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Some reflections on the development of an undergraduate nursing course.

That the introduction and development of a new vocational course within the setting of a traditional university environment should pose a number of contentious issues is inevitable.

It seems appropriate therefore to present an introductory paper, the aim of which is an attempt to familiarise those involved, irrespective of their direct or indirect relationship with the course, with some of the more problematical issues. I hope to be able to provide further clarification not only of what is involved in the setting up of this new course, but also of its implications for students, Department, the College and for the subject matter . The paper is meant as an invitation to cajole, to comment disagreeably and or to help with further suggestions.

To understand how nursing courses have come to break through the traditional and precious boundaries of tertiary educational institutions, a very brief historical gallop through British nursing education development should set the scene. This will be followed by an attempt to discuss the nature of nursing and subsequently a curriculum outline, considering statutory and other constraints.

Nursing education:

What has been and still is a specific characteristic of nurse education is its training subordination to hospital based service commitments where formal education, the pursuance of knowledge in a manner of reflective paedagogy, has never been part of a training deeply rooted in practice.

The beginnings of U.K.'s professional nursing are located during the mid nineteenth century with the establishment in 1860 of the Nightingale Training School at St. Thomas's hospital in London. I am inclined to agree with Davies[1] who as a result of her research reflects that that school and many others were schools in name only . They did not exhibit structures typically associated with educational institutions: a stated philosophy of educational principles; an independent and coherent group comprising students and lecturers, and a body of specific knowledge to be transmitted. The pre-registration era (this refers to the period before 1919 after which date part of nursing became legitimised through the promulgation of the 1919 Nursing act constituting the Gneral Nursing Council, nursing's statutory body) heralded a type of nurse training chracterised by specifically prescribed skills, underpinned by a requisite number of 'correct' attitudes, and a manual, an instructor for nurses prepared by a surgeon of St.Thomas's hospital, a Mr. Croft.[2] Though this type of nurse training was prescribed

for St.Thomas's nurses only,the importance of the Nightingale Training School as a pace setter for nurse training generally ensured its model to become the example.In the manual,knowledge fell clearly into different sections: anatomy and physiology; medical and surgical aspects; bandaging and bandages and an introductory course for probationers generally. The knowledge thus transmitted was largely determined by those medical practitioners who pursued their craft in hospitals and who determined the roles and functions of nurses. From then onwards till the present day,acknowledging minor shifts in orientation, nurses' main knowledge was and is hospital based and oriented.

In nursing schools the nurse apprentice is inculcated with such knowledge as is deemed sufficient to practise her skills. The base of the knowledge is non-specific for nursing. Its existence is derived mainly from areas of medical and biological sciences and from public health, coupled with a good dose of rituals, based on 'experience'. It is wrapped up in a cloak of dedication and its equivocal nature is comfortably shielded behind notions of great professionalism. (The specific knowledge needed for nursing has yet to be defined and developed.)

Nurse training which is predominantly service-oriented,neglects to attend to specifically learning-conducive experiences. Those responsible for allocating resources, be they of time, fiscal or any other variety, always considered nursing a Cinderella occupation. In the hospital patients have to be looked after continuously and in the customary division of labour doctors were not going to take on that part of the work which involves physical involvement with patients now known as the 'caring' functions. Their expertise emphasises the 'curing' component of medicine; someone else had to 'care'.Nurses,while doing nursing could learn it with little effort. Sheer repetition of tasks would eventually result in expertise,but far more importantly, it would provide the hospital with the much needed labour force,one compliant, willing and cheap.[3]

In 1919 the General Nursing Council was created. Its function concerns the creation of a register for trained nurses of varying specialities and the provision of conditions to ensure such registration. So that nationwide standardised examination can be realised, the General Nursing Council regularily publishes its syllabi which form the legitimate guidelines for nursing schools' curricula. A scrutiny of core content reveals that over the years, inspite of considerable modification, it has remained remarkably static, denoting the heavy hand (call it domination) of hospital-oriented medical sciences to the exclusion of almost anything else.The main emphasis has always been the perfection of nursing techniques.

The ~~result~~ remains of the knowledge rests on pillars of (household) management and medical sciences as is exemplified in the numerous textbooks published between the war years and since. It is only very recently and on the whole rather tentatively that the syllabi and the textbooks (many of those used in Britain come from the USA) indicate changing orientation in the direction of inclusion of social sciences. The most recent General Nursing Council syllabus,1977,[4] includes subjects like 'human behaviour in relation to illness' under the section, principles and practices of nursing. Another section looks at the study of man and under one of its subsections, the promotion and maintenance of health,is included 'the influence of the patient's cultural,home and economic background in the prevention of ill-health and as an associated cause of disease.' Yet the section, nature and cause of ill-health, deals only with medically conceptualised aetiology of disease.

