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The Hospital Centre

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- A QUESTION OF ATTITUDES -

(first series)

BY

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An account of the first series of meetings held at the Hospital Centre from October, 1968 to January, 1970, during which nurses explored their attitudes to their patients.

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INTRODUCTION

by

Tom Caine

The attitudes that nurses adopt to patients are created by a number of different pressures. At a very basic level the fact that these days we regard the patient as being ill (rather than being possessed by devils, as in the past) has profound effects on our attitude towards him, and on the type of care we are likely to dispense. Although this may seem to be something of an advance, just how much of an advance is it? In one sense the basic attitude may not have changed at all. Today we simply attack the virus, the microbe or "the condition" in much the same way that previously we attacked the evil spirit. Both are thought of as essentially different from or alien to the person involved - who doesn't really matter as a person in the treatment process. This disease concept of medicine is being questioned today by some people, and particularly so in psychiatry where the difficulties of isolating diagnostic categories or of defining mental illness are very great. One of the most obvious examples of the inadequacy of this disease entity model is in the field of psychosomatic medicine. Here it is recognised that the attitudes, the emotions, and the interpersonal relationships of the patient can have a profound effect on the development and course of the physical aspects of his illness. Some authorities even go so far as to say that we are treating the wrong patient. We shouldn't be treating the individual at all - we should be treating the family or even the society in which the patient lives since conceivably he may be justified in being maladjusted in a brutalising environment.

In trying to answer some of these very basic questions - Who is the patient? What is he suffering from? How should he be treated? - one is struck by the heated arguments that go on at every level of those concerned with patient care.

In many areas, particularly in the psychosomatic and psychiatric field, there is no general concensus of opinion. In any case it would be consensus of opinion rather than scientifically established fact and, let's face it, opinions have been wrong in the past. Ambrose Pare, the founder of modern surgery, was a real member of his society when he insisted that witches should be burned and not treated. Our more materialistic society tends to go to the opposite extreme

and insists that all illness including emotional illness must have an identifiable physical cause. There are, of course, dissenting voices.

Another powerful influence on attitudes to patient care is the general approach of the institution in which one is trained. The evidence shows that the institutional ideology about patient care can vary tremendously between one hospital and another - even in one specialised field - and that attitudes to the patient involve much larger issues including those of staff relationships. Finally, at bottom, our conceptions of the problems of illness may be rooted in ourselves. We may be predisposed by some personality attributes to tend to favour one type of approach rather than another. We may tend, for example, to prefer a tough minded, practical, scientific, materialistic approach to problems (not only medical and nursing ones) rather than a tender minded, religio/philosophic, mystical one. We may not be aware of this tendency nor of what effects such unproved basic assumptions about the nature of the problem may have on our treatment and care of the patients. They may, however, be proved subsequently to be profound.

Our society is still evolving. We are still in the process of changing and modifying many nineteenth century ideas. One of the modifying influences, as far as medicine is concerned, has been the development of psychotherapy which has far wider implications now than it had in the confines of its infancy at the turn of the last century. But we are immediately in deep water again, because there is no agreed definition as to precisely what psychotherapy is, how it should be practised, who should practise it, on whom it should be practised, and why it works if, indeed, it works at all. All one can say is that it has now a fairly long history, that it is probably here to stay, and that its influence will probably go on increasing. Many psychotherapeutic concepts and ideas have permeated into the everyday thinking and operation of our society. As far as medicine and nursing are concerned one of the most obvious examples of this permeation is the realisation that a profound emotional trauma may result from the hospitalisation of very young children. Because nurses are the first people to contact these children, other patients and relatives, there seems little doubt that they will be seen more and more in a therapeutic role in the future. The Central

Health Services Council* considers that the psychiatric nurse is 'the key therapeutic figure'. In her particular setting, so is the general hospital nurse.

In this very complex field, it is all too easy to ask awkward questions. But what is a therapeutic figure? How does one relate to patients, patients' relatives (and colleagues) in a therapeutic way? If the opinions of professional psychotherapists (Freudian analysts, Jungian analysts, Rogerians etc.), and the more scientific reports of investigations that have been conducted into the nature of therapeutic relationships are examined, one finds no consistency. Again one is dealing with opinion and not fact. Opinions range from the 'remote figure' theory - the view that the therapist should remain a shadowy, detached figure serving as a screen for the patient to project his fantasies upon (as in classical psycho-analysis) - to the opposite view that the therapist should strive to be himself, to be warm, empathic and honest in his relationships with the patient (as in Rogerian psychotherapy).

Other problems arise when the needs of the patients are considered. To what extent should true blue psychotherapeutic relationships (if we could decide what they are) be attempted in a general hospital setting? Nothing is more irritating or frustrating than to be given psychotherapy when you don't want it or when what you really need is practical help. My own feeling is that this applies more to the 'remote figure' theory of the therapist and the psychotherapeutic technique of interpreting the underlying reasons of the patient's behaviour and feelings to him.

What is certain, however, is that there is no consensus of opinion among the medical or nursing professions. What is needed is a cool, close look at the patient and his emotional needs in the wide variety of situations in which he is in contact with medical and nursing staff. A similar look should be directed towards the types of people most predisposed (by way of personality attributes and by training) to meet these varying needs in these varying medical and nursing situations. The medical and nursing fields call for such a variety of skills, interests and aptitudes that - within reason - almost anybody can be accommodated. The great thing for effective treatment and for psychotherapeutic relationships is to get the right people in the right places.

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* Central Health Services Council, (1969) Psychiatric Nursing Today and Tomorrow. H.M.S.O.

Chapter 1

HOW IT ALL BEGAN

You could say that Sans everything started it all, and so it did, in the sense that it focussed attention on a problem involving the maltreatment of patients, in which the attitudes of nurses certainly had a part to play. But it was Bill Kirkpatrick, himself a contributor to the book, who provided the initial impetus for the Attitudes meetings at the Hospital Centre.

In December, 1967, he wrote to Irfon Roberts, assistant director at the Centre, suggesting that the King's Fund might be interested in setting up a research project into the problem of attitudes. In this letter he quoted a paragraph from the East Anglian Regional Hospital Board's report on the conditions of old people in its hospitals. It said:

> "It may not be an over-simplification to suggest that the care of the patients in hospitals, particularly elderly patients in psychiatric and geriatric wards and units, hinges on two main factors. The first is the nature, quality and amenities of the accommodation they occupy, and the second is the morale of the staff, involving as it does, their personal attributes towards patients in their care. The latter is the more important, but inevitably it is influenced by the former."

From this and from the rest of the letter, it is clear that at this time, Bill Kirkpatrick was thinking in terms of a research project into the morale of nurses.

The Hospital Centre expressed an interest and the matter was passed to Janet Craig who followed it up with a 'sounding out' meeting held in January, 1968 between Mr. Roberts, Miss Craig, Professor Revans and Bill Kirkpatrick. Nothing positive emerged from this meeting, but it was thought Bill might find it useful to talk with Derek Dean, then assistant to the director of nursing at Severalls Hospital, Colchester, now chief nursing officer at Napsbury Hospital, who had experience, through the Hospital Internal Communications Project, of staff discussion groups.

The attitudes project took another step forward in April, 1968 when Janet Craig and Bill Kirkpatrick met again to try and find a starting point for research. They discussed the possibility of finding out what nurses' attitudes were through a series of discussion meetings at the Centre and because of the inhibiting factor of the ward and hospital hierarchy, they thought it might be best to hold meetings for separate grades of staff.

By this time Derek Dean was closely involved with the project and shortly after this two more of those who were to convene the meetings were brought into the picture - Jillian MacGuire and Barbara Bellaby.

This period of planning shows how the ideas which led to the final shape of the attitudes meetings were formed. Although the project had started as an idea for a piece of research, it eventually evolved into a concept of discussions on nursing attitudes. It was felt that research projects might emerge from these discussions, but that even if they did not, the meetings would have been worthwhile simply for the value of getting people together to explore their difficulties in communicating with patients and each other.

At this time, too, the planning team was thinking about who to invite to take part. They were tempted - because staff attitudes probably stem from the attitudes of those at the top - to invite members of management committees and senior officers. But this was finally abandoned in favour of trying to find out something of the attitudes of those most closely involved with patient care - a group ranging from nursing auxiliaries to ward sisters and charge nurse.

By May, 1968, the planning team had decided on the people to take part, the number of meetings, the number of hospitals to be invited to send representatives (24 general and 24 psychiatric), and were casting round to find suitable team leaders. They were still thinking in terms of group discussions under the guidance of group leaders. At this time too they were also thinking about publicity, a problem which led to much heart searching and much debate on the pros and cons. It was finally decided to seek no publicity as such, but to provide a written report at the end of the seven meetings.

The shape of the meetings gradually began to change. Fears were being expressed about the problem of too many people being involved as group leaders and a certain emphasis on informality was making itself felt. Eleven people had initially expressed a wish to get involved with the meetings as group leaders and several of these were seeking discussions at this time to clarify their doubts which seemed to centre around the idea of having group leaders as such at all. After a great deal of discussion, the final group emerged: Janet Craig, Jillian MacGuire, Barbara Bellaby, Derek Dean, Bill Kirkpatrick and David Boorer. Several discussions took place within this group before the final shape of the first meeting was decided.

A short account such as this can certainly not do justice to the enormous amount of work and thought which went into the preparation for these meetings. They evolved from the original conception of a piece of research into a general agreement to get people together to talk about their attitudes. They continued to evolve right through the series.

FIRST MEETING

If anyone expected anything much from this meeting in terms of a discussion on nurses' attitudes to their patients, they were doomed to disappointment. This is not to say that the meeting lacked value. It was most valuable, more, perhaps, than the participants realised, but its main importance lay in the fact that people had a chance to talk with each other, in the experience they gained in group sessions and in the realisation that 'reporting back' to nearly 100 people wasn't half as bad as the unfortunate rapporteurs had suspected. To the convenors, or to some of them at any rate, the meeting gave the first inkling of the complexity and delicacy of the task which lay before them.

It all started simply enough with coffee (the first taste of Hospital Centre hospitality) and then a gentle introduction from Janet Craig who took the chair for the day. She was at pains to dispel any illusions about the 'them' and 'us' syndrome. Although, she said, someone had to organise the meetings and make decisions we were really all in it together - all seeking to find out more about nurses' attitudes to patients. She outlined the background to the meetings, introduced the conveners, gave a general idea of the purpose and functions of the Hospital Centre and described the groups into which people had been placed. For this first meeting, like was with like, sisters and charge nurses from psychiatric hospitals formed one group, sisters from general hospitals another, and so on to nursing auxiliaries from general hospitals. At this point the first dissenting voice was raised. Would it not be better, asked a ward sister, for the groups to be mixed up both by type of hospital and by rank? This cross section would give a better flow of communication. But the idea was vetoed at this early stage because some people feared the domination of groups by senior nurses. But change, said Miss Craig, could come later, as decided by the meetings.

And so to the first attempt to discuss nurses' attitudes. Few people have had better experiences of being on the receiving end of medical and nursing care than the late Douglas Ritchie, author of "Stroke. A diary of recovery." A tape recording made by that indomitable man was played to the meeting and formed the first subject for group discussion.

This is what the first meeting heard:

"The Master of the King's Music, Sir Walford Davies, used to tell

this story about a very ancient judge. The judge was deaf and had difficulty in speech, but he had a dry sense of humour. Walking in the Temple one day, he called out: "Davies, h-h-h-have you got h-h-half an hour to spare for f-f-five minutes' c-c-c-c-conversation?"

It's like that with me. In talking of good and bad 'care' of patients, I intend to deal with a physical and not a mental case - I mean myself - and will be referring to 'care of the body and of the mind'. I am sure that some doctors and some nurses think only of 'care of the body' and write off 'care of the mind' as 'bedside manner'. This attitude could not be more unfortunate.

By the way, I am not a 'professional patient' who is in and out of hospital all the time. Previously I had been in hospital only once for a week when, 11 years ago, I suffered a stroke. I was visiting my parents in the country. I lost consciousness and was taken to a nursing home down the road. When I woke up, three days later, I was paralysed down the right side and I couldn't speak. But I was still able to think.

I tried desperately to make out what had happened to me. I remember my wife saying 'cerebral thrombosis' but I hadn't the least idea what this was.

I was in the nursing home for two months and I was in an angry state most of the time. The doctors and nurses all annoyed me. Looking back I am sure the consultant physician saved my life, but at the time he addressed me as though I was deaf, or a foreigner, or half-witted. He used to pitch his voice up and ask me 'How are you doing?' and then say to my wife, in a lower tone, 'I think he understood that'. I lay helpless, unable to utter a word, in a furious rage.

One of the nurses used to put her head round the door and say: 'Peepbo'. If I left a tray with some food, she would say: 'Naughty boy. He must finish up his tapioca - it's good for him.'

When I left the nursing home, I was sent to London and handed over to my G.P. He knew there was not much he could do for me: spontaneous recovery if any, or physiotherapy, which was a long job, and he was busy so perhaps it wasn't odd that he called infrequently. My spirits fell and soon I was in despair. However, a physiotherapist came twice a week and taught me to walk in about seven months.

I did not go to a speech therapist until nine months after the stroke. She was in a Bloomsbury hospital and I was pushed there in a wheel chair. All this time I thought that the doctor and the hospital should cure me - speech as well - and send me back to work; I could not for the life of me understand why they didn't do so. My wife did not have that simple idea but she thought they ought to try something instead of leaving me to die or live like a vegetable. So she haunted the hospital almoner and from her heard of the Medical Rehabilitation Centre at Camden Town. (None of my previous doctors had heard of it).

I was admitted to the Centre after two months on the waiting list. I

worked hard. For eight hours daily I was kept hard at it - doing exercises for legs, arms and hands, and occupational therapy and speech therapy twice a week. I had expected to go to the Centre for about a month: I stayed 18 months.

Now for the good and bad care. I obtained good care of the body from everyone - from the nursing home, the hospitals and the Centre. For the Centre I cannot find enough praise. I did not like it much (I didn't like anything much about this time), but my recovery, such as it is, was founded during my time there. I think this result was due to the fact that the staff of the Centre co-operated and worked together as a team. And each week the staff had a meeting at which each patient was considered as an individual and his progress discussed.

But care of the mind was not so good, and in this connection I have already mentioned the consultant physician and the 'peepbo' nurse who used baby talk to me. This is not a trivial complaint. I was 50. I had had a terrible shock and I could not speak or move. Of course, nurses have their mental shadows, I realise now, but at the time it was unbearable. I think that doctors and nurses must not talk down to adult patients. Talking down is an assault on the personality of the patient. While the patient's mind is mending in the early stages of a stroke - indeed, of any shock - he may not retain all you say and he may not even understand it, but approaching him as a sophisticated adult will comfort him and save his personality from these bruises.

The doctor who dealt with me as though I were deaf or mentally deficient had not the time, or did not take the trouble, to learn about my mental condition and he forfeited my respect at a critical stage. (I must confess now that I do not know if it matters; the first important things were to lower the high blood pressure, to bring to an end the nasal feeding, the bladder trouble, and so on. But it certainly was intolerable !)

The most serious inadequacy in this 'care of the mind' was the lack of information. I do not want to be dogmatic because I know each case needs to be considered separately, but I am certain that I want information when I am ill; and that means heart, cancer, further attacks of cerebral thrombosis, or anything else. If I cannot stand it I can always insulate myself by not believing the doctor. And the doctor is not always right !

I had this stroke a year or so before I realised it was a stroke, or what a stroke was. It was two years before a doctor at the Centre lent me a book on aphasia which suddenly shed real light. This was followed by a book on stroke. My confusion slowly cleared up. Doctors could help me a bit, I thought, but it was only I who could help myself to recover. From that moment I began to recover. 'Care of the mind' in a serious case is at least as important as 'care of the body'. The body is not enough without the mind. It is through the mind that the will comes to recover and the understanding of that recovery."

