other fundamental moral value is given priority after due consideration of the different claims in the light of all of the agreed moral values and in accordance with the formal principle of justice then justice, it seems to me, is done.

Thus if, in the context of allocating scarce medical resources, practical systems were set up for resolving conflicts about which value, in a particular case, should have priority, and if those systems took account of the fundamental moral values of respect for autonomy, beneficence, and non-maleficence, and if their deliberative structures incorporated Aristotle's formal principle of justice with its demands of formal equity, impartiality, and fairness then they would be just systems and their deliberations could be expected to yield just results despite (perhaps because of) the conflict within them. I doubt if better than that is achievable. Is less acceptable?

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Dr Gillon's articles on philosophical medical ethics will resume later in the summer.

Green College Lectures

Contemporary challenges in education for the caring professions: education for nursing, midwifery, and health visiting

JEAN McFARLANE

Diversity of roles in nursing

The "greater nursing profession" encompasses many roles as expressed in the *Report of the Royal Commission on the National Health Service*¹:

"Within nursing there are many levels of skill and different roles. . . . Nursing is an immensely varied profession. In hospitals, nurses work in acute, long stay, children's, psychiatric, maternity, and other specialised units. Outside hospital there are health visitors, home nurses, midwives, and nurses working in clinics and in general practice, as part of the primary health care team. Nurses work in administration in the NHS and health departments, in education and research, the armed forces, voluntary organisations such as the Red Cross, occupational health and international agencies. There is a great deal of overlap in the knowledge required in many branches of nursing."

This diversity of roles, however, encompasses many different competencies and models of care. The nurse in an intensive care unit needs to combine a high level of technological competence with individualised care that supports the patient, who is experiencing

not only physical but psychological and spiritual trauma. By contrast, the psychiatric nurse uses the skills of person to person interaction as a therapeutic tool. Much of the work of nurses in the area of mental handicap lies in the use of education strategies for social skill training. The paediatric nurse needs to be able to integrate therapeutic skills with care that will facilitate and maintain normal human development. Midwifery and health visiting have been identified as separate professional roles. The midwife assists the mother in a normal human function that is only potentially related to pathology (which the midwife must be able to recognise). She is a practitioner in her own right and has considerable decision making autonomy in her area of competence. She spends a high proportion of time using health education skills. The health visitor has a major concern with primary prevention and uses skills of health education, counselling, and social advice. The role of the health visitor is in the domain of health, but she uses knowledge and skills from the disciplines of education and social work.

Commonalities and interfaces

The nursing curriculum has thus to be designed to prepare for a diversity of roles and models of care. We have to question what commonalities exist in the knowledge and skills needed and to what extent there is a core curriculum or foundation course that, desirably, should be common to all. At what stage should specialisa-

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tion begin? Can we afford the length of education that would prepare for a diversity of professional roles or can we afford the cost of re-entering the educational system when mobility of manpower and retraining may be required between specialised roles?

Some of the commonalities I would identify are skills in communication and interpersonal relationships and in education and decision making and the ability to assist with daily living activities. These then need to be applied in special settings. The commonalities of knowledge underlying these skills are the health sciences (anatomy, physiology) and the behavioural sciences (psychology, including social and developmental psychology, the sociology of health and illness, and social policy). Some medical sciences are important. There is a case for all having some knowledge of epidemiology and pathology, but a knowledge of pathology may be less important in the case of health visitors and mental handicap nurses.

Developments in the nursing curriculum

Early curriculum structures were detrimental to nursing practice, creating a yawning gap between theory and practice. They were pale reflections of the medical curriculum and dealt with body systems and diseases. Much of that was redundant knowledge because it was irrelevant and neglected the emerging body of knowledge relevant to nursing practice. The nursing curriculum has passed through fashions of attempting to integrate the content or use a dialectic theme such as human development or "total patient care." More recently, a problem orientated approach has been used. In my own department the second year core curriculum is organised round commonly occurring patient problems—for example, fluid and electrolyte balance, mobility, stigma, grief. Focusing on patient problems that are responsive to nursing care enhances nursing decision making. As yet I see no sign of a coherent organising framework in the statutory syllabus. It shows a mixed approach and retains remnants of the old alongside the new. Furthermore, preparation for different aspects of nursing (general, psychiatric, sick children, etc) is most often undertaken on a serial basis.

