relate these by identifying the following links among them: all three are foodstuffs, all are measurable and countable, all can be used in baking and/or cooking, in terms of weight A is twice B, in terms of number of units B is twice F, all three could combine separately with different ingredients, both A and B are derivatives — flour from wheat and butter from cream — while F is a primary product. The list could be extended by pointing out their individual roles in different contexts, eg, in baking, flour gives consistency, butter gives smoothness, egg gives flavour and volume.

3. The nature of each process involved. The process of relating is different from the process of integrating.

In the case of integration, fusion occurs and the distinction between A and B becomes blurred and, to an extent, lost. The cake in this example is made up of flour, butter, and egg, but these ingredients cannot be reconstituted in their original forms, nor identified as "wholes" in the cake. This could be graphically represented as in Figure 2.

In the case of relating, the distinction between A and B is retained as well as the individuality and identity of each A study of A and B provides information which helps to establish links similar...
Experimental design (8 weeks)

Figure 1

Blurred boundaries

Figure 2

Key
E = Experimental group.
C = Control group.
AI = Adult I verbal reasoning test given to both E and C group.
HO = Handouts given to both groups. These included: objectives of the course, principles of psychiatric nursing, observation guide, and legal notes. All were written in jargon-free language.
T = Teaching (which was the only different activity). The topics taught were the same, but the approach different.
Ev = Evaluation of the course by the students of both groups. This was in the form of a rating scale of the different activities (e.g., nursing lectures, hospital seminars, work on the ward), and the handouts, as to the extent each of these helped them understand and work on the ward.
Qu = Questionnaire about the students' perception of the relatedness of the theoretical instruction to the practical experience.
F = Factual test, for general knowledge gained during the experience.
I = Inferential test, specially constructed to test the inferential ability of the students.
1-8 = Weeks, psychiatric secondment being of eight weeks' duration.
ties and differences) between them. They can be combined in numerous ways so that there is more room for flexibility. A return to the basic element is easier and follows clearer lines. Graphically this could be represented as in Figure 3.

On the basis of distinctions such as the above, it seems reasonable to suggest that relating is more appropriate and has better prospects of effectiveness than integrating, when applied to education and service or theory and practice. Education and service each have their individuality and identity. Education is mainly conducted in the school and follows a predetermined plan within a time limit specified in advance. Service takes place in the community (hospital, centres, clinics, homes) and only its general structure is planned. Problems arising from the variety and complexity of activities within that structure are dealt with as they arise. Furthermore, there are no rigid time limits. While change occurs in both fields, education and service, the time scales and directions of such change are not necessarily the same.

Factors such as these, and many others which no doubt the reader could supply, tip the balance in favour of relating.

What is it that needs relating?

A closer look at the relatedness of theoretical instruction to practical hospital experience is best achieved through a study of the relatedness of education and service.

As a starting point, education could be considered as the planning, organisation, and execution of nursing care (in its broadest sense) to patients, clients, and mothers. Both education and service occur within the same frame of reference, namely nursing.

One can go a step further and say that basically what needs to be studied is the relatedness of nursing, education, and service. This can be diagrammatically represented as in Figure 4.

There is mutual interactive relatedness among the three elements. Which of the three is dominant at any one time depends on the nature of the situation and one's standpoint at that time.

Hence, in order to plan, to organise, and to execute an educational programme, one needs to establish:

(a) the context in which it takes place, i.e., nursing;

(b) the purpose it is trying to achieve, i.e., service.

Guidelines for the educational process

Another aspect to consider in arriving at such a programme is the answer to the following basic questions:

(i) What is it that we want the student to learn? Is it a certain amount of knowledge and a number of skills? Is it a way of thinking and an ability to apply the knowledge and skills gained?

(ii) How will she best learn what we hope she will learn? Is it by lectures? By discussions? By demonstration? By examples?

(iii) What is the purpose of this learning? Is it to cope with the variables of a situation, one or more of them at a time? Is it to cope with the situation as it occurs in toto?

