THE UKCC - HISTORICAL INSIGHTS INTO TODAY'S DECISIONS

A conference at the King's Fund Centre
on

25 May 1984

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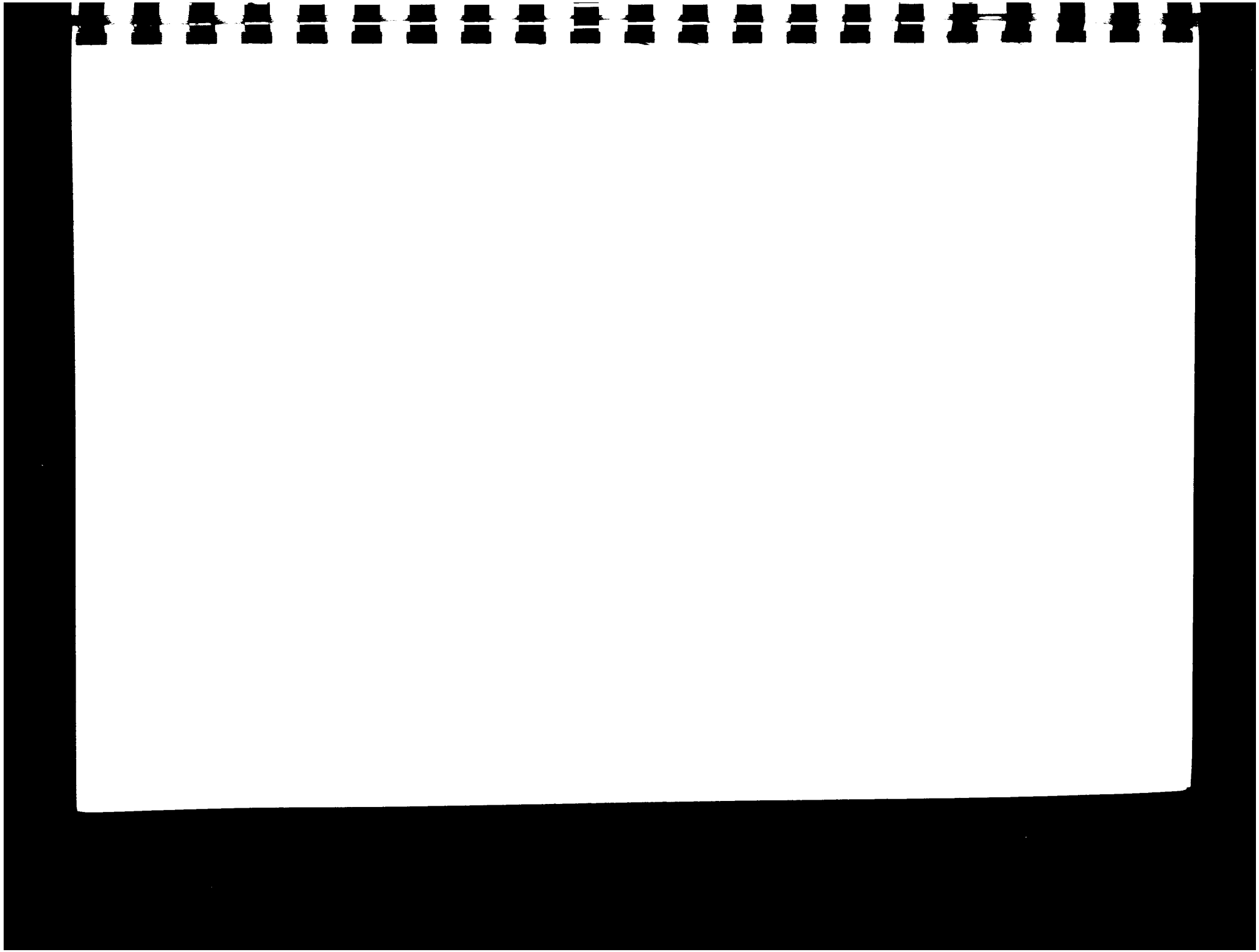

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Introduction

This was another day devoted to a study of the history of nursing and the lessons it has for nurses.

There were four speakers, each of whom volunteered a topic appropriate to the title of the forum. No other direction was given to them except that Lockwood and White amicably agreed to speak on the same title. The History Group felt that this was an area of immediate interest and that two views would be both interesting and challenging.

In the event, it was remarkable how diverse all their papers appeared but, after careful study, how much common ground they produced. Only one speaker, Anne Lockwood, took a courageously personal stance but, even so, some common points could be found.

Hector plotted a cyclical history for nurses from the pre-Nightingale, untrained attendants, through the dedicated, committed nurses who fought for a better training and professional authority, to the coming of the NHS and the dilution of trained staff with untrained labour and the present disillusionment of many nurses.

In the same way, she saw a series of changes from those nurses who wanted better training, through the phase of the doctor's handmaiden, to the professionalisation of some nurses, the bureaucratisation of the nurse managers (Hector described this as a return to our military heritage) and a growing division in nursing today between the upper grades and the clinical grades.

Throughout her paper Hector emphasised the female image of nursing and its dedication, both of which factors have been exploited by the authorities to ensure a depressed social status for nurses and a low level of pay.

Hector finished her paper by observing the growing alliance between the lower grades of nurses with the domestic and ancillary workers: an apparent full circle return to the pre-Nightingale days. She balanced this observation with the view that the more significant developments in nursing today appear to be in the clinical areas where nurses are trying to examine their role and their ways of caring for their patients.

Storr made a review of the history of the Enrolled Nurse. She described from the enrolled nurses' point of view, the uphill struggle to become established and the hurdles that they had had to overcome. Even today, the status of the enrolled nurse is still in jeopardy and the 'pivotal' role described for ENs in the Horder Reports has not been conceded by registered nurses or the GNC.

Like Hector, Storr found that the chronic sick and long term patients have been looked after by the nurse with a shorter period of training: the rejected caring for the deprived.

With the low educational entry requirements for student nurses and the limited career prospects for ENs, there was little inducement for recruits to choose a pupil nurse training. The EN fell uncomfortably between the poorly trained registered nurse and the untrained domestic.

In spite of this, many reports recommended greater use of enrolled nurses. If the same work could be done by a nurse with two years preparation, why employ a nurse with three years' training? The answer, of course, was that training was cheaper in those days and trainees were cheaper than qualified nurses. A three years' training was therefore of more appeal to the authorities. Now that training has become so much more expensive, could it be this reason why there is a move to drop enrolled nurses?

Anne Lockwood and Rosemary White were the last two speakers and both discussed the educational entry requirements for registration, offering different perspectives.

Lockwood showed how standards of recruitment were depressed by the pressing needs of the new NHS. She discussed the merits of selection by educational tests and seemed to believe that those standards do not disclose the presence of compassion, her criterion of a good nurse.

Lockwood found the problem of the relationship between educational standards, selection criteria and the traits of a good nurse to be complicated. She demonstrated that the qualities required of a nurse have not so far been identified and concluded that criteria for selection of recruits vary with demand and supply. Higher educational levels for entry, as proposed by 'the nursing profession' (not all, surely?) she finds to be a manifestation of status seeking rather than to the good of the patient.

White took a contrasting view of educational needs for nurse training and asked why a better education should necessarily preclude compassion? Do the uneducated have a monopoly on compassion? She considered the criteria for selection should be linked to standards of training and, also, to the way in which nursing is structured.

White's paper concentrated on the part played by the GNC in setting the minimum standard of entry in 1962.

Whereas Lockwood argued that personality traits were more important in recruitment than educational attainments, White found evidence to show that the low standard of entry for student nurse training was the cause of the failure to recruit pupil nurses and lay at the root of the wastage and failure rates.

White also made a contrasting analysis of the entry test devised by the National Institute of Industrial Psychology. Whereas Lockwood maintained that the Ministry of Health would not support the test, White produced evidence to show that the GNC connived with the Ministry to select the lowest score for their eventual criteria which were produced in 1962.

Lockwood maintained that the subsequent move to raise the standard of entry was prompted by the search for professional status but White argued that, after the inception of the NHS, the GNC was more interested in recruitment than in education.

What then, are the common factors in these papers? All tend to show that there was a clear deterioration in the entry level of nurses to student nurse training. All seem to agree that the Ministry of Health played a significant part in this movement by omission, if not by commission.

Hector, Storr and White seemed to agree that governments have sought to economise on the costs of the health service by means of recruiting nurses at the lowest possible standard and by dilution of the trained nurses. Is this the reason for dropping the enrolled nurse? Hector mentioned the loss of trained nurses by emigration; White saw the loss of good recruits through the maintainance of a low level of entry. Storr feared for the loss of pupil nurse recruits because of restrictions in their work and future uncertainties. Lockwood did not discuss these aspects. Her call was for a better understanding of the qualities required for the nurse and selection based on those criteria. In this, she came closer to Storr whose paper seemed to argue that continuing care must rely on the EN rather than the more mobile registered nurse, even though Hector thought that the movement was towards greater concern for clinical matters among registered nurses.