Though this sprinkling of social science-oriented subjects now appear in the syllabi and are indeed discussed in the textbooks, as a regular General Nursing Council Examiner I note that they receive very much a peripheral consideration,subordinated to the medical and biological studies. This may probably be not only because the syllabus lists them as separate entities, but also because teachers may perpetuate these divisions. Sometimes in the syllabus, the social science perspective becomes the nursing perspective itself, and sometimes it is seen as yet another perspective, also to be considered. It is as if the human being, the central focus of nursing, is divided between the environment and his or her genetic endowment. Most of the nursing tutors' educational preparation is likewise heavily steeped in the medical and biological sciences,suggesting a biologically deterministic model .

It seems also on the whole as if social changes have hardly been noted. For example: changing disease patterns; changed demographic patterns; increased understanding of socially-induced ill-health.The complexities of health definitions and needs are being by-passed though with notable exceptions by some tutors in favour of pursuance of high technology medicine.

Apart from the fact that the implications of social changes receive little attention, the importance of recognising patients' responses to illness as being socially determined is also underplayed. True, psychology receives more than a mere mentioning. But here, the argument always end up in a cul-de-sac. 'It is all due to personality' - ' and so it goes' to paraphrase Kurt Vonnegut's observations in his book

The Sloughterhouse. The social dimensions of behaviour receive very little recognition bar the comment: ' It is all common sense .'

The most recent General Nursing Council syllabus,1977, indicates a change of emphasis as already stated. Despite ~~of~~ the new divisions of knowledge, which anyhow exhibit muddled thinking, it attempts to focus first and formost on the individual's specific health needs which may or may not arise in connection with a medically defined disease entity. But as most of nurse training takes place in acute hospitals and though according to the syllabus some of the emphasis may have changed, nursing's ideology takes its cues from what happens in acute hospitals.

Two more educational facts need exploring.One is the difficulty of defining and recognising what constitutes a 'need'. In terms of physiological functioning a need can be measured. But in other areas this becomes a problem .The other concerns the syllabi.Those of today similar to their counterparts yesterday, contain bits of discreet knowledge culled from various disciplines, including so-called 'pure' ones. While the added bits probably reflect changing trends in medical, technical and social science spheres,little attempt was made till relatively recently, (from 1962 onwards) to synthesise this knowledge into one coherent whole. The argument supported by many nurse tutors that for each bit of knowledge that is newly incorporated into the syllabus, another bit of knowledge needs discarding, still holds true. In other words, the syllabus is seen as a collection of bits of knowledge. Though each bit is considered important, no imperative guidelines exist,neither substantiating its inclusion nor indicating the level of its direct relationship to the central subject matter: nursing. Answers given in the General Nursing Council examination papers reflect now as before the dominance of medically conceptualised thinking on health and disease, despite the changed syllabus.

Apprentice-type nurse training has been its hallmark. Far from it being considered an unsuitable vehicle for education, a report published in 1943[5] legitimised it as sound educational practice. That the system might cause strain was conceded. As an answer, a block system whereby periods of ward work would alternate with periods in the classroom was initiated.

Nursing is viewed essentially as a 'doing' activity. To nurse is to do something, to be physically active,to be engaged with someone ill and or incapacitated in the process of carrying out a physical task. Therefore to learn to nurse through an apprentice system seemed to many the most appropriate way to become one. For example, the taking of clinical responsibility early on in one's training is thought to guarantee the production of a competent nurse. A constant and close involvement with

with hospital ward activities is thought to be a necessary pre-requisite for the handling of nursing care loads, culminating in management at ward level. But apprentice schemes rest on receiving a salary, albeit in the form of a training allowance. The resulting conflicting demands between education and service needs produce frustration because the first allegiance of the learner must be to the employing authority . While the economic debate (the provision of cheap services)overlapped with the educational debate, (that apprentices become the best nurses) there were some recommendations in 1932 and again in 1937[6] that nurses be taught similar to medical students and that nursing studies be moved into university settings. While nurse apprenticeship education fulfilled requirements of providing cheap labour, nurses' education was said to be unsatisfactory.[3] Those who run the nursing schools demand that the nurse learner fulfill a set of educational requirements. Those that are responsible for the provision of nursing services are dependent on the contribution that can be extracted from the nurse learners, and therefore a different set of requirements is demanded of them . Nurses engaged in routine tasks, such as the making of beds, the taking of temperatures, the giving and collecting of bedpans, - inbetween trying to exchange an ocassional word with the patient and or relative - have little time to pay attention to the actual study of nursing . Work has to be completed around the clock. There's no time to think about one's activities, to ask questions about their very nature or to pick up a learned book or a journal. Nor is there time to engage in therapeutic relationships with patients, friends and or relatives. Free moments to spare on the wards means the cleaning out of yet another cupboard or indeed to engage in personal chit-chat with one another, always at the expense of patient-centred care. The patient is distant, unless he or she requires nursing and or medical procedures.