This could have sparked off a heated discussion as to why some nurses behave like this, but nothing of the kind took place. At the reporting back sessions it soon became clear that most groups had taken a superficial view of

the problem and had come up with blanket answers like 'better communications', 'team work', 'mixed wards', 'comprehensive nurse training', the need for leadership and so on. One or two groups frankly admitted that they had no idea why they had been asked to the meetings, nor what they were supposed to be discussing.

This was hardly surprising. Nobody had much idea at this point and the discussion served a useful purpose in breaking the ice. But attitudes did come out in discussion, if only on an 'unconscious' level. The state enrolled nurses from general hospitals, for example, felt that the patient would be a lot happier if everyone (the staff, that is) were treated as equals. They were not so happy, however, about the idea of unrestricted visiting. This, they said, 'was not terribly practical in an ordinary general hospital because obviously while visitors are on the wards, you can't do the work the same. If they were on the ward (continued the rapporteur) I don't think they would be taking much interest in the patient they had come to see. I think they would probably be taking in more what we nurses do and how we do it and have a good moan about it when we've gone."

Hinderances to good nurse/patient attitudes cited by other groups include the size of wards (sisters from general hospitals), not enough teaching in the wards by sisters (pupils from psychiatric hospitals), the 'superiority' of sisters, often caused by the fact that junior nurses think of them as superior (SENs from general hospitals) and a lack of information about the patient's condition and a lack of time to talk with them (from students in general hospitals). The rapporteur for this group said, "Most of the time you walk up a ward and the patient says, 'Nurse, what's wrong with me?' Well, you can't sort of tell lies, and you can't tell the truth, and you sort of fiddle, and say 'Um, um', and the patient knows you are going to evade the main fact and gradually loses confidence in you. So we think guidance should be given to the nurses as to what should be told to the patients." This must be a problem almost as old as nursing itself, but it is obviously one that is still causing deep concern. So is time to talk with the patients. As the same student nurse said, "They (the patients) want to talk, but who can they talk to? They see you rushing here and there and sometimes when we do stop to talk, worse still if it's a man, sister thinks you're chatting him up! She says, 'Don't just stand there; find something to do.' But I think it does a lot

if you stand by a patient and say, 'Oh, that's a lovely picture you've got there ! ', and he says, 'Oh, yes, that's my grandson; he's just like his dad.' It doesn't mean a lot to you but it means a lot to him."

There was also the perennial problem of friction between the enrolled nurse and the SRN, expressed by nurses from psychiatric and general hospitals and a fairly slick account of the ideal way a ward should be organised from the psychiatric staff nurses. This first meeting have a distinct impression that concern for the patients was expressed more forcibly by those most junior - which may imply something about the work-load and pressures on senior staff - but certainly it was student nurses, pupil nurses and nursing assistants and auxiliaries who came closest to talking about attitudes. Perhaps the nicest comment of all came from the nursing auxiliaries. Those in the general hospitals were a very humble and contented group, "We don't know whether we are supposed to know anything or nothing", said their spokesman, cheerfully, but they were in no doubt at all that they had something to offer if only because they felt themselves lacking in status and the awe surrounding that status and therefore much nearer to the patient. They told a story to point this out. A patient said to an auxiliary, "Are you important? Have you any position?", the auxiliary said, "No, I am not important, I just don't count." At which, she said, the patient told her everything and as a result was able to be helped in many ways.

Nursing assistants from psychiatric hospitals consider themselves a 'pretty high morale lot". They felt themselves to be fully used and didn't feel that lack of training or status told against them. And this group seemed to come nearest to regarding the patient as just another human being. As one nursing assistant said, "I have problems in life. Insofar as I am a bit more successful in trying to cope with them, I am not the patient. This is the approach we ought to have."

All of which goes to show that the meeting did not discuss attitudes in any depth and this was summed up by Janet Craig when she said, "The worst of pioneering anything is that you don't really know what you are doing. At first you have to talk a whole lot of stuff that goes out of the window but until it's gone out of the window, you can't really get down to the meat of what you are doing." And this, she said, was as true of the conveners as it was of anyone else. Everyone was in the dark and all that the conveners knew about attitudes was that "it was a subject that needed airing", that it was something that was particularly troublesome to nurses and that nurses should have an opportunity of talking over their attitudes to patients in hospitals.

Chapter 3

SECOND MEETING

Because the conveners felt it important to keep the ball rolling and to try and maintain some continuity between meetings, this second of the Attitudes meetings received a feedback in the form of questions derived from the notes taken at the first meeting. They also received yet another tape recording from a patient.

This had come about because the first meeting gave members of the convening group furiously to think. It seemed to Janet Craig and me, for example, that the reports following the first set of discussions fell into two main kinds - those groups who took patient care as the problem and those who took attitudes to patients as the problem. In a letter to the rest of the conveners Janet Craig explained it like this.

"We saw a danger in allowing attitudes to patient care to get the upper hand and felt this would happen unless we took active steps to prevent it. This feeling was based on the knowledge that it is easier to talk about patient care and become involved in schemes to provide a good service, leaving out the patients' attitudes or the nurses' personal involvement with the patients.

The problem of nurses' involvement with the patients, caring for them as people, not just as patients was, as David and I saw it, the main reason for collecting the nurses together. Because of this we thought it best to give them the opportunity of hearing a patient's point of view once more."

Hence the tape recording.

The questions they were handed for discussion were as follows:

(a) Ward sisters and charge nurses seem less aware of the problems of caring for the individual patient than the junior nurse. This seems to imply a gap in communications between sister and junior staff. How can this be overcome? What should be done to overcome it by the ward sister or charge nurse and by the student, pupil, SEN or Nursing Auxiliary?

(b) "It is easy to forget that hospitals are strange to outsiders." This is true, and no doubt leads to some thoughtless forms of behaviour such as regarding admission procedures as a matter of routine, and not realising that the patient may be afraid; such as 'talking over' a patient when carrying out nursing procedures; such as the indiscriminate use of words like 'duckie', 'pop', and 'dearie'. Such patterns of behaviour seem to be adopted almost without realisation by the nurse. How can this be avoided?

(c) "Some nurses are scared of sister - think she is superior."

(d) "We should encourage patients to talk, but if we do - especially if it's a man - sister tells us off."

(e) "How does one deal with a private patient who because she is paying wants to have a say in everything?"

(f) "Until there is complete freedom of exchange of ideas the attitude of nurses will always be governed by those received from their superiors."

(g) "Nurses get tired and short-tempered."

(h) "Nurses should be formal with the patients and wait until the patient shows that she is ready for greater familiarity."

These questions, and the points (c) to (h) that followed them had been derived partly from the overall implications of the first meeting and partly from what rapporteurs had themselves said. On top of this they received a tape.

This tape was an edited tape-recorded version of an article entitled, "A patient's point of view', written by Dr. D.F.E. Williams, lecturer in philosophy, Bristol University and published in The Hospital of September, 1968. The article itself was a shortened version of a paper given by him at the annual conference of the South Western Region of the Institute of Hospital Administrators on April 6 of that year.

The way in which this tape was prepared and presented gives an interesting example of the work that went into planning each one of these meetings. The first task obviously was to edit the original article. The second was to put it on tape and to provide a linking commentary to join the extracts together. Miss Valerie Mills, assistant exhibition officer at the Hospital Centre and I did this together.

Commentary:

Dr. Williams begins his talk by comparing hospital needs with those of the Army and discusses such aspects as concern with matters of life and death and instant obedience to orders from commanders, who in the hospital's case, of course, are physicians and surgeons. Doctor Williams then goes on to comparing hospitals with prisons and gives examples.

Dr. Williams:

"The army is not the only 'total institution' whose attitudes have been

taken over by the hospital. There is a distinct trace also of the prison. We are 'sent' into hospital as we are sent to prison, and in both places we remain until we are 'discharged'. While 'inside' we are quite probably condemned to wear special clothing. If lucky, we may from time to time be let out on parole, but it is difficult to obtain permission for this.

During my second stay in hospital, I gradually realised that the only reason for my being there was to receive physiotherapy. The physiotherapists, however, only worked from Mondays to Fridays, and my treatment only took place in the mornings. There was nothing, therefore, to prevent my leaving the hospital before lunch on Friday and returning shortly after breakfast on Monday. My family were able and willing to collect me and bring me back by car. I put the plan to the physiotherapists, who saw no objection. I put it to the nurse in charge of the ward - there was no sister at the time. Her attitude was not encouraging. It would mean that she would have to admit me to the ward every Monday and discharge me every Friday - the book-keeping problem was difficult. It seemed odd to me that I should have to stay in uncongenial surroundings for some 70 unnecessary hours every week to save someone five minutes' writing in a register. Nevertheless, the nurse promised to speak to one of the medical staff about it. I don't think she did, because as I remember it, I had to button-hole one of the junior doctors myself to put my plan to him. His first reaction was that it would not be fair to the other patients. Why should I spend pleasant weekends at home when some of them were in plaster cases, or required to stay in to receive six-hourly doses of antibiotic? I don't think he began to see the queerness of his reasoning. What had fairness to do with poliomyelitis? Was he going to abandon the use of his legs and join me in a wheelchair to forgo the unfair advantage given him by his ability to walk? Was it fair that I should have to spend even Monday to Friday in hospital when other people were free to go home every night? Or were there two radically different classes of human beings: the healthy who were free to use their leisure time as they pleased, and 'patients' who were kept segregated from the healthy and not allowed to bring disaffection into the wards by obtaining glimpses of how life was lived out there?

This feeling of imprisonment in hospital is no doubt irrational and possibly childish. But a patient, like anyone else, is irrational in many of his attitudes; and childishness is one of the results of hospitalisation to which I wish to return later. There are nevertheless things that hospital authorities could do to alleviate these feelings. It is not enough that the patient should be free to leave the hospital when he wishes, with or despite the advice of the doctors: he should be seen to be free. Above all he should not be spoken about as if he were not free. Words like 'discharge' and phrases like 'allow to go home' should be deliberately avoided - even at the cost of everyone's seeming for a while to be mealy-mouthed. Doctors may give orders and instructions, if this is necessary, to their juniors and to the nursing staff: patients are not there to be given orders by them, or permissions: they are to be given advice. They are not the doctor's servants: the doctors are theirs and should behave as such."

Commentary:

The second extract from Dr. Williams' talk is concerned with the question of good manners.

Dr. Williams:

"Let me do no more than to point to one common manifestation of authoritarianism which is to be found in hospitals - one which I find particularly offensive. I refer to the practice, common amongst senior medical staff, of calling male patients by their surname without the prefix 'Mr.' We tend to laugh at people who show themselves fond of being called 'Mr. Robinson' or 'Mr. Jones', or Dr. Stickleback', and give themselves these titles when answering the telephone. This should not blind us to the real blow a middle-aged man may feel to his dignity when "How are we today Robinson?" trips condescendingly from the tongue of the consultant. But no one supposes that patients are going to start addressing the consultants as 'Stickleback', though I should be delighted if someone were to retaliate in this way. Unfortunately, it is not only consultants who treat the patients with this lack of manners. A cousin of mine who trained as a nurse shortly after the war, tells me that student nurses at her hospital were forbidden to call male patients (except, I have no doubt, those in private wards) by anything more than their surname unadorned. She remarked that it was often all she could bring herself to do to call men old enough to be her father 'Jones' or 'Smith' but failure to comply with the regulation brought a swift rebuke from the sister. I can only hope that that distinguished hospital has in the last 20 years bethought itself of a little elementary courtesy."

Commentary:

In their effects on patients, hospital wards, says Dr. Williams, are very much like schools.

Dr. Williams:

"Not all of us have the boarding school experience but all of us have been to school of some sort. A newly admitted patient finds himself interpreting the complex relationships into which he enters by becoming a member of the hospital community. He finds himself in relationship to fellow-patients, to nurses, to doctors, and immediately construes these relationships on the model of those which existed in the nearest approximation to the total social institution to be found in his previous experience, namely the school. His own role is subconsciously assimilated to that of the child. There are conspicuous superficial similarities. He spends his time in a large room with 20 to 40 human beings in a similar condition. A little corner of this, containing a bed and a locker, is his own domain: he is instructed to keep this tidy as he was once urged to keep his desk tidy. Meals are dispensed at regular intervals, not by a teacher, but by a ward sister who seems to occupy a position vis-a-vis the patients remarkably like that of a teacher vis-a-vis her class. One is scolded for 'not eating up' one's dinner. At the other end of the day one is scolded again for not having gone to sleep. This, too, is reminiscent of childhood days, though for most people it is not of that part of childhood with which school was concerned."

Commentary:

The next and final extract, you will be interested to hear, is entitled 'Nurses as Mothers'.

Dr. Williams:

"Nurses as Mothers. The sick, like the old, are constantly treated as children. Nurses, of course, are the people to whom the message needs primarily to be brought home. I have heard it suggested that it is a psychological necessity for nurses to adopt to patients the attitudes appropriately, or at least conventionally, adopted to a child. Only so will they be able to feel the sort of compassion which will make their unpleasant tasks bearable. If we want nurses to be motherly, patients will have to be treated as children. Motherliness, however, does not seem to be a characteristic principally sought by the hospital service in those recruited to have most contact with patients. For our present system is to recruit for this purpose girls between the ages of 18 and 21 - in orthopaedic hospitals, with which I am mostly familiar, girls of an even younger age - who on the whole have not yet developed the motherly instincts which might seem so important. Again, my own experience has often been one of relief when, perhaps, in the evening, some part-time untrained or semi-trained auxiliary nurse came on duty and took over from the 'bright young things' running the ward. Women like these- middle-aged and sensible, brought one immediately a feeling of security, a feeling that there was someone experienced and sympathetic on whom one could rely. The 18 year-olds who normally surrounded one were incapable, with certain admirable exceptions, of acting towards one in this sort of way. They were too interested in what they were going to do with their off-duty periods, in who Nurse So-and-So's new boyfriend was, in the latest pop tunes. They burst into the side-ward first thing in the morning after one had spent a miserable, exhausted, sleepless night, and demanded that the Light Programme be switched on 'to liven things up a bit'.

The childishness of adolescent nurses may deprive patients of the sort of motherly care which could be a real comfort to them: it does not prevent these youngsters from adopting the scolding, 'don't bother me now, I'm not going to take any notice of you' attitudes that mothers adopt towards their children. A middle-aged, or worse and yet more commonly, an elderly patient is likely to discover after a few days in hospital, that the word 'naughty' has suddenly come back into use. Suddenly he is told that he is naughty because he has left his face flannel in the bathroom - or the like. It can come as quite a shock. In time however, this treatment becomes familiar, and familiarity brings further degradation. Constantly spoken to as a child, the patient begins to act as a child, to talk like a child, to think of himself as a child. I can well remember the period during my first stay in hospital after polio, when I was required to lie on my back at night, which seemed to make sleep impossible, and after an hour or two produced a great feeling of soreness. I could not turn myself over, and when my patience was exhausted, used to ring for the night-nurse to come and turn me over. This was a 'naughty' thing to do, but the relief and the possibility of an hour's sleep in the new position was worth the grumbling and scolding. Eventually, however, the night superintendent came to disapprove strongly of this bell-ringing and had the bell removed. Still my patience was too weak and I was reduced to crying 'Nurse' pitifully at intervals until I could attract attention. While doing so I can remember, as it were, standing outside of myself and noticing the childish tone of my voice, remarking that my behaviour was exactly that I would have shown when I was six or seven and wanted my parents to come to me after I had been put to bed. It was not pleasant to realise that one had been reduced to a state of childishness that one was unable to throw off.