If we use these diverse papers as the basic of 'Historical Insights into Today's Decisions', do we find them helpful?

Hector provided a thoughtful and colourful reminder of past trends. Storr demonstrated that we have failed to recruit, and keep, the basic or 'pivotal' grade of clinical nurse.

Lockwood and White agreed that it is the government rather than the profession which, in the final analysis, controls the quality of entrant to nursing. In this, Hector and Storr also seem, in their own ways, to concur.

Perhaps that was the lesson for the day.

> "Can history provide the answers men seek? Men often ask the wrong questions of history and are disappointed by their failure to get satisfactory answers. The properly organised study of history... would teach men not to expect past events to repeat themselves infallibly, nor to predict the future on the past basis of very fragmentary evidence, nor to draw 'lessons' from the past because of chance similarities. It would perhaps prevent them from evading the realities of the present... to understand exactly how heavy the forces of the past are in relation to forces for change, without leading them to underestimate the difficulties of genuinely radical change". J D Heydon, 1969.

Rosemary White
1984

THE EVOLUTION OF NURSING STATUS

Winifred Hector

Facts do not speak for themselves, they speak for the person who selected them from a mass of information in order to put forward a course of action, to convert the reader, or perhaps to startle or amuse. Selection of facts for presentation is biased by the writer's experience or lack of it, and the interpretation put on undoubted facts may be subjective. I would also remind you how much more widespread hindsight is as a virture than foresight, so that one speaks of events a century ago with more conviction than those of today.

On looking back over our not very long history one is also struck by the cyclical nature of our problems, and of the solutions offered. The introduction of a second statutory grade of nurse is seen as alarming, then inevitable, is accomplished and now this grade seems likely to vanish again. Preliminary training of students in a school before they begin ward practice is seen as a goal to be striven for, and is universally adopted. Then someone asks, why are students thwarted by being kept away from the work they long to do? After an interval, preliminary training once again seems desirable but, is new born as 'pre-clinical teaching'.

Nursing historians of the early twentieth century contrived for nursing a long history going back to saints and holy Roman matrons. Florence Nightingale had a more realistic view; she dated the beginning of nursing from the foundation of the Nightingale School in 1860. She wrote in 1892:

> "There comes a crisis in the lives of all social movements. This has come in the case of nursing in about thirty years. For nursing was born but about thirty years ago. Before, it did not exist, though sickness is as old as the world."

I am going to accept her date in considering the evolution of nursing status. The purpose of this paper is to suggest how the image of the nurse has evolved in this time. It would appear that self-perception by nurses has altered a great deal but, that the public view has been remarkably faithful to the belief that a nurse is female, dedicated, underpaid and over worked. The people most often meet nurses when they are sick and need help and relief. They probably know that there are regional nursing officers, teachers and administrators, but these do not impinge on their consciousness. When the question of increasing nurses' pay arises, the public response is always in their favour.

I would like to draw your attention to two very percipient items in the quotation from Miss Nightingale.

First, she recognised that nursing had arisen in response to social factors. Secondly, she knew that the fact of sickness did not automatically produce nurses. Since the time of Christ it had been the duty of all Christians to care for the sick, to feed and clothe the needy and to visit prisoners. By dating the origin of nursing from the date of the first school, Miss Nightingale also implied that nursing had a theoretical and technical content that could be taught. She was aware that nursing had a definite entity apart from medicine.

For those who belonged to a family, care during sickness was part of the household routine, like feeding and clothing the group. After the dissolution of the monasteries, philanthropic institutions took care of the indigent and homeless. The middle classes took care of the sick at home themselves. The Clerk of the Society of Apolthocaries, giving evidence in 1904 to a Select Committee on Registration of Nurses said:

> "Speaking for myself, I never saw such a thing as a nurse inside my home. Now, my boy has hardly anything the matter with him, before in comes a nurse first thing, before we can say Jack Robinson. We were able to get on perfectly well in those days. I think there is a good deal of unnecessary fuss made these days about illness."

Florence Nightingale appeared to head the emergence of nursing at a time propitious to its inception for social, medical and emotional reasons. There were in 1881, according to the census, 6½ million women without occupation, and nearly half of these needed to support themselves. Advances in medical and surgical treatment meant that doctors were willing to hand over some of their work (such as taking temperatures) to nurses.

Miss Nightingale's work in the Crimea showed what an opportunity there was in hospitals for women who wanted work and training. She was an excellent administrator and a good statistician, but these were not the qualities that gave her charisma; it was her image as the lady with the lamp, whose shadow on the wall the wounded soliders turned to kiss. The prototype dedicated nurse had appeared.

Nursing became an occupation for women, who were open to exploitation on more grounds than one. Female workers were (and still are) underpaid; dedicated people were thought to work for love, and therefore not to need money, and nurses had emerged as the servant of the doctor not of the patient. This subservience was heightened by the Victorian tradition of female dependence on the 'stronger' sex, and the fact that the work of nurses consisted of duties delegated by the doctors and had no real content of its own.

I would like to draw attention to a fact that has received insufficient recognition, but has had a profound effect on nursing, and has had serious social consequences. This is the way that medical training developed in the first half of the nineteenth century.

The emergence of the middle classes in search of training and equipment for life meant that surgeons and physicians in London and the big provincial cities were looking for practical experience for students. The hospitals that they used or founded became known as teaching hospitals, and developed into places for acute medical and surgical patients who were thought to be 'good teaching material' or 'interesting'. The mentally ill, the handicapped and the chronic sick were outside the pale of medical interest, and in spite of the proportion of the sick they represented, were consigned to limbo. In spite of the heavy load of dependency involved, these specialties have never recovered from this initial neglect, nor have they, more than a century later, reached parity of esteem with acute hospitals. This applies to medical as well as nursing staff. It is comparatively recently that financial and other resources have been allotted to them in an endeavour to correct this historical imbalance.

It is not proposed to make a detailed list of dates and events in nursing history, which might result in obscuring the wood by trees. The past century will be looked at in three phases.

a) 1880 to 1920, which is seen as the time of working towards professionalisation.

b) 1920 to 1947. This was the time of post war depression, unemployment and the second world war. It is marked by consolidation of statutory gains and the creation of order among different grades of nurse. It was the heyday of dedication and the strengthening of the public image of the nurse in that role.

c) 1947 to the present. The National Health Service was established and a series of organisation and reorganisation imposed on nurses. It ends with the upper echelon of nursing discouraged and seeking early retirement, while, at the clinical level, nurses are seeking to define their role (for instance through the Nursing Process) and to explore their real relation to other health workers. It is seen by your author as the most hopeful sign of nurses taking an active part in their own affairs since the campaign for State Registration at the turn of the century.

1880-1920

One cannot fail to be impressed by the amount and quality of the work done by nurses themselves during this period. There are two main stands in this, typified in the beliefs of Miss Nightingale and Mrs Bedford Fenwick. One can well understand Miss Nightingale, who knew the kind of people who were hospital attendants before 1860, wishing to establish nursing as an occupation for women of good character, religious beliefs and integrity. On the other hand, it is very difficult to understand how much Mrs Bedford Fenwick formulated her beliefs and prescriptions for a nationally recognised, well educated group of professionals. She and her colleagues had no model and yet produced detailed, practical plans and goals, some of which had to wait half a century to be achieved. Mrs Bedford Fenwick said at a meeting of the International Council of Nurses in 1907:

> "To enumerate our most pressing needs; we require preliminary education before entering hospital wards; we need postgraduate education to keep us in the running; we need special instruction as teachers to fit us for the responsible positions of sisters and superintendents; we need a state-constituted board to examine and maintain discipline in our ranks, and we must have legal status to protect our legal rights, and to ensure us ample professional autonomy."

It is possible that the UKCC could produce today such a clear and authoritative statement of aims that could be seen as acceptable eighty years on? Her aims in the Nursing Record at the end of the century:

> "Lastly, will not colleges of nursing be connected with universities, which will give a degree in nursing to those who satisfactorily pass through the prescribed curriculum, and so place the coping stone on the fair edifice of nursing education? Surely the new century must bring all these good things to nurses. Shall we live to see them? We do not know, it matters not, let each do her part."

Lest it be thought that the eyes of the pioneers were fixed on the future and not on the problems of daily life, it should be recorded that in her weekly letters to her Board, Mrs Bedford Fenwick tells of recruitment, wastage rate and its causes, asks for improvement in the food and pensions for those retiring and reported regularly on the infectious diseases from which the nurses suffered, and of which the cause was still unknown.

The period under discussion ends with the 1914-18 war, which of course had an enormous effect on nursing. Nurses were needed in unprecedented numbers; men left the mental hospitals to work at the front. There were two million casualties in Flanders, mostly men, so that there were many spinsters and widows who would need to support themselves after the war.

State Registration so earnestly striven for, could not now be witheld. It was necessary to try to bring some order into the ranks of those who nursed, some trained, many not. In 1920 the General Nursing Council was established to compose a syllabus for teaching and examination and to keep a register of trained nurses.