Advances have certainly been made. We have attempted to integrate theory and practice in modules of experience. The modules include experience in community and hospital settings and in the major areas of nursing, but we have sacrificed time for consolidation of practice in acute and general settings to gaining a breadth of view in different areas of nursing. We have made some advances in teaching communication and interpersonal relationship skills, but the hours available and the preparation of those who teach are inadequate. Of the three years allowed for basic training only 26 weeks are school based, and there is now a formidable group of studies that show the inadequacies of the ward as a learning environment.^{2,6}

Progress was made in post basic clinical education by setting up the Joint Board of Clinical Nursing Studies in 1970. Although the courses were established in response to the felt need of both medical and nursing professions, there does seem to have been a great proliferation of specialties. In 1982 there were certificate courses in 70 clinical areas and "statement of attendance" courses in 27 (J Rogers, unpublished data) which raises the question of whether some rationalisation of advanced clinical roles is not needed. Despite prolonged discussion the profession has still not established how advanced roles can enhance the clinical function of the nurse and how they should relate to established roles like that of the ward sister. Post registration clinical education is thus available but lacks a clear career structure, and relatively few registered nurses are seconded to the courses that would give them the most adequate preparation.

Educational advances have been made in primary care nursing. Health visitors have profitably clarified the principles underlying their function,⁷ and their one year courses in the higher education sector with well planned field supervision of students are probably a model for professional education. District nurses have achieved similar access to higher education, a lengthening of their course to nine months, and a curriculum based on a decision making model.

The length of midwives' training is now 18 months after state registration. These are no doubt advances, but how far have we progressed in the adequate preparation of nurses, even at basic level, for patient care?

How well are we doing?

That question may be answered by drawing on some of the studies that have been carried out at Manchester for degrees at master's and doctoral level. In brief, they indicate many inadequacies in nursing practice. There is a lack of ability to assess patient needs and plan focused care, an inadequate basis of knowledge for care of the elderly and for intensive care nursing, and of basic research. Care is often physically orientated and lacks provision for psychological, social, and spiritual needs; it is often routinised rather than individualised. Further studies show that students are inadequately prepared for communicating with patients and that during training, skills in empathic relationships are not improved to a level needed for a helping relationship; indeed the experience of nursing education appears to inhibit rather than foster human relationship skills.⁸⁻¹⁴

I suggest that, despite its very best endeavours, working parties and reports in each decade, and a new statutory structure, the system of nursing education has not equipped practitioners of nursing with adequate knowledge and skills for twentieth century practice in a diversity of roles. Hopefully, there are at the moment at least three groups (Royal College of Nursing, United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, and English National Board for Nursing, Midwifery, and Health Visiting) attempting to find solutions, and we await their reports with interest.

The future

My personal view is that nursing is a practice discipline ideally functioning in a complementary relationship with medicine and other health professions. Its special domain is the daily living or self-care activities contributing to health, but the objects, methods, and requisite models of care vary considerably in different nursing roles. Education for nursing needs to be soundly grounded in those skills and sciences that give insight into human functioning as outlined above. The present system is inadequate for this, and we must now make an informed decision on whether or not to maintain the status quo, recognising that the standards of physical and psychosocial care we have expected of nursing cannot be met.

If we do maintain the present position, then we must absolve nurses from striving to meet unattainable expectations. Consumers of health services must be made aware that they cannot expect a nurse to be caring; she will give maintenance care, and in some roles custodial or routinised care, but she will not be equipped to think, make decisions, or recognise changes still less to comfort, console, counsel, or teach. She will be a passive pawn with prescribed moves in the game of health care. If, however, nursing is to give personalised and humanistic care, to research and innovate in its own field, complementing the work of others, then this must be made explicit and strategies for its achievement developed. These include entry to the profession, the learning environment, teaching strategies, and the structure of nursing education.