Now I realise well enough that sheer physical weakness and mental distress that were part and parcel of a severe illness were partly responsible for my behaving in this way. People when they are ill, weak and helpless are rather like children. What I feel as something that could be changed is the tendency of hospital staff to reinforce, rather than to minimise this feeling. Childish behaviour from patients should be met, not by use of the vocabulary we have all learned from parents and teachers as appropriate to such behaviour, still less by lecturing the patient on the dangers of relapsing into childishness, but by an immensely tactful ignoring of the phenomenon. The best way to meet the problem is to be punctilious in using the conventional expressions of respect normal amongst adults. Good manners towards patients are a great deal more important than good manners towards consultants and other dignitaries in the hospital hierarchy."

This is strong stuff. Perhaps in retrospect, too strong for the meeting at this point and perhaps, taken together with the questions and discussion points, too much to consider in ne day. Certainly they reacted to it on a superficial, basically defensive level, and it seemed to me, took refuge in diagnosing Dr. Williams, rather than discussing the observations he made. They also spent a large proportion of their time in discussing the questions they had been given.

Little that was new emerged from the reporting back sessions, although, as had happened at the first meeting, sisters came in for more than their fair share of critical comment. The question of sisters' 'superiority' received another airing and the answer seemed to be that sisters were superior, in training and experience, that they should be respected for this and, ideally, as people as well. Some of the more junior nurses felt that sisters were no longer so frightening because they were younger, suggested regular refresher courses for older sisters and said that, in any event, they preferred the married ones! Solutions put forward to overcome this problem included consultation between all grades of staff in the wards, better links between training school and wards and the appointment of a nurses' personnel officer. The sisters themselves did not feel superior and wondered why the nurses thought they were.

The second question and the quotes from the first meeting evoked some fairly shallow answers. Everybody thought it was a good idea to talk to patients, but not to talk 'over' them and many people were honest enough to admit that they did just that. All were agreed on the vital importance of admitting patients correctly, recognising that many patients felt nervous and afraid at such times, but pleaded rush and tear as one reason for not doing this properly. And do nurses lose their tempers? Of course they do, being only human and everyone

was aware of this. Tensions in the wards, overwork and a 'lack of good, nutritious food' were some of the reasons put forward to account for this.

It is only fair to report that some people saw the causes of failure quite clearly. The staff nurses from psychiatric hospitals spoke of the loneliness of the ward sister, "When you are more or less at the top you need more support than ever because you just can't do it on your own." The SENs from general hospitals were critical of 'mechanical' matrons rounds which, they felt, put them into an embarrassing position vis-a-vis the patients. "... you hear the patients say, 'she'll come and she'll say, "Good Morning" and "How are you?", and pass on, and to the patient it is something mechanical and they just don't feel that the matron is really interested in them. And then as soon as matron's gone you have to try and cover up for her and say, 'Well, of course, she has got the whole hospital to do.' "

Reporting back was followed by a discussion of Dr. Williams' views and the meeting generally failed to come to grips with what the man had really said. Even so the comments made revealed more about attitudes than had previously been shown. The tape, which was given a second run, produced comments like these, "That man is odd and had odd ideas. That type of patient merits the type of treatment he gets." A classic example of a person who is having his body treated and his mind neglected - reactive depression with anxiety features." Another group felt "... he was being obsessional. He was unfair as opposed to Mr. Ritchie." But another group took a more reasoned view. Dr. Williams, they felt, had personal problems. People suffering from long illnesses, they said, think of themselves. He needed consideration and was not selfish.

No-one dealt with the points he had made - they were concerned with his reaction and not with the shortcomings he described. Despite their anger at his comparison between hospitals and prisons as 'total institutions', and despite the fact that at no time did he say hospitals <u>were</u> prisons, nurse after nurse, in seeking to justify the liberality of their own hospital's routine, used phrases like 'leave' and 'allow to go home' and yet, apparently, failed to see the relevance.

It was an interesting exercise for all concerned and for some of the conveners, an object lesson in how far there was to go before any real attempts at discussing attitudes to patients as opposed to patient <u>care</u> could begin.

As usual, the conveners had a meeting of their own after the main event, partly for mutual support, partly for an appraisal of the meeting and partly to plan ahead. This one was quite cheery and those who had sat in with groups felt that defences were gradually coming down. In response to popular appeal expressed in the main meeting it was agreed to get a small panel of patients together for a future meeting. People seemed to want this kind of thing and the conveners felt it important to keep them on the track of attitudes to patients. The people at the main meeting had also decided that they were ready for general and psychiatric groups to mix.

Chapter 4

THIRD MEETING

By the third meeting we still hadn't got at the question of attitudes. People were still evading this issue, as Bill Kirkpatrick pointed out from the chair, asking, as he did so, whether we were afraid to discuss them and wondering whether the loss of the nurses' personal authority over the years was one reason for this. Are the patients and the nurses, he asked, afraid of each other?

Although this meeting also failed to get down to cases, it was different from its predecessor in two respects. For the first time groups were mixed, psychiatric with general nurses, although still in the same grade, and it was the first time that people were to hear about this question of attitudes from a doctor rather than a patient. The doctor in question was Dr. J.L.T. Birley, of the social psychiatry research unit at the Maudsley Hospital and a detailed account of his paper is important because it explains much of what happened afterwards.

Dr. Birley began by questioning the purpose of the meetings and doubting their success. Attitudes, he said, was a highly charged but very vague topic and in his experience discussions of this kind tended to be either unsatisfactory or to degenerate into 'a game for two or more players'. Then he let the meeting have it.

Nurses, he said, were not good at translating causes into action. Women were not good at thinking abstractly - this was mainly a masculine attitude. Nurses don't think much about attitudes - they act them out. The most 'masculine' nurse was Florence Nightingale - a woman with a most unusual mind. "Perhaps", he said, "you need a mind like this to come to grips with present problems."

He seemed to imply criticism of the make up of the meetings when he said that nurses' experiences are so varied that they have little in common - you could even have a widely disparate set of problems in the same ward - a man with cancer and a man with an ulcer as examples. There were also attempted suicides - nurses took a dim view of these - and this wide range of patients could all be looked after by the same nurse. How does one have a flexible yet uniform approach so that the organisation does not break down? he asked.

The answer, it seems, lies in assuming that 'people you have to work with are second rate' because you cannot have an organisation of people who never take time off etc. It was, he said, a question of balancing the needs of

the staff against those of the patient. "We can't have an organisation which doesn't look after the staff."

This led to a rule - "the more unstable an institution, the more ritualised it becomes." Teaching hospitals are more ritualised than general hospitals because they have students who fall between many stools. Teaching hospitals are extremely formal organisations.

The patients are the lowest status group within the hospital. Doctors and nurses with the lowest status, said Dr. Birley, are those most "Patient oriented". GPs have a lower status than consultants. The GP organises his surgeries to suit the patients. The consultant never does. Venereologists are another low status group. Visiting times were a compromise between patients' needs and staff needs. The timing of ward routines were very much related to institutional needs.

We all have a concept of what the patient should be like and the patient has to fulfil a certain need for the staff. Because of this patients become trained, like pets he said, to meet those needs and to become the kind of patient who does not threaten the staff. In other words the patient should not read his notes, know what was wrong with him or have his children to visit him in hospital. He learns the correct pattern of behaviour. Instead of saying, "I'm fed up", he says, "I'm depressed". If this is true, if a nurse needs ill people then, said Dr. Birley, there is a problem for people who get better. "In other words", he said, "nurses are keeping the patients ill."

This need for security, for changelessness, extends to new members of the staff and to the whole, vexed problem of communications, or, as Dr. Birley prefers to call it, 'exchange of information', disliking the 'mystical overtones' of the other term. This, as everyone knows, is simply littered with pitfalls, ranging from one's own concepts and attitudes, to training and to the fact that different people need to know different things. "You must all be aware", he said, "that you get information from patients. Some you feel you can deal with, some you feel the doctor needs to know and some you feel you would like to tell someone, but nobody wants to know." This was illustrated diagrammatically.

Person A has information as follows		Person B wants to know	Person B doesn't mind knowing	Person B doesn't want to know
I	Person B ought to know	1	2	3
II	Person B perhaps ought to know	4	5	6
III	Doesn't need to know	7	8	9

1 = O.K.
2 = O.K.
3 = Troublesome
4 = O.K.
5 = O.K.
6 = May be troublesome
7 = Troublesome
8 = ?
9 = ?

Dr. Birley's talk was followed by a sporadic and inconclusive discussion which centred mainly around the problem of communication in the ward. The majority of the meeting put up a spirited defence against what they obviously regarded as an attack and Dr. Birley did his best to demolish the barricades. It was obvious that confusion abounded at this point and Janet Craig suggested that groups might like to concentrate on Dr. Birley's diagram for discussion purposes. During the first session, she said, they would look at the information that should be handed on as if they were person A and in the afternoon reverse the process, imagine they were person B and decide the information they would need to know.

It didn't work out quite like that. The ward sisters, for example, took a severely practical line and discussed things almost solely in terms of 'lists' of questions they would expect the patient to ask and that the patient would want to know. They automatically assumed that as A they were the sisters and that B was the patient. They made little attempt to look at problems in terms of barriers to communications, raised the old problem of who tells the patient he is going to die (it is the consultant's job, they said) and generally shied away from fundamentals. They assumed that the climate was right for them to get the information they needed, but they did say "good relationships" and creating the right atmosphere in the ward all played a part.

Other groups were not so sanguine. In fact one or two disregarded their brief almost completely and used the time to exchange ideas and information and generally as a 'getting to know you' session. (This, it must be remembered, was the first time that the psychiatric and general hospital groups had been mixed). Yet another group considered that the question of communicating with patients had been dealt with and talked, they said, "about everything from partial gastrectomy to schizophrenia. We ended up by deciding how to assassinate someone passing up the Edgware Road." This group thought communications "basically common sense", recommended a ward diary in which "anybody can write anything" and concluded by congratulating Dr. Birley on his courage.

But the majority of the groups had a go at the problem, usually prefacing their remarks with a crack at Dr. Birley's view of the nursing profession in general and the female sex in particular. But many expressed confusion and one group downright despondency. "Pupil nurses can't voice opinions. We fail to see how these meetings will benefit us - we can't change our hospitals." Other reports were not illuminating. The usual range of solutions, from teamwork through to patient booklets were suggested and we were still, it appeared, discussing administration and patient care rather than attitudes.

This emerged during the final discussion when Janet Craig and Bill Kirkpatrick pointed out yet again that the question of attitudes was being avoided. It seems that on this occasion Dr. Birley's talk had confused some and antagonised others. This was a pity because much of what he said was true and almost any single point he made would have formed the basis for a useful discussion. But at the end of it all we were no nearer to attitudes than at the beginning. The general reaction ranged from, "We want a real, live psychiatric patient" to a suggestion for a confrontation with an "old fashioned principal tutor, a modern matron and a group secretary to get their views on attitudes and to define how things are changing." This, added one speaker thoughtfully, would also "give the sisters a chance to shoot at somebody."

Chapter 5

FOURTH MEETING

This was a meeting at which people probably thought they could sit back and relax but towards the end it erupted into tension and we came nearer to discussing our attitudes to patients than at any time before.

It all started quietly enough. Barbara Bellaby was in the chair and spent a little time recommending the works of Erving Goffmann and paid particular tribute to his description of the 'moral career' of the patient, which describes how a man can change from a person to a patient and the roles of the people involved in this process. She then read an essay, "From Hell to Heaven in Four Days" which turned out to be a vivid description of the process described by Goffmann and which showed how an acutely ill psychiatric patient not only rationalised his illness but also felt that as a person he had ceased to exist. His constant use of the words, "I was bundled" showed, said Barbara Bellaby, that "He felt he was a parcel that was being shifted through a machine." Her point was, of course, the role of the people who 'mediate' for a patient throughout this process and who can minimise its effects. Nurses are among this number.

She then introduced Dr. Tom Caine, consultant psychologist at Claybury Hospital who described his work in attempting to define why certain nurses took up certain jobs, how they see their roles, what they think is important to them and what they think is effected in their nursing practices. He then described his questionnaires which the meeting was to complete (see Chapter 7 and Appendix 1) and answered some questions. Everyone then settled down to fill them in. (Dr. Caine, incidentally, was so well received by the meeting and took such an interest in our work that he was soon adopted as a fully-fledged member of the convening group).

The subsequent discussions centred around the questionnaires and during reporting back sessions group after group gave painstaking and detailed accounts of what they thought of the questionnaires and why. It seemed for a time as if this would be a fairly bland sort of meeting because once again people seemed more concerned with detail (although one or two questioned the relevance of the exercise) than with attitudes to the questionnaire and to their work.

The SENs started the ball rolling. Referring to a suggestion made at a previous meeting for a 'real live psychiatric patient' their spokesman was

worried about possible damage to the patient - a risk, he felt, which would outweigh any possible advantage to the meetings. "and", he went on, "what about the tape from Mr. Ritchie? Some of you made excuses, some thought he was mentally ill. Your hostility was apparent and the atmosphere was so emotionally charged that we lost the point of the exercise. We were under attack and we stood shoulder to shoulder and fought and lost the point." It was a pity, at this stage, that Janet Craig pointed out that the speaker was confusing the group's reaction to Mr. Ritchie with that to Dr. Williams. He lost his nerve and sat down.

But the point was made. The meeting had been sympathetic to Mr. Ritchie and hostile to Dr. Williams. Why was this? Someone said, "But he answered back - nurses don't like patients who answer back." Others felt it was due to the fact that he had compared hospitals to prisons which led to the aggression and the meeting came a tentative step nearer the point when someone said, "I said it with both - that physical well-being was looked after, but no-one was looking after the patient's emotional reactions. Everyone has emotional reactions - we all have - to these meetings."

That gave the chairman a chance to invite comments from people about their reactions to the meetings. These were varied and showed, if nothing else, just how diverse were people's views. "Some points you recognise, you wish didn't exist. You can see where you can be criticised and you are criticised. It's not a nice feeling to have this put in front of you." "We've been white-washing it." "I don't know how anyone else got picked for these (meetings) but I thought it was because I was being punished. I said a patient was 'fat and lazy'. Matron sent me to the meetings."

And about the tapes. "The atmosphere after the first was one of sympathy. After the second - I was sorry for him - but he was an irritating person. Others thought so as well or they wouldn't have punished him. He obviously thought he was the only pebble on the beach." At this point the chairman returned to the question of selection. Why were others chosen for the meetings? "I've heard it said," she remarked, "that some people were chosen because matron relied on them not to let the hospital down." "I gather I was chosen because I have a reputation for being rather cheeky and not caring for authority." "None of the dates of the meetings fell during my holidays so that's why matron chose me." "Lots of students told me they envy me the chance of going to these meetings."

Getting a little closer to the problem once again, a question from the chairman, "Do people feel it would help them to have patients here?" The responses were illuminating. "I would like to know why people want to have a patient here. Is it for someone to hide behind? Is it so that they can shoot him down? Or is there a real reason?" "Are we setting ourselves apart? We must all have been patients, surely we can remember what it was like." "Some of us have never been ill and we need to know what patients feel like. The tape recording was unfair - the patients were not there to defend themselves."

At this point Barbara Bellaby wanted to know why everyone assumed that the patient would be under attack. So did Janet Craig. She said, "Why do we assume that the patient will be under attack? You are contradicting yourselves. You say you are ordinary people, then you say you will be under attack." Because", said someone firmly, "we are whitewashing."

Then we moved on to horror stories after Barbara Bellaby said, "If we have a patient who can fight back he will be atypical. Even I didn't write to the group secretary." She went on to describe her confinement where she had been put through a degrading routine by staff in a hospital with an obviously low morale and where she became known as "the patient for whom sister had removed the bed pan". Other stories followed. Of the SRN who received preferential treatment, of the two SRNs who didn't, and who got the reverse simply because they were SRNs. The meeting slid into a general discussion of the purpose of the exercise and people at long last, seemed to be showing some insight. We didn't get very far because it was the end of the day, but everyone felt that a start, however small, had been made.

FIFTH MEETING

At last we had our 'real, live patient'. In fact we had four real live patients, people with a wide range of experience in both general and psychiatric hospitals. And, to be honest, we wasted them and the opportunity they presented.