1920-1947

It is very easy to recruit student nurses in times of high unemployment, but it was not easy to retain them in the twenties. Successive reports tell of long hours, low pay, old hospitals and (continually) of harsh discipline, sarcasm and verbal abuse in front of patients. Students who left took a poor report back to the community and patients could see for themselves what conditions were like. This was the time when the public image of the young, overworked, ill paid nurse-image took root, only too well founded in fact.

Senior nurses were busy over problems of registration, curriculum development and education. They were also beginning to realise that in allowing the State to control registration they had surrendered something very important. All governments have wanted to run a health service at the lowest possible cost; they have no interest in improving conditions or educational standards if these cost money.

For junior nurses in general hospitals, oddly enough, it was a time of great stability and complete role acceptance. They knew their function well; it was to give comfort to the patient. What are seen now to be the most trite of cliches were accepted as axioms by which life could be lived. The hierarchical system produced by 'set' entries meant that peer groups were friends for life. Attitudes of seniors might be harsh and hypercritical, but it must be remembered that medical students were treated by consultants with the same unkindness and sarcasm. "The patient comes first"; "being a good nurse is more important than passing examinations".

Such were the truisms of hospital life. Pride in one's training school was high and attitudes to other hospitals parochial. These attitudes seem odd to nurses today but enabled us to survive; they also enabled the government to accept our own view of dedication and to continue to exploit it.

The Second World War and after

During the war nurses were too busy to think of much besides work. A Civil Nursing Reserve was established of trained people who had left nursing, assistants with some experience and orderlies with mostly domestic knowledge. The government found itself employing a very large number of grades and in 1941 recommended that all hospitals should pay their nurses the same salary as the Reserve, and receive central reimbursement. This was the first big step towards the National Health Service.

The war had opened up many fields of work for women, and nursing had lost its place as their major field of employment. It had also lost its old care appeal. Rest in bed was now seen as highly dangerous to many, technical resouces were increasing and more was heard of medical cure and less of nurse care. Women now saw nursing as an area of low pay and hard work in terrible conditions and more were now unwilling to tolerate them.

The exhausted and impoverished country was unable to raise pay, reduce hours and build hospitals. Instead, an attempt was made to fill vacancies by using more auxiliaries and recruiting more students, so the ratio of trained to untrained staff worsened. The age of entry was lowered, in the hope of recruiting people too young to nurse but who might otherwise look elsewhere. Many 'cadet' schemes to bring children into nursing were started, 'crash' courses of a year for those with some experience were numerous. All these tended to lower the proportion of trained to untrained staff.

It was sad that the National Health Service should have been inaugurated at a time of such low morale. It was a great social experiment but throughout the fifties and early sixties nurses were in no position to appreciate it. Doctors, the public, the general and nursing press, the Royal College of Nursing and the General Nursing Council, all had ideas on how the ailing nursing service could be helped but most had different ideas. All agreed that many students were unequal to the demands of the syllabus and that their inevitable failure was hurtful to them and discouraged recruitment, but all (except educationalists) believed that an educational prerequisite for entry would mean fewer hands to nurse patients. In a search for labour, tribute was exacted from the third world. Matrons went in search of recruits as students, pupils and auxiliaries from the Caribbean, Africa and Asia. Statistics from the time are not very good but in 1961 wastage overall was 39% and 35% of nurses came from overseas. Another important loss of trained staff was to North America and Australia, in search of better conditions and salaries. Morale had never been lower and headmistresses were unwilling to recommend nursing to any but the least endowed of their scholars.

It is convenient here to mention, quite inadequately, the role that men have played in modern nursing. Women around the turn of the century were in desperate need of work and did not surrender this area without a long and determined campaign against men. In this they were helped by the traditional nurse-image as female and by the fact that pay was so low that only men with a real love of nursing wanted to undertake it. But after the war men who had nursed in the armed services began to enter in some numbers. This is not the place to record their history, but to acknowledge the debt nursing owes them. They brought forward and sustained the fact that dedication must not imply exploitation and that a nurse might be the head of a family and deserved just reward. The other contribution is the advance of unionisation with consequences of far reaching importance.

The last twenty years

In 1962 the General Nursing Council was able to reintroduce the educational test for recruits and the nursing syllabus began to take into account the needs of the old and mentally affected, and was no longer based entirely on the care of the acute sick in general hospitals. The last period can be seen (rather simplistically) as a time when the upper grades of nurses received three administrative upheavals from which they have not yet recovered. In 1965 the Salmon Report initiated the series of changes which resulted in the creation of many new grades, an accent on the military part of our heritage (Sisters became Officers) and an apparent diminution of esteem for clinical work.

The other two upheavals were, first, the regionalisation of the health services and the 1982 readjustment. These both resulted in a lot of demoralisation, as nurses who had filled posts for years found that they could be rejected for these posts when they had to apply for them. The cost of early retirement, £54 million was six times what the government expected. It will take time for confidence to be re-established.

The interesting developments in the nursing role today seem to your author to come from the clinical side and the lower, most numerous nursing grades. These believe that the nurse has a role quite distinct from medicine, that can be quantified, recorded and tested. In all kinds of hospital and in the community, nurses aim to discover the patient's needs, to decide if nursing measures can be taken to meet them and to assess the degree of success.

There seems to be a division appearing between nursing grades. Upper ones are thought to be 'ex-nurses' rather than nurses divorced from the real action. The 'professional' role is thought to be elitist and unrealistic. The doctor may be the natural colleague of nurse administrators but many clinical nurses feel that their natural allies are the domestic and similar grades of workers who share with them the real burden of clinical work. This may be seen to those who have striven for professional esteem, academic education, raising the roof and polishing the image to be a sideways move. The social and economic mill will produce its own grist, and we must not be dismayed by change.

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THE ENROLLED NURSE PAST, PRESENT AND FUTURE

Fannie Storr

I hope that in the next forty minutes of historical review you will be stimulated into discussion of today's decisions as they will affect the future.

Whilst doing the reading in preparation for this talk I was struck by the amount of negative terminology that prevails in reports and articles about the Enrolled Nurse. She is described as being 'caught in a double bind', the 'piggy in the middle', 'in a catch 22 situation', 'as the rope in the tug of war' and 'as feeling muddled, anxious, despondent, dissatisfied and inferior'.

In 1962 the RCN expressed grave concern over the failure of the nursing, medical and allied professions to recognise the E.N. as a trained and skilled colleague. The situation has changed but little. However, there is also a positive aspect that the E.N. provides continuity and stability in the nursing team that the Staff Nurse cannot provide as, by reason of the qualification that allows her to develop professionally, her appointment must be a short term one. The first report to describe the EN's role anything but tentatively looked to her to provide balance in the nursing team and described her anticipated role as 'pivotal'. Certainly when you read most nurses' ideal role of the nurse at the bedside, it is the E.N. who appears to fit the picture.

In 1905 the 21st recommendation of the Select Committee on the Registration of Nurses was that four years after the establishment of a register for nurses the Body concerned should investigate and report on 'the desirability of a separate register of nurses whose training is of a lower standard than that laid down for the Register of Nurses'. At that time the recognition of the nursing profession was dependent on the establishment of a well qualified body of people who could support the theory that every registered nurse had a matron's cap in her laundry bag and nothing could be allowed to detract from that aim in spite of the economic realities of the labour market. It was to this end that Mrs Bedford Fenwick fought to the end of her life and in 1919 the Nurses Registration Act was passed with not a mention of the possible need for a second grade of nurse.

In the 1920s the shortage of nurses, trained and untrained, grew to impossible proportions. As long as there were patients to be nursed, those who failed the standards set by the GNC continued to work as long term 'probationers' and some who never registered even became matrons in homes for the elderly and chronic sick. The Lancet Commission was set up in 1930 'To enquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals'. There were not enough people to do the job, even during a time of depression and high unemployment, let alone willing to undergo a rigorous training to do it. Section G of the Report, published in 1932, consisted of recommendations on policy 'though outside the official terms of reference' which very briefly suggested that consideration should be given to 'recognition of two grades of nursing'.

The situation did not improve; meetings arranged by various organisations produced argument and counter argument; letters of protest and counter protest were written but the undeniable fact was there that assistant nurses were being employed and without them many patients would have gone without any care at all. The GNC were powerless because the 1919 Act had given them no way to deal with the problem.

In 1937 the Government set up the Inter-Departmental Committee on Nursing Services under the chairmanship of the Earl of Athlone and its terms of reference were:

> "To inquire into the arrangements at present in operation with regard to the recruitment, training and registration and terms and conditions of service of persons engaged in nursing the sick and to report whether any changes in those arrangements or any other measures are expedient for the purpose of maintaining an adequate service both for institutional and domiciliary nursing."

Its primary recommendations, made in an Interim Report in 1939, because the threat of war was imminent, were in regard to the improvement in the salaries and conditions of work for qualified nurses in order to improve recruitment but its final recommendation was that a second grade of nurse should be enrolled by the GNC. Predictably the report was swiftly followed by a letter from the Royal British Nursing Association and the British College of Nurses to the GNC protesting against the formation of such a roll.

