THC Reprint no 756 (£0.25p)

ATTITUDES AND ASSESSMENT

An account of how teams of nurses from six hospitals came together to design projects to help them understand more fully their attitudes to their patients and to each other.

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February 1973

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INTRODUCTION

The study of nurses attitudes to patients (and to each other) has now reached the point where individuals are benefiting, where the subject is being fairly widely discussed but where little action and little change is taking place in hospitals. If the study of attitudes is to have an impact, if it is to bring about change, this can only take place among nurses (initially at least) in hospitals.

It was in an attempt to help people take this next step that Miss J B Craig, assistant director, the Hospital Centre, developed the idea of linking the discussion of attitudes with the problems of assessment. A group of hospitals, general, mental and mental subnormality were invited to select teams of six nurses of all grades for monthly discussions at the Hospital Centre during 1972. To increase the chance of such discussion spreading to the hospitals concerned, chief nursing officers and their senior nursing staff were visited and later met at the Hospital Centre to try to define guidelines along which the teams could work and to ensure that teams would be given the support and help they would need. How this idea worked out in practice can be seen in the following pages.

CHAPTER ONE

INVOLVING THE CNOs

Previous attitudes meetings, as Miss Craig pointed out, had worked the other way round, with people from hospitals coming to the Hospital Centre, discussing attitudes but with no real support from the top. This was the first time that chief nursing officers and their staff had been involved from the beginning. She hoped that they would consider

- what it was the study teams were being asked to do
- how best to support them
- whether the best way to operate was for each team to pursue the line of enquiry it felt best or whether all teams should carry out the same investigation so as to compare results and get mutual support.

People then introduced themselves and described how their team members had been chosen and what they hoped for from them.

In almost every case, team members had been "picked". Nurses had been chosen from among those who had been given information about attitudes meetings and who appeared interested. Those selected had been chosen for their ability to contribute to the meetings and to 'feedback' results to their colleagues.

Why the teams were chosen

The reasons for selecting teams varied. One CNO was faced with a move to a new hospital. She realised that the attitudes of her nurses would have to change. Patients would also need to get accustomed to the move and nurses would have to help them too. Another CNO, in charge of a large mental subnormality group, recognised that attitudes at the top are wrong, that poor conditions can affect attitudes at all levels and hoped that "My team of six will spread an awareness of attitudes".

In yet another group, morale was a bit low because of Salmon and the changes which were taking place. The CNO in this case had high hoped of the meetings. She was interested in the attitudes of students among themselves, in the attitudes of first line managers and also hoped to encourage people to take initiative and to "think for themselves". The attitudes of nursing staff in transplant units where "attitudes sometimes conflict with ethics" also interested her.

The teams chosen, by whatever means, were representative of all grades from students, pupils and nursing auxiliaries to clinical teachers and nursing officers.

How best to support these teams and how best to make use of anything they gain from the meetings was the subject of a long discussion. There are three main problems, all inter-linked. One is to maintain the enthusiasm of each group; the second to support them in the hospital when things get rough (as they probably will) and the third is to ensure that discussion centres around attitudes to patients and that it doesn't wander too far off the subject. As Tom Caine said, "They must be prepared to talk about their own attitudes, not about someone else's." This, of course, needs trust. People are still afraid of talking to their seniors as individuals. It is a long slow process.

But assuming that the teams do talk about attitudes, that they do reach some conclusions, when then ? How will they spread these conclusions around their own hospitals ? Who will enable them to do it ? Who will support them while they are doing it ? Above all, who will help them face the aggression that will come their way when they make critical comments about their own hospitals ?

There were no clear-cut answers but at least people seemed aware of the problems. Regular reports from each meeting - to be distributed as, when and to whom the teams wished, is one way of spreading information. People also felt that the "mix" of the teams would encourage a wider dissemination of information than would be the case if all team members were of the same rank, while others thought that some arrangements might be made for teams to hold regular meetings with other grades of staff.

The question of support

But the question of support was much more complex. CNOs felt reluctant to offer much more than moral support because of the risk of influencing their teams too much and also because of the danger that teams might come to be seen as part of some senior management plot to change things. It was generally felt that nursing officers would play a key role in creating a receptive climate of opinion, in helping team members to spread information and in supporting (or protecting) them while they did it. What would happen if nursing officers were the subject of overt or implied criticism, no one said.

And of course, members of the Central Team are willing to visit hospitals and to give all the help they can.

This support is a vital question. It is vital because attitudes meetings which are too bland, too vague, too safe, get nowhere. It is only those meetings in which participants mention specific cases in which the discussion is uncomfortable, even threatening, which make progress. Any in circumstances such as those teams will need all the support and help they can get. They will certainly need to know that people in their own hospitals are aware of what they are doing and why.

Supposing that meetings are meaningful and do highlight genuine areas where change and improvement are needed, what then ? In that situation CNOs themselves will need support. In such a situation it is possible that those at the hospital who are interested in the attitudes meetings will evolve into "support teams". Certainly, CNOs would be advised to find those who are sympathetic to the idea of change and to involve them. But it will all take time. And what to do with those who resist change is another thing altogether.

Agreeing this report should be circulated to the hospital teams - that basically is how the group left it. If members of the group really meant what they said, it appears that the attitudes study teams, when they meet, will get support and that they will be the ones to decide how and when information from their meetings is to be passed on to their seniors. So far as the Central Team is concerned, help will be available when needed.

The study of attitudes is not easy, but the guidelines worked out by the CNOs and senior nurses at this meeting, together with their own involvement with the project, seems to offer the best start that has yet been made.

CHAPTER TWO
LOOKING FOR GUIDELINES

Most of those who took part in the first meeting were keen, had done a fair bit of preparation and all had an idea of the kind of projects they wished to undertake. What they were not so clear about was how best to undertake the studies they had planned. "We are looking for guidelines," they said.

But the whole project belongs to the teams. It cannot be passed to the Central Team at the Hospital Centre because, as Janet Craig put it, "Your work is of prime importance. The Central Team are here merely to assist." She also warned against "a spiral of competition as to who can produce the best study." "Attitudes", she said, "is not an easy subject. You can get frustrated because you don't get anywhere. But sometimes recording failures is as important as successes."

The teams are engaged in varying projects, all concerned with some aspect of attitudes. Many had been lent impetus by changes taking place within the various hospital groups.

One team intends to study attitudes among patients and staff in a large, new maternity and gynaecological unit. This group was keen to look at the attitudes of staff to patients in the new setting.

Another group - who hadn't managed to hold a meeting before coming to the Hospital Centre - decided to look at the problems caused by a therapeutic community working in a conventional psychiatric hospital. Staff in this hospital are divided about the community and there is conflict. The team hopes to act as a bridge between the warring factions. They recognised that "there is a terrible lot to look at" and, like many of their colleagues, hoped for guidelines from the Central Team.

A team from a large scattered mental subnormality group had managed to hold two preparatory meetings and although they confessed to "feeling vague" about the whole project, actually had a fairly clear idea of what they wanted to do. Basically they intend to look at attitudes in "the present day of change and trouble." Their hospital problems centre around Salmon, ward alterations and divisions into smaller units, staff shortages and the critical publicity mental subnormality hospitals have been receiving recently.

One team member, a ward sister in a 50 bed children's unit which is being divided into two 25 bed units, wants to study the attitudes of nurses to this change. A staff nurse, working in a small unit recently hived off from a larger one, hopes to compare the quality of care received by the patients before and after the division. The student nurse in the team had held a meeting for fellow students which lasted for two hours and which, apparently brought many problems and grievances to light.

The pattern of the patients' day

A large scattered general hospital group, planning a move into a new building, is concerned with the pattern of the patients' day. At present the wide variations which exist affect not only the time patients wake up but also the training and reception given to student nurses as they move around. The present problem, described as "one big muddle" meant, said the team's student nurse "that students have to change their attitudes the whole time."

Questioning this team (a feature of this series of meetings) led to some mild disagreement between those who believe in uniformity and those who are unhappy about it. People wondered if plans to standardise the patients' day would lead to better care or whether "you are just fitting them in with the staff." "It sounds," remarked a psychiatric nurse, "as though you are planning a military operation." Even other general hospital staff questioned this team's apparent devotion to conformity.

But the discussion ranged wider than that. The student nurse had mentioned the effects, of having to adapt to different wards and different routines at fairly frequent intervals, had on nurse training. In some wards, where sisters were not prepared (or able) to give a full introduction, this could mean a fortnight's training time lost or at least not fully used. One sister thought that students should be prepared to ask for help. "Their attitudes were at fault," she said, "if they did not." But students believe that some sisters are not approachable. Is this true ? Or is it the results of rumours about dragon-like sisters among the students themselves ? It is a bit of both probably but if students believe that they can't ask, then they won't, no matter whether their belief is true or not.

It wasn't until the end of this discussion that someone asked about the effect of standardising the patient's day on the patient. "Had this team," they said, "recognised that different patients did different jobs and therefore were accustomed to waking at different times ?" The student nurse realised this. "We need to plan the patients' day on the lines of the outside world rather than how the hospital runs. The majority of people have nine to five jobs

(sic) and we should adjust waking hours to suit them."

Another general group is to move into a new hospital, lock, stock and barrel, and members of this team - hoping for guidelines - intended to look at various aspects of this problem. One is to compare the attitudes of trained staff with those in training, another to look at the attitudes of patients towards the move. A third is interested in the attitudes of staff to staff together with the attitudes of staff nurses to patients, and vice versa. The state enrolled nurse team member is interested in "trying to maintain the atmosphere of the old hospital when we transfer to the new."

Problems of staff reporting

Discussion brought out some of the problems involved in staff reporting. Many reports are not written up until weeks after the nurses have left the ward. Some people felt there should be an interim report, during which the trainee nurse should be present.

And, on territory familiar to many nurses, the status of the SEN - "in charge one day, a dog's body the next," was raised. SENs sometimes have to fight for the recognition that automatically goes to the staff nurse. Part of the problem lies with the rivalry between the SEN and the third year student nurse and part, apparently, with the failure of some ward sisters to indicate clearly to whom they wish to delegate authority.