The little teaching that is carried out on the wards is by and large related to the perfection of techniques.These refer to a number of technical procedures which arise out of and in relation to a patient's clinical condition. Some of these were those initially performed by medical doctors. When they were later discarded as medical procedures, then, depending on the ease,status and reliability with which they were invested, they returned as nursing ones instead. For example, in many hospitals, the ward routine of taking temperatures, pulses and respiration of all patients is a nursing activity, the importance of which is considered second to none, it was originally an important medical procedure.[7] But today doctors on the whole pay little attention to those measurements. Either they have been superceded by more precise technologically obtained criteria or else these

traditional measures are not accurate enough anyhow from which to make reliable assessment as to further treatment .

Two sets of requirements, those demanded by the school of nursing and those demanded by the pace,complexity and scope of the ward work find themselves in constant conflict. Many a learner is left exhausted,disgruntled, dissatisfied with her or his initial enthusiasm for nursing severely dampened. Probably all this leads to the high wastage rates with which hospitals and nursing schools have been battling for years.[3] Resulting nurses' anxieties are said to have called for their own particular type of defence mechanism which Menzies suggests in her study, is embodied in the characteristic form in which hospital nursing organisation has developed.

Nursing's perennial wastage problems initiated yet more reports[9] suggesting changes in emphases.What was required was the consideration of more criteria giving educational principles and methods a precedence over service needs.

Changes have come about very slowly. Educational entry criteria into nursing have been upgraded. Area nurse training committees were formed with separate funding from those of the service.[10]But apprentice-schemes persist and continue unabated .

Experimental courses:

The first notable changes in nursing education in the U.K. occurred during the 1960s largely because of the concern over high wastage rates. Both the Glasgow Royal Infirmary and the St. George's hospital in London set up experimental courses for students with good educational qualifications.[11]They were to complete the traditional General Nursing Council three years training course within a two year period.

With the addition of some teaching sessions from areas in psychology and sociology, these courses followed the traditional General Nursing Council syllabi. The evaluation of those courses demonstrated that students taking the shortened courses performed well at examination. There was less wastage. Within a two year period,constantly integrating theoretical with practical aspects, students of the course claimed to be able to make quick and informed decisions about their work. They felt confident to shoulder ward management responsibilities.The researchers expressed surprise.[11] But given the high nurturing context of the experimental courses in that there existed an almost one-to-one student staff relationship, these results are none too surprising . Additionally, though nursing wastage rates were very high, this really only mattered because it produced the high labour turn-over. Educational establishments have long known about 18 year olds' and their vacillatory habits - and have given up

worrying.

Remaining questions as to appropriate course content and the function of nurse education were never investigated . They did not form part of the remit of the research . Nursing as such was never scrutinised. All that the courses were supposed to show was whether professional nursing could be learned in two rather than three years. The results showed that given particular types of students and particular types of hospitals, this could be done most effectively .

Next, there was a lot of talk that nursing needed university-educated personnel; that reform of the nursing scene demands cadre development; that 5% of the nursing service should be graduates.[12] (No one was ever very clear about how the magic number of 5 was arrived at .)

Nursing has slowly moved into institutions of higher learning. The courses vary considerably. All offer nursing qualifications with degrees. Some courses emphasise social and others biological sciences. More and more courses have opted to focus on the study of nursing itself and the first such course was started in the department of Social and Preventive Medicine at Manchester university in 1969.

Similar courses have mushroomed in other institutions. Today there are about twenty undergraduate courses with about twenty to thirty students each, leading to degrees in nursing in the universities of Edinburgh,Glasgow, Liverpool,Hull,Wales,Surrey,Southampton,London and in Polytechnics which grant C.N.N.A. degrees also in nursing . All undergraduate courses offer a four year study programme attempting to link and or to integrate simultaneously theoretical with practical work . Three Masters' programmes exist: one at the university of Edinburgh, one in Manchester and one at the Institute of Education of London University . They deal with nursing education and administration . Edinburgh University, Chelsea College and Northwick Park each have a nursing research unit .

Towards a definition of nursing:

One or two observations on what is thought to constitute nursing . It is the very problematic of this issue which causes considerable concern when devising an undergraduate curriculum as part of the preparation of the professional nurse.

Lack of precise definition has been a bone of contention among many nurse educators and nurse administrators . The furtherance of professional development is said to be jeopardised as a result of such a lack,whereas others argue the very opposite, that precise definition would rob nursing of its professional flexibility,transcending boundaries as it does. On the

hand, the law makers of the German Federal Republic for example,[13] have stated quite clearly why their nursing act omits a legal definition of nursing activity but instead provides legal protection for the title of the nurse as someone who has undergone a presribed type of training. Their argument points towards labour policy concerns. If nursing is to be clearly defined, during periods of low recruitment the state might be embarrassed because it could not fulfill its commitments to the nursing service. That legalistic nicety indicates that, whereas not all are entitled to call themselves a nurse, it may be assumed that nursing activities can be carried out by anyone, trained or untrained.