The war exacerbated the situation and in the emergency the RCN established the Nursing Reconstruction Committee under the chairmanship of Lord Horder to consider ways of implementing the Athlone Report.

It took as its first task the review of that large group of unqualified women engaged in nursing, finding that 'many such women were doing excellent work especially in hospitals for the chronic sick'. In the foreword to their report they wrote

> 'The Assistant nurse of the future should become one of the most stable elements in our National Nursing Service..... an integral part of the profession, and a person whose status offers the key to the improved training and employment of her senior partner the State Registered Nurse'.

Many of those SRNs disagreed with them and the attitude still prevails in some areas today.

The Committee's first recommendation was that 'A second grade of nurse should be recognised by the GNC.' A roll should be set up and 'for a limited period' nurses would be admitted who were either over 30 and had five years' experience and were competent, or under 30, two years' experience under supervision.

As we shall see it is a pity that the 'limited period' was not specified.

They proposed that the GNC should lay down a syllabus of training, regulate conditions of training and assessment and admission to the roll, establish a design of badge and uniform that were clearly identifiable from that of their SRN colleagues, ensure that no training was undertaken in wards, and in many cases even hospitals, where there were probationers in training for the register.

The majority of EN's were expected to work in geriatric hospitals and in the care of the chronic sick. There were no prospects envisaged for these nurses in the acute wards of the voluntary hospitals.

As so often happens, war expedited change and the 1943 Nurses Act followed the recommendations of the Horder Report (1942) almost to the letter and the GNC established the grade of State Enrolled Assistant Nurse. Predictably, not without protest from the 86 year old Mrs Bedford Fenwick who lobbied members of Parliament almost continuously and attended the House for all three readings, but to no avail. She stated that she was appalled at the damage done to Registered Nurses and to nursing by this Act and expressed a wish to trundle the responsible MPs to Tyburn and leave them there.

As to be expected, the GNC's first draft syllabus published in 1944 caused concern at both ends of the spectrum.

The Nursing Times commented that "It would appear that the training of the assistant nurse was being designed only to meet the shortage of candidates". The Hospital stated that "There is and will be for a long time a definite place for the assistant nurse and it would be very dangerous to limit her training too greatly and to diminish rather than increase the amount of skilled attention possible for the sick".

Other fears were that the syllabus would be "beyond the powers of the present assistant nurse" and that "with the present assistant nurses trained to the standard proposed, general practitioners and the public would cease to demand the services of SRNs."

The GNC went ahead and published the syllabus in 1945. The length of training was two years, of which not less than one year was to be spent in nursing the chronic sick.

By the end of 1946 about 27,000 nurses had been admitted to the roll by virtue of experience but by 1947 there were only 554 pupil nurses in training. In 1946 the country was preparing for the implementation of the National Health Service. It was recognised that this would increase the demand for nurses even above the current level. The Working Party on the Recruitment and Training of Nurses was set up under the chairmanship of Sir Robert Wood to undertake a comprehensive review of the whole nursing service and to examine such questions as:

> What is the proper task of a nurse?
>
> What training is required to equip her for that task?
>
> What annual intake is required and how can it be obtained?
>
> From what groups of the population should recruitment be made?
>
> How can wastage during training be minimised?

It is easy to see the similarity to the terms of reference of the Committee on Nursing set up over 20 years later when similar questions were still being asked.

In its report made in 1947, the Working Party identified a further question in the chapter on the "Assistant Nurse". The basic problem, it stated, was "whether or not it is necessary to employ an ancillary nursing service comprising persons who, for the purpose of the duties assigned to them, do not require the training of the recognised State Registered Nurse".

They went on to discuss the pros and cons of that argument and came down firmly on the side of discontinuing the State Enrolled Assistant Nurse, while of course protecting those who already held the qualification, and reached the conclusion that "in hospitals of all types, though in varying degrees, there is room for the employment, in addition to the qualified SRN, of a nursing orderly grade which would be concerned with the simpler and more routine duties that do not require a background of full nurse training". They went on to advocate further study to determine the correct ratio of nursing orderlies to trained nurses and to "re-define nursing" and its content.

There is a further paragraph that I would like to quote in its entirety for it gives perhaps one of the clearest historical insights into the position of the SEAN at that time. It is to be found in the chapter on Nursing the Chronic Sick, para.16:

> "It is an instructive comment on the present position to point out that chronic sick patients are not generally admitted to the hospitals which provide medical teaching and research: they are hardly more welcome in many municipal hospitals. They are more or less abandoned to institutions where they receive the barest minimum of medical attention, and where little if any scientific effort can be devoted to the study of their disabilities. The reason often given is that chronic sick patients are nursed by Assistant Nurses and their presence is alleged to have an adverse influence on the training and attitude of the student nurse."

The 1949 Nurses Act, which enabled the GNC to function within the NHS, ignored Wood and preserved the status quo as far as the SEAN was concerned and, with the rapid growth of the Hospital and Health Service, came an expansion of the role of the SEAN. By 1951 there were 2,500 pupils in training in 210 hospitals and by 1957 this had increased to 4,780 in 459 hospitals, mostly small hospitals that could not undertake SRN training. However in 1954 the Assistant Nurses Committee of the GNC approved an experiment to allow student and pupil nurses to work together on the same wards and by the end of that decade the larger teaching hospitals were planning to open their doors to pupil nurses to train them for the roll.

In 1961 an Amending Act was passed that allowed the term 'Assistant' to be deleted from the Statutory title because it was a deterrent to recruitment. But in the meantime the post of Nursing Auxiliary was becoming firmly established in the fields of chronic and elderly care and was rapidly encroaching into the acute areas and history was already repeating itself.

There were still unqualified people carrying out care at the bedside. However, the early 1960s were to prove eventful from a professional point of view for the SRN.

In 1962 the GNC were finally able to establish a minimum educational requirement for entry to the Register, albeit only two 'O' levels even in that decade of rapidly increasing educational opportunity, and this promptly improved recruitment for entry to the roll. Failure to reach the required educational standard has continued to be the prime reason why people wishing to nurse have become enrolled nurses though occasionally there is still the person with several 'O' and 'A' levels who see the SEN's role as potentially more satisfying. However, they often discover the limitations to this work are too restricting and they then leave, especially as it has gradually become more difficult, if not almost impossible, to transfer to training for the Register.

Also in 1962, at last, the making up of the SEN from the grade of Nursing Auxiliary after five years service with the support of the nurse manager, was finally to be discontinued thus ending the 'limited period' of the 1943 Act. But more of that later.

In 1962 the RCN produced a report on the Position of the Enrolled Nurse, which advocated further developments.

The salary of the SEN was to be re-assessed and increased to above that of the Nursing Auxiliary, who was paid according to domestic workers' scales, which at this time were being negotiated before those of the nurses.

Two years later the SEN was established in the mental health field and once again provision was made in the Nurses Act of 1964 for applicants to enrol if they had two years' full experience as Nursing Assistants, under the supervision of Registered Mental Nurses. By 1967 over 16,000 had enrolled by this method.

After just two years the position of the SEN had been eroded again. However there was a major plus side that year in the recognition of the grade of Senior Enrolled Nurse and the recognition of the ward management skills of the SEN. 1964 also saw the revision of the syllabus for enrolled nurse training with at least six months' acute medical and surgical nursing, eight weeks' paediatrics and a minimum of just three months' long stay experience instead of the previous year's requirement of the 1943 Act.

In the meantime the RCN had produced a report entitled A Reform of Nursing Education or The Platt Report. If it had ever been implemented it would have raised the standard of the Registered Nurse whilst at the same time giving the SEN a well defined position in the nursing team. Their suggestion for reform would have enabled more than lip service to be paid to the philosophy that the student nurse should be a genuine student, studying principles and their application, whilst the pupil, undergoing an apprenticeship, learns functions and their meaning. The difference between the two, said Platt, would lie in the range of functions performed and the degree of responsibility carried, with clear recognition being given to the share carried by the SEN, even to the appointment of SENs to selected sisters' posts.

The Platt Report probably roused more SRNs to protest than any other and the SENs were too few to be heard.

In 1968 the National Board for Prices and Incomes published a report on the Pay of Nurses and Midwives in the NHS and, without a nurse amongst them and with their terms of reference to examine only the pay of nurses, produced a report of ten chapters. Only two were on pay and the rest of their proposals were on training, deployment, shortages and nursing management in hospital and community. They were in favour of making better use of enrolled nurses, complaining that "Many hospitals do not make full use of their range of skills and thus deprive themselves of a valuable source of nursing labour".

1969 saw the approval of the Enrolled Nurses Rules by the GNC which still allowed for enrolment solely by virtue of experience gained in nursing before 1949. Few candidates were likely to do so but the possibility detracted from the status of the Enrolled Nurse. In the meantime, the numbers of Nursing Auxiliaries were increasing and soon they were to be knocking on the doors of the RCN demanding admission.