If some sisters find it hard (because of frequent staff changes) to give adequate information to junior nurses, who do those junior nurses turn to ? Some go to nursing auxiliaries who appear to be more approachable. This worried a nursing auxiliary. She felt that she didn't know enough to be of help. Do patients teach nurses ? Should they ? Perhaps they should. Perhaps this would make them feel more at home. Perhaps patients often want to help but find it as hard to approach nurses as many nurses do to approach their seniors.

The final team to report represented a mixed group which included psychiatric and general hospitals. Their original plans, to study "everybody's attitudes to everything" were modified during their journey to the Hospital Centre. They finally settled on looking at attitudes to patients on admission and discharge. This group is also affected by Salmon and other changes. The team had taken the precaution of electing six reserves fully involved in the first team's plans and who can stand in when needed.

Keeping to the point

One of the problems of previous attitudes meetings was keeping people to the point, to help them maintain an awareness of attitudes. Various methods - tape recordings and panels of patients - were used with varying degrees of success. This meeting had a film strip entitled Nurse/Patient Interaction, the first in a series on loan from the USA.

It described clearly the stress experienced by a patient before, during and after admission to hospital, his gradual loss of identity, his subjection to hospital procedures and his increasing sense of isolation following fleeting contacts with members of hospital staff all concerned to do things to him. More importantly, it showed how an independent person, previously responsible for his own life can, insensibly and gradually, develop into that favourite of most nurses and doctors - The Good Patient. He becomes grateful, self-sacrificing, uncritical, because he is afraid of being rejected or ignored. Such a patient may be denying medical and nursing staff essential information because of his need to appear cooperative - a need which nurses and doctors do little to diminish.

The teams broke up into groups to discuss this film. Some apparently found it hard to relate the American scene and patterns of care to their own situation while others rejected it out of hand. Only one group forgot its transatlantic origins and concentrated upon its principles considering, with much honesty, many of the things hospital staff do to patients and wondering why.

A long way to go

The final session showed clearly how far the teams have to go, not only in a real discussion and study of attitudes, but in the acceptance of their own vital roles in such studies. They seemed aware that they would need support and that the going could get rough. But were they clear that the project is nothing more than a vehicle for getting into the generalised area of what are the attitudes of all the people who live in each hospital ? This is the crux of the whole exercise. The Central Team, as was said many times during the day, will help, as a group or individually, at the Centre or in each hospital. But only the teams can tell them what needs to be done.

CHAPTER THREE
AN UPSETTING MEETING

This meeting shook and distressed people. Those shocked were general hospital nurses. Those providing the shocks were nurses from mental subnormality hospitals. Their description of the conditions under which they worked distressed several general nurses.

This shock may lead to deeper understanding of the problems facing mental subnormality nurses. It is to be hoped so because some of them, together with their colleagues from the psychiatric field, were obviously feeling sore and some obviously felt that the gap between their problems and those faced by general nurses was too wide to bridge. To some, much of the discussion appeared irrelevant. Both "sides" had some difficulty in seeing each other's point of view.

The whole day was spent in reporting team projects. Some teams have started well. One general hospital team, concentrating upon assessment, have asked to speak at nine meetings in their hospital group. They met as a team and decided which of them should attend which meetings to talk about their projects. They found, they said, that it was hard to encourage people to attend meetings. Once they came it was fine - but how to get them there ? The tutors they had not involved yet. After some careful cross-questioning, they agreed that they may have been reluctant to involve tutors in the first place. Had they left the tutors out of the project ? Should they have involved them earlier ? The team generally accepted that they had and that they should.

The team's student nurse had held a meeting attended by about twenty out of a possible 150 students. She is trying to find out more about the attitudes of trained staff to those in training and vice versa, with special emphasis upon the role of the staff nurse. Why, for example, do student nurses say, "We daren't go to sister ?" Why, on the other hand, do sisters say, "We're always here, but nobody speaks to us ?" Someone made a suggestion that trained nurses should sit in on student nurses' lectures. Nurses in training wanted observations of their progress during their period of experience in a ward, not only at the end.

Do staff nurses get any help to <u>become</u> staff nurses ? They can be third year students one day and staff nurses the next. Apparently they receive little guidance as to the best way to assume the mantle of their new responsibility. Many of the group were in favour of

learning management by example, preferably during the third year of training. A SEN thought that pupil nurses needed help and guidance at the end of their training. A careers person was needed to advise students at the end of their training on what sort of work was available to the nearly qualified nurse.

This team is really involved in action research. They are considering questioning patients for their opinion and are also considering involving doctors. They want to produce a questionnaire to be used at interview and have received offers of help from Tom Caine and the Hospital Centre.

A militant occasion

The team from a large mental subnormality group have done no more than talk. Some of them felt they were wasting their time. Their project - care of the patient - was mentioned in the hospital magazine but they want more help. They were wondering about questionnaires and about ways to get more people to attend team meetings. The team's student nurse held a meeting which was attended only by nine of her colleagues and at which Paul Sommerfeld was a guest. Despite the small numbers, it was a lively - not to say militant - occasion. The students were angry at the kind of care given to patients in their hospitals and thought they might take over a nurses' home, kidnap some patients and show the rest of the staff how it should be done. The idea turned out to be less revolutionary than they had thought. Many of the group considered it a good idea, said that something similar had been done in other hospitals but suggested that the students should only undertake such an exercise with official blessing and as an experiment.

This team have decided that there are various kinds of nurses - interested, dedicated, or apathetic. This applies whether the nurses are trained or untrained. They felt that many trained staff say, "Go on, try it. But it won't work, believe me." (In a previous series of attitudes meetings, Jillian MacGuire referred to this kind of remark as a "killer phrase".) People advised them to have any project they undertook evaluated half way through as well as at the end.

A general hospital group looking at admission procedures and at staff and patients' problems in two units, based part of their project on what patients were reported to have said in a sociological study. So far they have failed to find a patient with a complaint. But one midwife, looking at nurse/patient interaction, studied a patient who was considered difficult

by one pupil midwife. The patient was elderly (by midwifery standards) and was having her first baby. It turned out that, in addition to many personal problems, she was a trained nurse and a midwife and, not unnaturally perhaps, was expecting the worst. The midwife felt the discussions she had had with the patient for the benefit of the project, had also benefited the patient.

The PPC conveyor belt

The team's ward sister in the gynaecological department and currently working in the admission unit, had looked at progressive patient care. She found that the patients liked it but the nurses hated it, finding it, they said, "soul destroying." This conflict of views was explained by the fact that patients on the "conveyor belt" of PPC, stick together in a group from admission to discharge and like it that way. One woman, whose progress was held up, became most anxious to rejoin "her group". Nurses, on the other hand, feel frustrated because they are unable to follow their patients through. Perhaps the solution, someone suggested, was to put the nurses on the conveyor belt too. "No," said the team, "this had been discussed, but wasn't possible."

Failing to find any unhappy patients, "what," asked the team, "were they to study ?" Janet Craig wondered if they were, by undertaking what amounted to a study of patients' attitudes, avoiding looking at themselves ?

Discussion about the team's problem raised the question of nurses accompanying patients to theatre and staying with them until they are anaesthetised. Does a patient like having a nurse to hold her hand ? "No," said the ward sister, firmly. The group were not so sure.

Afraid of doctors

There was, however, one criticism made by patients - of doctors. Patients sometimes feel frightened of them. Nurses in training are afraid too - of admission procedures. "Quite often," they said, "they didn't know what to do unless they had the help of a kindly senior nurse." They felt that their ignorance could lead to bad relationships with patients.

The team from one general hospital whose plan was to discuss the patient's day, reported after their last visit to the Hospital Centre, to their chief nursing officer. They wished to clarify that, as a team, they were not looking at Salmon, but at the patient's day. Some of the main group wondered why they had asked her at all.

This team appears to be having problems in settling down. So far they have not had more than four team members at any meeting. Generally, though, they are looking at the attitudes of the patients to their day and are also talking about the community's reaction to the hospital and vice versa. Are they, too, getting away from personal study ?

The team from a mental hospital with a therapeutic community in its midst was not at all happy. They were unhappy about the report of the last meeting which, they felt, had identified them too clearly. Equally clearly, the team has problems, lack of support from the top being one of them. It was said that most nurses who came to the Hospital Centre from special units of any sort in a psychiatric or general hospital, felt a sense of being alienated from the rest of the hospital. A unique view of one of the problems created by a therapeutic community was presented by one nurse. "Patients," she said, "in a therapeutic community, are bound by no rules at all. Yet the nurses who care for them are subjected to dozens of rules. Why is this ? " Some nurses also felt that the lack of respect for nurses from patients in a therapeutic community made their work more difficult.

The large mixed general and psychiatric group have decided to produce a questionnaire concerning the admission of patients for staff, patients, GPs and consultants.

At the first meeting, a nurse from one of the hospitals which had been subjected to an unpleasant court of inquiry, was present. This time he was accompanied by a colleague. They are keen to take part and will think of a project.

The second part of the film strip on nurse/patient interaction, was shown and discussed for fifteen minutes. Again, not everyone saw its relevance to their own situation. This was especially true of people from mental and mental subnormality hospitals.

This meeting, which created a great deal of emotion, tension and strain and which left everyone tired, showed clearly the gap between the kinds of problems faced by nurses in general, compared with those in mental and mental subnormality hospitals. It showed also that while some hospital teams are off to a good start with their projects, some are running into problems of forming a team and some need to be careful that they are not "escaping into studies about patients rather than about their own attitudes. And, as usual, it was the student nurses who were the least reluctant to question themselves and what they are doing.

CHAPTER FOUR

UNRECOGNISED ACHIEVEMENTS

This meeting was quieter and, perhaps more thoughtful than its predecessor. The emotions engendered at that meeting were not re-awakened but no one appeared complacent. Indeed, considering the short interval between meetings, teams had achieved a great deal - more perhaps than many of them realised.