Whereas in the USA nursing is classified as belonging to the professions allied to medicine, in the U.K. there exists only paramedical professions. These are occupations considered supplementary to medicine and their list does not include those of the nurses. In the U.K. nurses say of themselves:

> "the role of the doctors and nurse or midwife are complementary" and that "on particular occassions their roles may be interchangeable."[14]

McFarlane further makes the point that the role of the nurse is central in those situations " where the 'curing' function (as distinct from the 'caring' function) is subordinate or non-existent.[14] This might apply particularily to areas concerned with much of chronic illness, but also to those concerned with health promotion and or its maintenance.

It is current policy in most British nurse training schools to accept Henderson's definition of a nurse[15]:

> "the unique function of a nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death), that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independance as rapidly as possible."

This function Henderson relates to what she terms 'activities of daily living' of which she has isolated fourteen. They are: breathing; eating and drinking; eliminating; moving and maintaining posture; sleeping and resting; selecting suitable clothing and dressing; maintaining body temperature; keeping body clean and protect (skin) coverings; avoiding dangers and injuries to others; communicating; worshipping; working; playing; and finally learning and discovering. While both the function of nursing and what are considered to be vital daily living activities beg more and basic fundamental questions, an activity of helping is conveyed, an activity concerned with both 'well-ness' and 'dis-ease'. In this sense nursing is concerned with what people usually do for themselves except in such circumstances where they are unable to do so . While this definition is clearly not exhaustive, it can stand as a guideline for part

of a curriculum .

The notion of ' caring'.

There exist in the literature a curious split between 'caring' and 'curing'. Nurses say of themselves that they are the 'major caring profession'[12]. This implies there to be a clear-cut divide between a caring and a curing process, see the previous McFarlane comments. It might,however,be a political expediency to divide medicine into caring and curing aspects to delineate both medical and nursing roles from one another so that each has a clearly defined field of operation. But it is difficult to comprehend that while a doctor ' cures', 'caring' does not take place, and if it does, it is less than the nurse would offer. Vice-versa, it is equally difficult to comprehend that while a nurse 'cares', the 'curing' process is absent, or if it is present, it is less than the doctor would have to offer . Further by annexing to itself the title of being the ' major caring profession' it denies an essential caring role to others, be they health workers, be they lay people. What needs to be examined are some of the unspoken theories and theoretical sets behind the discourse on nursing and on caring. The ambigious shifting between caring,curing and nursing conceals the precise nature of theories and epistemologies which go under its name.

Inherent in using an unqualified notion of caring is that it is meant to express absolute values that its pratitioners hold. The implication of this is a tempting and comforting view of nursing to be timeless and classless, and that its ultimate pinnacle is its humaneness. This re-ification of occupational transmission leads to a potential deadness of the whole edifice of professional verbiage. The refusal to recognise the social base results in blindness to its own social placement .

Where does nursing take place - what type of nurses are there?

Historically nursing has always been very closely associated with hospitals. As institutions hospitals have a certain glamour and sophistication so that it is not surprising that the courses have proved popular in many quarters. Be they headmasters,career advisers, those who want to become nurses - all look to the hospital as the most obvious and indeed only place where nurses work. There are general acute hospitals, there are hospitals and homes for the aged; there are hospitals for long-stay and psychiatric patients. But empirical evidence suggests that much of nursing also takes place outside hospitals.

There are District nurses who care for people in their own homes;

there are Health Visitors who advise people about health-related problems and who usually work from health centres and or doctors' surgeries. There are midwives who work in hospitals, health centres, General Practitioners' units and in peoples' homes. There are Clinic nurses who work in doctors' surgeries and or health centres . There are school nurses whose work is concerned with health surveillance of school children; there are occupational health nurses who work in factories, are attached to mines, work in shops. There are various grades of nurses and there are those who do about 40% of nursing in hospitals[16], but who are themselves totally untrained, are called auxillaries and work under the jurisdiction of the trained nurse. There exist ~~three~~ four types of basic training: that leading to the SRN (state registered nurse), that leading to the SEN (state enrolled nurse), and that leading to the RMN and RNMS (registered mental nurse / registered nurse of the mentally subnormal). All other type of specialised training is built upon the basic training.

Nurses not only deal with the sick, i.e. with those that receive legitimate medical certificates. Nurses also deal with the well: with childbearing women, with babies, toddlers, children, adolescents, parents, single adults and the aged, depending on their respective health needs. Health promotion activities and health maintenance programmes are not usually associated with hospitals. They deal only with pathogenicity and its investigaory procedures. A lot of nursing is in fact to do with the well. The question arises therefore whether a hospital is the ideal place where most of nurse training should take place .