In 1970 the profession was introspectively contemplating its navel again through the Brigg's Committee, whose terms of reference were "To review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service." All this in anticipation of the first, but not the last, reorganisation of the NHS in 1974.

Before the report came out, another report of the Standing Nursing Advisory Committee, The State Enrolled Nurse was published in 1971, after a gestation period of five years.

They commended for further consideration the concept that all nurses should train for a Certificate of Nursing Practice, albeit by different routes, depending on ability.

They advocated an extended role for the SEN with planned post-enrollment training, including management, and suggested that the SEN should wear the same uniform as staff nurses. Most Health Authorities now provide supervisory skills courses for SENs but most nurses still lay great store by the wearing of distinctive uniforms and, over ten years later, there is still a reluctance to accept the SENs by some Registered Nurses and there is still conflict between the third year student and the newly qualified SEN. This usually manifests itself in demarcation lines over drug administration rather than who should be left in charge during unsocial hours.

The Report also recommended a syllabus of training for enrolled nurses which was implemented and was revised and updated in 1980, but is still not statutory.

The Briggs Committee reported in 1972 and their comments on the enrolled nurse were very brief but very much to the point so I will quote the relevant paragraph in full.

> "Although enrolment and registration are distinct qualifications leading to very different career prospects within the profession, the actual level of work assigned to some enrolled nurses is often very similar to that assigned to some registered nurses in the staff nurse grade. We believe this can only lead to confusion and bitterness."

In the recommendations they propose the solution of "one basic course of eighteen months for all entrants which would lead to a statutory qualification, the Certificate in Nursing Practice".

Very little anxiety was expressed at that time by the SENs because they easily identified their training with that required for the Certificate.

However, this aspect of the Briggs Report was overtaken by the EEC directives which finally materialised in 1977 and which made it clear that no training of less than three years was acceptable for recognition by the EEC. Whatever plans we have for any form of a single portal of training for a basic Certificate in Nursing Practice will have to be for a course lasting at least three years and at present the enrolled nurse qualification is not recognised by the EEC.

GNC rulings continued to exacerbate conflict and disillusion in the 1970s. A student nurse who failed any practical test on the three occasions that resulted in the discontinuation of her training could promptly transfer to become a pupil nurse and on, completion of the balance of weeks of training, could sit the written assessment and become enrolled, without even having to pass all the practical assessments required of other pupils. Even more galling was the ruling that was not revoked until 1980, which allowed a student who had failed the State Final written examination to apply for and be admitted to the Roll without sitting the written assessment but purely on her three years' experience as a student nurse. A glaring anomaly which provoked very little protest until the late 1970s.

Although in 1943 the SEAN was acclaimed as the "pivot", and in spite of a considerable amount of evidence from research carried out especially in the last fifteen years, the membership of the nursing team has continued to be based primarily on two empirical considerations. Who is available and how many of them can be paid for out of the current budget. To quote the RCN evidence to the Royal Commission on the NHS in 1976, "In good times the nursing service recruits, in bad it cuts back and replaces trained staff with untrained".

It is the EN who is probably most vulnerable to the effects of that policy though ultimately it is the patient, for whom she often provides the most valued care, who suffers most.

So what of the present?

Is it that most controversial consultative paper published in 1982 as a stimulant to discussion by Working Group 3 of the UKCC, on Education and Training? Sixteen foolscap pages in which were hidden two fateful paragraphs on the possible future, or should it be demise, of the State Enrolled Nurse?

As a result eminent schools of nursing discontinued EN training forthwith and 14 year olds, deciding on their 'O' levels all over the country, will be taking the Working Group's views into consideration.

I wish I had the key to their success, for I have a great difficulty in persuading many of my colleagues to read a single page of foolscap on any professional matter and 75% of a group of ward sisters we interviewed recently to become practical assessors could not tell us what the UKCC and ENB stood for.

Now we have a UKCC circular ADMIN 84/03 entitled: The Central Council and the Future of the Enrolled Nurse. I think it was meant to be reassuring but I think if I was an enrolled nurse I would have given up in a panic long before reaching the final sentence which reads, "Wide consultation would precede any changes suggested and the profession can be assured that currently there is no change envisaged in the position of the enrolled nurse".

This was swiftly followed by a press release by the English National Board and repeated in circular ENB(84)15 that, "The Board will recommend to the UKCC that, in future, there should be, within statute, training for only one grade of nurse. When this change occurs, there must be support for, and protection of, existing Registered and Enrolled Nurses who will continue to work within these grades for many years". The circular goes on to explain that in the view of the ENB the concept of a new single grade of nurse should not be seen as synonymous with either of the existing grades.

I would like to ask this audience if, from this review of the past, it would be possible when these decisions are made for some of the most glaring mistakes to be avoided? Shouldn't it be the nurse, who is physically and not metaphorically at the bedside, who is carefully trained in the skills of nursing and communications, and whatever other education and training that is needed to take a select few up into Sister's office and beyond should come later?

THE EDUCATIONAL ENTRY REQUIREMENTS FOR NURSES: A PERSPECTIVE

Anne Lockwood

A paper produced by the UKCC in September 1982 stated that from 1 July 1984 the academic entry requirement for State Registration is to be a minimum of five 'O' level, A, B, or C grade, passes. A safety net is included stating that entrance could also be via an educational task set by the Council.[1] The move to institute an entry standard of 5 'O' level passes has been made possible by the decreasing number of job and educational opportunities for well qualified school leavers. Whether increasing the entry requirements for nurse training is in the patients' best interests is in question. Are there sufficient numbers with 5 'O' levels seeking nurse training to justify this action? And if there are, that is not to say that this action is the most appropriate for patient care.

The fundamental issues that underpin the educational entry requirements to nurse training are what qualities should the candidate possess in order that they will make a good nurse and are there sufficient nurses with these requirements to meet the demand for nurses? Nurses as a group have professionalised the care of the sick and this means of all the sick who may benefit from expert care, not just those few who live sufficiently close, for instance, to an elite hospital whose ability to attract well qualified entrants has never presented a problem. Thus there must be sufficient nurses at any level to meet the demands made by the sick. If there are insufficient nurses to meet the needs of the sick, however well qualified, patients will inevitably suffer.

The issue is one of supply and demand. This also applies to the nurse in training. The nursing recruit, on entering training, becomes involved in caring for patients. The hospitals are reliant on the labour power of the nurse in training for a major part of patient care. Therefore the needs of the hospital to maintain the recruitment of nurses in training, in order to care for patients, is of paramount importance to them. In consequence, the question of supply of suitable candidates for nurse training is inevitably fundamental in all decisions that are taken with respect to entry to training.

The demand for nursing services, Brian Abel-Smith states, "is part of a wider demand for medical care. It is influenced by national wealth; by medical skill and by the public recognition of it; and by the extent of ill health and cultural attitudes to it".[2] During the 19th and 20th centuries the demand for nursing services had changed dramatically in response to changes in national wealth, medical skill and the public's recognition of it. The cumulative effect of the growth of knowledge during the 19th and 20th centuries changed the care of the sick from little more than custodial care, towards the hope for a cure. Medical practitioners began to need nurses of a type who would not jeopardise their treatment in their absence. They needed to be able to leave the care of the patient in the hands of a nurse who would be able to carry out the treatment which they had prescribed and who would be competent to observe and report any change in the patient's condition.

The popular image of the 19th century nurse did not meet these criteria. The image ranged from being a decent woman of char woman type[3] to that of being an ignorant and immoral drunk.[4] As medical care improved, medical practitioners reported their patients' lives were being threatened by illiterate nurses giving topical preparations orally and patients being poisoned by overdosage of oral drugs.[5] Thus the need for literate and numerate nurses had arrived. Developments in health care also coincided with a rise of the feminist movement which led to a demand for work amongst a small group of women whose survival did not depend upon their capacity to earn. To those encouraged by a religeous vocation, nursing offered an opportunity for service to God and a chance to work. Educated ladies with a mission thus joined the ranks of the frequently illiterate nurses seeking to earn a living at the time when the demand for nurses able to respond to the new developments in health care arose.

The need for a literate nurse set a baseline of educational attainment for care of the sick with respect to safety. However, other issues began to be involved as Brian Abel-Smith states,

> "an extremely varied group of people were engaged in the practice of nursing. Ladies with excellent instruction and servant girls with a minimum of training belonged to the same occupation and there was little by which the general public could judge their professional competence. To remedy this situation a group of ex-lady-pupils banded together to introduce a firm distinction between the trained and the untrained by establishing a register of nurses".[6]

Thus a register of nurses would protect the sick from being nursed by untrained people believing them to be trained. It would not in itself produce more nurses to meet the growing demand for care and thus meet the total needs of the sick.