ENTRY TO THE PROFESSION

Entry to the profession may well be achieved by a common core or foundation course, which could then lead directly into a specialised area—for example, general, children's, or psychiatric nursing, midwifery, or health visiting. This direct entry to specialist areas, as opposed to a qualification in general nursing being a pre-entry requirement to all areas, would save resources. It may lose some of the breadth of view and sharing of outlook that is inherent in the present system, but these can be provided for in the common

foundation course. Some people also question whether entry to health visiting could be via social work, and mental handicap nursing via education, as well as through nursing.

LEARNING ENVIRONMENT

The academic environment for learning the biological, behavioural, and research basis of knowledge must change. There is no essential reason why a school of nursing could not offer as good a course as a college of higher education and in a better physical environment. Though I admire much that I see in schools of nursing, somehow they are not producing the kind of practitioner we need. It is partly because they are unidisciplinary monotechic establishments, often teaching nursing in a teacher centred way with the teachers acting as generalists to the whole syllabus and lacking a knowledge of research. It is not enough for the school to call in one or two psychologists, physiologists, or pharmacologists, or even to make a full time appointment from each of these disciplines. The teachers of the support sciences in nursing need to be drawn from those disciplines and be versed in the scholarship and research of their discipline. More explicitly, I am convinced that education for nursing needs to be set in a multidisciplinary college where the standards of scholarship can enhance the study of the discipline of nursing. This will mean a careful choice of suitable academic environments and also re-education of nurse educators so that they can adapt to and use and contribute to the learning communities. A range of such environments should be explored; some will, as in my own case, be set in a medical learning environment but as part of a larger learning community. What I am not advocating in the first instance is a move to higher education for the purpose of becoming a totally graduate profession. I am advocating a different kind of learning community with a multidisciplinary faculty and strong research base and the ability to move between diploma and degree level work.

The myth dies hard that it is impossible to organise a programme that leads to clinical competence from an academic institution. The medical schools have excelled at it for many years. My own department is currently celebrating 25 years doing just that. Health visitor and district nursing education is organised effectively in this way from polytechnics. I am glad that the Royal College of Nursing has commissioned manpower studies and economic studies of the comparative cost of educating nurses in different settings, for these are the facts on the basis of which we shall have to make decisions. In Australia the whole of nursing education is being transferred into general education with projected savings. As I have travelled I have been able to assess nursing degree programmes in Iraq, Saudi Arabia, India, and the Philippines. In Canada, New Zealand, and Australia the transfer to general education has been made or is being made. It seems that we lag behind the rest of the world. With a contracting pool of available manpower for entry into nursing, midwifery, and health visiting, it is worrying that we may allow the cream of potential students to be recruited to other professions so that the least well endowed and the less creative are those who will enter this profession—one that demands high level scientific and humanistic skills.

The clinical learning environment is as important as the academic learning environment, and for nursing, midwifery, and health visiting this consists of community and institutional settings. In general nursing the ward environment has been shown to be unsatisfactory in several studies.^{2,6} Skilled performance will come only with repeated practice so the student will give service in the process of learning to nurse, but that is no justification for the student holding employee status or being left unsupervised. There is evidence that close supervision and feedback are needed especially in the early stages of learning skills; in the first year there should be particularly close supervision as in a good apprenticeship. Since that word has many misconceptions associated with it I believe that there should be a system in which registered nurses would be identified as preceptors who work on a one to one basis with students, integrating theory with practice, giving feedback, and assessing clinical competence. The preceptor should have a

joint function relating to the school and to service and carry her own patient case load. She should be recognised as one who has shown excellence in patient care and who can manipulate clinical experience to the advantage of the student. She should be trained for her role in teaching as are the field work instructors and practical work teachers in community nursing. Student status does not imply the withdrawal of all student service from the wards. It does mean controlled and supervised experience. The present apprentice/employee status is in my view a deterrent to the effective learning of nursing.