Jillian MacGuire was in the chair and set the scene rather nicely when she said, "I think we have now reached the stage where I hope we can explore nursing attitudes with the patient without nurses feeling on the defensive or necessarily asking the patient to understand the nurse." She was partly right. We had progressed far enough to discuss the comments upon our practice that the panel placed before us without feeling defensive, but unfortunately, not yet far enough to look deeply and honestly at the reasons why.

But first the patients. Mrs. Ethel Morgan spoke both as a patient and a relative and in the latter role recounted a sad story of unimaginative treatment. Her mother was admitted to hospital 200 miles away for an operation. Two days after admission, following a general anaesthetic, she thought, naturally enough, that she had received the operation and was deeply disturbed to be transferred, without warning or explanation, to a long-stay ward. Mrs. Morgan was also worried, telephoned the hospital and was given "grudging permission" by the ward sister to talk to her mother. Mrs. Morgan did what she could to reassure her mother and promised to look into the matter. The whole thing turned out to be eminently sensible. Her mother had not had her operation simply because she was overweight, had raised blood pressure and needed to diet. Unfortunately no-one told her. When Mrs. Morgan rang to explain all this, her mother was naturally relieved and equally naturally, wept a little. But when Mrs. Morgan rang the following day, the sister refused her permission to speak to her mother, because, she said, "You upset your mother last time."

The upshot was a successful operation and an elderly lady with an abiding horror of that part of the hospital. Mrs. Morgan herself, when she visited, was upset to see "nurses behaving in a most bullying way. They spoke to middle aged and elderly women as though they were delinquent children."

Mrs. Morgan's experiences as a patient were much happier but she still found the routines of the hospital, undressing on admission, walking down a corridor in her night clothes, the lack of introduction to patients and staff and

above all, the complete lack of information, most trying. She questioned, really, the practice under which wards operate, the way one of her visitors was evicted at lunch time because sister said, "I'm very strict about these things", the lack of sleep, the problem of being woken up to take sleeping pills and a complete lack of information and support on discharge. Perhaps she summed it up best when she said, "I would like to think of nurses as the protectors of patients. You're the people who see us at our worst, you know what we're like all the time and I think you can prepare us for the things to expect and teach us how to cope with them and you can protect us from some of the medical groups and some of the other aspects in illness."

Mrs. Flock, the second patient and herself a nurse, had much the same kind of thing to say. She told of the contrast of being received at the hospital by a bright friendly receptionist who quickly put her at ease and in the ward by an obviously busy and rather pre-occupied staff nurse. She spoke of the patient's loneliness and the reassurance she gained from the sister and from nurses who came on duty in "crisp dresses and aprons, well made-up, with well-brushed hair, properly put on caps and polished shoes". She too disliked the lack of information, even about the many pills she had to take and about the reason for the delay at her out-patient appointment.

There were two points she stressed. "Nursing", she said, "is almost an art form just as much as acting. For us to nurse we need the same discipline and technique and we need the same lively imagination and keen observation that a good actor has. And like acting to have that intangible star quality, well, it's just an attitude of mind." And the second point? "... and another thing is loyalty. Loyalty to sister. I've heard so many nurses complain to patients, 'Oh, sister does this, sister does that...' It's terribly bad. It negates you in the eyes of the patients because you are on a pedestal. Nurses are absolute angels when you are sick and afraid."

Mr. Brown, who spoke as a psychiatric patient was also a member of the Attitudes Meetings, and as such, had done more than anyone else to try and get his colleagues to talk about attitudes to patients. His contribution to this meeting, unfortunately, left us all standing because he took us away at a tangent and asked us to consider the ministry of the patient "whose duty is to suffer". As he said, we know a lot about the ministry of the doctor, the ministry of the nurse and little

about the ministry of the patient. The patient's task, however, can be made worse. "They will suffer not only their illness, but they will suffer on top of that all that you, as nurses, pile onto them, working out your sadism, sentimentality, mistakes, lack of training and wrong procedures. All these things a patient will suffer on top of his illness". Mr. Brown really touched on too many points in a short talk for him to have the impact he deserved.

And finally, Mr. Sarson, also a member of the Attitudes Meetings and almost the only person who had spoken up in support of Dr. Williams. In fact his experience as a patient paralleled that of Dr. Williams almost exactly. Admitted as a polio patient at the age of nine, unable to speak or move, and very frightened, he had experienced a total lack of communication from almost everyone. He owed his recovery, he said, to an enema and to the fact that the first words spoken directly to rather than over him were, "Hold it in!" At one point he was given a bell to call for attention but "the nurses fixed it so I couldn't use it." Although Mr. Sarson said he was never neglected or ill-treated, he did feel "that a little more consideration for me as a human being, especially a frightened child, would not have been too much to ask. Even in the acute stage, the mental well-being of the patient should not be excluded for the sake of efficiency and nursing procedure."

And there, as Mr. Sarson put it, the prosecution rested its case. There was no defence. Every group agreed wholeheartedly with what the panel had said. Every group put forward solutions, mostly of an administrative nature, for overcoming or avoiding these problems, even after a clear brief from the chairman who said, "If we accept that the patients are not asking things which are impossible or that they have no right to ask, then ask yourselves in discussion groups why is it still that we are incapable of re-ordering our priorities in such a way that we do meet what we see to be legitimate demands. I think that should be the focus of the discussion this afternoon."

Unfortunately, it wasn't. Nobody asked themselves the 64,000 dollar question, why? We had the usual list of 'simple' answers - streamlining admission procedures, the need to consider carefully what to tell the patient and when and, of course, some heartening examples of how it is done in some hospitals. Communications, (that 'glib word' as Mrs. Morgan later described it) came in for its usual bland misuse and there were various suggestions made such as the use of volunteers, the provision of 'reception centres', the need for more psychology in nurse training and so on.

One or two people moved in the right direction when they said things like, "We're very enlightened here because we've had this brought to our notice but a lot of people are being brainwashed without realising it's happening. We thought that sisters and charge nurses might be moved periodically so that they don't become institutionalised like their patients." "We thought it would be a good idea if the administration staff could go to meetings like this one, but we thought it would take them longer to realise the need for change." "... all nurses, no matter how junior they are, should make a stand to do what they think is right towards their patients..." "We feel that newly trained nurses need some sort of protection because they're suddenly thrown into the big, wide world of being responsible for everything they do and say." Such statements may not have said anything much about attitudes to patients, but they said a great deal about nurses' attitudes to nursing and to other nurses, especially towards the more senior ones.

But once again attitudes were revealed unconsciously by, for example, the nurse who said she'd quite like children to visit the ward, "provided they were well-behaved." This, said Mrs. Morgan later, was perhaps the crux of the matter. "It seems to me indicative of the attitude that you want us all, visitors and patients, to be well-behaved." And she touched on a point that was beginning to worry some of the conveners when she said, "It seems to me that you are going to increase your own fears and anxieties." And this, of course, is the danger, but so far everyone had escaped from it.

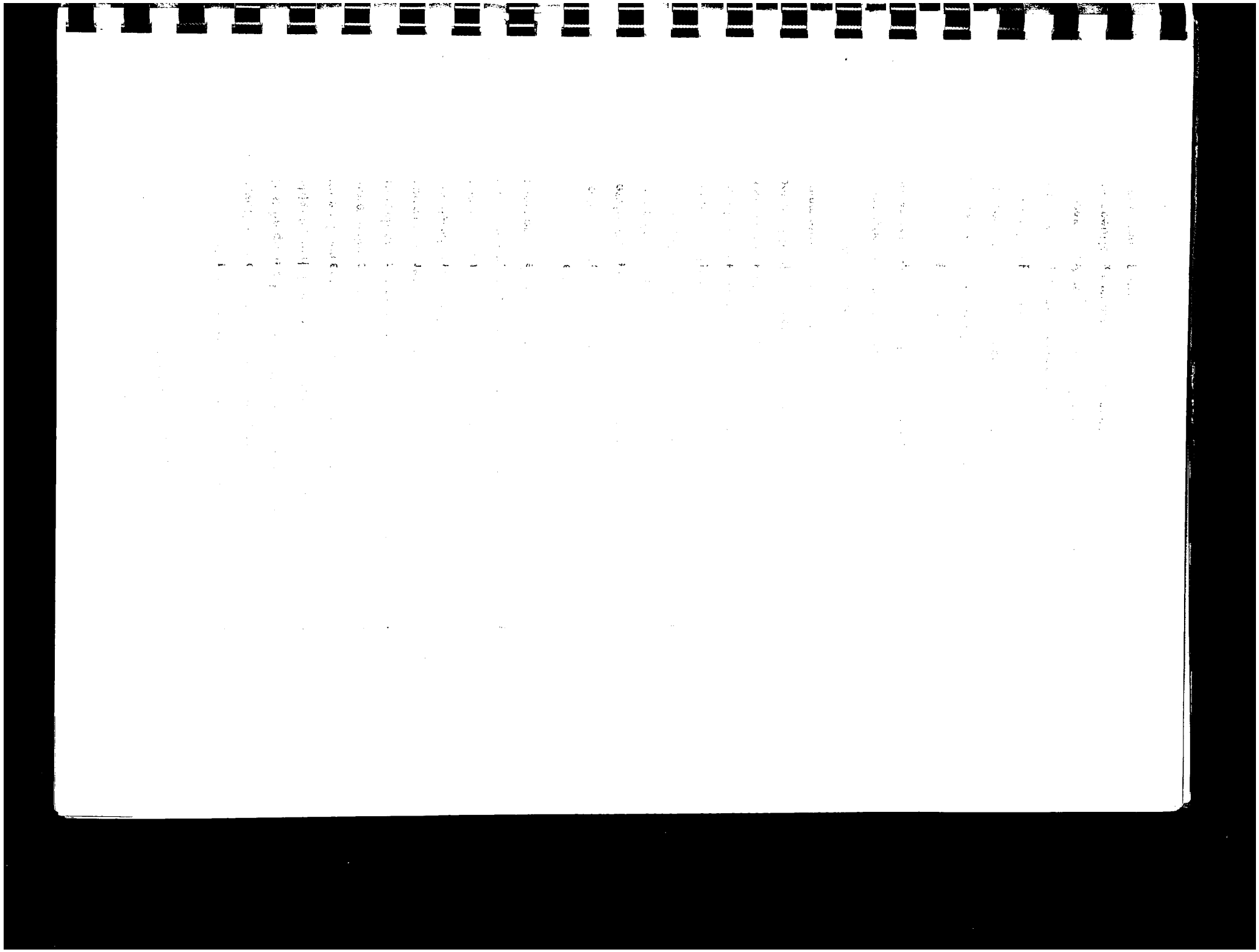
SIXTH MEETING

During the February meeting, we had all filled in Dr. Caine's questionnaires. Now he returned to tell us what kind of people we were. But first he gave a brief description of a therapeutic community, its aims, and its objects, and then went on to the fact that some nurses found it hard to work in such an environment, where patients were encouraged to criticise staff and where staff were under continual strain. This led him to wonder how fair it was to place people in such an environment without the most careful selection. The therapeutic community method of treatment, he said, had proved effective and again he wondered why. To find out he interviewed all the staff involved and a large number of patients who had completed treatment. From this interview he "pulled out" those questions that constantly recurred and these formed the basis of the questionnaires that we all filled in.

One questionnaire had been given to a large number of mental hospitals, both therapeutic communities and the more conventional kinds. Analysis of the results showed that there were tremendous differences in the answers given and Dr. Caine found that "you could measure the atmosphere of hospitals from the questionnaires". There might be two reasons for this. The first could be that people were just reflecting ideas that they had picked up or been taught, and the second could be that certain people may feel more at home in one situation rather than another and that some self-selection was going on. Dr. Caine felt that there were personality differences. Some staff and patients could not cope with a therapeutic community. They felt insecure.

He then asked the medical staff from a wide range of psychiatric hospitals what type of treatment they personally preferred and he again found great differences between the "physically oriented" and the "psychotherapeutically oriented".

This led him to the conclusion that certain treatment attitudes may not just be being "parroted". More basic personality factors seem to be involved, and he suggested that only people with both the right attitudes and personality should do certain jobs. And this in turn brought us on to the crux of the whole thing - that nursing is a vast subject and it is unfair to expect a nurse to be all things to all men. Just as it is vitally important to select the right people for work in a therapeutic community, so it is equally important to select the right nurses for other kinds of work.



Some years ago Dr. Caine contrasted general nurses with those in a therapeutic community. He found that general nurses had a preference for working in a concrete practical situation. They were more extroverted and preferred an active social life. Therapeutic community nurses, on the other hand, were most interested in theories, the meaning of life and so on. "Some people", said Dr. Caine, "fit into a therapeutic community because they like discussions about these problems." Basically, as he said, this is the difference between an introverted and an extroverted thinker. "My bet is that you'll not turn one into the other. You'll not do this by training. It would be unethical in a way."

And so to the results of the questionnaires. The first to be discussed was the Direction of Interest Inventory (a test of introverted thinking) based on an average score of 5.71 derived from people who have nothing to do with nursing. We scored an average of 6.08 which Dr. Caine said was not significantly different from the general population. Psychotherapists in the therapeutic community, on the other hand, scored an average of 12.45, a very high score in the direction of introverted thinking.

The second questionnaire to be discussed revealed differences between general and psychiatric nurses. On a scale designed to define whether nurses are more conservative than radical in their attitudes to a wide range of 'fringe' social activities, the psychiatric nurses scored 42.69 and the general nurses 51.15 which indicates, said Dr. Caine, that general nurses tend to take a more conservative view of things generally than their psychiatric colleagues.

Attitudes to treatment and patient/staff relationships came next and again there were wide differences between these groups, therapeutic community nurses, psychiatric nurses and general nurses. All three groups had somewhat different attitudes with regard to treatment and to staff roles and relationships with the general nurses at one end of the scale, the therapeutic community nurses at the other and psychiatric nurses in the middle. And to what extent are these differences due to training, personality and the institutes in which nurses work? "That", said Dr. Caine, "is being tackled now, together with the problem of extending this research into general hospitals."

This led to a sporadic discussion on the questionnaire and its application to the work of the nurse and, in a mild sort of way, we found ourselves talking about attitudes. One nurse in the general hospital liked Dr. Caine's

emphasis on the importance of a therapeutic community nurse "being herself" She said, "There is a lot of role play in a general hospital. I remember being caught singing by a junior nurse and thinking, 'Oh dear, I shouldn't.' But I can't say why I shouldn't." Another nurse wondered if complaints in a general hospital stemmed from the fact that a patient feels that the staff don't like her. If she was given a chance to talk about it, that might help. And another: "In general hospitals there is a great deterrent to being honest because the patient may complain. I'm sure there are many times when a nurse would like to give the patient a few home truths and vice versa."

Perhaps Dr. Caine had lit a spark because the afternoon session turned out to be the most honest yet. It began rather vaguely with a discussion about visiting and patients' clothing. Many people apparently feel strongly about this problem of patients' clothing, but, they asked, who should buy the clothes? Some said that the hospital agreed in principle to staff making these purchases but would not give them time off to do it. Attempts to buck the system apparently threaten people's careers. "If you buck the system", said one nurse, "you get 'bad' geriatric wards."

At this point we have to be honest and admit that our records system broke down. Neither tapes of the meeting nor the notes that were taken give an adequate picture of what happened. But relying solely on memory it seems to me that things became pretty heated, with a great deal of aggression being expressed about patients, and especially geriatrics. Even the conveners felt secure enough, for the first time, to disagree strongly rather than tactfully.

A great deal of time was spent bewailing the problems involved in dealing with incontinence and various suggestions were made for coping with it. At this point I remember pointing out, rather crossly, that no-one had considered ways of avoiding incontinence and that everyone was talking as if it was an insoluble problem. And it seems to me, looking back, that apart from some pretty incredible attitudes (one man referring to the patients as "livestock") some deep seated anxieties and aggressiois came to the fore. There were, of course, those to whom work with geriatrics was both a challenge and a reward, but many more who obviously felt themselves hard done by, lacking in support and actively unhappy. The saddest thing of all was that attempts to suggest positive action were met with stories of victimisation which, apparently everyone agreed, were all too possible. Shades of Sans everything !