First was the team from the large mixed general and psychiatric group. They had, they said, "floundered" at their first meeting and had found the problems posed by devising a questionnaire insurmountable. They were not at all sure what they wanted to achieve, but individual team members had done some useful work.

One had discovered that patients in a small general practitioner hospital liked it because they knew everybody, because it was small and because there was a friendly atmosphere. But the team also discovered some anxiety among patients - especially men due to be discharged. They were not sure how soon they could return to work, or indeed, what physical limitations their hospital stay had placed upon them. The team said that one of the medical wards produced a booklet of Do's and Don'ts for coronary patients and wondered if this would be a good idea for all patients. Patients also said they liked to be admitted in groups, that they liked to go to a ward where other patients were recovering and that they found other patients more consoling than staff.

The psychiatric nurse member of the team had tried to get colleagues to talk about attitudes but, he said, nothing much came of it. "There is nothing we can get our teeth into."

"My attitudes are perfect...."

The general nurses were rather more successful. They went back to their hospitals, observed and took notes. A problem for the team is to get time off to attend meetings. One sister had said, "It seems that the sudden craze nowadays is putting everyone off the ward." Asked about taking part in attitudes meetings, another sister said, "I don't really feel these attitudes meetings are important to me - my attitudes are perfect." And another, "If there is a patient I dislike, I dislike him and that's it - I can't help my feelings."

The team's student nurse had discussed attitudes with other students and again there seemed to be a problem of getting time off, of which the following remark, from a sister is perhaps

the most revealing. "Will you be on duty tomorrow, or will you be attending one of your meetings ?"

Stories worth telling

This student also collected a series of incidents and stories which are worth quoting in full because they illustrate clearly the range and kind of problems still to be met in hospitals. Here they are, exactly as she reported them:

. A student nurse who has been feeling under the weather lately visits her doctor. She is diagnosed as having chronic frontal sinusitis and is also anaemic. She is advised to stay away from work for a few days. Thinking it would be better if she took her sick certificate to the nursing officer in question rather than send it, she knocked on the officer's door. On seeing her the nursing officer quickly hid behind her desk, her back to the nurse and said, "You are so bunged up with cold that I don't want to catch your germs - hand me the certificate. Do you know that staff nurse is on her own in the ward ?"

"I am sorry Miss ..... but in this case my health comes first."

Looking at the medical certificate, the nursing officer notices that the girl is anaemic. "You girls are all anaemic," she said, "and you are always in the kitchen."

. A sister shouted right down the ward at the student nurse when she was asked to repeat what she had said.

. A nurse makes the patient aware of the fact that she is a nuisance.

. A night nurse insists on leaving lights on in the sluice which reflect in the ward and keep the patients awake.
On comes the night nurse at 8.15 pm - receives the report. She "dashes" into the ward, gives hot drinks and bed pans, treats pressure areas. This is hurriedly completed by 9.20 pm. Naturally, having been settled, the patients tend to go off to sleep and some do. Come 10.00 pm, asleep or not, they have got to have their sleeping tablets.

. A nurse who looks upon the patient covered with psoriasis as unclean. There is a tendency to avoid such a patient.

. A nurse will not work in harmony with her colleagues. "She may be senior to me but I am older than she is, have children older than she is and therefore although she is in charge, I will not do as she says," - this is sometimes the train of thought.

. "I don't care," said the student nurse, "I have taken my examination and if I pass I won't be staying here anyway."

This team has done a fair bit of work, asking gynaecologists about their attitudes to patients (the need for teamwork and for patients to have time to get to know nurses were among the

answers), anaesthetists and patients whether they thought patients should have a nurse to accompany them to theatre (the anaesthetists said "Yes," all but the most nervous patients said "No,") and asking students which wards they liked best. Students found "they had more confidence in the gynaecological ward and could get on with patients easier than they could in medical wards."

Despite all the work they have done, this team are not sure of their next step. They hope to talk with someone to see if they can simplify their questionnaire. Cross questioning brought out a piece of work carried out by the team's reserve team, work which highlighted the sense of isolation experienced by night staff and the problems created by the fact that such staff regard the night as "their day" and act accordingly, forgetting that to patients it is night time.

Is the study of attitudes a threat ?

Does the study of attitudes create anxiety among other hospital staff ? Is the ward sister typical who said, "I don't like talking to you because I feel you're assessing me all the time." There seems to be a possibility that an attitudes study can have a divisive effect among staff although this team felt that their work was having the opposite effect.

But is the discussion of attitudes threatening ? One charge nurse said that his increased awareness of the need to examine his own attitudes made it harder for him to take decisions. And it is one thing for people to meet at the Hospital Centre to talk about attitudes but what about colleagues in hospital who lack this experience ? Perhaps, as Tom Caine pointed out, the use of the word "attitudes" was threatening. Perhaps the answer lay in getting people to talk about specific problems from which attitudes would emerge.

This team had found itself confused and bogged down by the complexities of preparing a questionnaire. The two people from the mental subnormality hospital which had been the subject of a court of inquiry had no such problems. They had gone ahead with a simple questionnaire which they are circulating widely among staff. At the same time they are talking to staff about attitudes; getting responses which vary from "It's a load of rubbish" to expressions of enthusiasm, with the latter predominating.

Another team from a psychiatric hospital with the therapeutic community in its midst still hadn't got together as a team and one member said, "I don't know whether we'll meet as a team ever. We're still going it alone." But despite this pessimism and despite a principal

nursing officer, who apparently said she didn't understand what the attitudes meetings were all about, this team has done a great deal of useful work.

For a start they have identified much of the aggression and confusion in people's minds who are not members of the therapeutic community and who do not understand it. Many people who criticised the unit had only the haziest idea of its work or of the patients within it. The therapeutic community patients were frequently blamed for incidents caused by patients from other wards; duty doctors called to the unit appeared unsure of their role and the team had found a crucial communications gap about the work of the community between medical staff. "They never talk to our doctors about these things - there's some sort of war going on between the consultants."

And few people outside the unit seem to realise just how changeable it can be. Some patients readily work together as a team but the introduction of a few "high" psychotics can completely change things. "People from outside just haven't a clue. It's a bit of a worry having to go there relieving."

The most significant advance had been made by the nurse who, at the last meeting, had complained about the contradiction in a situation where therapeutic community patients had complete freedom while nurses who cared for them were hedged around with restrictions. She had written to the group secretary, had held a meeting with him and had achieved the setting up of a representative body to review and decide on nurses' home rules.

This team had also arranged to have attitudes discussed during a meeting run by a nursing officer. People had been interested, had wanted a "proper meeting" with someone from the Central Team present. "But," said one of the team, "It all boiled down to nothing in the end. It ended up with everybody at loggerheads with everybody else."
"It always does," said Tom Caine. In the face of all that this team had achieved, Janet Craig's remark, "In two weeks you've come quite a long way," was no exaggeration.

It seemed that most teams felt rather pessimistic but had in fact done a great deal. A third team from a general hospital said they hadn't got far, and felt they "needed to rest and recharge our batteries after the last meeting" had decided to produce two questionnaires in an attempt to pinpoint problem areas within the group to use as a basis for attitudes discussions. The questionnaires would seek to elicit identical information but would differ in phrasing according to whether they were aimed at trained or untrained staff.

This team, whose neglect of the tutorial staff had been highlighted at the last meeting, had now redressed the balance, had put their tutors in the picture and felt they had gained their support.

In addition they had "interested and involved" six students and pupils, looked at the question of nurses' uniforms on the psychiatric unit (finding that men nurses took a laissez faire attitude to the question but that women liked them) and had asked patients for their views about staff attitudes. They were found to be fairly friendly.

It was true, as Paul Sommerfeld pointed out, that this team had made a good start. And, as he said, there was no need to get too hung up on the technicalities of questionnaires.

The safety of patients

At this point there was a discussion about the degree of responsibility that nurses have (or believe they have) for the safety of their patients. It started when someone mentioned that one patient had objected to telling the staff his whereabouts. It made him feel, he said, as if he was being treated like a child. Most people agreed that patients should let them know where they were, even in psychiatric hospitals. "Common courtesy," "You'd do the same at home," "After all, the hospital is the patient's home" were some of the remarks made. Nurses seem to be anxious about this problem; the shadow of the coroner's court looms large and few seemed to accept Tom Caine's view that, in a therapeutic community at least, people had to take a calculated risk in allowing patients the maximum amount of freedom in order to avoid building up their dependence on the institution.

Part three of the film strip, entitled "The Interaction" was shown. On this occasion, the commentary was read by Hazel Edwards and her English accent may have helped get the message across because group discussion on the theme of a deliberative approach to the patient was the liveliest yet. Perhaps Paul Sommerfeld's amusement at the patient's anxiety when faced with the prospect of being seen by her husband without her dentures helped too. Certainly his group took him to task most severely ...

No unhappy patients ?

The fourth team working in the new maternity and gynaecological unit still claim not to have found any really unhappy patients, although some doubts were cast upon this and some people asked if the team had asked the right questions. But perhaps the team is right. Perhaps

the fact that patients are told exactly what is to happen to them and when, is important. Perhaps patients like the reassurance of being in the grip of this kind of routine. They may be on a conveyor belt but it is, as one of the team pointed out, a conveyor belt which moves towards discharge.

Give a dog a bad name ...

Cross questioning did reveal through the more junior nurses, that at least two patients were not happy. This team have come to the conclusion that attitudes between staff are the real problem. One incident illustrates this: apparently all the patients in one side ward were up in arms about the behaviour of one student nurse. She had been late on duty. Her colleagues, about to make the patients' beds, had been asked by them not to do so. They were quite comfortable, they said. So the nurses did not more than tidy them up. When the offending nurse came into the ward she was appalled, called the place a "pig sty" and promptly reported the matter to her senior. The senior's reaction was immediate, "If that's the way you feel," she said, "You go and make them." So the student nurse, now in a furious temper, did so, kicking the linen around the ward and swearing roundly at the patients in the process.