TEACHING STRATEGIES

The student needs to enter a learning community that is less teacher centred and didactic, and that fosters self-actualisation and flexible and creative behaviours. If the humanistic and moral objectives of education for a caring profession are to be achieved then the nurse needs to develop as a person. Not only is education in communications and social and educational skills needed, but the practitioner needs also to be capable of making decisions including ethical decisions. Murphy¹⁵ showed that most nurses were arrested at Kohlberg's conventional stage of moral development—that of maintaining authority and social order.¹⁶ Few nurses seemed to reach the level of principled action. That ideal can be achieved only in an educational setting in which moral conflicts are confronted and worked through rather than in one in which the rules of an organisation are arbitrarily applied.

STRUCTURE FOR NURSING EDUCATION

As with other caring professions, the regulation of the three professions has much to do with regulating entry through the educational system. In the case of nursing, midwifery, and health visiting in the United Kingdom the Briggs Report (1972) resulted in the Act of 1979. Nine bodies that previously regulated the professions were brought together in five new statutory bodies—the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting and four national boards. The independent statutory status of the boards has provided for a sharing of responsibility that allows for unifying policies to be made by the central council and for liberal interpretation of policy by each of the four boards. The role of the council in respect of education is to establish and improve standards of training and, by means of rules, determine the conditions of a person's being admitted to training and the kind and standard of training to be undertaken with a view to registration and further training. The boards' role is to provide or arrange for others to provide at approved institutions courses of training and further training for nurses, midwives, and health visitors and to hold or arrange for others to hold examinations to these ends. This they must do in such a way that the requirements of the council regarding content and standard are met. The shadow council and boards composed of appointed members were established in 1980 and served until elections took place in 1983. They had the gargantuan task of taking over the staff and functions of the existing bodies and of attempting to establish working policies from very diverse approaches to approval of training institutions, conduct of examinations, etc. For example, some had centralised examinations, whereas in others this function was devolved to the training institutions; some had centralised staff who acted as inspectors in training institutions, others had regional staff who acted in an advisory capacity. Besides all this, the preceding bodies had very different approaches to the control of professional conduct. It is of credit especially to the staff of the new and old bodies that they are now in place and functioning. The central council has developed new rules in consultation with the boards. These allow for a less restrictive and more innovative approach to nursing education and are framed in terms of basic competencies. The rules are the "touchstone against which existing syllabi, examination systems, and regulations" have to be tested. In England the syllabuses developed in 1982 for mental and mental

handicap nursing are in accord with the rules, but those in general and paediatric nursing have not been changed for some years and need revision. The rules relating to midwifery training were the subject of a consultative paper from the central council in 1984. Work is in progress in respect of the approval of training institutions, the content of syllabuses, and methods of assessment and examinations. The new rules seem to have enough flexibility to allow for innovation and the possibility of producing a practitioner of nursing, midwifery, or health visiting more closely allied to present needs. But whether the whole statutory framework with council, boards, and committees is too cumbersome and totally unrealistic in its demands on members is debatable. It endeavours to do what the General Medical Council and all the royal medical colleges do for medicine—a profession which is numerically far larger. The size and cost of the nursing service are such that the economic and manpower implications of any changes must be given serious consideration.

Conclusions

If I have painted a somewhat negative picture of the present state education for nursing, midwifery, and health visiting it is not that I am unaware of progress but conscious of the needs to diagnose our inadequacies if we are to meet the needs of the future. Those health care needs are far wider than I have had time to refer to here. The need for emphasis on primary care, as well as on high technology care, and the need to develop new ways of caring for the elderly, the long term sick, and those with diseases of self infliction challenge us. I would regard it as a professional responsibility to carve out a future

in which nursing makes a responsible contribution, but that can only be done as we consult and interact with other health care professions.