From the literature one can infer that innumerable abilities, knowledge, and skills are expected of the student nurse. These need to be thought of as pre-packaged qualifications already present at recruitment, rather than potential abilities capable of development through the educational programme. For instance:

- "The profession must recruit . . . from people of widely different abilities and temperaments. Among them must be people capable of initiating ideas, carrying heavy responsibilities, and meeting on equal terms with opposite numbers in other professions . . ."

Or again:

- "The need to attract into the profession tolerant, experienced and well-educated people."

The literature also indicates a tendency towards the study of the variables involved in a situation: one or more studied at a time, rather than the study of the whole (gestalt) situation and the relatedness of its variables.

- "However, the educational process is a complex set of interacting influences and no attempt should be made to evaluate it through a single all-inclusive study."

Unfortunately, this tendency leads to fragmentation and distortion of the real situation. Discussing the artificiality of a controlled situation Parlett and Hamilton (1972) say:

- "rarely can tidy results be generated to an 'unreal' reality."

And Piliner (1973) says:

- "The results of the experiment are nearer and more precise. The account written for the appropriate journal has the appearance of a four-square and complete job - yet the whole exercise may turn out to be of dubious relevance to the teacher in the classroom and the children under his care, simply because it is too aseptic, too cleaned up . . . "

In short, there is a need to take into account the "unreal" reality of the situation in order to avoid frustration, disappointment, and wastage of effort all round.

Suggested approach

Bearing in mind that learning is multidimensional, that it takes place over a period of time, and that it occurs within a context, my suggested general answer to the previous questions is as follows:

We need to help the student achieve in a way of thinking which will enable her to understand the situation in toto and to develop the ability to infer from that situation the relatedness of its variables in order to make decisions about its management.

The concept of a situation is multidimensional, with:

1. a framework consisting of human, temporal/chronological, geographical, and environmental components - this last includes material and immaterial variables of the situation, e.g., policies, culture, feelings, etc;

2. dynamics: the result of interaction among the different components (represented in Figure 5 by the arrows and circles);

3. volume: the extent and depth of involvement of the variables in a given situation.

For example, a typical teaching situation involves a tutor and one or more students (human component). Teaching takes place in a classroom or laboratory, or on the ward (place/geographical component) and this influences what, how, and why a certain topic/subject is taught. Also present is the "atmosphere" which qualifies the relationship between students and tutor (environment). The whole situation takes place at a certain time, either before, during, or after a given activity (time/temporal component). Each of these variables plays its own role and their interaction defines the situation. It is to be expected that some variables will play a greater part than others in defining different situations.

This concept of a nursing situation was the basis of the experiment in teaching: the subject matter was organised and presented in accordance with this concept. The situations used for teaching were chosen from the reality of the hospital wards in the belief that this would help relate theoretical instruction
to practical application at a fundamental level. It was hoped that this approach would increase the students' awareness of the different variables involved and their relatedness in given situations, and that it would help to develop their inferential ability.

**SUMMARY**

The approach that I advocate consists of an informed way of organising one's thoughts about nursing in order to make maximum use of the potentials which are present. By an informed way, I mean one which fosters awareness, knowledge, and understanding of the elements involved and of their relatedness.

Our perception of the standing of education in relation to its content and purpose, as well as our understanding of the process chosen for such a study, ie relating rather than integrating, is basic to our achievement of an effective planning, organisation, and execution of the educational process. In relating, even if only few links were to be established, this would be informative, meaningful, and useful in generating new connections. Integrating implies unification which, even if achieved, would be infertile in the study of education and services as they each have their own identity, losing such identity could only add to the complexity of the problem.

I see the approach I have outlined as a way of planning, organising, and conducting nurse education which enables us both to practice what we preach and to preach what is practicable.

**References**


My thanks to my supervisors and colleagues for their help in reading this script and suggesting changes.