What of university education for nurses and for nursing ?

Both Robbins and Ashby when examining[17] the function of university education in 1963 and in 1974 respectively accepted as given that the business of universities is the pursuance of truth. This is said to be accomplished through rigorous analysis of subject matter, through nurturing of reasons and a strengthening of the power of the mind through scholarship and objectivity which would include an exploration of how the pursuit of knowledge is affected by class interest . These qualities then are the quintessence of the academic which at least theoretically should be as applicable to practice oriented professions as well as to abstract subject matter .

Compared to other occupations, nursing is late knocking on the door of academia. The Church, medicine, the law , pharmacy and engineering have all been there much longer . Their apparent reasonably comfortable institutionalisation is proof of their satisfaction that the university is quite able to prepare competent practitioners in their respective fields.

Over and above this, the university claims to have unique values to offer its students. Competency for the job rests on bodies of knowledge which however rudimentary and fragmentary, have the potential to enrich the individual participation in collegiate life. The process of pursuing relentlessly the ' truth ', the process of bringing together other bits of knowledge to bear on the subject matter in hand, the process of the cultivation of a catholic mind through both cathartic and eclectic methods is in itself an experience worth having.

Comparative and historical evaluation[1,18] of nursing practice suggests that it may be seen as a residual occupation:- one which other occupations no longer see as their major concern .It is something which newly created professions do not wish to have any dealings with; it is something which closely-related professions claim is not theirs; it is something that is left over, after everyone has attracted to themselves that which they regard as unique to their professions. At one period the medical orbit included doctors who diagnosed and ' cured'; dieticians who dealt with food regimes; priests who dealt with psychic elements; and nurses who cleaned and washed and scrubbed and performed other less delicate functions. Balances of power, areas of authority were clearly defined and there were few quibbles -or so the history books will have us believe. Now we have doctors, nurses, domestics, clerks, technicians, physiotherapists, social workers, occupational therapists, inhalation therapists, nurse practitioners, medical aids, speech therapists, dietetics dieticians and others. And while most of them have managed to carve out a niche for themselves, nurses are left with what others are not doing: what needs to be done during the hours when the others believe they have finished their work, at week-end, during the evenings, late at night, in peoples' homes or wherever, because although the others have gone home, patients' needs continue over the twenty-four hour period. And though nurses may not be in a position to meet all of patients' needs, they will have to learn to recognise them for subsequent referral to other agencies.

The university's contribution to the study of nursing would be to disentangle this plethora, to remove the dogma and to identify sex/gender relationships, the division of labour, the changing occupational roles, all in relation to social, political and economic institutions. Nursing itself as a form of social institution needs exploration. The nature of the exploration would be to establish what links and relationships can be uncovered and what bridges can be built between the various components subsumed under the heading ' nursing studies'. The linking process and the building of the bridges might be the beginning of a dialectical model rather than a continuation of the present General Nursing Council syllabus which manifests its fragmentary orientation by for example empahising that 'patients' cultural, home and economic backgrounds are an associated course of disease .'

While these links should transcend immediate concrete issues and abstract that which is essential so as to arrive at understanding, they might also lead to explanatory and predictive theories relating to nursing in particular and to health care generally . These theories, if they are to be developed, must be fitted into social theories of society .

Students confronted with medical and biological sciences usually find difficulty in taking the social sciences seriously. Their notions of science needs to be made explicit. What science is and the uses to which it is and can be put and how science as a question of class politics enters into the formulation of health . Their narrowly conceived understanding of causal relationships often prevents them from being receptive not only to other areas of knowledge, but also to other means of obtaining such knowledge. Their basis of knowledge rests on the collection of numerical facts on a given subject where 'facts' are taken as things known to be true.

The university's contribution to a professional-vocational course is teaching the development of perpective. Areas of professional practice will throw up concrete problems which will exhibit characteristic impasses. The resolution of such impasses requires the development of perspectives, a distancing from the subject matter to comprehend the picture more clearly by identifying the various relations. These perspectives must have been developed,digested,allowed to unfold,perhaps tossed and turned in a kaleidoscopic fashion in order to achieve adequate analytical mastery. Yet they must be clearly relevant to the needs of professional competency .

Are there any pointers towards a specific knowledge-pedigree likely to engender nursing studies?

Specific areas of knowledge, so the argument runs, give rise to characteristic disciplines. Yet the various and varied levels and dimensions into which disciplines can be and are divided indicate discipline determination to be a highly complex issue; last but not least associated with 'property aspects of knowledge and the market situation'.[19] Bernstein makes the point in relation to the creation of new knowledge that as it weakens other disciplines' hold over theirs,hierarchial power positions are reduced and this is the source of much of opposition to the creation of something new.