Chapter 8

SEVENTH MEETING

This was the last meeting of the series as such. It was a time of review and appraisal, a time when we hoped we would decide what (if any) action was to be taken in the future. What had we achieved? What were we going to do? These were the questions set before us by Derek Dean who took the chair.

It is important to record his thanks to those people - the majority - who had attended our meetings with such unfailing regularity (see also Appendix 2) and especially to those who had come in their off-duty time. "A pity", said Derek Dean, "but perhaps an indication of some people's attitudes to attitudes." What had we been trying to do? A paragraph from the original letter of invitation went like this:

"There can be little doubt that the attitudes of nurses towards their patients and towards those with whom they work is an important element in the standard of care achieved by the patients. Very little is known about the nurses' understanding of their patients' needs, nor do we know enough about their reaction to the day to day problems of ward administration as it affects patients and staff."

"We hope", said Derek Dean, "that we have learned a little about the nurses' understanding of the patients' needs, we hope that nurses who came to these meetings have learned something about patients' needs - and about their own." It was, he said, not possible to say if we had achieved this object. We may have a better idea after today. The brief, for the morning session, was to discuss "What has been learned?" Groups were reformed into their original combinations (see Chapter 2) and a new group, consisting of the conveners and Dr. Caine, met to consider the same question.

Those who imagined that the conveners had their fingers on the pulse of the meetings and knew what they were doing and why they were doing it, would have found their meeting rather illuminating. This widely disparate set of people simply could not decide whether there had in fact been results from the seven meetings nor even, it emerged, what the real purpose of the meetings had been. Those who came along to the meetings and who worked to the programmes set before them (the main body of the kirk, as it were) may have thought the conveners knew what they were doing but this was far from the case. They were equally in the dark. Some of them had hoped that the meetings would, "indicate

an area for research"; others, perhaps less optimistic, believed that the objectives of the meeting had been achieved by the mere fact of getting nurses together to talk about a problem that hardly any of them knew existed. And this is why their report back was so inconclusive. They were waiting to hear what everyone else had to say and would be guided by that - as they had all along.

To those who had hoped for little more from these meetings than an exchange of ideas and perhaps a growing realisation that attitudes are a problem, the reporting back for the morning session was cheering. Not one group considered the meetings a waste of time. It was summed up by one spokesman like this, "Rather than learning something new we have become aware of the situation. We have woken up to reality and to the fact that we don't always pay due attention to our patients." Everyone agreed with this. They had, they felt, become aware and in some cases, had looked again at their behaviour in wards and to their patients and were trying hard to practise what had been so vigorously preached. "We are not so afraid of speaking to colleagues about their errors," said another group. "We now speak up for the sake of the patient." And what had they learned? "We don't seem to have got anywhere very much except self-examination."

Groups were aware, it seemed, that we had not really gone very far, that there were many problems still to be considered. They had enjoyed meeting nurses from other hospitals, had been reassured by the discovery that they shared common problems, but recognised their own limitations when it came to taking action. The sisters, for example, had talked to their staff about the meetings. They had also talked to older sisters. "They don't seem to want to change and take a lot of convincing."

Another group, while agreeing that, "the meetings have influenced most of us", were not optimistic about taking further action. With junior nurses, they said, it was easy, "we can convey our ideas to them by what we do." But matrons? "It is hard to convey these ideas to our matrons - they're not interested. My matron has never asked me how the meetings are going on. It is hard to go to a senior nurse and put to her what she is doing wrong."

There were one or two people who realised that we hadn't gone very deep ("just as well" someone muttered) and who said so and there were others (a few) who seemed to have missed the point of the whole exercise. One, reporting back, ostensibly for his group, but more probably for himself, treated us to a

long, angry dissertation on the injustices inherent in the way the Press reported scandals in mental hospitals ("an easy prey for the sensationalist press"), deplored the fact that they never said anything about the number of staff who were injured by patients, expressed his deep dislike of "psychopaths and other patients" and floored us all when he said, "In psychiatric hospitals wrong attitudes are not tolerated."

All this led on to the question "What next?" Here again the conveners were in a dilemma, not being clear about the progress we had made, nor the action for the future. In the end it was agreed to encourage people to undertake small "research" tasks for themselves, to find out, for example, how patients like to be addressed by nurses, and to be directly supported in this by members of the convening group, who all felt most reluctant to lose touch either with the project or with its participants. (A couple of nurses had already carried out their own "patients' satisfaction study" and reported on this to the meeting).

Suggestions for future action from the groups left no doubt that they wanted something to happen. Suggestions included a further series of meetings of new groups "beginning where we left off", similar discussions with consultants, a written report, a series of meetings for other members of the team, "matrons, occupational therapists, tutors and so on," films on attitudes, a final meeting with senior and junior nurses "where they could reach agreements on which of the report's recommendations would be practical", and variations on these themes.

This is where we left it with a promise to come together again in December so that nurses could report on their progress and comment on the report. We also agreed to invite matrons and principal tutors from participating hospitals to give their views on the whole thing.

WHAT THE SENIOR NURSES SAID

On November 5, matrons, chief male nurses, principal nursing officers and principal tutors from hospitals which had sent people to the Attitudes Meetings came to the Hospital Centre to discuss the interim report, the project and to make suggestions for future action.

It was a heartening and curious meeting. It was curious because in some respects it was a microcosm of the seven main meetings. In a highly compressed fashion we went through many of the stages that the rest of us had expreienced over the seven months. We had an introduction, tape-recordings and a general discussion. During the discussion there was a period, albeit a short one, during which people seemed unable to get to grips with fundamentals. They too 'escaped' for a time into a discussion which seemed more concerned with finding excuses for the shortcomings our tapes had shown and less with looking at the attitudes underlying those shortcomings. It only took a short while but it was interesting while it lasted.

This was a very informal meeting with Janet Craig in the chair only for the purpose of introducing people to each other and for telling us when it was lunch and tea time. She began with an expression of thanks to those present who had made it possible for us to hold the main meetings and then went on to thank them for turning up themselves and for filling in Dr. Caine's questionnaires in such numbers. At this meeting there were also people who had not been involved with the attitudes meetings as such, but who were interested and whom she welcomed on our behalf.

And so to the tapes. We wanted the people at this meeting to experience something of the atmosphere which had been evident during the first and second of the Attitudes meetings and to this end two tapes had been prepared. One was an account, taken from an article in the Nursing Times, and recorded specially for us by Joan Glenn, the author (herself a nurse), of her fears during radiotherapy treatment for a facial tumour. The other was a story culled from the Nursing Mirror of a patient's experience in a psychiatric hospital. The theme was of unimaginative, neglectful treatment by hospital staff of patients who were afraid and bewildered. In her introduction, Janet Craig explained why we had chosen examples from both the general and psychiatric fields. It was, she said, to ensure that neither the general nor the psychiatric nurses could say that such

things did not apply to them or to their hospitals.

The tape taken from the general hospital went like this:

"I had a small tumour removed from my face, and 10 days later learned from my doctor that I had to have a course of deep ray therapy. This knowledge filled me with despair and anguish, and being a trained nurse I had more knowledge than the ordinary patient.

The day arrived for my first appointment in a large city hospital and I went along to the appropriate department. Hospitals are all much the same to a nurse: they are familiar places with familiar smells.

I sat in the outpatient department awaiting my turn to see the consultant. My name was called and a woman in a white coat came over to me and said 'Have you been marked?' I said no, and I was then ushered into the consulting room while the consultant went on writing up the notes of, I suppose, the previous patient. My notes were perused and then I was truly marked with purple - I believe it is called a 'field' - and then a purple cross was put in the appropriate place to mark the spot.

Now I was taken along the corridor and told to sit down and 'they' would come for me in a few minutes. My name was called again and I was taken into a bare room with three chairs along a wall, an examination couch along another wall and a special chair with a head rest on it near another wall.

Two girls in white coats told me to put my things on the chairs and to come and sit down on the 'special' chair. One girl said 'You won't feel anything - sit quite still and the treatment is five minutes.' Up to now, apart from being a little apprehensive, I accepted this impersonal atmosphere and told myself not to be stupid.

I was sitting in the chair and a great big grey 'monster' was being pushed up to my chair and a sort of piece of square Perspex was pushed up against my face. The 'monster' was switched on and apart from a slight warmth I didn't feel anything physically. The two girls now went out of the room, and, leaving me alone with this vibrating monster, peered at me through a small glass window.

By this time my terror was almost indescribable. My heart was beating so hard and fast that I literally thought it could leap out of my chest. My eyelids were moist with unshed tears and I just closed my eyes and wished that I could die at that very moment.

The five minutes seemed like five hours and my mind was conscious of the fact that these rays were burning deep down into my flesh. My terror was quite the most awful type that I have ever experienced. Then came a 'whirr' and my agony was over, although I felt spent and exhausted, not so much with the treatment but with the terror of the unknown.

When I got my thoughts sorted out again I told myself that I was far too emotional, my nursing experience and knowledge made me far too apprehensive and I was determined to be calm and collected next time.

My next treatment was the usual procedure, but as I was waiting in the clinic a woman sitting next to me started a conversation and told me all about herself and her treatment. I listened politely, and then she said, 'How long have you been coming?' I told her. She asked, 'Were you very frightened the first time?' I told her that I was absolutely terrified. She then told me that her terror was so awful that she too wished she could die.

What is wrong that patients cannot be prepared beforehand and told exactly what to expect, and that they might experience fear? Nurses are taught in their training school that the patient/nurse relationship is the most important thing.

This experience happened to me, a qualified nurse who is quite used to a hospital atmosphere, and I record it here in the hope that something is done to alleviate patients' fears and terror of the unknown. Someone kind and understanding should talk to them before the treatment, so that at least they haven't to suffer from shattered nerves on top of a distressing and still fearful complaint."

The tape from the psychiatric hospital showed up similar problems in a rather different way. Unfortunately, owing to copyright reasons, we are unable to reproduce this article in the report. For those who should wish to look it up, it was entitled - "Stay of a short stay patient in a large psychiatric hospital", and was published in the Nursing Mirror of November 22 1968. The reaction was interesting. For quite a little while people sought to explain away the events described. They said, for example, that the radiotherapy patient would not have suffered such unimaginative and 'very strange' treatment had a nurse been present. But of course nurses are in short supply and cannot be spared for such tasks. Others felt it was a doctor's explanation that was lacking, that a nurse would have given that explanation for him and that all would then have been well. Perhaps, said somebody else, it was all due to a lack of communication. If the patient had been known to a member of the nursing staff, the surgeon would have had a talk with her. And anyway, the responsibility was that of the consultant. "Far too much", said the speaker, "is being put on a nurse's shoulders which isn't actually a nurse's responsibility."

That led on to a discussion as to whether or not a nurse should get priority treatment. All patients should be treated alike, and the speaker who made this point said that she had been admitted to a hospital where the staff did not know she was a nurse. A nurse put her head around the door of her room and said, "My God ! Another one ! " This speaker, who had been a nurse tutor and was now an administrator, went on to say that she had always taught her nurses that patients were guests and nurses were hostesses. Are other staff ever taught this?, she wondered.

People reacted to the psychiatric tape in a similar way, wondering for example, whether the patient, a self-confessed lover of the countryside, lacked contact with the staff because she "must have spent a lot of time outdoors" or whether it was not dangerous to "generalise on account of one psychiatric patient." This speaker went on to say that we must realise that a "person suffering from a psychotic episode is not a very good witness."

There was some more of this kind of thing but to be fair people generally took a surprisingly short space of time to get to grips with the situation. They wondered, for example, whether preparation of a patient could ever be adequate. "If I was told I was going to have an operation", said one, "I would still be scared."

Quite early on in the proceedings the word "attitudes" was actually used and people wondered why nurses neglect their patients. Where did such attitudes come from? Do nurses start with the right attitudes and then "get contaminated by other attitudes they see in the wards?" Are attitudes the same in all hospitals or do they change from hospital to hospital? Do nurses need support from doctors and equally, do doctors themselves need support?

Why (referring to the psychiatric tape) was the occupational therapist so friendly and human and the nurses so distant? Is it, as one speaker maintained, because occupational therapists get a better training, especially in psychology, or is it because they have an "easier" job, nine to five only and free from the tensions in the wards?

All these questions and points were raised and led, naturally, to a discussion about the attitudes of those associated with the Attitudes meetings. One matron had admitted herself disturbed at the fact that patients and nurses still 'disperse' when she does a ward round but felt that things had improved over the year. Another said that her two nurses who had attended the Attitudes meetings had taught her a lot. On ward rounds for example she said, "I used to say, 'Good morning. How are you?' I now try to think of something else." This was the matron who had said to her two nurses "Do I to anything wrong?" And who received the reply from a nursing auxiliary, "Oh, yes Matron, lots."

Some of the reports given about changing attitudes must be taken cautiously because there is, as yet, little real evidence to support them. But generally speaking people were agreed that there was an increased awareness

about the whole subject. Certainly this group appeared aware and many of them seemed perfectly prepared to look again at traditional practices and beliefs. This was shown when one speaker challenged another who had been unwise enough to claim that the days of the matron as a dragon have gone. "This", he said, "is not entirely true. It is interesting that it is always senior staff who say that dragons are gone. What would happen if we asked our juniors? Is the new student nurse still in fear and trepidation?"

This provoked a wide range of reactions. Not so much about dragons but about the possibility of changing attitudes. Some felt that attitudes can be changed, others were not so optimistic. It was here that the difference in attitudes between some of those who run psychiatric hospitals and some in general hospitals became apparent. One eminent psychiatric nurse administrator greeted with delight the relationship (expressed in the interim report) between attitudes to staff and attitudes to patients. This was fundamental, he said. He believed that he could change attitudes. "If we can produce this rather hard type of staff, surely we can produce right attitudes." He also commented on the use of phrases like "my hospital" and "my patients" which, he said, "reduces things to us, the staff, looking after those poor unfortunates, the patients."

Nurses involved in therapeutic community work will, no doubt, take this point but it led to an acute division of opinion between some general hospital nurses and one or two other people. The fact that the word "my" may imply a lack of teamwork might have been taken as a point by some, but the discussion led on to the use of words like "sister's office" and "consultant's room". It really boiled down to a division of opinion between those who believe in labelling rooms for administrative reasons (and after all it could be important for the patients and relatives to know which office is the ward sister's) and those who worry about and see the risks in the territorial claims implicit in such labelling.

A detailed account of this part of the meeting would vacillate forwards and backwards between discussions on administration and training and on attitudes, with statements and solutions ranging from the "easy" ones like "attitudes are surely a matter of common politeness" to a recognition of the complexity of the whole business. But many of this group recognised the importance of attitudes and continued to talk about them throughout the morning.

The afternoon session began with an introduction to the interim report in which I made clear my own worries about the complexities and difficulties inherent in the task we had all undertaken, asked why it was that nurses found it so hard to talk about their attitudes, said how important I thought the whole project was and wondered about the reasons for the problems we had all encountered. This was followed by Tom Caine who gave us a similar resume of his research to that included in chapters 5 and 7. He also presented some of the findings from his analysis of the questionnaires sent out to the senior nurses (see Appendix 1).

For a time we had a red herring kind of discussion about selection methods and research into wastage and this period was really only relevant to the subject of the day's meeting in the differences it showed between the attitudes of some of the people present. There is no doubt at all that Tom Caine's explanation of his research left some people in a complete fog and that there were others who were inclined to reject his ideas out of hand. One lady waxed quite bitter about people in industry who tried, she said, to tell people in hospitals how they should run things. She could not see any value in their advice at all: "We are dealing with people, not products." She was immediately attacked by a former personnel officer from industry, now a nurse, who expressed herself, "absolutely appalled at attitudes in hospitals where", she said, "there is no team spirit." Industrial techniques, she felt, could teach us a great deal.