The General Nursing Council, established in 1919, set about controlling standards of entry with little thought for the numbers of nurses that would be required. Mrs Bedford Fenwick, who was very prominent in the battle for registration, secured the chairmanship of the Registration Committee and she was so anxious about the threat to the status of nursing that the progress was exceedingly slow and "the chairman of the council and sixteen members resigned in protest leaving Mrs Bedford Fenwick and her five friends unable to form a quorum".[7] The Ministry of Health was required to step in, taking the stance that "public interest required that the supply of nurses should be sufficient to staff the Hospitals. However, the GNC put the emphasis on quality - how hospitals staffed their wards was their affair, not the concern of the Council".[8]

The question of quality presented the GNC with a problem: "the standard of training schools themselves varied widely between the high quality of most of the large London hospitals and the low quality of those smaller and poorer establishments".[9] The Education and Examination Committee of the GNC set about seeking to rationalise the training. The chairman of this committee was Miss Lloyd Still, Matron and Superintendent of the Nightingale Training School.[10] The suggested training reflected her chairmanship, as it was largely based on the training given in the Nightingale School at St Thomas' Hospital.[11] The decision to follow the training of St Thomas' meant that the standard was set at a level which did not reflect the general level of nurses in training throughout the country. All but two of the nurse members of the first GNC were Matrons of prestigious voluntary hospitals. Their standards were inappropriately high for training schools with less esteem and almost inevitably shortages developed.

Up until 1936 the measures that the GNC had taken to control quality concentrated on standards of registration. However, when the Lancet Commission, set up in 1932 to seek solutions to the shortages of nurses, reported a 40% failure rate at the final exam,[12] "the council's rather clumsy answer to the problem was to introduce in 1937 an educational test for probationers starting training".[13] Any candidate who did not have the general certificate of education must take this test. The educational test was in the form of two papers: an arithmetic paper including addition, division, multiplication and ability with fractions and decimals and an English paper in which the candidate had to answer such questions as "in which book do the characters John Silver, the Mad Hatter, Titania, Minnehaha, Elizabeth Bennett, appear?"[14]

Although the arithmetic test certainly came within the framework of the baseline of literacy and numeracy suggested by Dr Anthony Todd Thompson in 1845, the English test did not meet this objective. Knowledge of Shakespeare, Jane Austin and Lewis Carrol could only be used to identify the girls with the sort of background Mrs Bedford Fenwick would wish to attract from the less well educated. It would in no way identify ability to care for patients.

Thus a standard of entry was set. By 1937 in the face of the continuing shortages, the Ministry were drawn to act by setting up a Committee of Enquiry, chaired by the Earl of Athlone "To inquire into the arrangements at present in operation with regard to the recruitment, training, registration and terms and conditions of service of persons engaged in nursing the sick and to report whether any changes in those arrangements or any other measures are expedient for the purpose of maintaining an adequate service both for institutional and for domiciliary nursing".[15] The outbreak of war resulted in the publication of only an Interim Report recommending a roll for assistant nurses under the control of the GNC.[16] The RCN stepped in to fill the gap left by the non-continuance of Athlone by setting up the Horder Committee in 1941.

The Horder Report (1942) begins its opening paragraphs with a quote from Athlone. Referring to unqualified nurses it states "their uncontrolled employment constitutes a definite danger to the patients under their care and tends to lower the status of the whole nursing profession".[17] We return to the issue of drawing a baseline below which nurses become a definite danger to patients, which is a certain level of literacy and numeracy. The level of entry to training certainly needs to be above this level. But what of the other level? This becomes a level of status.

The outbreak of war had increased the demand for nurses and the Ministry took the opportunity to suspend the entrance test. A predicted increase in demand was also expected from the establishment of the National Health Service. In response to this the RCN appointed a sub-committe to propose a scheme of training within the NHS which decided in 1947 that the certificate of general education should be the absolute minimum and that this should include general science, English and arithmetic.[18] In the same year the Wood Committee, set up by the ministry "to review the position of the nursing profession and survey the whole field of recruitment and training of nurses",[19] researched the academic background of recruits to nursing. From the figures gathered it was shown that only 36% of those entering voluntary general hospitals had reached matriculation level or above, whereas this applied to only 15% of those in municipal hospitals;[20] clearly not a level at which the hospitals could be staffed.

At the cessation of hostilities the question of the re-introduction of the test was raised again at the RCN. With plans afoot for the establishment of the National Health Service the Ministry were concerned about recruitment; even without the entry test and at the low educational levels reported by the Wood Report there were still difficulties in maintaining a sufficient supply. In October 1949 a film was released by the Association of British Pathe Limited. The action of the film took place in a ward of a wartime hospital in Burma. The characters were soldiers with the exception of one woman, an army sister, played by Patricia Neal. The publicity for the film was to be co-ordinated with the publicity of recruitment of nurses.[21] The nurses were not amused.

The recruitment campaign for nurses entered the cinema with special posters bearing the caption "Patricia Neal in the new British Picture - The Hasty Heart - an epic of the nurse in wartime - nurses are always needed - consult your local hospital or nearest office of the ministry of Labour". The Royal College responded. The Scottish Board deplored that the Ministry of Labour could base recruitment on such a film and the RCN took the matter up with the National Advisory Council on Nurses and Midwives.[22] Methods of attempting to boost recruitment based on a film showing a romanticised view of nursing was not in accordance with the approach which the RCN had to recruitment.

That is not to say the RCN were not concerned about the shortage. In 1947 the RCN discussed the age of entry at a special council meeting.[23] It seems that in order to meet the increasing demands for patient care with a shortage of recruits, hospitals were turning to girls as young as 15½. Patients sick in hospital required nursing care and with continuing shortages recruitment was aimed at any available labour. The RCN, on the other hand, stated that "the College strongly deprecates this practice".[24] The Council were of the opinion that girls who wish to nurse should stay on at school as long as possible,[25] presumably taking their matriculation.

In pressing for an entry to training of the certificate of general education, the RCN proposed that those candidates who did not reach the standard should be given the opportunity to train in assistant nurse training schools,[26] in order that they would not be lost to nursing. In the post-war period the GNC did not suggest a standard of certificate of general education but had instead been working with the National Institute of Industrial Psychology who devised a test for them.[27] Even after seven years' work the Director of the NIIP, who was not exactly unbiased, had to admit that he was not free from doubt about the suitability of the test for entry to nurse training.[28]

This left the problem of how nurses can be selected for nurse training. The Ministry of Health was reluctant to allow the GNC to adopt a test of questionable value. However, as the RCN wrote to the Minister, the lack of a nationally recognised educational standard of entry lowered the status of British Nurses.[29] Status was important to nurses and social class, as well as education, is another aspect of status seeking. A Nightingale nurse wrote about her entry to her training school, "all the girls come from good expensive homes"[30] which would have pleased Mrs Bedford Fenwick who was anxious to attract from such categories. However, the recollections of another post war Nightingale indicate problems caused by this elitism. She recalls making a cup of tea for an old Lambethian, who was awake in the night, to which he responded "thank you old cock" - she says that it was not until he pressed a bar of chocolate - then rationed - into her hand that "I

realised this was his greatest form of endearment".[31] Her 19th century counterparts would not have had to bridge this class barrier in order to understand their patients and understanding is the beginning of compassion.

Compassion cannot be measured by entry tests or by 'O' levels and in pressing these aspects for the sake of status, rather than seeking to meet patient need with the best possible care, the shortages continued and patients were put at risk. An article in 1961 in the Nursing Times entitled 'Crises in Nursing' stated "By constantly failing to cut our coat according to our cloth or even to examine very clearly either the material or the system of manufacture, we have failed to use the resources we have to best advantage. Inadvertently patients have suffered, they still suffer".[32]

A means of evaluating compassion as a standard for entry has not been developed but a research project published in 1951 in the Journal of Applied Psychology showed the other side of the argument. It drew the conclusion that firstly, personality variables, though these did include education, were more important predictors of a good nurse than were measures of intelligence. Secondly, selection tests that depended on measures of intellectual capacity were ignoring a vital component in the make-up of a good nurse.[33]

The problem therefore remains unsolved: what is a good nurse? Florence Nightingale's principle objection to registration had been that it would involve the introduction of an examination for nurses. She believed that the professional competence of the nurse could not be judged in this way.[34] Brian Abel-Smith says of Florence Nightingale "she laid great stress upon the personal qualities required by nurses. If a public examination were to take the place of assessment by the individual hospitals, she feared less attention would be given to personal qualities in the selection and training of nurses".[35] However, in spite of her influence the Register of nurses became a reality and entry to it was by examination.