Disciplines are classified into natural,technical and social sciences and further subdivided into pure and applied ones. New areas are found in the field of the humanities, the bio- and the geo - sciences. Methodologies include descriptive,experimental,empirical and theoretical tools for analysis. Each area of study shapes tools which it argues are appropriate for its needs.

Where does nursing fit ? Opinions range from those who would place it with the medical and biological sciences to those who believe its place to be within the social sciences. Some would deny it any scientific association, claiming it to be (merely) an art and a craft . Substantive arguments can be brought to legitimise all those points of view. However, a basic question remains: is knowledge produced in each area mutually exclusive to the other, or rather should groupings of areas of knowledge be considered in relation to each groups' quintessence and subsequently in relation to nursing ?

Nursing as an integrative study.

The building blocks of nursing need to be based upon knowledge derived from the basic sciences and from the areas of biological, physiological and medical sciences. The inclusion of doctors to provide part of the curriculum should be determined in relation to their hegemonic characteristic vis-a-vis that of nursing . The pivot of the argument is who defines nursing . Nursing also needs the knowledge from the behavioural sciences: from psychology and sociology, the demographers, the historians etc. Without their respective contribution knowledge would not be available for example, in the areas of mortality and morbidity, resource allocation, power politics and authority, order and control, change and development, professions, role-conflict, social and sensory deprivation, women studies, divisions of labour, the family, socialisation and others, all of which impinge characteristically on health .

Like anthropology and psychology, nursing's central focus is the human being, his concrete existence in its dialectical relationship with his environment. Its more specific activities are concerned with individuals' and groups' health maintenance, promotion and rehabilitation, as well as the shaping and delivery of a comprehensive nursing service. There is a lot of discussion between so-called basic and technical nursing skills. While for example activities of bed-making, feeding and toiletting are considered basic, that is more menial tasks, catheterisation and wound dressing are thought to fall within the more advanced technical competence. However, it requires an affectively able nurse to carry out sensitively those physical tasks on behalf of someone else to ensure a patient's dignity, his safety, his comfort and his warmth. This requires a highly individualised education and training. Health, at one level an ability to cope given adversary situations[20], depends on varied and subtle ways on social conditions which in turn give ride to its determination.

To enable nursing to carry out its activities effectively, knowledge needs to be created through the composite nature of Nursing Studies.

Nursing's integrative characteristic becomes apparent as areas of knowledge which constitute nursing studies are first isolated and then transmitted. During their process of sequentiality, knowledge can be made to transcend and finally form into the new, that is nursing, which becomes recognised through its practice. My attention in this connection has been drawn by Davies[1] to Bernstein's explorational study[19] of the sociology of knowledge in relation to paedagogy . He distinguishes types of curricula in relation to learning-effective experiences. He argues that a curriculum which is 'clearly bounded' (one where the contents are well controlled and insulated from one another) encourages passive reception by the recipient, the learner. Whereas an 'integrated' curriculum (one where the contents are not kept separate from one another), depends on the active participation of the learner. He will bring it all together and help to shape it into an integrated whole which is more than the total sums of its parts. As an integrated curriculum can also draw from concrete life-experiences from outside the classroom,students' horizons should expand as the result of their own learning involvement .This places the onus on the teacher to facilitate such experiences rather than merely to impart knowledge. Bernstein claims that an integrative curriculum will emphasis ' ways of knowing', whereas a 'clearly bounded ' one is concerned only with 'states of knowledge.' He further elaborates on ' integrated codes'. Where the theory of one subject is used to underpin another, he calls this an 'intellectual relationship'.Integration,however,refers to 'the subordination of previously insulated subjects to some relational idea which blurrs the boundaries between the subjects'. It would be comforting to know that he might consider nursing as such a relational idea.

Concrete problems with the setting up of the current course.

One of the main constraints on the construction of the course is the fact that at the end of the four years,the student will have to be a competent practitioner,able to work without supervision . The doctor-student even after six years of training and working as a 'houseman' works under the strict guidance and control of the registrar. A staff-nurse is expected to make her own decisions and to shoulder her own responsibilities. Further constraints which arise out of that are the General Nursing Council's requirements. They require about 3000 hours of practice, and the rest to be 'theory', while the EEC requirements are 4600 hours of nursing of which no less than 1/3 is to be ' theory', and of the remains,no less than 50% is to be practice,the rest 1/6 can be allocated to either area. For the purpose of this argument 'theory' seems to refer to anything that happens in the classroom as opposed to what occurs in practice .

Another constraint: EEC requirements demand

Another constraint: EEC requirements demand that ~~either~~ each nursing student acquires competency in seven subject areas. They are: medical and surgical nursing which includes accidents, emergencies, intensive care and 'theatre' training; paediatrics; obstetrics; geriatrics; psychiatry; and community nursing. The implications of this requirement is that nursing students from Bedford college compete with the traditional student nurses for practice-placements in those areas of which usually there are less and less.