Indefensible conduct ? Perhaps. But could the senior nurse not have handled the matter more skilfully ? And why was the student nurse in a bad mood to begin with ? She was disliked, said the group. Why ? No one really knew but she had "a reputation". "She's that kind of person. It's her whole attitude. She has a problem." "Has anyone asked her why she's unhappy ?" Apparently no one had. But, as someone remarked, "She's labelled now, isn't she ?" And went on, "It is a fact that if you create a bad impression in one ward, your reputation goes before you unless you're lucky enough to get someone to break the chain and give you a chance."

Perhaps the team didn't realise what they'd started with their story. The subsequent discussion showed how relevant this incident was to the whole topic of attitudes. The team had begun by looking at patients attitudes, had found them "happy", then turned to the study of staff and found an immediate problem. Reporting back had lead to a description of an incident widely known among patients, students and staff nurses but to no one higher. It had also identified an unhappy nurse and, possibly, highlighted some of the ways in which she could be helped. As Tom Caine said, "This is what the attitudes meetings are all about. We get off the point because we don't know how to handle people who are difficult." And the need not to become preoccupied with techniques was again emphasised by Paul Sommerfeld,

"Incidents like this illustrate the type of problems we are looking at. Let's try to find out feelings and the interaction of people."

The large mental subnormality team have had two meetings, are doing a fifty item questionnaire, which they are keeping simple so that anyone can answer it. They are also planning to look at Albert Kushlick's work with the mentally subnormal in Wessex. This is part of the student's plan to "take over" a hostel, acquire some handicapped children and run it themselves. So far the plans have come to a full stop until it is known whether GNC regulations will permit such a venture. But the nursing management is sympathetic and the group suggested one or two ways of getting round the legalities. The student nurse doesn't seem deterred by the obstacles.

A sixth team from another large general hospital - who previously confessed themselves shaken by what they had learned of conditions in mental subnormality hospitals, had been talking about attitudes to sisters, staff nurses and students. Sisters gave them a mixed reception - "Too introspective," "Doesn't apply," were among the responses received, but at least, said the team, all the sisters know what we're doing. The staff nurses were enthusiastic but the students were sceptical.

This team has looked at patients' attitudes and found that although many were anxious on admission, some "were reluctant to go home." They also felt that many student nurses find it hard to remember names and diagnoses of all their patients and find it even harder to think of them as people with homes and problems. But, they said, patients still confide in students and many patients still regard sisters as unapproachable.

Staff-nurse-itis

The team's student nurse has been moving round the hospital and talking to all sorts of people about all kinds of problems. There is, for example, the problem of "staff-nurse-itis." This afflicts the newly qualified. "One minute they're talking to you, next minute they're not. Then they become sisters and cut you dead in the corridor." Students had told her that all but two of the nursing administrative staff were unsympathetic; that their problems were either dismissed as soon as their backs were turned, or were received negatively. All those she spoke to, she said, echoed the same sentiment "Nobody cares," a feeling increased by the way sick nurses were treated. They were expected to get back on duty as quickly as possible, regardless. This is not peculiar to nurses. A receptionist told her the same thing.

People also felt there was a rift between the education staff and nursing staff and that some nursing administrators were disloyal to their hospital. (This later lead to a discussion about the numbers of middle managers who used their hospitals as stepping stones to higher posts, creating as many changes as quickly as possible in the process). And some of the other problems are drearily familiar; students feeling guilty about talking to patients, the need for "more psychology" in training so that nurses can relate to patients more efficiently rather than learning by "Putting our feet in it."

One or two people who had missed the chance to report back during the morning session had their say and discussion centred around open visiting, the conflicting attitudes of obstetricians and paediatricians about the presence of visitors' children in the ward and the conflicts between night and day staff. Internal rotation of night duty had resolved this in one hospital.

Do psychiatric and general nurses feel that this kind of broadly based discussion is relevant ? Most do apparently, because no one really took up Janet Craig's question about dividing the meeting into two main groups with any enthusiasm. Nor was there an obvious response to her suggestion that those teams who find it hard to get together in hospital time should use the days set aside for meeting at the Hospital Centre for a hospital based meeting.

Ward sisters in general hospitals who doubt the value of ward meetings, or who claim they are too busy, should have heard the tape made by one of their colleagues*. She, having read the reports "A Question of Attitudes" and being impressed, set up fortnightly meetings in her own busy general ward. She described, in detail, the trials and tribulations, and the rewards of such a venture and, it seems, many tensions were dissipated and several problems solved as a result of her efforts and of her willingness to listen to and to accept criticism. The Hospital Centre has produced a typescript of this tape as a reprint.

* See chapter twelve

CHAPTER FIVE
QUESTIONNAIRES AND A STORY

Two of the four teams present dealt in detail with the questionnaires they have been using as a basis for their projects. The questionnaires showed two totally different methods but were, basically, getting remarkably similar results.

The enthusiasm of the small team from the mental subnormality hospital which is still suffering from the effects of a court of inquiry, has more than made up for their late start at these meetings. Its nine item questionnaire, simple in style, and trying to assess nurses' attitudes to the future pattern of care - and community involvement very much in the foreground - had been delivered by hand to respondents and replies are still coming in. The team made no secret of its intention to create enthusiasm, to encourage "positive thinking" and reported a heartening level of enthusiasm and interest among those approached.

If nothing else this questionnaire showed how concerned mental subnormality nurses are about their future; how many of them feel, with a great deal of justification, that "all the perks are being taken away from us" and some, certainly, are prepared to do something about it.

Although the questionnaire can be criticised (and was by the student nurse member of the team) on the grounds that it has little to do with attitudes, the response it is pulling in and the enthusiasm it is creating among hospital staff of all kinds show it to be a worthwhile exercise. It is a very good beginning and if the team involve other members of the staff in analysing it and use the problems it throws up as the basis for discussion, it should prove a most useful tool.

As an example of the different responses the questionnaire brought out, the answers to questions 1, 2 and 6 given respectively by a male nursing assistant and a nursing officer are of interest.

Question 1	How do you see the future role of hospitals for the mentally subnormal ?
Answer (N/A)	"Cushy."
(NO)	"I see the future as a progression of present trends, ie small units, intensive therapy, a move towards hostels for the low

	dependency patient with subnormality nursing attaining its rightful place as a very skilled profession."
Question 2	How do you see the future role of the nurse in the hospital for the subnormal ?
Answer (N/A)	"Cushy."
(NO)	"As a coordinator of the total care of the patient with the image of a house parent providing a figurehead for the family group. The vital role of the nurse serving to establish family groups."
Question 6	What kind of changes would you like to see from the nurses' point of view in the future ?
Answer (N/A)	"None."
(NO)	"Better conditions of service to include more pleasant working surroundings, MORE PAY, MORE NURSES."

Excitement

This questionnaire led to a great deal of excited discussion and to some disagreement from the student nurse. His own distribution of questionnaires had achieved a negative response. In contrast with his colleagues, who had presented questionnaires personally to each respondent, the student had merely left them in people's rooms. He failed to see, he said, why anyone should be coerced into completing a questionnaire and did not appear surprised at the apathy he had found. But generally people felt that this hospital had made a good start and that the questionnaire was the beginning of something exciting.

The other questionnaire, from the only general hospital team present (the rest being unable to attend because of a rail go-slow), was lengthier, much more complex, much more carefully structured. In fact, this group had produced two questionnaires, one for nurses in training and one for trained staff. They too, had presented their questionnaires most carefully. Nurses in training had been invited to a committee room to fill them in. The team felt that this would mean that the nurses "would not feel that sister was looking over their shoulders." This also gave the team members the chance to help people with the questions and to put them at ease.

No one to turn to

Trained nurses received their questionnaires from a nursing officer and returned them completed to a named member of the team. The team, which has received an excellent response, reported on its preliminary findings in detail and some dichotomy between the views of senior and junior nurses became apparent. Perhaps the most revealing centred

around the person who the junior nurse felt she could approach in time of trouble. Pupil nurses felt they could go to the tutor or home warden. But students felt they had no one to turn to.

Comments included "Only my best friend." "It (the problem) would spread around the hospital like wildfire - all the senior members of the staff seem to do is gossip." And about going sick, relationships with seniors and views on the profession, "You're not allowed to go off sick until you're dropping." "I personally detest sarcasm and being made to feel small - which is why I find it hard to approach senior staff." "Anyone thinking of taking up nursing, I would put them off." This last, incidentally, from a student nurse, who said, in the same questionnaire, that she received satisfaction from her job.

As with the simple questionnaire (which has since been adopted in its entirety by another hospital), this questionnaire raises exciting opportunities for further discussion and, hopefully for action.

Another large mental subnormality hospital, which said it had become "bogged down" with its questionnaire and which has borrowed the questionnaire, has made progress on two fronts. The "revolutionary" project for student nurses to take over and run their own hostel for children has received sympathetic attention from the group's chief nursing officer, who, it was said, was rumoured to be looking for a suitable building. An "off the record" chat with an officer from the General Nursing Council seemed to show that the GNC would place no major obstacles in the way of the project provided the problems of responsibility for drugs and twenty-four hour coverage could be overcome.

A revolutionary move

An even more revolutionary move, in the world of hospitals at any rate, was the sending of a swingeing letter from the hospital's student nurses' association to a "wide range of interested people" including press, radio and TV. The letter, timed to reach a local member of Parliament before a question on the hospital was raised in the House of Commons, set out in no uncertain terms the hospital's condition (described as "deplorable") criticised the lack of community care and demanded action on the nine month old report from the Hospital Advisory Service. "What we feel is needed," said the letter, "is a complete rebuilding and a radical change in the approach to the mentally subnormal." This hospital is not one to hide either its light or its problems under a bushel and the meeting, impressed by this example of pressure

applied in the right places, wondered if hospitals such as Ely and Farleigh would like to send follow-up letters in a similar vein. Although the original letter had to be sent in a hurry, photocopies had been circulated among the staff and it was estimated that the letter would have borne four hundred signatures if time had allowed.