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APPENDIX IX.

Statistical Appendix

Chi-square test:
This is a test used to determine whether differences among sets of discrete frequency data, are significantly different from expectation.

The basic formula is:–

$$X^2 = \sum \frac{(O - E)^2}{E}$$

where

- $\xi$ = Sum of
- $O$ = Observed data
- $E$ = Expected value of the data

Kolmogorov-Smirnov Test:
This is a non-parametric test used to determine whether two independent samples could have been drawn from the same population or from populations with the same distribution. The one-tailed version of the test has the power to establish not only the significance of a difference between two sets of data but also the direction of that difference. The test focuses on the larger of these differences, $D$.

The formula is:–

$$D = \text{maximum} \left[ S_{n_1}(X) - S_{n_2}(X) \right]$$

where
- $n_1$ = first population sample
- $n_2$ = second population sample
- $X$ = Score corresponding to the different categories making up $n_1/n_2$

$S_{n_1}(X)$ corresponds to the value of the sum of each score $X$ divided by $n_1$ or $n_2$ accordingly, the significance of $D$ is calculated by applying the formula:–

$$X^2 = 4D^2 \frac{n_1 n_2}{n_1 + n_2}$$
Which was shown by Goodman 1954 (in Siegel 1956) to have a sampling distribution approximated by the Chi-square distribution with two degrees of freedom.

**Kendall's co-efficient of concordance - W.**

This is a non-parametric measure of correlation used to determine the degree of association or agreement among several sets of rankings of N objects or individuals. Most other rank correlation techniques are limited to two sets of ranking of N objects or individuals and hence would not have suited my purpose.

The formula is:

\[ W = \frac{12S}{K^2 n(n^2 - 1)} \]

Where \( S \) = sum of squares of the deviations of the total of the ranks obtained for each object from the average of these totals, i.e.

\[ S = \sum x^2 - \frac{\left( \sum x^2 \right)}{n} \]

\( n \) = number of objects ranked
\( K \) = number of sets ranked

\( W \) can have a value between 0 and +1; 0 indicates total disagreement and 1 total agreement.
**Student's t Test:**

This is a parametric test used to determine the significance of the difference between the means of two independent samples of observations, derived from normally distributed populations.

The formula is:

\[
t = \frac{x_1 - x_2}{\sqrt{\left(\frac{\sum(x_1-x_1)^2 + \sum(x_2-x_2)^2}{n_1 + n_2 - 1}\right)\left(\frac{1}{n_1} + \frac{1}{n_2}\right)}}
\]

\(x_1\) and \(x_2\) are the sample means.

\(\sum(x_1-x_1)^2\) and \(\sum(x_2-x_2)^2\) are the corresponding sums of squares of deviations from these means, \(n_1\) and \(n_2\) are the sample sizes.
Pearson Coefficient of correlation $r$:
This is a parametric test to establish the degree of correlation or correspondence between two sets of scores or marks $x$ and $y$ which represent measurement on an equal-interval scale.

The basic formula is:

$$r = \frac{\sum (x-\bar{x})(y-\bar{y})}{\sqrt{\sum (x-\bar{x})^2 \sum (y-\bar{y})^2}}$$

Where the symbols have the same meaning as in the formula for Student's $t$.

The coefficient of correlation can range in value from $-1$ to $+1$, where $+1$ represents perfect agreement, and $-1$ represents perfect disagreement. Intermediate values represent degrees of imperfect agreement or disagreement. $r = 0$ represents complete absence of relationship between the pair of measures (randomness).
Analysis of Co-variance:

This is a statistical procedure of control, which allows more flexibility in experimental designs. In comparing two methods of teaching, for example, it can be difficult to match the experimental and control groups on an extraneous factor like intelligence, or length of time studying. This could be done by using analysis of co-variance which establishes the connection between final attainment and intelligence 'within each group'. If one group is superior in intelligence, the co-variance procedure takes account of this in estimating attainment.