This brought us right back to attitudes and finally to a discussion about the whole project. We received ideas for the future but from a minority of those present. One suggestion was for a whole series of meetings for those who had attended this one, another, along similar lines, was for a series for those present and all those who had taken part in the Attitudes meetings. It was here again that a division of opinion, or rather of attitudes made itself felt. Those in favour of a series of meetings for senior nurses only were diffident about the whole thing. Their attitude was "let us catch up, in all humility." The others felt it better for everyone to get together and obviously did not feel the need to learn anything beforehand. After some to-ing and fro-ing it was agreed to put these suggestions to the meeting on December 11 so that the rest of us could decide what we wanted to do.

Apart from this we received some valuable feedback about the impact that the Attitudes meetings have made on participants and hospitals. This varied

from statements to the effect that participants did not really appreciate the value of the meetings until they returned to their hospitals, to a report of a complete change of attitude for the better on the part of a ward sister ! Other people said they thought the meetings had been valuable because action had resulted. "How often do you get this as a result of a conference?", they asked. Yet another speaker thought that this kind of thing was good preparation for Salmon and for staff reporting which is bound to involve "a certain amount of confrontation between junior and senior staff."

There is one question that has exercised us all. How were people chosen for the Attitudes meetings? Some were sent because it was felt they would benefit, others because it was thought that they already had the right attitude, and therefore, we would benefit. Methods of selection varied. Some student nurses were chosen because their study blocks did not clash with the dates of the meetings. One matron asked the nurse allocator to "find" a suitable pupil nurse and another requested her ward sisters to nominate one of their number. One matron put up a notice, asked for names and then chose the lucky two out of a hat. She was delighted with the feedback she received and her staff nurses want a study day on the subject.

This was a heartening meeting for many reasons. It was heartening first of all because of the numbers who attended - not everyone to be sure - but a goodly number none the less. It was heartening because of the interest shown in the project and the awareness of its importance which was expressed by many people. Above all it was heartening because some of these senior nurses told us that our seven meetings had achieved something, that there had been feedback to individual hospitals and that, in some cases, attitudes had been modified as a result. So it seems that none of us were wasting our time.

The usual conveners meeting considered all the suggestions that were made for future action and the upshot was a suggestion to hold another meeting in the new year at which everyone, senior nurses, and those who had attended the Attitudes meetings would come together for a discussion on the whole subject. That of course was a decision that would have to be taken at the meeting on December 11.

Chapter 10

DISCUSSING WHAT THE SENIOR NURSES SAID

"What the senior nurses said" was followed on December 11 by a meeting to discuss their findings and to decide lines of action for the future. It was an indication of what seasoned campaigners we had all become that this was one of the most outspoken meetings yet, airing, with great frankness topics that had only been touched on, or shied away from, at previous meetings.

Tom Caine took the chair and began the day by describing the results of his research. It was cheering to discover that a shift of attitudes, nearer to that found among therapeutic community nurses, had been one result of this series of meetings.

A great deal of time was taken up during the morning session with a detailed discussion of Tom Caine's questionnaire, discussion which highlighted the fact that just as physically ill people need emotional care, so do the mentally ill need physical care - and they don't always get it. It also led to a discussion as to how far group methods can be used to resolve emotional problems in general hospitals. After the usual list of reasons why such meetings are difficult if not impossible (pressure of work and so on) someone made the point that regular group meetings, even in a general hospital, could be a very useful way of spending time. Such meetings would lead to a better standard of organisation and understanding in the wards.

A question that fills many nurses with anxiety is the one that goes, "How much should the nurse tell the patient about her (the nurse's) private life?" As somebody pointed out, we, as nurses, expect patients to spill out all their private affairs to us and yet we usually respond with formality. Certainly we rarely respond in kind. Should we? This divided the meeting rather sharply. Some could see no advantage (and even some harm) for the patient in such mutual frankness. Others believed that frankness of this kind and the knowledge that nurses, too, are human and have personal problems,could lead to greater mutual trust. The discussion really boiled down to a question of "What is a personal relationship?" Is it this kind of intimate secret-swapping or can there be degrees of personal relationships? Can, indeed, a nurse have (as one claimed) 'personal relationships' with upwards of 50 patients? The involved discussion that took place showed very clearly just what a difficult business real communications are.

This discussion also raised the question of honesty. How honest should nurses be with patients, with each other and with their senior colleagues? How honest can they afford to be? As Tom Caine said, "Unless we learn to be honest we will be in trouble." ("We're there already", someone muttered). Such a topic raises all kinds of problems. Is a nurse afraid to be honest with her superiors? Is she justified in this fear? Is it <u>really</u> a matter of the right approach? Do the patients want nurses to be perfect or is it that the nurses really desire to appear perfect to their patients? Needless to say widely differing views emerged from all sides. The discussion actually grew so heated towards the end that it was very hard to persuade people to break for lunch.

The afternoon session began by asking people to comment on the report of the meeting with the senior nurses ("What the Senior Nurses Said" - Chapter 9) but this, apparently, was of no great interest to them. Some expressed surprise that there had been such a meeting and others took the opportunity to comment on the lack of feedback they had received from their senior colleagues. One said, "I got a little bit of feedback, but it was only a little bit of sugar after receiving a rocket." But people were generally interested in the tapes that the seniors had received and particularly in the fact that the psychiatric tape showed up a better relationship between OTs and patients than between nurses and patients. This, they felt, was not due to any question of OTs having an easier job or a better training, but simply to their success in building up better relationships.

The meeting was unanimously in favour of another meeting with the senior nurses for a variety of reasons: one being the fact that "We never meet them in our own hospitals." People were obviously feeling secure enough to meet and discuss problems frankly with senior staff even from their own hospitals.

The afternoon session suddenly came to life again when someone said, "The problem in general hospitals is mostly nurse to nurse relationships - not nurse to patient relationships." This sparked off a wave of discussion and widespread agreement that this was indeed the case. We heard statements like, "Attitudes of junior nurses change according to how they are treated by their seniors." The junior nurse will put it like this, 'I spend my days in the sluice.' We don't have teamwork in the general hospitals." This if true, seems very sad because the same speaker said, "When nurses join they want to be part of a team, to help and to know. You want to be happy in your work. Most of us are not happy. You

can't get through to matron or to sister. If nurses are happy, then patients will be." This situation, of course, is changing, as many were quick to state. But where it still exists it may be due to fear on the part of the senior staff. "They (the seniors) don't like to admit they're wrong. They're trying to preserve their image. I don't know about senior nurses being dragons - lots of them think they're God '." Although this statement may not be true, it is important because at least one nurse thinks it's true.

The crux of the whole problem, in both general and psychiatric hospitals, lies with the attitudes of staff to staff. Attitudes to patients follow on naturally. But improving attitudes between staff, as one speaker pointed out, is not easy. He said, "In these meetings we have gone a long way towards understanding better attitudes to patients. But we have neglected material things which could bring those attitudes about - being used as pairs of hands. I'm looking after 45 to 50 patients. Changing nurses around makes it impossible for them to know their patients." There was some agreement with this view but others believed that nurses should stop complaining and get on with the job. Even Tom Caine's statement, "I can't understand how students can be expected to be human and humane when we treat them so differently," brought sharp disagreement from one ward sister who said, "It is not always the case that they are treated inhumanely. After all it takes two to make a difficulty and some students can be jolly difficult."

Mr. Brown, whose efforts to keep us all on the basic subject of attitudes, had been such a valuable feature of the whole series, had one last go and in doing so, illustrated, I think, how superficial the great majority of our talk had really been. He referred us to three paragraphs about the Pinkville massacre in The Times of December 2. Two paragraphs were from a Sergeant Olsen in a letter home to his father and the other was from a US senator. Sergeant Olsen said, "Why in God's name does this have to happen? These are all seemingly normal guys, some were friends of mine. For a while they were like wild animals. It was murder and I am ashamed of myself for not trying to do anything about it", and later, "It was simply a case of the wrong people in the wrong place at the wrong time .... the people I knew who did the shooting were not the most stable people." Of the whole unhappy incident, US Senator George McGovern said, "I think it is more than just Lieutenant William Calley involved

here. I think the national policy is on trial. We put these men in a situation where it was inevitable that sooner or later events of this kind would take place."

It is a measure of how far the meetings had brought us all that there was no emotional outrage (as there had been in response to Dr. Williams' tape), even at the mention of Pinkville in the context of a meeting on attitudes to patients. But it is also, I believe, a measure of how far there is yet to go that Mr. Brown's quotations and his final remarks - "We must consider first of all our own attitudes, then we must go on to consider ways, means, atmosphere, rules and pressures to see if there is a way to get more suitable conditions for better attitudes" - stimulated no discussion at all.

People then went on to agree, very quickly, that they would like to meet the senior nurses and that that meeting should be divided up into fully representative groups.

Chapter 11

THE FINAL MEETING - AND ITS RESULTS

Two very cheering things emerged from this meeting between those who had attended the whole series and the senior nurses. One was a general agreement that the whole series had been of value. The other was an equally general agreement that something more should be done.

1 This was a rather more formal meeting than usual. It was formal because it was hoped to get some suggestions for future action. To this end people were divided into "across the board" groups which represented not only the different grades of nurses but general and psychiatric hospitals. The questions they were asked to consider were:

- What should be the outcome of the series of meetings, apart from the promised final report?
- What can be done with each or any Metropolitan Hospital Board area?
- What can be done within each hospital involved in these meetings?
- What should the Hospital Centre do next?
- Has the convening group any future role with regions, the hospitals or in the Hospital Centre?

People stuck, commendably, to their brief. There was general agreement that something needed to be done to spread the gospel of the importance of attitudes even further and suggestions from the groups ranged from study days within hospitals to another series of meetings along the same lines, but involving an entirely different set of nurses, to be held at the Hospital Centre.

Ideas on the future role of the conveners varied. Some considered it best that they should act as advisers to individual hospitals attempting attitudes meetings of their own while others thought that people from the convening groups should be called in at a later date to "see how things are getting on."

But while it was considered important that attitudes meetings should be held in individual hospitals people were also aware of the problems inherent in such plans, especially in general hospitals where regular and frequent meetings are not so much a part of hospital life as they are in psychiatric hospitals. Encouragement from HMCs, it was felt, would be helpful and some suggested involving RHBs, and in particular their training staffs, in the subject.

A rather more ambitious plan involved RHBs and the Hospital Centre. Meetings between 12 or so hospitals could be arranged on a regional basis and each hospital would act as 'host' to the others in turn. The groups involved would need to return to the Hospital Centre from time to time for 'supportive and learning discussions.'

Similar ideas abounded, the most heartening thing being that something must go on. People also considered widening the scope of the attitudes meetings to include other grades of staff, to as they put it, "overcome bad attitudes between various grades in hospital." Someone else suggested involving HMC members and doctors, "doctors' attitudes could do with a bit of looking at."

So we were agreed, in principle if not in detail. But some criticisms were made. The length of the interim report was criticised by several people (a point which had also been made in written comments from people not involved in the meetings as such). It was stated, with some truth, that people simply will not read lengthy documents and it was felt that something shorter was needed. However, it was recognised that a full account of all the meetings would be needed as a working document and that this should be supported by something much briefer which would set out the main lines for discussion and action.

Although people stuck pretty much to their brief this meeting was not without its controversy and showed that few of those present felt complacent about their own attitudes, or, indeed, about those of their colleagues. People still wanted to know why nurses felt themselves to be different from other people. Why do we tend to treat patients differently? Part of the reason, perhaps, was too much responsibility too soon leading to the development of a "bit of a skin". Shortage of staff and bad deployment coupled with a lack of adequate explanation for moves from ward to ward were given as another reason and one nurse cited the case of the trained mental nurse, doing post registration general nursing, who was placed, without any prior warning in charge of a surgical ward. "It shook her and she couldn't complete her training. It shows we don't take enough care of our nurses." Examples of night duty problems for student nurses and nursing assistants were also given. One matron rose to the defence of her colleagues and sparked off a brief but spirited exchange when she said, "You all talk as if the matron just sits there in her office and picks names off a list and takes no interest in where she places her nurses. I've never heard such a load of old rubbish. It doesn't happen."

"It does happen !. "

"It does not happen !. "

All of which shows, I suppose, the dangers of arguing from the particular to the general, and also the general security felt by everyone present that they could tolerate such an exchange.

It would be wrong to claim too much even from the enthusiasm of this final meeting. There is a long way to go yet. Several nurses who had reported back, in writing, to their own hospitals told of varying results. Some had their reports accepted, some had to work hard even to get them read. Some meetings to discuss the reports had been promised but had never materialised. "Was there," asked someone, "a feeling of Jack trying to teach his master?" But despite the problems there was general agreement that the series had been important and useful and that something should be done to spread the gospel.

The thought and suggestions put forward at this meeting and at previous meetings proved of immense value in planning for the future and the programme that has been worked out is based entirely upon suggestions received. It is probably true to say that those involved in guiding the original series cannot, for many reasons, develop them into pieces of research in individual hospitals or even in hospital groups. The most that people at the Hospital Centre can do is to continue to try and create an awareness of the importance of the whole question of attitudes, both to patients and to staff and to provide a forum for the free exploration of this subject. This is what is to happen during 1970. A group, consisting of some of the original conveners and it is hoped, some of those involved in the first series of meetings will organise and take part in another series as nearly identical to the first as possible. There will be changes of course. One will be the fact that people from mental subnormality hospitals will be invited to take part this time. Another will centre around the selection of hospitals. This time hospitals in the same groups or in close proximity to those who sent people to the first series of meetings will be chosen. In this way there might be some cross-fertilisation of ideas and experience, if not now, then in the future. Perhaps the most important change will be the inclusion, right from the start of the new series, of senior nurse administrators (matrons, chief male nurses, principal nursing officers) and tutors. The need for this was made apparent on several occasions.

Demands of time and the complexities of the task have made it impossible for those of us in the convening group to become involved in detailed arrangements for attitudes meetings in individual hospitals. But we very much hope that such meetings will take place and we will certainly do all we can to help the people involved.

Finally it is not our intention to publish another full-scale report at the end of the next series. But we will publish a summary of what takes place which, added to this report will, we hope, do something to keep it up to date.

Questionnaire is attached

Appendix 1

THE QUESTIONNAIRE AND ITS RESULTS

by

Tom Caine

The questions we have been asking people involved in the Attitudes meetings are exploratory ones. How much agreement about their jobs is there among nursing staff of different grades and different training backgrounds? Can differences, if any, be related to personality factors? Another question we had in mind was whether the series of conferences we have been having on attitudes to patient care have had any appreciable effect on the attitudes of those attending. Another related question is whether an apparent change in attitude has any great effect on actual behaviour.

A certain amount of preliminary spade work has already been done in these areas, but this has been mainly in the psychiatric field. Briefly, the general finding is that among medical staff, those who prefer a physical rather than a psychological approach to the treatment of patients tend to be more outwardly directed in their interests and thinking than their psychologically minded colleagues. Outwardly directed interest in this sense means being interested in concrete, down to earth problems which can be resolved in a practical way by definite methods or techniques. The opposite, inwardly directed interest, is an interest in problems involving abstract ideas, theories, emotions, feelings and beliefs. This approach has been extended to nursing and occupational therapy staff with similar results. Another possible significant aspect of personality is how conventional or unconventional one is prepared to be or is prepared to let others be.

We have been able to relate these personality traits to our Attitudes to Treatment Questionnaire (ATQ). This questionnaire has been built up over a long period of time, again using psychiatric groups. Just how relevant it is for the various general hospital nursing situations is a matter for investigation, and this will be part of our analysis. Our main concern has been with nineteen particular items out of the whole questionnaire which form themselves into a scale which we know separates therapeutically oriented psychiatric nurses from other psychiatric nurses. The areas covered by these nineteen items include discipline, personal involvement with the patient and his problems and relationships with the doctor.