This letter and discussion on the questionnaires were the high points of the day. But in general discussion some other familiar problems emerged. The team looking at attitudes in a therapeutic community and attempting to compare them with the rest of the hospital had found this task harder than anticipated. They are now looking generally at staff attitudes towards each other and towards patients. One member had held a meeting with the night staff which revealed that they did not feel involved in the activities of the hospital; that there was little communication between night and day staff and that the night staff often received blame for the day staff's shortcomings. A familiar problem. But one being coped with in some hospitals by the appointment of a senior officer to night duty who is allowed to arrange his working hours as he sees fit. Such a person can be seen to be representative of the night staff's interests. Internal rotation of night duty solved the problems in some hospitals but not in others.

This group is still trying to hold a meeting of the full team but nonetheless reported optimistically on the work they were doing. People generally, they said, are interested and enthusiastic. Even consultants are consulting with staff but "it is very hard to get the overall picture - there is so much going on - Salmon, appraisal forms. People get mixed up."

The story of Peter

A guest at the meeting was Ali Baquer who described his project on coordinating services for the mentally handicapped. This set out to involve the providers of services in identifying their own needs, designing their own questionnaires about the quality of services provided and because they were involved, led them to take action. He commented upon the questionnaires that the teams were using and said, "Any questionnaire can be improved, but the main thing is that when people come together to ask the right questions, to ask themselves what is really happening."

His work has shown gaps in the services provided; gaps now termed illuminative incidents, which could be used as valuable teaching tools. He gave, as one example, the story of Peter, aged 16, who heard of a job going outside hospital and asked for it. The medical

officer referred the case to the social worker. Peter got the job, walked out of the hospital on the way to work and was run over. Many people in the hospital, the psychologist, people in the occupational therapy department and the ward staff, all knew that Peter had no road sense. But for various reasons, some involving personal antagonisms, no one communicated this fact. Examples such as this, once guilt and the fear of accountability have been overcome, are excellent teaching material. Nurses, faced with the aftermath of successful suicides, have similar problems.

With only one general hospital present, the enormity of the problems faced by mental subnormality nurses was again highlighted. As one general nurse said, "I feel very isolated from you. Our problems are so minor in comparison." The mental subnormality nurses disagreed. "This is not true. Every hospital has its problems, and your problems are major to you." This is no doubt true but mental subnormality nurses are aware in a way that perhaps their general hospital colleagues are not. They are aware of their problems and above all, aware of the need to do something about them. The action taken and the enthusiasm shown by the mental subnormality nurses at this meeting makes this abundantly clear.

CHAPTER SIX
A SALUTARY EXPERIENCE

If seeing ourselves as others see us is salutary then this meeting underwent a salutary experience. The person who saw "us", warts and all, was a nineteen year old American girl who has spent several months working in Britain, first as a nursing auxiliary in a new general hospital and then as a nursing assistant in a large psychiatric hospital. Her experiences leave little room for complacency.

As a nursing auxiliary in a general hospital she was made aware of her total lack of status. She was "punished" by reprimand, for talking with patients and, worse crime of all, for asking questions of the medical staff. She was told never to sit by patients and found that the ward sister would only talk to her while no other nurses were present. Generally speaking she had a miserable time. Even her observations about patients were ignored. It was as if someone as lowly as a nursing auxiliary could not possibly have anything of value to contribute.

Then she moved to the large psychiatric hospital and, she said, "Found salvation. It was totally different. If I were the person with a patient my views were listened to. At my other hospital my views weren't listened to. Not being able to speak to a patient is something in a general hospital which really should be changed."

To the credit of this meeting there were few people who tried to pretend that this was an isolated case. In fact her experience reflected that of many other people. But why did it happen ?

Is one reason the fact that, she, as a nursing auxiliary in a general hospital, was in a minority ? One speaker suggested that in hospitals where the majority of staff were nursing auxiliaries, the reverse could apply. "Students get the dirty jobs. I wonder if it's anything to do with the majority having the upper hand ?"

Fear of involvement

Is it bad management by the ward sister ? Or is it, as someone said, "This rotten class system we work in. We've got patients, students, staff nurses, the lot. Patients react like we expect them to. But when we meet them in a pub, we become human beings." Do people, in other words, react as others expect them to ? This meeting suggested that they do. "But some ward sisters are expected to react like this by students." "Patients expect nurses to react in a certain

way." "We expect patients to react in a certain way." "We all look down on patients."

But part of the problem, apart from the complexity of the whole subject of attitudes, may lie with fear of involvement. It's not easy, always, to become involved, to cope with pain and suffering and we may, as one or two people suggested, "Build a shell around us." Some people thought that nurses in general hospitals do become involved with their patients; others disagreed. Some considered it a weakness to show affection to patients, others wondered how far it should be taken. In general hospitals there is intimate contact by touch. Does this make a difference ? And what of the charge nurse who asked, "If my wife cries I put my arms around her. But if a young girl patient cries, do I put my arms around her ?"

Perhaps the cause of the problem lies with the word "patient". This was suggested by Tom Caine who said, "I think the word patient should be abolished. They are people like us. To classify people in a group is the root of all prejudice." "You're being awfully idealistic," said someone.

Many questions and no clear answers. Perhaps this is why the meeting turned, briefly, to a discussion of the pros and cons of using first names. But this too brought them back to involvement; to stories of emotionally upset nurses who lacked support, to the need to let people see that we, as nurses, care for people's suffering and grief and, by definition, for the need for someone to support nurses who offer such solace. And, it seemed, that while no clear-cut answers emerged, people were generally in agreement that involvement was not a bad thing but that it was hard to practice it in a framework of formality.

"You don't have bad attitudes between nurses"

Reporting back from hospital teams showed some interesting problems. Students in a gynaecologi unit had held a meeting with members of their set. It was not easy. "We had our tutor there. We had to be careful what we said because we didn't want to upset her." It emerged, though, that the tutor was pretty blinkered. When one student said, "If attitudes between nurses are bad, it'll come out on the patients," she replied, "You don't have bad attitudes between nurses. This lady stoutly refused to believe that wards had any shortcomings at all, either in staff or equipment and obviously labelled some of her students. One said, "Every time I get my ward report she says, "Still speaking up, I see." And another, "I was called Bernadette Devlin II by one of our tutors." But then this seems a rather old fashioned hospital where change is hard to achieve because the matron runs everything. "If you lose an apron you have to report it to matron. You have to do everything through her. It's a complete breakdown."

The large general hospital group has now implemented its new patients' day and felt rather optimistic about the results and about the progress it is making with discussions of attitudes. The nursing officer had held three meetings and had received an invitation to "sit in" at a medical committee meeting. She said "There is lots of cooperation and goodwill."

But the student nurse member of the team, as always, was not so happy. In fact she was upset because the nurses' representative council in her hospital was defunct. The PNO wanted to start it again because she "wanted better cooperation throughout the hospital. Students have been talking among themselves and are not happy. Everyone feels that the move to the new site is a terrible change. Morale dropped badly because of changes at the top and because of Salmon. Everything just fell to pieces ....."

This hospital, everyone agreed, is the most formal of all those attending the meetings. The student and the nursing officer both felt this. The student said, "I hate this formality. But I can't drop it here (the Hospital Centre). After all, I am the student." The nursing officer: "It is formal. Salmon came in in a very formal way ..." Apparently even complaints which could be dealt with informally have to be processed according to the Salmon structure.

As Tom Caine said, "You're going to have a great deal of difficulty in discussing attitudes in such a formal setting."

Despite the admission of formality, people from the hospital felt that "attitudes are good, there are only minor problems," and they stoutly defended their hospital against some critical remarks. But even their answers showed that all is not well. As one student said of her colleagues, "They say 'If I'd known what this hospital was like administratively, I wouldn't have come.'" But, she added, "They love nursing, which is why attitudes are right."

And what happens to nurses who get emotionally upset ? "Usually they go home and talk to their flat mates." The ward sister: "They'd go to their nursing officer." The student: "No, we wouldn't."

A confused CNO

The mixed group confessed themselves bogged down and decided to look at admissions and discharges. They have found some gaps in the discharge services and have arranged a meeting

with the PNO of the district nursing service to work towards better liaison. They have also tried to reorganise admissions to fit in with the 40 hour week but came unstuck when a consultant wanted patients admitted before he did his morning ward rounds. They are now revising the scheme.

Their CNO attended one of their meetings and then wrote to each member of the team. She said, "I found myself confused. The team appeared divided: some were objective, some subjective. Time and again individuals were trying to rationalise their own attitudes. After three meetings in London I am not sure that the team is clear about the differences between attitudes and personality ..." The team "found this interesting. After looking at this we decided to come down to brass tacks and start looking at mechanisms."

The students took a precis of all the meetings to their tutors. This "opened their eyes a bit because they felt there were things they could have told us in school." The school has now agreed that the team can talk to new sets of student and pupil nurses.

The large mental subnormality group have had two meetings, have formed a project team to look at the resources of the hospital and to try and develop them for the use of the patients and have been given a grant of cash to visit other hospitals. "We have also got a hot line to the chief officer executive."

They have discovered some anomalies in the present industrial and occupational therapy set up (due to staff conflicts), feel that the patients' school is not fully used and are working hard to put these right.

According to the students' grapevine the CNO is looking at a five bedroomed house. But they're not sure if this is for their hostel project, a new nurses home or for the CNO himself.

The small mental subnormality hospital is now engaged in following up the results of its questionnaire.

The psychiatric hospital group have still not managed to meet as a team but have had a large meeting "well attended by all grades of staff" at which they looked at the "validity of the whole subject of attitudes." People generally were glad of the chance to talk about attitudes and some anger and aggression were expressed. Two of the team met the CNO and felt that, although people were interested, "We were not making a terrible lot of progress." It is, as Janet Craig pointed out, hard to assess progress, but she said, "I am sure you've created a climate where people can talk."