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MATERIA NON MEDICA

Transatlantic chat

In the first place I could not find my way to the television studio at all, and when I did it was on the top floor of an enormous skyscraper. I was late and this made me even more nervous than usual. As it happened, my host had not arrived either. Nor did he appear as the minutes ticked by towards the deadline. To let you know, I was one of an international group visiting American hospitals and for some reason they had volunteered me to appear on his chat show.

At last he rushed in, shouting loudly to the studio crew, "Where's the blasted guest?" I stepped forward. "What's your name? What do you do?" he bellowed, shedding his hat and coat haphazardly. I told him as best I could. "What kind of a doctor is that?" he cried in horror. Before I could answer he carried on, "Married? Any family? How old? Where's your wife? I'll call you Bill, OK? You're an expert on health economics, right?" "No!" I yelled in desperation. "I know nothing about them." He glared at me aggressively. "What do you know about then?" "Well," I said, feeling faint, "I've just published a paper on health centres." He stared at me suspiciously. "What the heck are they? How can I put this show on the road? Nobody knows from what."

While this frenzied exchange was taking place and I was stuttering answers, we were being brushed, combed, powdered, and led over to a corner of the studio. This was laid out like the hearth of an upmarket home. Two easy chairs were placed on either side of a low table on which rested coffee cups and a plate of biscuits. As I sat down in a state of panic bordering on *angor animi*, a disembodied voice echoed overhead, "Five, four, three, two, one and—now!"

The change in my interrogator was remarkable. Mr Hyde became Dr Jekyll. He smiled benignly into the camera. "Well folks," he said, "this afternoon we are mighty privileged to have with us a doctor from the British Isles. Bill—he says I've to call him that—is over here to see how we run our hospitals—and show us a few things too, I bet." He beamed at me affectionately. "The good doctor," he continued, "I am glad to say, is happily married to a charming Canadian lady and he has two sons. Both, he told me as we chatted together before the programme, are working hard at university back home. And that is why your good lady is not with you, eh, Bill? Someone had to stay behind to keep an eye on them, right?" He chuckled happily.

"Well, Bill," he carried on as I sat there mesmerised, "I know you are an expert on health economics but over here in the States we are beginning to hear tell of things called 'health centres'." His voice became deep and sincere. "Now I'm going to be a touch unfair, Bill, and pitch this ball at you straight away. Let's have a cup of coffee and a cookie and while we're doing that, maybe you'll tell us, right off the top of your head, something about these new fangled clinics."

And I did. I was in the hands of a true professional.—WILLIAM THOMSON, chief administrative medical officer, Lanarkshire.

Civilities. . . and hostilities

Five years old, and I was in Aberdeen with my parents. It was high summer. The Studebaker car kept developing punctures at awkward moments. My father had, perforce, many times to remove his jacket, jack up the car, and put it right. So his hands got filthy, and my mother fumed at missing so many garden parties laid on for delegates and their wives attending the British Medical Association meeting in 1914.

But one function we did get to. I remember it well. It was in Hazlehead Park.

"Wait beside this tree," said my mother, "and don't move until I get back. Understand?" I nodded.

She and my father moved off to shake by the hand each of a long line of magnificent men in rich robes, headed by the most splendid of them all, who had a glittering chain around his neck. It was too much for me to miss—so I joined in the fun. I'll say this, the bailies of the Granite City played up superbly—once they had taken their cue from the startled and amused Lord Provost, who bowed low over my outstretched hand. Then back to the tree and a hissed tonguing from my mother for my disobedience. As usual, I'd been bad.

Indeed I got the impression that my crime had been pretty heinous when next day my mother packed hastily and we were on our weary 20 miles an hour journey on the uncertain tyres of the Studebaker back to Greenock where we lived.

In time, of course, I learned that I'd had nothing whatever to do with our sudden departure. It was the Germans who had been bad: the great war of 1914-18 had begun.—MURIEL J F BARNETT, Edinburgh.