At present nurses are most widely used in a psychotherapeutic role in therapeutic communities, although some may be involved in group therapy to some extent. If it is true that in the future nurses may be seen as the key therapeutic figures in other nursing situations then presumably something can be learned from nurses already involved in psychotherapeutic roles. The scores reached by therapeutic community nurses on this nineteen item scale have therefore been used as a base line for our present comparisons. Unfortunately the therapeutic community group of nurses have only completed the Attitudes to Treatment Questionnaire (the personality questionnaires hadn't been worked out at the time this was done). In making our comparisons we have used the average scores on the various questionnaires for the groups concerned. In addition it has been possible to test those who attended the whole series of Hospital Centre meetings at both the beginning and the end of the course, which allows us to gauge something of the effect of the discussions.

In order to see if the general trained nurses differed in any way from the psychiatric a number of comparisons have been made of the first set of results. We have confined our comparisons in the first instance to the nursing hierarchy of nursing administrators and tutors, ward sisters, charge nurses and staff nurses, and student nurses. We did this because the ordinary channel of promotion is through these grades and to this extent these represent a genuinely linked nursing hierarchy.

DETAILS OF THE STATISTICAL COMPARISONS

The comparison of the numbers in each grade

	General	Psychiatric
Administrators and tutors	20	23
Ward sisters, charge nurses and staff nurses	14	12
Student nurses	8	5

The numbers in each grade are clearly very similar and statistical calculations confirm that there is no significant difference in this respect between the general and psychiatric nurses. This is very helpful since any great discrepancy in terms of the numbers in the various grades might well affect any subsequent comparisons of questionnaire scores.

Age differences

Age is another factor that might affect score comparisons:

	General	Psychiatric
Average age	37.00	40.38

Again the difference between the groups is small and statistical calculations confirm that the groups have a similar age distribution.

The Attitude to Treatment Questionnaire (ATQ)

The average scores of the various groups on the scale of nineteen items are shown below.

	General	Psychiatric	59 Therapeutic Community Nurses (for a base line)
Administrators and tutors	61.59	53.55	
Ward sisters, charge nurses and staff nurses	61.50	54.70	
Student nurses	62.38	59.50	
Total	61.72	54.70	41.86

These results show that the therapeutic community nurses are the lowest scores, the general hospital group are the highest and the psychiatric nurses fall in between. These differences are statistically significant. There are no significant differences associated with the hierarchical structure of either the general or psychiatric groups. All grades of staff tend to score the same. The differences are due rather to the type of nursing.

A rough grouping of the items according to content, gives an indication of how these differences have arisen. In most cases the disagreements are not clear cut but rise from the significantly greater number of one group answering in a certain direction relative to the other nursing groups. I have shown the general nurses as G, the psychiatric nurses as P and the therapeutic community nurses as T. Where nursing groups have not differed they are shown together.

1. Items having to do with ward discipline, cleanliness, efficiency etc.

		Agree	Disagree
Part of a nurse's job is to keep discipline on the ward	G + P	65	6
	T	26	16
It is important to have the ward organised according to strict rules	G	14	19
	P + T	12	69

...../

		Agree	Disagree
The nurse should always make sure that the patients are neat and well-groomed	G + P	51	16
	T	13	32
A ward in a mental hospital should be kept up to the same standards of cleanliness and efficiency by the staff as a ward in a general hospital	G	33	3
	P	16	14
	T	6	40

2. An emphasis on diversionary activities rather than a concentration on the patients' problems.

		Agree	Disagree
Part of a nurse's job is to make sure the patients don't have time to think about their problems.	G + P	34	28
	T	5	44
The point of a patient being in hospital is to have his mind taken off his problems	G + P	16	50
	T	3	49

3. Getting involved with the patient

		Agree	Disagree
A nurse should take care not to show too much interest in patients' deeper problems in order to avoid getting involved	G + P	27	37
	T	10	35
Patients should be discouraged from developing feelings towards staff members	G	17	12
	P + T	25	55
Staff being too friendly towards patients makes for poor discipline on the ward	G	11	22
	P + T	16	68
Patients should not call nurses by their Christian names	G	26	6
	P + T	11	64

4. Views about the doctor and his relationships

		Agree	Disagree
It is important that the doctor should not show his real feelings to the patient	G + P	41	17
	T	15	29
It is an important part of treatment for the patients to believe that the doctors are all-powerful	G	11	21
	P + T	5	77
Nurses should never disagree with doctors in front of the patients	G	36	0
	P	27	8
	T	18	25
Patients would be helped more often if they could see their doctor individually more often	G + P	62	4
	T	9	31

SUMMARY OF THE RESULTS

The differences in attitudes may be summarised as follows. Relatively, the general nurses emphasise the need for organisation, discipline and cleanliness in the ward. They lay less stress upon the need for personal involvement with the patients. They tend to stress the role of the doctor more, particularly with regard to his individual relationship with the patient which must not be disrupted by the nurse disagreeing with him publicly. They tend to play down the importance of the doctor's feelings, giving greater weight to the scientific and physical aspects of treatment. Very broadly the therapeutic community nurses tend to take opposite views. Psychiatric nurses fall, somewhat indecisively, in between, sometimes agreeing with the general nurses, sometimes with the therapeutic community group.

The Personality Questionnaires

The Direction of Interest Questionnaire (DIQ)

This questionnaire measures whether one's interest is inwardly or outwardly directed; whether one is interested more in problems within the person or problems external to him. The higher the score the more one's interest is internally directed. The statistical analysis showed that the scores obtained were not related to nursing status in the psychiatric group but that among the general nurses the student nurses were more internally directed than were their senior colleagues. Indeed, they scored higher than any other group. In comparing the psychiatric with the general nurses the psychiatric group were more internally directed than were their general hospital colleagues, general hospital student nurses excepted. The following average scores for the groups shows the position.

	Average scores
General student nurses	8.00
Psychiatric nurses	6.20
General administrative and trained ward staff	4.65

It is of interest to note here that the average score of a group of 17 psychotherapists is about 12.00.

"Conservatism - Liberalism" Scale

To recapitulate, this scale is not a political attitude scale but is one which is related to how much one is prepared to agree or disagree with "way out" activities which are a feature of our so-called permissive society. The idea was that those closely associated with the mentally ill or maladjusted might be expected to have a higher tolerance of "way out" activities and this has proved to be the case. It is very interesting to note that again this difference is not associated with nursing grade. The younger junior nurses are not more accepting or unaccepting of these activities than are their older and senior colleagues. The difference lies in whether they have been drawn to work in psychiatric or general hospitals. The average scores are shown below. The higher the score the more 'conservative' the attitude.

	Average scores
General nurses	51.98
Psychiatric nurses	41.15

How the questionnaires are related to age and to each other age

Age was found to be related to only one questionnaire and that was the Direction of Interest Questionnaire. This was so in the general nursing group only and is related to the high scoring of the general student nurses. Being a younger group this automatically resulted in an age association. However since there were only eight students involved this result may not be confirmed when larger groups are used.

The Attitude to Treatment Questionnaire and the Direction of Interest Questionnaire

A fairly high significant negative correlation was found between these two questionnaires in the psychiatric group. A negative correlation was found in the general nursing group also but this was very low. In other words a tendency was found for nurses with the more therapeutic community attitudes to their job to be more inwardly directed in their interests.

The Attitude to Treatment Questionnaire and the "Conservatism - Liberalism" Scale

Positive correlations between these two questionnaires were found in both the general nursing group and the psychiatric. In only the former was the

correlation "statistically significant" and in their case very highly. This indicates that, as predicted, the general hospital orientated nurses tended to be more "conservative" in their acceptance of "way out" activities.

The Direction of Interest Questionnaire and the "Conservatism - Liberalism" Scale

In both the general and psychiatric group there was a lowish negative correlation between these two questionnaires. Although not statistically significant they are both in the same order and in the same direction.

Conclusions to be drawn from these first comparisons

Any conclusions to be drawn from our analyses must be tentative until the findings are generalised to other samples of nurses. With this in mind the following points can be made.

- General nurses, psychiatric nurses and therapeutic community nurses can be differentiated by a questionnaire designed to measure certain attitudes to patient care.
- In both the general and psychiatric fields, all grades of staff from student nurse to nursing administrator seem to have the same attitudes to patient care. Either these attitudes are inculcated at an early stage in the nurse's career or the nurse enters the field of nursing which seems most likely to confirm her existing presuppositions about the job.
- General and psychiatric nurses can be distinguished in terms of certain apparently more basic personality factors involving their direction of interest and their apparent acceptance of nonconformity.
- Attitudes to patient care can be related to these more general personality attributes.

The Re-test Findings

The nurses who had attended the series of meetings were asked to complete the questionnaires again some months after the series ended. Our purpose in asking them to do this, was to see if their experience at the Hospital Centre had had any measurable effect on the initial expressed attitudes. Sixty-four per cent returned completed forms with all grades and kinds of nurse equivalently represented.

The Attitude to Treatment Questionnaire

In one analysis it was decided to restrict ourselves to a rigorous test of whether attitudes had actually been reversed on second testing, rather than

accepting a slight modification. Taking "strongly agree" and "agree" as positive and "strongly disagree" and "disagree" as negative a shift from negative to positive is a move away from the therapeutic community nurse base line, whereas a move from positive to negative is a shift in that direction. We found that there were thirty-three moves in a positive direction whereas there were exactly double, or sixty-six in a negative or therapeutic community direction. This is statistically significant. A similar analysis is simply to count up the number of scores that have increased on second testing and the number that have decreased. Again a decline in score is to be taken as a move in the therapeutic community direction and again we find that the number of scores going down are more than double the number that have increased. The average scores for the trained ward staff and the student nurses show the tendency.

	First test	Re-test
General nurses	59.50	55.93
Psychiatric nurses	56.46	53.38

Both the general and psychiatric nurses change in score in all the five areas noted above. The general nurses declined most on the group 3 items having to do with getting involved with the patients. The biggest change of all was on the item "patients should not call nurses by their Christian names". The general nurses now seem more prepared to allow patients this amount of familiarity. The psychiatric nurses declined most on the group 1 items having to do with ward discipline, cleanliness and efficiency, showing a more relaxed attitude in these respects.

The Personality Measures

No significant change was found as far as either of the personality measures was concerned. The re-test results were virtually identical with the original scores as the average scores shown below affirm.

	First test	Re-test
The Direction of Interest Questionnaire		
General nurses	5.86	5.43
Psychiatric nurses	6.00	6.07

The "Conservatism - Liberalism" Scale

	First test	Re-test
General nurses	47.28	48.50
Psychiatric nurses	44.08	43.69

The Re-test Reliabilities

The re-test reliabilities for the Attitude to Treatment Questionnaire and the personality tests are shown below.

	Reliability Coefficient
Attitude to Treatment Questionnaire	.79
Direction of Interest Questionnaire	.81
"Conservatism - Liberalism" Scale	.70

These reliability coefficients are all statistically significant and show that there has been considerable consistency between the two testing sessions. It means that the nurses have ranked themselves in roughly the same order on the two occasions. Those who tended to score higher than the others at first did so again the second time. The fact that there has been a general decline in score, as on the Attitude to Treatment Questionnaire, has not interfered greatly with the rank order of the nurses themselves. This gives us some confidence in the measuring instruments as such.

This re-test study suggests that attitudes, as measured by our Attitude to Treatment Questionnaire, have been modified even by the limited number of sessions held at the Hospital Centre. Other evidence is needed before we can say just how permanent these changes are and whether such changes have been translated into actual action. The personality measures are more resistive and have not been affected. The precise significance of this too will require further study.

Personal Conclusions

This pilot study has confirmed the view that nurses in different branches of nursing have different attitudes to patient care. This is inevitable since the demands of the job and the needs of the patients are clearly very different in different nursing situations. We have seen that the differences are in terms of attitudes to discipline and organisation, attitudes to the required degree of personal involvement with the patient, attitudes to a formal versus an informal

approach, attitudes to free communication and a questioning of the fundamental scientific status of the work including the value of the formal diagnosis. We are all aware that these questions form the corner stones of the training of nurses. A nurse trained in the beliefs and attitudes of one type of nursing, or indeed one institution, may find that she is required to completely reverse them on transferring to another. To what extent is this possible when one of the essentials of good nursing is to maintain one's own integrity?

A further complicating problem is that these attitudes have been shown to have deeper personality connections. It may be that some self-selection is going on and that students are being drawn to particular nursing fields because of some innate preferences for working in certain ways. The effective nurse presumably is the one whose personality inclinations fit the psychological and interpersonal requirements of the particular nursing situation in which she finds herself. Lip service and a conforming attitude are probably not enough. This is certainly true for psychotherapy in which, as we have discussed, the personality of the therapist, in terms of warmth, empathy and genuineness may be all important. This seems to be the key to the problem of the difference between what one says one does and what one actually does in particular situations.

The criticism can be made that our Attitude to Treatment Questionnaire is too psychiatrically biased. This is partly because most work in this area, with the exception of that of Professor Revans, has been done in the psychiatric field. In our defence the areas touched upon by the nineteen items we have analysed are of general significance and one needs little specialised knowledge, if any, to answer them. They have application to both fields of nursing.

My own feeling about the series of conferences on patient care and our analysis of the data we have collected is that all we have done is to throw up a number of fundamental problems without being able to provide the answers to them at this stage. I am convinced that there is much to be learned about ourselves and about others from the process of formal psychotherapy (including therapeutic communities) and I am sure that some of what we can learn can be applied in other nursing situations in varying degrees. However I also think that before this can fruitfully be done a much closer look must be taken at the psychological needs of different sorts of patients and different sorts of nurses. Finally I would argue that

underlying all fields of nursing is the fundamental truth that all patients and all staff are people and not simply diagnostic categories or nursing grades. The full recognition of this is possibly the most therapeutic attitude of all. Perhaps the most important things to find out are how we came to lose sight of this truism, how we can relearn it, and having done so what we can do about it.

SOME RESULTS

What can we claim as a result of all this work? Not too much in any direction because this series has been an exploration not a piece of research. But, as Tom Caine has shown in Appendix 1, we can claim a shift in attitudes for the better and, I believe, we can also claim a heightened awareness of the importance of the whole problem. It would be foolish to claim that we had brought about any major or permanent changes as a result of these meetings but there is no doubt that many of the people who took part went away the better for it and, what is more, have done their best to disseminate what they have learned. Some of them met with encouragement; some did not. An analysis of a questionnaire, (not to be confused with Tom Caine's), compiled by Hazel Edwards (Nursing Officer, the Hospital Centre) gives a clear picture of the efforts made and some of the snags met:

Out of a total of 51 completed questionnaires

32 people attended all meetings

10 missed one meeting

7 missed two meetings

2 missed three meetings

Out of 19 separate absences

7 were due to sickness

5 were due to holidays

3 to other educational commitments

2 to shortage of staff

1 to hospital fete

1 to transport and weather difficulties

Communications

42 were able to talk to others about the meetings

7 were not able to do so

2 did not indicate either way

To whom did they talk?

30 spoke to student nurses

27 spoke to ward sisters and charge nurses

22 spoke to pupil nurses

20 spoke to staff nurses

To whom did they talk? (continued)

17 spoke to matrons and CMNs

13 spoke to assistant matrons

7 spoke to tutors

5 spoke to doctors

5 spoke to patients

3 spoke to principal tutors

3 spoke to deputy matrons

2 spoke to occupational therapy staff

The following staff were mentioned once:

ward orderly, group matron, home sister, friends, vice president of the National Association of State Enrolled Nurses.

Of the seven who did not report back two gave reasons:

(i) "Only attended the kind of meetings at which such a report would be inappropriate"

(ii) "Staff of ward only interested in so far as I had day off. Some senior staff interested".