CHAPTER SEVEN
A REACTION

Some people who attended these meetings were surprised that so much emphasis was placed on the views of the American nursing auxiliary in the last chapter. One person couldn't even remember anything the girl had said. Prepared though they were to accept that what she said had been said in good faith, several people were inclined to regard her experiences as isolated incidents, ones which certainly could not happen in their hospitals.

The girl did not believe the incidents to be isolated. The hospital in which she had suffered - one of a group - was considered better than many others in this respect. Nor was such treatment meted out solely to nursing auxiliaries. Student nurses came in for the same kind of thing.

Perhaps, somebody suggested, she was too intelligent, asked too many questions. Perhaps some nursing auxiliaries preferred not to be intelligently involved in what went on in the ward. Perhaps too, she had it coming in other ways. She was a newcomer and therefore should expect a period of strangeness, of isolation. As one student nurse said, "If I had a new person I would probably have snapped at her and told her not to talk to patients because of the stress on me. Anybody new to the profession is going to get snapped at more."

Perhaps it is a group thing. Strangers in any group - not just nursing - can feel isolated and outside. And perhaps also the girl suffered because she bucked the system. Perhaps she shouldn't have spoken to a patient already under pre-medication. But, as she said, "It's like treating a vegetable. For a terrified woman how much harm is it going to do to calm her ? Should you leave a patient crying and utterly miserable just because she's had her pre-med ?"

Many reasons for the incidents were put forward, including the fact that the girl had chosen to look at nursing as a nursing auxiliary rather than go the whole hog and train as a student. Some people thought she was fortunate to be able to pick and choose; some put it down to her intelligence and others thought the problem could be related to the size of the hospital, its location, its situation and its style of management. It seemed, at one point, that people were more concerned to rationalise the girl's statements than to discuss the implications of what she had said.

An unhappy tale

Unfortunately, the discussion could not continue because two hospital teams had yet to report

back. An unhappy tale emerged from the psychiatric hospital with the therapeutic community when the charge nurse member of the team began his report with the uncompromising statement, "I am here under duress." It appears that life, for him, was such a hectic round of ward and staff meetings and he was so short of staff that he had originally refused to attend this meeting, backed in this decision, it should be added, by his ward staff. A veiled indication from a superior (that non attendance "would affect his future") made him come. He said, "I would say more, but I would get it back."

"Is this true ?" he was asked. "It may be a fantasy for me. At work they can chop me for a No 7's job ?"

"Who's they ?"

"My fantasy is the No 7 'They'. My fantasy is that they would put me on a geriatric ward and I don't want to move. Therefore I don't talk."

Questioning revealed an apparently sad state of affairs in this hospital. It showed, according to this nurse, innumerable meetings, chronic staff shortages, ward problems, a CNO who was in favour of the attitudes meetings and one to whom he delegated, who "created hell when things went wrong." It was a gloomy picture. It was not, however, shared in its entirety by one other member of the team who wondered whether the charge nurse's problems would be so acute if his ward management was better. The student nurse member of the team remained silent.

But despite this and despite the inability of the team to hold any meetings as a team, the charge nurse, when asked what he had gained from these meetings said, "I've been able to look at the hospital from a distance, and to meet people."

One of the general hospital groups has gone a long way. Apart from holding a general meeting for about 80 people (with members of the Hospital Centre supporters), they have also begun to see changes in people at the hospital. As one of them said, "Everyone enjoyed the meeting, especially the nurses in training. We felt we were looking at ourselves, why we did things, that we were being self critical. We're beginning to see a little bit of change in this hospital." This impression of change was supported by a senior nursing officer who said, "Nurses are now prepared to speak out more. One said to me, 'I know that we can come and talk to you.'"

Their big group meeting, divided into syndicates to discuss items from the teams' questionnaires, had thrown up a variety of problems. Subjects ranged from the presence of students at ward medical rounds, through calling patients and nurses by their first names, to allowing nurses in training time to see and to comment on their ward reports and to the need for newly qualified nurses to have help in learning ward administration and the problems of coping with relatives.

Group reports from this meeting showed up a variety of views and approaches to problems by ward sisters. Plenty of anxiety was expressed, plenty of problems aired and some suggestions for improvement made.

CHAPTER EIGHT
THE PROBLEMS OF THE CNOs

It may hearten the attitudes teams to know that several of their seniors suffered problems, anxieties and stress as a result of their meetings. They may also like to know that in the eyes of their CNOs, the meetings have had impact, have improved attitudes and are considered worthwhile.

Information emerged from this meeting which the Hospital Centre team hadn't known before. They hadn't been told, for example, that many teams felt that pressure was being exerted on them in several ways, from other teams (in terms of critical comments about their hospitals and in a rather more subtle fashion where "successful" teams made those whose progress was slower feel inadequate), pressure from the Hospital Centre itself and from the prospect of reporting back at the October meeting.

Pressure from the Hospital Centre apparently stems from a belief among team members that they are expected to produce results. This is not so. The Hospital Centre team is interested only in experiences. Experience of difficulties is as valuable as the experiences of teams whose progress has been smoother.

And the October meeting is looming large in some people's minds. They feel again that the Hospital Centre will want results. It cannot be stressed too often that the only thing required will be an account of experiences. It is far too early to measure results, indeed far too soon to expect any.

Teams also suffered trauma. Some, whose progress had seemed smooth met with problems along the way. Their problems appeared at their most acute while they were trying to decide precisely what to do. Once that decision was made, life became easier. In fact the very process of suffering together probably served to weld a group of people (chosen in different ways for different reasons) into a team in the real sense.

In several cases the teams' traumas were shared by their CNOs. One was quite overwhelmed by her feelings of inadequacy in the face of her team's pleas for help. She said, "I felt, 'oh, why did I get involved in this - I must ask the Hospital Centre for help.' But I felt I had to see it through." And she did (she can't say how precisely) but "I went to a psychiatrist actually. He could not help except to raise my morale."

Another CNO became quite worried because her team hadn't asked for help. She eventually put this down to the fact that she was habitually in frequent contact with the nursing officer helping with the project and to the fact that her hospital group has been undergoing change for some time. The introduction of staff appraisal meant, she felt, that "everybody had some kind of trauma." The team were looking at the problem of assessing student nurses and this helped because traumas were shared.

The six meetings at the Hospital Centre have had impact in almost every hospital. Some nurses have changed their attitudes for the better (according to their CNOs) and in some areas communications between various disciplines have been opened up for the first time. Even those hospitals where progress has been slow reported an increased awareness of hospital problems and with the exception of those not present to express their feelings, it appears that every CNO learned something from the series.

The Hospital Centre team learned something too. Apart from the information about the teams' expectations and fears, they learned that some team members sensed the uncertainty felt by the Hospital Centre team itself and realised that they were not (indeed could not) be merely detached observers. In their own way the Hospital Centre team has lived through the experience as the hospital teams have.

One of the problems which came to light was the pressure sometimes exerted on teams - and on some CNOs by these reports. Despite their anonymity, several people believed they could identify themselves or their colleagues. This added to the pressure. One general hospital group made a point of reporting everything they had said to their CNO in case "it got back to her." And one CNO was threatened with an infuriated nursing officer's resignation because the latter believed she had been the subject of some critical comment. This threat was not carried out because it gave the opportunity to examine the cause of unrest in open discussion and a better understanding prevailed.

All agreed that the meetings were worthwhile and should continue. The question "What next ?" led to the problem of involving people from other disciplines, notably doctors, in a future series. Some doctors apparently don't see the point at all and think such meetings a waste of time. Janet Craig said some fear them as "dangerous". And some feel that nurses are getting above themselves. One consultant asked his CNO ".... to let me have some more pupil nurses. They don't ask so many questions." Perhaps some doctors feel left out or insecure. But if doctors and people from other disciplines are to be involved, the discussions must be relevant to their problems and not solely to those of nurses. In any event it is likely to be a "hot potato" as someone put it. Attitudes to patients must surely be a

common problem.

And that, more or less, is where the meeting ended. It is to be hoped that the CNOs in their reporting back, told their teams what Janet Craig said "We are not asking for results. If they (the teams) feel they've failed, it is important that they should say why they feel this way. All the teams have worked hard. Whatever they say or do will be of benefit.

CHAPTER NINE

REPORTING BACK
By Shirley Hardy

The great day had arrived at last; the culmination of nearly a year's work for the teams, the day on which they reported on their projects to their nursing officers and a wider audience of nurses from other hospital groups. This was the project teams' own meeting, with their own programme and their own chairman, Terry Bishop, a student nurse from Farleigh Hospital. Before he introduced the teams, Janet Craig explained the history of the series of meetings and said that the participants in this third series had learnt from each other and achieved a great deal during the year. The work on attitudes which they had undertaken was now attracting international interest and one of the teams had been invited to go to Belgium to talk about the work.

Confusion and problems

The first team to report was made up of psychiatric nurses from the St Birinus Group of Hospitals. They had chosen to look at the attitudes of nurses towards patients and in beginning by looking at their own attitudes, had realised that people were either sure that they had good attitudes, or if they had bad ones would not admit to them. The team had, however, resisted the temptation to escape into questionnaires at this point and had gone on to decide that nurses did not have attitudes to patients as such but to people in general and that these attitudes were influenced and created in all sorts of ways, for example, individuals or types of people were given labels by the press which influenced the attitudes of readers towards them. Attitudes might also be coloured by what the patients represented to the nurse rather than what they really were.

This team included a pupil nurse who had conducted her own project among her fellow residents in the nurses' home. They were upset that patients in the hospital's therapeutic unit appeared to have more freedom than the nurses in the home, and felt that nurses who were expected to carry considerable responsibility in their work were not given equal responsibility for their private lives. They had organised a residents' committee and held meetings with the group secretary and the nursing officer to try and bring about changes in the rules, but they had not been successful because the hospital felt itself to be responsible for young learners. The residents were very disappointed and, the pupil nurses said, felt just like any other employee. They felt that they were only working for their money until the end of their training, when they would leave the hospital with nothing changed.