Florence Nightingale's objections were not without foundation. Rather than asking what are the qualities of a good nurse and how may these qualities be selected for and evaluated the examination for registration and the selection for training followed the orthodox pattern of professional exams. Selection for entry to training and examination for registration are inextricably linked. As the Wood Report pointed out, in order to pass the state registration examination an I.Q. greater than that recorded for the lowest one third of the population was needed. Of the hospital nurses tested it was found that 24% were in the lowest 30% of the population.[36]

A study published in 1981 stated that the pass rate in October 1979 for those with two or more 'O' levels (this being the GNC minimum standard in 1976) was 72.23% and for those with the entry test (re-instated in 1962) the pass rate was 57.05%.[37] Thus 'O' level passes increased the likelihood of passing the state registration examination. However, a study published in 1975 by Dr Eve Bendall entitled So you passed nurse, states,

> "As this study has shown those training to nurse are a highly diversified group on many variable characteristics; but many persist in believing that there is an ideal type for nursing. The only measurable criteria that is used is educational background. There is a minimum national standard of two 'O' levels, or a pass in an entrance test but above this elite hospitals set their own criteria, despite the fact that there is no objective evidence as to a relationship between education and a satisfactory standard of nursing ability. An interesting and complicated situation exists. There is a lobby of opinion mainly among tutors (and backed by the influence of the Royal College of Nursing) which states that the minimum standard should be raised to (say) five 'O' levels, while the General Nursing Council has encouraged some training schools to develop special courses for graduates or combined nursing/degree courses. These moves can be seen mainly as status seeking".[38]

From this statement I take issue with only one point: that the situation is complicated. Essentially it is simply that the urge exists to push the standard of entry to nursing as high as possible. This is only countered by the fact that the Department of Health and Social Security retained the final word on such matters from the 1919 Act and so maintains the standard of entry at a level that is practical. Florence Nightingale has been shown by history to have been justified in her view. The problem remained intractable: what are the qualities required of the nurse and how may the nurse be judged to have those qualities? Until these questions have been answered it remains an issue of demand and supply in which the nursing profession pursues a higher academic entry primarily to protect its status and with little thought for patient need.

FOOTNOTES

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35. Ibid.

36. Wood Report, (Footnote 19) para.56.

37. James A Straw, Entrance to Nurse Training by 'O' levels and the GCE E Test, Nursing Times Occasional Paper, Vol. 77, No. 29. 21.10.1981.

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THE EDUCATIONAL ENTRY REQUIREMENTS FOR REGISTRATION

Rosemary White

Educational entry requirements have always centred around the problem of recruiting enough nurses to the NHS. For many years after 1948 there was a strong belief that a minimum entry level would act as a deterrent to recruitment. However, after the reintroduction of the two 'O' level standard in 1962 recruitment jumped from a declining trend to a new level which was maintained for several years. When the minimum entry level for psychiatric student nurses was introduced a couple of years later the same phenomenon was reported.

Whilst the general policy was to decrease the number of registered nurses and to increase the number of enrolled nurses, this goal was never achieved. Most investigations have confirmed that recruitment of pupil nurses would continue to be low as the entry level to student nurse training was only two 'O' levels. Most matrons, however, preferred to recruit and train student nurses for two reasons.

In the first place, matrons of student nurse training schools received a salary preferment which matrons of pupil nurse training schools did not get.

In the second place, student nurses gave three years of service compared with the one or two years of the pupil nurses' training.

My paper today can only examine one area of the question of the minimum entry requirements for student nurse training. This topic is a very complex matter which includes the unresolved problem of whether there should be separate trainings for the pupil and student nurses, the so called "two portal" system, whether there should be a single portal with a form of progressive training leading first to a license to practise and, subsequently, to a certificate.

Other aspects which have a bearing on this topic include the question of whether or not there should be two grades of qualified nurses (which the Single Profession Register does not answer), the question of the standard of training and also the nursing structure.

Since 1948, and up to 1981, I identified some 136 papers or reports on nurse education, not all of much substance but all of which I have studied.

As it is not possible to deal with all the aspects relating to the educational requirements for registration, I propose to discuss today, the part played by the GNC in setting the minimum educational standard which was introduced in 1962.

The General Nursing Council for England and Wales was set up in 1919 after many years of wrangling by nurses and others who wished to have state registration for the protection of the public. When it was set up, nurses hailed this as an achievement which would allow them to regulate their own affairs and maintain a high standard of nurse training.

Most British nurses today are unable to distinguish the difference between the GNC, a statutory, body and the Royal College of Nursing, a professional association. Brought up to believe in the ethic of altruism, the majority of nurses believe that all our institutions are there to pursue the best possible standard of nursing care by means of a high standard of professional training.

Until recently, most historical studies have tended to reinforce this ideology. My paper questions this and seeks to show that the GNC, willingly or unwillingly, was in effect, an agent of the Ministry of Health and assisted in a process of de-skilling nurses which I have described more fully elsewhere.[1] This paper will show that the GNC, after the coming of the NHS, was not so much concerned with improving the quality of nurse training as it was with recruiting the highest number of trainees and that, in order to achieve this, they had to depress the standard of entry and, therefore, of course, the standard of their qualifying examinations.

Before the war, the GNC set the minimum entry qualification for nurses entering training at the School Certificate level and also had its own educational test for candidates without formal qualifications. This entry requirement was lifted in 1939 for the war-time emergency but in 1945 the GNC asked the Minister to reinstitute the test of education. The Minister refused on the grounds that there was a critical shortage of nurses. The GNC and others in the profession, continued to ask for the return of the test until it was finally agreed in 1959, to take effect from 1962.

The GNC was concerned to resume the test for a variety of reasons which tended to be adjusted in priority rank order through the years. In 1945 the main reason seemed to be that the lack of an educational test made it difficult to recruit enrolled nurses since most candidates preferred to take the registered nurses' training. This reason was reinforced when the Wood Report (1947)[2] proposed that the roll should be abandoned.

Another reason was the snub received from the Registered Nurses Association of British Columbia who wrote in 1947 to the GNC retracting their reciprocity agreements. The RNABC explained that nurse education in this country had failed to keep pace with British Columbia in respect of the minimum entry standard and of its quality.

In later years, wastage of student nurses became a matter of concern. The GNC maintained that a prime reason, apart from poor salaries, was the lack of selection of students. They claimed that too many students were leaving because they could not stand up to the learning process and could not pass (or thought that they could not pass) their Preliminary and Final examinations.

A sequel to this came in the 1950s when there was an acute shortage of tutors. Discussions with the University of London who conducted the tutor course, exposed the problem that the tutor students very often were deficient in basic scientific knowledge. A working party was set up to investigate the training of tutors under the chairmanship of Dr Janet Aitken, a Principal Medical Officer at the Ministry of Health.

In the meantime, (1950) the GNC engaged the National Institute of Industrial Psychology to devise a suitable test for recruits in anticipation of any eventual agreement by the Ministry of Health to introduce it. A preliminary report from the Institute indicated that reasons for wastage were (a) intellectual inferiority, (b) unsuitability, (c) health and vague reasons and (d) extraneous reasons.

Taking a maximum score of 200 for suitability factors, including intelligence, with classes of 20 marks, the Institute found that the mode was 100-119 with a slightly skewed curve towards the lower classes. If 40 were to be taken as a critical score, about 22% of the students investigated would have been excluded. The investigation showed a slight correlation with continuance of training but a much better correlation for success in examinations. The GNC asked the Institute to continue its study which then took the form of a longitudinal project.

In 1953 the Oxford Area Nurse Training Committee (ANTC) asked the GNC for research funds to make a study into the recruitment and training of student nurses. Although the Education Committee of the GNC recommended funding, the Finance Committee rejected the request.[3] An earlier report from the Oxford ANTC on the recruitment and training of psychiatric student nurses had found that "student nurse training in the majority of mental hospitals had been merely a token affair". The GNC maintained that they "thought it to be obvious without investigation that one of the chief reasons for the wastage of student nurses in the mental field.....was the acceptance of unsuitable candidates and that until the Council was in a position to reintroduce a minimum educational entry.... there would appear to be no advantage in the investigation".

This comment actually related to the proposals of the Wood Report, that training methods should be studied, but the GNC took up the same position with the Oxford ANTC whose earlier report had shown that a number of leavers were, in fact, those with secondary education.

The final report of the National Institute showed that 48.3% of their population had continued to the Final State Examination; 38% had discontinued training and, of these, 25.8% before the Preliminary Examination and 12.2% after it. The Institute found that the relationship between the Test Score and the successful completion of training was significantly positive. The GNC eventually decided to accept a minimum score of 30, which would exclude only 10% of recruits.

Another study in 1953 made by the National Advisory Council on the Recruitment of Nurses and Midwives reported that 15% of the leavers were for educational reasons.

In 1954, the Aitken Report on nurse tutors[4] was completed and found that the quality of teaching in nursing schools was deficient, there were not enough candidates coming forward for training as tutors and that many of the candidates were unsuitable for training. The working party felt that service needs detracted from the training of student nurses. They described the tutor:student ratio as ranging from 1:21 to 1:84 with an average of 1:41. Of 1244 full-time tutors, only 854 were qualified. Many tutors whom they had interviewed felt that the educational level of students was such that it was very difficult to train them to the examination level.

In 1957 the South Eastern Metropolitan ANTC published a report on "How far the pattern of the hospital affects the work followed during the various years of training".[5] This report found that the work pattern of the student nurse depended more on the numbers of domestics available on their wards than on their training needs. The researchers thought that students were used as ward labour rather than trained to the GNC syllabus, that their allocation to wards was for service needs rather than training purposes, and reported the dissatisfaction voiced by many students in the quality of the training syllabus and their training standards.