Replies showed that many people had been very much encouraged by the attitudes of their senior staff and colleagues when they had reported back. Some hospitals obviously had good systems of communications already established and this made the task easier.

The few negative replies came from people who had felt disappointed at the apparent lack of interest shown in their work at the Centre by those who had sent them.

The following theme occurs frequently: "After the February meeting at the Hospital Centre I was asked to speak at a sisters' study day about the meetings. Matron and administrative sisters were present, a few staff from the local convalescent home attended. They showed great interest in the discussions. The SEN who accompanied me to London was also present and added comments. I spoke to the sisters' meeting about the latest developments and stated that I hoped we might be able to do a survey in our hospital in due course. I shall be passing round to my colleagues some ideas about what questions could be asked and seeking their comments and suggestions, if we can get the approval of our management committee."

Some people had altered some of their practices as a result of the meetings. "Following my visits to the Hospital Centre, and after reporting back to the ward staff, we agreed to carry out more active ward meetings and group meetings with patients, which proved to be rewarding and enlightening. Some specific topics were useful, e.g. admissions to wards, introductions to other patients, calming their fears and apprehensions, talking with patients rather than over them. It helped in our attitudes to ask patients how they felt about things. After the series of talks I sought out the principal tutor and discussed it with him, he was very interested and asked me to hold a series of discussions with the PTS class which I did for four days. The students showed keen interest in what I had to say and also came up with some interesting suggestions which I am at present sorting out to see if they would be of some use to us. I am also holding more discussions with another class, then with all these suggestions I shall see what comes up most often, and do something about it."

Accounts of negative reactions to the report back included the following: "There did not seem to be any great interest as they felt that nothing would become of the talks, but we hoped it would. I gave a written account to matron, but I have not been asked about it, or the meeting since in fact nothing more has been said. One of the tutors was extremely interested and asked me to keep him posted of future events."

"Only one charge nurse had any sympathy with the aims of the meetings. The rest adopted aggressively defensive attitudes such as 'if you are short of staff, short of clothes, of well-designed wards and facilities and have to heave fifteen or sixteen stone patients about who are confused, you might be short of temper.' I must apologise for not being of much assistance in your task, also I must admit that my reporting back is probably influenced by my bias. However overall I think the suggestions from my colleagues is that the problems should be viewed as a series."

Another reply seemed to suggest that nurses' attitudes could not be viewed in isolation but must be seen against the background of personnel policy in hospitals right from the top.

"The CMN did not show much interest at first, but after the publication of the Ely report became more interested. He is of the opinion that any real change must come from the top. He tends to think, and I agree, that much rubbish was

talked at the meeting and the problems should be attacked in four ways - equipment and facilities, selection of staff, staff morale, school and ward co-operation. He feels that the people to coax from their ivory towers are the regional boards, and these people should attend such meetings."

Some replies showed that something might be done in the 'here and now'.

"I have discussed the meetings at the Hospital Centre with all my staff and they all agreed that the attitude of the sister and charge nurse to the junior staff played a very important part in the junior nurses' attitude to the patients. I realise how valuable the meetings have been to me. I think a lot more about my attitude to each individual patient and nurse."

A disappointed respondent wrote: "The matron has asked me to write a report for the HMC as they allowed my fares to and from the Centre. No further interest was shown. I do feel most strongly that meetings of administrative staff in hospitals should be held in order to get to the bottom of the lack of interest shown by such staff in treating people as individuals and human beings with a personal life to lead as well as a life in the hospital." The writer then goes on to quote a conversation overheard in an administrative office. "Thank goodness Mrs .... isn't pregnant again yet, and she will be with us a little while longer." This staff member had lost her baby last year. This illustrates some nurse administrators' attitude to nursing staff."

In sharp contrast to the last example some replies showed that people felt they had gained some insight not only into the difficulties of patients, and their own colleagues, but could also appreciate better the strains faced by the nursing administration.

"I felt that if we were to get our attitudes to patient care in right perspective we should get our attitudes to each other and all grades of nursing staff clear first. With this thought in mind I tended to mingle and listen to my colleagues in general hospitals, rather than in my own field. I must say I derived great satisfaction from the course. It gave me much food for thought and I shall try to apply the knowledge gained to the best advantage. May I thank all concerned for the welcome and friendliness I received at the Hospital Centre."

"You don't realise that sister has to take her orders from above and matron has to answer to the management committee. I found the groups rewarding, and

now feel that I understand what nursing means, and I hope I shall show it to other people."

Some members were fortunate enough to return to a working situation in which the work of the group was seen to be valued.

"After a talk with the tutor she was impressed, and she allowed me to talk to other pupils for a whole afternoon instead of having the scheduled lecture. I was rather nervous but with the help of a visitor whom I took back from the Hospital Centre, we had a good discussion. When the question of staff relationships came up the ward sisters were most strongly attacked for their military attitudes. On the whole I am pleased to say that we all agree that it is the patient who suffers in a disorganised ward, and as nurses we can only do our best to create a better atmosphere. Sister Tutor has acquired a copy of Mr. Ritchie's book 'Stroke', and it had been read by most of the pupils. I found Sister Tutor most helpful. I had a discussion with matron, and she too has been most helpful; she is getting some questions printed and she has given permission for these to be displayed on the ward, and also for me to maintain further communication with the Centre."

A surprise was registered by one respondent: "I am at the moment trying to establish some of the practices suggested at the meetings in my own wards but surprisingly I am meeting with resistance from the nurses themselves."

Some people found a wider audience interested in the work of the group:

"I gave a written report to matron who was most interested. I told my consultant who was most interested, also the house officers. I also mentioned it on a first line management course at the local technical college."

Several replies showed that the participants, while warmly agreeing with the views of the group, were troubled about how to link them up with the practical pressures in the work situation.

"My staff nurses, part time and married, but young and very enthusiastic, were very interested in what we did at the Hospital Centre. There seemed only too little time to discuss more with them, but I put through all the essential questions as they appeared to me. The sisters did not show much interest on the whole. I felt this was mostly because they felt the subject to be too far removed from their daily problems. It might help if some of them could go to a study group. I am

sure it would help if most wards could arrange a discussion group maybe once a week to bring up problems of any kind concerning staff relationships and stress. To find this time would be a miracle, for the constant pressure on all nursing staff, and the never easing demands of nurses seeking to recognise patients' needs, do not allow for this, for who would look after the ward if we all disappeared to have a good discussion? This does not mean to say I have given up trying, but it does make clear that to give one's best we have to be both realistic and idealistic."

It will be seen that most replies showed that members of the group had felt encouraged by friendly appreciation and interest which they received on reporting back to their colleagues in the hospitals, only those who did not receive this support felt disillusioned and disappointed. On the whole the people who participated in the Attitudes Meetings felt that it had been well worth while and several mentioned that they would like to feel that their findings would be available to interested members of the nursing profession. As well as completing the questionnaire several letters were received at the Centre. In conclusion are quotations from two of them.

"Although I think the anomalies in the Health Service should be publicised I feel that undue emphasis is being put on the wrong issues. At present the emblem of success in nursing is an administrative post, when it should be the treatment of patients. As a result we have too many Chiefs and not enough Indians. Many nurses keen on the trail of success tend to delegate their duties to juniors to avoid losing status and as a result patients get neglected; this I know to be very true. More emphasis should be placed on training nurses at bedside level, so that both patients and relatives are handled with sympathy and tact.

What is required is a much closer scrutiny of the entire nursing profession by an outside body, with the power to make sweeping changes and to put the basic principles right. I realise I may be controversial in attitude but I am sure you would rather know what I really think."

The last word is appropriately about the patients

"I would like to thank you for giving me this opportunity to realise and think about the questions raised and debated at the talks. I feel and hope that something constructive will arise to make a patient's day in hospital more comfortable, friendly and reassuring."

This shows, I think, that the whole exercise was worth while. Other sources have reflected this view. The interim report was circulated fairly widely and brought in some critical comment. Not everyone agreed with the way in which the meetings had been conducted but not a single person considered them a waste of time. With a subject like this, you can't ask much more.

Appendix 3

MEETINGS OF THE CONVENING GROUP

It is impossible to give a full account of these meetings because they were rarely formal meetings as such. The group did, it is true, usually get together for an evaluation session after each main meeting - often in a state of acute emotional exhaustion - but they also met at odd intervals, wrote letters to each other and talked on the telephone. The only person who could write a really adequate account of what was said and done and why, was Janet Craig, who because of her position in the Hospital Centre, found herself, willy nilly, acting as co-ordinator for us all.

But the point which emerges most clearly to me is that we were often as confused as everyone else. People may have imagined that each programme was carefully planned according to some longterm policy. Careful planning indeed, (and much hard work) went into each programme, but there was no longterm policy. How could there be? The conveners were feeling their way and completely dependent upon what they thought others wanted. And it was not always easy, after a general meeting, to decide precisely how far we had progressed and where we should go next.

There were many reasons for this apparent confusion. Somebody once described the Attitudes meetings as a "fascinating example of group dynamics". They could have said the same, with equal truth about the conveners' meetings. There we were, six people, with different backgrounds, different views, different motives and, I suspect, with different ideas of what we should be doing. Some of our meetings were fairly tense. There were times when it seemed impossible to communicate, others when some of us felt threatened and at risk, and we all, I am sure, at one time or another, felt worried about the ultimate effects of the Attitudes meetings upon those who were taking part.

And, of course, we sometimes felt frustrated. There were times when a carefully planned programme fell flat on its face, when it seemed that attitudes would never be discussed and we wondered how far we dare go to 'force' people away from their protective pre-occupation with patient care and its administrative problems on to the realities of attitudes to patients. In retrospect it is easy to see that we were all exploring a delicate and potentially dangerous situation together, but at the time many of us felt that we were walking on extremely thin ice.

It was almost as frustrating to sit through a whole day of comparatively innocuous talk, listen while people spoke of "communications", "teamwork" and the need for better training, and then suddenly, at the last moment, realise that we were actually talking about attitudes, that people were letting their hair down and revealing their true feelings. This kind of thing usually happened in the last half-hour and we used to wonder afterwards, whether we had, in fact, achieved a breakthrough, whether the meeting would go on from there next time, or whether we should have to start all over again. We usually did and it was this lack of continuity that made programme planning so difficult. It was our very real feeling that we had to move slowly and circumspectly and only go as fast as we were allowed, that made us so diffident (apart from one notable occasion) in the general discussions. But we enjoyed it all and, I am sure, learned a great deal and found it all immensely valuable.

Appendix 4

THE CONVENERS

David Boorer
Freelance Journalist

Barbara Betlaby
Post Graduate Research Student
Cambridge

Derek Dean
Chief Nursing Officer
Napsbury Hospital

Jillian MacGuire
Director of the Research Unit
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Name_____ Age____ Date_____

Status_____

How to answer the questionnaire:

This questionnaire is in the form of statements with which you may agree or disagree more or less strongly. We should be grateful if you would indicate your answer by putting a circle round the appropriate letters, which are explained as follows:

SA Means strongly agree

A Means agree or tend to agree

U Means uncertain whether you agree or disagree

D Means disagree or tend to disagree

SD Means strongly disagree

Please answer all the questions

A. Set out below are some activities which may be part of a nurse's job. Please indicate how much you would agree or disagree with a nurse working in this way by circling the letters next to each item in the way described above.

1.	Keeping discipline on the ward	SA A U D SD
2.	Making sure that patients don't have time to think about their problems	SA A U D SD
3.	Suggesting to patients the underlying reasons for what they (the patients) say or do	SA A U D SD
7.	Taking care not to show too much interest in patients' deeper problems in order to avoid getting involved	SA A U D SD
10.	Talking to the patients and trying to get to the root of their problems	SA A U D SD

B. Below are various statements about the types of treatment, the patients and the staff in a hospital such as this. Please indicate as before how far you agree or disagree with the statements.

11.	It is important to have the ward organised according to strict rules	SA A U D SD

P.T.O.

16.	Patients should be discouraged from developing feelings towards staff members	SA A U D SD
17.	It is an important part of treatment for patients to believe that the doctors are all-powerful	SA A U D SD
19.	One of the most important things in treatment is to establish the correct diagnosis	SA A U D SD
20.	Staff being too friendly towards patients makes for poor discipline on the ward	SA A U D SD
22.	Once the senior doctor has made up his mind nobody should question his decision	SA A U D SD
23.	The nurse's uniform is bad because it makes a barrier between nurses and patients	SA A U D SD
24.	Nurses should never disagree with doctors in front of the patients	SA A U D SD
29.	The doctors' knowledge makes them the only people capable of treating the patients	SA A U D SD
32.	There is fundamentally no difference between staff and patients	SA A U D SD
34.	The nurse should always make sure that the patients are neat and well-groomed	SA A U D SD
38.	A patient should not be expected to discuss really personal problems with the other patients	SA A U D SD
39.	The point of a patient being in hospital is to have his mind taken off his problems	SA A U D SD
47.	Patients would be helped more if they could see their doctors individually more often	SA A U D SD
48.	Patients should not call nurses by their christian names	SA A U D SD
51.	Treatment in psychiatry is a scientific technique and should not involve the doctor's feelings	SA A U D SD
53.	It is important that the doctor should not show his real feelings to the patients	SA A U D SD
71.	Physical treatments (tablets, electrical treatment, etc.) are on the whole more effective than any other kind of treatment	SA A U D SD
74.	A ward in a mental hospital should be kept up to the same standards of cleanliness and efficiency by the staff as a ward in a general hospital	SA A U D SD

Score Sheet - Nurses Component 1

Item	SA	A	U	D	SD
1	5	4	3	2	1
2	5	4	3	2	1
7	5	4	3	2	1
11	5	4	3	2	1
16	5	4	3	2	1
17	5	4	3	2	1
19	5	4	3	2	1
20	5	4	3	2	1
22	5	4	3	2	1
24	5	4	3	2	1
29	5	4	3	2	1
34	5	4	3	2	1
39	5	4	3	2	1
47	5	4	3	2	1
48	5	4	3	2	1
51	5	4	3	2	1
53	5	4	3	2	1
71	5	4	3	2	1
74	5	4	3	2	1
Total					

To obtain score circle the number corresponding to the agreement **rating** for each item. Add the numbers which have been circled to give the total score.

Name.....Age..... Sex.....

Status.....Hospital.....Ward.....

Date.....

Attitude to Treatment Questionnaire (ATQ)

Nurses component 1

Normative data

Doctors

Orientation	n	mean	s.d.
Therapeutic community	22	37.23	7.00
Group or individual psychotherapy	10	43.80	7.05
Eclectic	40	49.80	9.88
Organic	6	54.17	6.41

Various samples	n	mean	s.d.
Specialized therapeutic community staff	18	31.83	5.68
Trained psychiatric nurses working in therapeutic communities	59	41.86	9.67
Psychiatric nursing staff working in traditional psychiatric hospitals (32 trained;5 students)	37	54.70	8.30
Psychiatric nursing staff attending a meeting on staff attitudes (status unreported)	36	58.94	10.11
Trained psychiatric nurses from three traditional psychiatric hospitals	40	62.60	10.82
Psychiatric nurses attending a conference (status not reported)	72	51.18	10.65
General hospital nurses attending a meeting on staff attitudes (31 trained; 8 students)	39	61.72	7.51
General hospital nurses attending a meeting on staff attiudes (status unreported)	45	58.24	7.64

Various patient samples

	n	mean	s.d.
Therapeutic community neurosis unit	18	39.94	7.38
Neurosis unit (eclectic)	13	64.69	4.00
Traditional mental hospital admission unit	15	57.18	1.95
Acute admission unit run on therapeutic community lines but using physical treatments	22	52.00	3.08

Correlations and reliability

Age

No significant correlation with age found in three large groups of nurses (n= 73,94,72)

Reliability

re- test correlation of .79 in a sample of 52 psychiatric and general nurses re-tested after about a year interval. Hall (in press) reports correlation of .76 for 16 student nurses re-tested after three months.