A charge nurse who worked in the hospital's therapeutic unit had made the attitudes that surrounded this specialised treatment situation his special project. He described the treatment programme and said that the unit staff worked differently to nurses in other parts of the hospital because they did not wear uniform and were all on first name terms, from psychiatrist to student nurse. They felt that they were treated as outcasts by the rest of the hospital staff who complained that the unit nurses were always at meetings and got no proper nursing done. The patients were given considerable freedom while most outsiders thought they needed a firm hand and were quick to say "I told you so" after a crisis. The unit staff had invited their colleagues to attend unit meetings but the invitations had not been taken up. However, as a result of the work of the attitudes project team, there did now seem to be an increased awareness among the nurses in general of the work which was involved and the team approach to running a unit. Another nursing officer said that he had wanted to look at the attitudes of nurses in relation to community treatment but had found that they reflected the attitudes of the community in general. He had, for example, begun by feeling strongly about the attitude of part of the hospital to the therapeutic unit as already described, until he realised that this reflected the attitude of the community at large, outside the hospital.

Summing up, this team said that they had started out with great enthusiasm but that this had not lasted because they had not felt supported within the hospital. They had been confused by the wide objectives set by the Hospital Centre and by the regular reporting back from the teams at each meeting, which had seemed to suggest that some teams were progressing much better than they were. This, added to the feeling of lack of support, had been very dampening. The details included in the reports of the meetings at the Hospital Centre had also added to their difficulties. A questioner then asked this team whether their "knocking" of their hospital administration was really justified. The team said that their officers had given what help they could but that it had been difficult to arrange meetings because the hospital was very short of staff. This might have been misinterpreted as a lack of cooperation. The team had also been very unsure itself as to what sort of support they wanted. They had been very unclear as to how the Hospital Centre could support the team. Asked whether the staff shortages accounted for the lack of interest towards the project in the hospital, the team said that the interest had been there, but that the shortages had added to the problem of getting together. They could not have arranged a back-up team as had happened in another group. The team were then asked about their use of the phrase "escape into questionnaires" and said that they had felt from the start that a better picture could be gained from open meetings than from anonymous questionnaires.

Nurses attitudes to each other

A team from the Portsmouth Group of Hospitals said that they had chosen to tackle the subject from the patient's point of view. They had looked at the attitude of patients towards being nursed in a new maternity unit and an upgraded gynaecological unit as against those who had been cared for in the old buildings. The patients had reported favourably on the appearance of the new buildings, the availability of information and the friendly staff, but had made no suggestions as to possible improvements. The nurses had, therefore, abandoned this project. They felt because they had found no complaints, teams from other groups had thought their attitude complacent.

They had gone on instead to look at staff attitudes to each other through a series of meetings. They had found that the SEN often got a raw deal as she was responsible for the ward at one minute and subordinate to the third year student the next. The SEN had special practical skills, and a nurses' status should relate to being the most suitable person to tackle a particular task. The pupil nurses had said that they were upset by the kind of trivial incident which could easily have been avoided, having to spend precious off duty time looking for a uniform which had been lost in the laundry, and for which the nurse not the laundry was blamed, and by the need constantly to relearn procedures on each new ward, and the "when you are on my ward you do it my way" attitude of some sisters. The project team felt that there should be someone outside the service area who could cope with these sorts of problems and save small worries festering into large sores. This might be a personnel officer who was known to be outside the mainstream of management and who would deal with problems with confidentiality. The public should understand that nurses were only human and needed to behave that way, even if only to a personnel officer. The team had, however, been encouraged by the realisation that the problems which existed in some of the other groups had been largely overcome in their own.

A sister from this team said that she had looked particularly at the attitudes of staff to one another and had sat in at unit meetings of all types, leaving interviews and so on. Her observations had pointed to a need for integration programmes to help newcomers to meet the other members of staff and to increased consideration towards students and junior trained staff who made ward changes. These young nurses worried about not being shown how to do things and where to find things on their new wards and the onus was on ward sisters to cover this before they started work. There was also a need to standardise and simplify procedures and storage arrangements throughout the group to save time on this. Her observations had also indicated that personality clashes did lead to problems which could be reduced by more

first line management, and had revealed criticism of administrators for not appearing to work, which could be avoided if nursing officers involved staff more deeply in their work of planning. It was unfortunate that some nursing officers appeared to have been selected without reference to their personality or ability to manage others.

The student nurse in this group said that she had been on the gynaecological unit at the start of the project and had decided to talk about it to the sister and all grades of staff. She had found that while students and pupils felt that they got on well with each other and with all other staff, they wanted ward sisters to give more time to their schedules and reports. They often had to go back to complete these after they had left a ward and when they felt that the sister could no longer remember their work well. The training school was in one of the three hospitals in the group and in the other two hospitals the students never saw the tutors and lacked contact with the school. They would welcome a channel of communication to deal with problems both inside and outside the work situation. Many students did not find their sister very approachable, could not get another member of the team to take an interest in their problems and would welcome a personnel officer. Nurses who lived in found that the home warden was a very useful person to talk to. They could ask advice without worrying if it would lead to any rebound.

The last speaker from this team, a nursing auxiliary, said that she still felt external to the whole problem of attitudes. She had been made more aware of them but did not feel qualified to help. She did not even know what the word "attitude" meant. She thought there was a need to communicate and break barriers rather than to stick to safe, set attitudes in a formal setting such as a meeting, and although she was aware of problems in a ward where the two sisters had a very different way of doing things, she had not followed this up. She had been pleased that visiting times in the maternity ward had been extended as a result of the project but she would have liked to exchange her place with somebody who could get more out of the experience. She was very happy. The student said that there were clinical teachers in the group, but they were few in number and could only cover a small number of wards. The students did not see them very often, but when they did, they were very helpful. Asked about the attitude of patients' relatives to the system of progressive patient care in the gynaecological unit, the nurses said that there was a location board which was kept up to date and the relatives were warned to check each night for changes. There had been some problems because learners could not get a complete picture of a patient's progress through the unit but since this study started, students working in the convalescent area now had an opportunity to spend a day on admission, take a patient down to theatre and then meet the patient again when she came into the convalescent area. The team were then asked how they

had been selected and said that this was because they had been working in the new wards at the start of the series, but that two SENs had had to drop out because of moves away from the group.

Getting people talking

The difficulties of starting on their attitudes project were described by the team from the West Suffolk Hospitals Group. They said that they had had an initial chat with their supporting officer and had been told that they would have a free hand. They had had a very vague idea of what they wanted to do with this but had thought they might do their project on assessment. They had found the train journeys to London a useful opportunity for discussion and the meetings at the Hospital Centre a vital stimulus to encourage them to keep going and a source of guidance and ideas from the other teams for the next step. They had realised that attitudes were very personal and hard to admit even to oneself. Their eyes had been opened by the exchange of views and especially to the conditions in hospitals for the mentally handicapped.

The team had decided to involve the other staff in the group through a series of nine meetings. It had proved quite easy to get at the trained staff through unit meetings and they had prepared two types of questionnaires with similar questions to distribute to their trained and untrained staff. The questions reflected the wishes of the nurses who had been at the meetings. Prodded by the other teams at a Hospital Centre meeting, they had sought the help of the tutors to make the questionnaires objective. The nurses were then asked to complete them, giving their status through not their names, and they were put in a sealed ballot box. The analysis of the questionnaires had been done by two team members and a report compiled. The answers had been very frank and revealed an interesting difference between the views of the trained and untrained staff.

The questionnaires had set the hospital talking about attitudes and the team arranged two smallimeetings based on the Hospital Centre notes. There had been a poor response from the learners who were invited but the meetings with trained staff had gone well. They then organised a larger meeting which was attended by about eighty people and led by Tom Caine and Lucienne Arnott from the Hospital Centre team. This meeting divided into small groups and produced some very free discussion. The next step, which had taken them away from their project topic, was the establishment of monthly informal meetings called "come and get together sessions". An evening meeting in the nurses' home was less successful than

lunch time meetings to which all heads of departments had been invited to send representatives. Participants talked round many aspects of patient care and aired problems and interdepartmental grievances. Some proved illuminating, eg the fact that a porter had been suspended for two days for calling the matron "Dear"! One outcome of this lunch time meeting was that porters are able to receive training in lifting patients by the physiotherapists.

They were continuing with these meetings and nudging other departments to send representatives. They had been surprised by the informality which had been achieved and were considering involving the other hospitals in the group, although they did not relish the additional work that this would involve. They also felt that it was essential to bring in the medical staff but did not know how to go about this. They had supplied regular progress reports to their supporting staff who were very interested, but the team had not asked for much actual help from them. The chairman of the HMC and the group secretary had also been interested and had read the literature. The team thought that the project had made some impact in the hospital and had certainly helped them personally. It had been hard work but they felt it had been enjoyable and worthwhile.

The team were then asked why they had used questionnaires and they said that it was to draw out topics for discussion in the groups and to highlight differences of opinion on topics between the various grades of staff. Individuals were able to express their views in a questionnaire without feeling threatened and the eventual discussion was much freer. The hospital staff might not have been talking about attitudes but they were talking. Tom Caine agreed that the questionnaires acted as a focus and could show that what was actually happening was different to what people thought was happening. Asked why the student nurses had been apathetic towards the project, the team said that they thought it was partly because of their hectic lives outside working hours and partly because they did not realise what was involved and saw the sessions as "just another meeting". This provoked the thought that nurses had, perhaps too many meetings to attend and a comment from a CNO that he spent 70 per cent of his week at meetings or on work connected with meetings. When the team asked the audience how they could get nurses together except by calling a meeting, the same CNO suggested that they "call the meeting a jamboree and offer free beer."