So as not to be too tied down to the number of practice hours, one can argue that nursing studies include nursing practice. This would require nurse practice hours to be incorporated into the nursing studies units; it would also mean that lectures, seminars, tutorials, projects and or research activities could be counted as nursing practice. At one level this turns out to be a semantic problem . In practice, university students have no more than twelve hours per week student-institution contact .The rest of the time is theirs: to read, to play, to discuss issues over coffee and to become involved in student union activities, an important area in terms of learning experience for adult life. We are supposed to produce the future change agents and it is in getting involved in students' union activities, that future change agents learn their skills. I would plead that the nursing curriculum makes allowances for such student activities. When out on practice-placements nursing students are often required to work late at night, to start out early in the morning and to work an eight hour day . One needs to enquire very carefully whether those practice-placements are really learning-conducive. Reading, writing and thinking becomes very laborious if not impossible following an eight-hour shift .

Practice-placements:

While all of practice-placements need to be carefully chosen and supervised, learning experiences need to be structured beforehand. If not, the student feels uncertain as to what he or she ought to be doing and the immediate practice-supervisor, the ward-sister or the District Nurse will use the student for the delivery of care, rather than allowing it to be a learning experience. Frustration can thus easily arise and it has a tendency to spread like wildfire. Experience derived from practice-placements should be utilised as a learning experience soon after each placement has taken place, away from the practice area. This provides the development of a perspective and misunderstandings and frustrations can be aired and if not rectified, at least analysed. Each practice-placement should be accompanied with learning, behaviour and achievement objectives

which can likewise function as an evaluation procedure and as a basis for teaching . At one level, there are valid arguments against the development of learning objectives. They are said to inhibit learning by discovery; they are said to engender a mechanistic way of learning . And while in principle I support this position, in practice, so far as nursing is concerned, I have moved away from this position . Young, inexperienced student nurses on practice-placements in the real world do not know what they are looking for, unless it has been pointed out to them .Student nurses' anxiety levels are said to be high when entering the practice area, Learning by discovery under those conditions are not likely to occur. The perfecting of techniques has much to do with gaining confidence so that when student nurses are chided for following a procedure ' incorrectly', the student can point out, that its principles have been safeguarded and that is what the objectives should contain . Nurses must learn to make decisions given certain limitations. Factors which influence decision-making knowledge - carried from the nursing studies components - must be clearly discernible and substantiated. It is the mark of the trained nurse coming from an 'academic' environment who can utilise research information to enhance her practice .

Legal responsibilities and implications:

Though all students are legally covered by their universities to pursue practical studies, it is advisable that appropriate legal institutions look into the possibilities of formulating additional contracts subsumed under the name of 'vicarious responsibility'. University staff are not usually around during all of the students' practice-placements. Reference is made particularily to university vacations - usually the only time during which research can continue - and students' night dutties. But even during term time, at least with the present staff of one or two, it is not possible to supervise personally all of practice placements. Though the appropriate Health authority is responsible for the students who practise within their institutions, an additional written contract would cover unexpected eventualities. The contract also needs to state - and this applies to disiplinary behaviour - (the taking of drugs; a student violating a patient inspite of provocative behaviour)that the Health Authority has the right to remove the student from practice areas until such time that the university can make its own decisions. University appointed nursing staff who plan to work with the students in the practice areas need likewise a contract .

The creation of knowledge,evaluation procedures,what constitutes an 'honours' degree and what constitutes 'academic' in nursing.

The beginning of the paper indicated that a lot of nursing knowledge is transmitted on the basis of 'experience'. While a lot of that experience is neither verified nor indeed documented, a fair amount of research information related to nursing practice is available.But it is only found at the moment in obscure journals. So that students learn to handle research material and to bring its findings to their practice, the appropriate knowledge for each practice area needs to be found, sifted,and accumulated so that instead of textbooks 'reference files ' can be constructed and be made available in the library .

A lot of knowledge just is not available. It has to be gleaned - perhaps from practice,perhaps from students' comments and participatory observation. It needs to be developed and documented.

For an ' hours' component students might be required to produce the traditional long essay - but one needs to stipulate the qualifying criteria - as well as a research paper on a specific topic. 'Academic' characteristics are those that exhibit analytical qualities,qualities which are able to link 'theory with pratice',qualities which recognise relationships,which ensure pursuance of the truth and which exhibit scholarly attitudes. These can be tested in essays, in seminar contributions and on practice-placements,providing agreement can be found among the teaching staff. Competency can be judged not only by knowing ' what ' but also by knowing 'why'as well as be aware of alternative possibilities.