The GNC substantially rejected these findings except that they agreed that too much domestic work was done by student nurses.

A report from the Oxford ANTC, which effectively agreed with that of the south Eastern ANTC, was found by the GNC to be "not helpful".

In 1957, the GNC produced a major policy document on nurse training.[6] The proposals were based on a number of important assumptions including the number of occupied beds in the training hospitals and, most important of all, the return of the minimum educational standard.

The objectives of the policy document were set out as being the raising of the minimum educational level for student nurses, enlarged nurse training schools by a system of grouping and an increased number of pupil nurses, training for the roll.

The Minister eventually agreed to these proposals, including the return of the entry test which was to start in 1962. The GNC set this level at two 'O' levels or the equivalent of a score of 30 in their National Institute test.

This low standard had to stand until 1984 as the substantive level against which the Final Examination for State Registration has to be pitched and has produced several generations of semi-skilled nurses. Why? Why was the level set at a lower standard than existed before the war?

We need to look at the minutes of the GNC to discover the reason which probably lay behind this extraordinary decision.

At the Ministry's insistence, the GNC in 1948 decided that the National Institute of Industrial Psychology should look for a cause of failure rather than to search for suitable qualities for potential candidates. The GNC was concerned not so much with producing good nurses as with training nurses to a minimum standard. They wished therefore to avoid screening out candidates, which might result in losing too many. They agreed with the Ministry of Health that they should only seek to eliminate the totally unsuitable person. This decision was clearly taken on the grounds of service needs and the shortage of nurses. Representatives of the nursing associations wanted the open entry policy to be reversed but representatives of the employing and recruiting agencies and the trade unions were of the opinion that an entry test would act as a deterrent to recruitment.

In the scoring distribution given by the National Institute, the critical score appeared to be 45-50 where the success rate showed a marked upward curve: they showed that at a score of 40, 50% of the investigated students had failed their Preliminary Examination at the first attempt. The Education Committee thought that a score of 35 would be an "expedient" level to adopt provisionally, but in October 1953, Council agreed to 30 as the minimum level, which would only have excluded 10% of the failures.

But, you will recall, there was an alternative test, the School Certificate. After the war it was decided to replace this with a General Certificate of Education and the GNC had to adapt their demands.

As far as I could see, there was no attempt to link the GNC test with the new GCE examinations. There was no discussion about how the Institute's scoring might correlate with GCE results. The two options seemed to have been dealt with quite separately even though the one would exempt a candidate from the other.

In 1949, the GNC consulted with the Association of Headmistresses about the new GCE examinations. There was an important difference between the GCE and the School Certificate examination which neither the headmistresses nor the GNC noticed. Whereas the School Certificate was a consolidated examination in which a minimum of five subjects had to be passed, the new GCE examination could be taken serially, one subject at a time. A total of five GCE 'O' levels need not therefore necessarily equate with the academic level of the School Certificate and one 'O' level was not the equivalent of a single subject in the former examination. Notwithstanding this, the headmistresses arbitrarily and rather randomly recommended that only two 'O' levels should be required. And the GNC accepted this without further debate.

After the Minister eventually agreed to allow the resumption of an entry test, the GNC once again discussed the level of the pass mark. The Education Committee continued to vote for a higher pass level than the main Council was willing, for political reasons (which were not clearly specified), to condone. They argued that if the score was set at a lower level, fewer potential candidates would be eliminated and, also, that the psychiatric nurses, excluded by the Minister from the entry test, might eventually be included.

The evidence which I have offered gives the appearance of being rather contradictory. On the one hand, the GNC fought for a return of the minimum entry level but on the other hand, the Council consistently over-ruled its own Education Committee and set a very low level for the eventual return of that very test. We need to find a way of explaining this discrepancy. I think that there are two explanations that I can offer.

In the first place, the membership of the GNC in 1944-45, which first set out the arguments for a return of the test, was substantially different from the compostion of Council voted into office in 1950. Both the earlier Council and the later one had a predominance of matrons but those on the earlier Council were still, largely, the pre-war matrons, who had qualified for training by taking the School Certificate, had been trained in the great teaching hospitals and who came, usually, from upper middle class families. Whilst education for girls before the war was poor and the curriculum thin, the women accepted for training in these hospitals generally came from educated families and were brought up in a cultured environment with strong ideals of service and concern for the welfare of the patients.

The Council of 1945-50 included 14 general seats, two mental nurse seats and one sick children's seat. Of the general seats, there were nine matrons of teaching hospitals, one superintendent health visitor, three superintendent district nurses and one sister tutor, also of a teaching hospital. These women brought to their work the values and goals of their hospitals but, more important, the values and goals of hospitals before their nationalisation.

It is not surprising therefore that this Council started early negotiations with the Ministry of Health for the return of the entry qualification based on the School Certificate, in order to achieve, once again, a more stringent selection of recruits.

The later Council, that of 1950-55, inherited that policy and had to continue to pursue it. But this Council was of a different consistency. Only five of the old Council were re-elected and nine were new faces. Of the 14 seats there were only seven matrons of the former teaching hospitals. But the most important change of all was the change that had taken place in the hospitals themselves and the values and goals of their senior nurses.

Whereas the dominant ethic of the pre-war and pre-nationalisation hospitals had been to do with standards of nursing care, even by 1950 this had changed and the prior concern of senior nurses was recruitment and ward cover.

Therefore, whilst the later GNC loudly called for a return of the entry test, they explained this by saying that it would make nursing more attractive to recruits. When they asked the National Institute of Industrial Psychology for a test, they stipulated that it should screen recruits in rather than exclude them. In fact, they searched for the minimum standard and, as their minutes said in 1956, [7] some hospitals had no choice but to accept anyone who applied and even those who failed the final examination had given three useful years of service.

The values of the 1950-55 Council were very different, therefore, from those of their predecessors: they were more interested in recruitment than in education.

The second reason for the discrepancy was the open recruitment policy itself. By 1950, there had been eleven years of open recruitment and many senior posts had been filled by nurses entering the occupation without formal educational qualifications. Those nurses felt vulnerable to the possible challenge from better educated recruits if a minimum standard of entry were reintroduced. They argued that nursing was a practical occupation and should remain so. They taught new recruits that nursing required practical skills rather than intellectual ones, that nursing procedures did not require a theoretical base and that academically orientated nurses were not the "best types" for the work.

In 1950 a sister tutor wrote, "Britain's reputation for producing first class bedside nurses is being imperilled by the amount of theory crowded into the three year training."[8]

In 1953 the prizewinning essay in the BMA Essay Competition (which was sponsored by the RCN and the Nursing Times) contained this paragraph,

> "Unfortunately.....the really brilliant girls have the wrong temperament for the work. Their alert, quick intense minds accompany an impatient and intolerant nature, and being rather excitable and erratic people, they are the types prone to panic"

and were, apparently, more concerned with their rights than with caring for the patient.[9]

The lesson was well taught and well received and the anti-education ethic took root.

The GNC could, therefore, show that it took the recruitment of nurses seriously by depressing the standard of entry so that the lowest possible level was introduced in 1962. Although the Ministry of Health had resisted the return of the educational test until 1959, there is nothing to show that they would have rejected a higher minimum score then. The GNC did not even seek for anything better and ignored the slightly more ambitious wishes of its own Education Committee.

Thus the GNC had changed its values and whereas the pre-war Council had been an instrument for improving nurse training, the post-war Council became an instrument for recruitment.

This level for recruits has been maintained against a trend of rising standards of education and increased demands for recruits to other comparable occupations such as teaching and the police.

In 1973-74, 50% of children left school with more than one 'O' level and in 1981-82 this proportion was 55%. The rise in 'O' level achievement has been more marked in girls than in boys.

This means that the quality of nurse training has been progressively devalued since the last war and the policy of the GNC has substantially aided and abetted this devaluation. Rather than safeguarding nurse education, the GNC has been an agent in the progressive de-skilling of nurses in relative terms at least, if not in actual, real value.

This change in the ethic of the GNC, from being an instrument of education to being an instrument of recruitment, became institutionalised and persisted until the demise of the GNC in 1983. It has been reinforced by the Ministry of Health and the DHSS's policy to maintain nurses as semi-skilled workers and by the rapid emergence of new structures of managerial authority which Carpenter (1978)[10] outlined. Dingwall and McIntosh (1978)[11] have also described how a powerful elite can shape the ethos attached to different types of occupational task and described:

> "the narrow economic rationality seeking the cheapest form of labour and the selection and intake of women at a particular level of the labour market"

It is too early, yet, to discuss the goals and values of the new statutory bodies. We have already seen, however, how economic factors do affect their priorities. Both the UKCC and the ENB have had to publish retrenchments in their programmes and it was with some interest that I noted that the ENB chose to cut back in their tutor training budgets rather than their student nurse programmes. It seems to me, taking a historical perspective, that this looks set to reduce the quality of nurse training rather than the quantity.

Are we then to see our new statutory bodies persisting as instruments of recruitment?

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