Staff:

At the moment one is in post (me) and one is promised and secretarial help is minimal in relation to the needs of the setting up of such a course. I am thinking in particular of the logistics of placements and keeping a constant track of the students so that they fulfill their required placement hours in order to qualify for General Nursing Council registration requirements. This is the work of a clerical officer. While the Middlesex hospital nursing school has promised to 'second' two of their tutors, one is anyhow not yet in post,but what is more important, their personnel do not fall under the jurisdiction of the Bedford nursing unit and cannot therefore be counted as full time staff for the course. From my own experience I know nursing students to be particularily demanding in terms of needing psychological support . At age 18 they enter the course and all they want to do is to nurse. They have in their mind a clear-cut understanding of what nursing is about. But their first realisation that nursing is to do with actual people who are not always nice,clean,pleasant or indeed grateful or interesting, usually produces a considerable amount of uncertainties. Student

counselling,again and again,is part of the staff's teaching role and takes up much of their time.

I have my doubts whether all this as outlined in this paper can be accomplished to the satisfaction of the College,the Department and the course organiser by a staff of one or two ?

Proposition of the development of the actual course;

The programme of study should focus on the development of a nurse's ability to carry out the unique functions as suggested in the Henderson model (p.8.).Some of the fourteen living activities are functions concerned with an individual's survival mechanism.Knowledge needs to be acquired which supports those mechanism so that life can be sustained at least at a basic level, if not more.This requires knowledge from the areas of physiology,microbiology, pharmacology and dietetics,all of which the nurse needs to learn to apply in different situations.

To shape a nurse's interpersonal skills whether this be with individuals - patients,colleagues,peers,relatives etc.- on a one-to-one basis or with groups- she needs practice,exploration,self-awareness and understanding. Knowledge from areas of communication and psychology is required.So that the nurse can carry out her function,whether this be in hospitals or outside, in patients' homes or in day institutions,the nurse needs to know about organisation of these institutions,about processes of socialisation and de-socialisation,and about the social,political and economic forces which help to shape them.She needs to learn to evaluate critically her position within the system.Many of her professional dilemmas arise out of her position of being a subordinate and dependent to primarily medical consideration,though nursing professional ideology will place her as an 'equal' to the doctor. Likewise,many of the nurses'moral dilemmas arise out of the relative positions into which 'care' and 'cure' divisions have been placed. This then should constitute the core curriculum.

Clinical specialities need to be added when suitable and required. Knowledge of pathophysiology and politics of health should be a pre-requisite.The nurse needs to learn, early on about the contradictions she faces when applying health promoting and maintaining strategies.Individualised nursing care may be defeated vis-a-vis socially-induced ill-health.The nurse needs to learn about limitations,but also about alternative actions.

So as to be effective,nursing care needs to be carried out in a systematic manner by assessing a patient's function (daily living activities) and working out an individual programme,drawing on appropriate research material,to sustain such activities.By learning to evaluate the programme and the assessment,learning should take place about modification and change of nursing activities.This could apply to a group of patients or to an individual.At one level the nurse must learn to evaluate constantly momentary

situations in relation to patients' changing conditions to develop appropriate responses.At another level the nurse must learn to initiate.

So that the nurse can be prepared for her immediate professional life,she needs to acquire managerial and organisational abilities to function within a highly structured institution.She needs to understand where society expects her to fit. If ultimately the nurse is to be a change agent she needs to become conversant with alternative models of health care delivery .

So that the nurse understand her place in society,nursing as a professional occupation needs to be explored from a historical developmental point of view. Nursing's paradoxes,many of the particular contradictions arise because of nurses being mainly women.More men do enter the profession and are occupying characteristically more senior positions in disproportion to their numbers.Nursing's problems can only be understood through the women issue,her place in society and sex/gender division of labour.An appropriate course of study should be given a place in the core curriculum.

The division of the nursing subjects traditionally follows closely that of medical specialities and rather than dividing the areas into medical and surgical nursing, I'd prefer to consider the divisions into age groups. The majority of practice-placements need to be taken during the second and third year, to be consolidated during the fourth year. Cognisance must be taken nevertheless that the very old patients and the very young and obstetric clientelle need special care and understanding,not usually to be found in the nursing novice. That experience should be as late as possible in the course. It would be ideal and highly desirable to start out placements during the first year outside the hospital - in the community - so that nurses before they enter the hospitals, find out something about the conditions from which most of their patients come and to which they are willy-nilly returned. If possible, during each placement in the hospital, the nursing student should follow at least one of her patients home to disover the effects of hspitalisation on the patient .There is little point in students spending a lot of time on practice-placements without an adequate knowledge in physiology and pathophysiology first. A fair amount of sociology is not likely to make a lot of sense until students have tasted practice in one form or another. So that the nursing studies unit becomes academically a viable proposition,research must become part of its activities,and presumably this will be built up as more staff come to join, developing their respective interests in the seven subjects outlined, otherwise teaching becomes stale. Whether one wants to pursue a masters programme in nursing studies or whether one needs to be thinking of developing an undergraduate course for the ' trained' nurse depends on available resources.

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