Apathy and attitudes

A period of general discussion followed and the first speaker took up the question of student apathy. She said that it had been eighteen months since a student brought her a schedule to complete and that although they were given appointments for this they did not turn up. The students at the meeting seemed to think that the problem was mostly the other way round and that they had to keep pressing their sisters to complete schedules, sometimes months after they had left a ward. They usually kept their schedules to offer to the sister in the last week of an allocation, to avoid any risk of their getting lost in the meantime. When this happened, a sister pointed out that a very busy final week might make the completion of schedules impossible. She asked for schedules to be handed in at the beginning of an allocation and then filled them in as she went along. This meant that she was not tied to the last week when there might be a crisis in the ward. Another sister said that she had provided boxes for the schedules which were kept in the ward. They could then be marked by any trained member of staff when a student had completed a new procedure.

Participants felt that the discussion had got away from the subject of attitudes, and returned to the question of why students could not be attracted to meetings even when these were held during duty hours. It was seen to be tied to the deeper problem of declining enthusiasm during training. The learners were very keen and interested when they arrived but after twelve months or so, had become clock watchers who bargained over every half hour. A student agreed with this and said that "second year blues" was an infectious condition, a feeling of wanting to give up. It was followed by the third year during which a student could not think about anything except final examinations. One speaker said that this absorption with examinations was self indulgence rather than apathy. Another pointed out that second year blues should not be confused with a necessary plateau in learning when the student was absorbing her initial experiences and preparing to progress to the next stage. Finally, a speaker reminded the meeting that apathy should not be isolated to nurses. It was something which existed in the country as a whole as a result of the great increase in prosperity, which had given people the time to sit back and realise that they were apathetic.

A nursing officer who had supported one of the teams said that the project had created apathy at all levels because in looking at attitudes they had "cracked a vessel which they lacked the skill to put together again, although they were now slowly moving in that direction."

A student from a psychiatric hospital said that a move to work in a therapeutic community setting had reduced his feeling of apathy. He had felt part of a team and had become clear about the aims towards which he was working. Several speakers agreed that apathy was something which had to be worked through. It existed inside and outside hospitals and there was no magic formula to solve the problem. In some ways the attitude project had helped. It had, for example, allowed nurses to speak out in front of their nursing officers and to voice their dissatisfactions. This was an opportunity to work through apathy and see a little change. Nurses could not expect to feel like Florence Nightingale all the time and being able to voice their feelings was the first step towards maturity and towards discovering the underlying causes for dissatisfaction. Fortunately for the patients, not all nurses felt apathetic at the same time!

One of the nurses asked Tom Caine if he could describe the difference between apathy and depression because the latter term frequently appeared on medical certificates. He said that apathy was related to frustration. People often expected too much to happen. They voiced their opinion and became apathetic when nothing changed as a result of this action. The nurses who had been involved in the projects were bound to feel like this because they were carrying the whole burden of frustration at their inability to set the world on fire. They had to share it with the other staff involved in patient care, particularly doctors.

Attitudes to patients being admitted and discharged

A definite need to work through apathy was described by the team from the Isle of Wight Group. Their team had been selected by the CNO and many had been worried as to why they had been chosen. There was also a second team of alternates and, as some people had dropped out, the two teams had now amalgamated. They met in each of the hospitals in the group in turn and because they were drawn from all these hospitals, many members of the teams had not met each other before starting on the project. They had felt at the start that they were embarking on a large course without the necessary knowledge and that although they needed guidance, none came. The Hospital Centre had left them to act on their own initiative. The process of getting to know each other while at the same time getting on with the project was very traumatic and produced a real feeling of apathy - "Why continue ?" Team members had become hypercritical of the nursing administration and introspective. One member had left but, although the others were very critical of each other, they persisted with the project. They had often felt bored and that nothing

was being achieved. They had felt in need of guidance from the CNO and PNO, but they too had felt inadequate to provide this.

The team were not even sure what was meant by "attitude". How were they formed ? Did they relate to education, upbringing etc ? Could they, and should they be changed ? It was easier to raise questions like these than to provide answers, but they felt that "attitude" was one's contribution of personality, behaviour and reaction to society, and more personally, to patients and fellow staff. The project had created a greater awareness of attitudes and people's feelings not only in the team members but within hospitals in the group generally and had raised some interesting implications which could be studied further.

This team's project had been concerned with the mechanics of admission and it quickly emerged that nurses were opposed to the idea of ward clerks because they preferred to be able to establish a good personal relationship with patients on admission themselves. They drew up a list of agreed objectives for the procedure and stressed that the patient should be put at ease and made comfortable and that the nurse should be calm and kind in her approach. They had looked at incidents which had been noticed in which the patient had been made ill at ease or had been depersonalised by concern for his condition rather than for him as a person. The project was explained to the consultants in the group and they were asked to comment on their attitudes to patients. Some thought that the whole project was a waste of time but others expressed views such as "his attitude was affected by a patient's appearance, manner etc" and finally that "he favoured the team approach to nursing and a patient being cared for by the same nurses throughout."

The details involved in the discharge of patients were usually left to nurses and social workers and the team went on to look at this area. This included a new system of liaison between the gynaecological ward and the district nurses to cover needs which were assessed at the time of admission; the issue of guidance notes to patients leaving the coronary unit and the introduction of special procedures for the geriatric patients. The team held a meeting with the area manager from the Department of Social Service to try and find out why it took them so long to arrange home improvements for the handicapped and were surprised to learn that four years ago the sum allocated for this purpose had been £200 a year. In 1971 this had risen to £2,000 and this year to £25,000 but it was easy to see why most people had died before anything could be done to help them. They had also noted that the social service department called people "clients", a term which seemed to imply that they were individuals who were capable of managing their own lives and affairs. Should they perhaps be "clients" in hospital as well. It would be a step forward if it helped to retain personal individuality.

A student nurse was the last speaker from this team. She said that the project had helped team members to question their own attitudes and had helped them both as individuals and by giving them a chance to cooperate as a team. It had not been easy. Many people became offended if they thought their attitudes were being questioned or criticised and the junior nurses had not felt that they were able to discuss the subject satisfactorily with people who were very much their senior. When discussing attitudes honesty was essential, but they had not always been entirely honest for fear of retribution. Attitudes also depended on what the student or pupil had been taught in school; and in situations when they were thrown on their own initiative, factors such as background and emotional stability played a great part. At the end of the project they all felt uncertain as to what they had achieved. They had looked more closely at their own attitudes and helped others to do the same but unless fuel was constantly added to the flames these efforts would have been in vain. If the subject could be carried further afield, they thought, then more definite results would be seen.

Other teams agreed on the problem of defining the term "attitude". Was it something which could only be seen by a third party or by the person with the exceptional ability to stand outside herself ? If you talked and wrote about an attitude, did it become an opinion ? The other teams agreed that they too had had to work through a negative period to get a more constructive approach to the subject and that introspection had been a general problem. Members had needed the team to boost each other along. In reply to questions, the Isle of Wight team said that their administrator had helped them with the mechanics of the project and that, while they had considered making tapes of patients' views, they had had so little negative comment that this had not seemed to be worthwhile.

A story of achievement

A story of achievement in face of considerable problems was described by the team from the United Cambridge Group of hospitals. Their spokesman said that two members of the original team had dropped out and that they had had to work in an atmosphere of great change. Change brought about by the introduction of the Salmon structure, a new system of student nurse training, an incentive bonus scheme for domestics and the building of a new hospital. The team members had, like others, been puzzled as to why they had been chosen and unsure as to what was expected of them. They had found it hard to arrange meetings and, although these had eventually led to some positive aspects, they had felt a need for more support.

Their project had arisen out of a desire to get more uniformity into ward routines to help the students who had to move around. Even meal times had varied from ward to ward. They had, therefore, undertaken a pilot study on the patient's day in three wards. This involved three changes which affected patients, relatives and staff. They were later waking of patients, open visiting from 2.00 - 7.00 pm, and a later lights out time. These received a mixed reception. Some patients liked the lie in, others, particularly men who were used to early rising did not. The staff took some time to decide what should now be done by night and day staff, who should be responsible for the 7.30 drug round etc. There were also mixed reactions to open visiting in the Nightingale wards. Basically, the short stay patients were in favour, while the long stay were not. It was felt that there should be an enforced limit of two visitors per bed and that they should be advised on how long to stay, so as not to tire the patient. The medical staff felt that open visiting reduced the patient's rest and privacy but that these problems would be reduced in the new building. Support for the later lights out time depended on the age and condition of the patient and the ward design.

The team said that these might seem to be small points but that the project took a considerable effort and had been a framework for a broader study of the attitudes of staff, patients and relatives. It had helped them to appreciate other people's problems and had suggested to them that they were, as nurses, too formal in their approach and that this could be modified without any loss of essential efficiency. They had discovered that the patients would like more privacy; that they would like for example, to have a day room to watch TV. They had found that their colleagues were indifferent to the project and to the suggested changes. They thought that tutors could take a lead in getting students to think about attitudes and about problems, such as the shape of the patient's day. The pupil nurse in this group said that she would welcome more meetings to discuss basic problems. Somebody wondered why this team had equated formality with efficiency. If the respect was there, it did not matter what nurses called one another. This comment revealed a difference of opinion within the team; one member supporting this view and another setting store by the formality of titles, even between friends, in the working situation.

Attitudes to mentally subnormal patients

The final presentation came from two teams of nurses caring for mentally subnormal patients in the United Bristol and Stoke Park Hospital groups. This opened with a sketch, written by the chairman of the meeting, which drew attention to public attitudes towards the mentally subnormal and to the conditions in the hospitals which were their homes. It pointed out that

many patients were taken into hospital because their families could no longer cope and placed in a situation in which one nurse was expected to look after perhaps sixty patients. It was a plea for an increase in public toleration of the handicapped, for smaller residential units, for more training schemes and for the realisation that "there but for the grace of God go I."

The two teams said that they had devised a questionnaire to test the attitude of nurses to the future care of subnormal patients and had analysed the results. They had found support for smaller units, the village approach to care, more nurse involvement in therapy to increase job satisfaction. There had been a demand for more community hostels and for more relative involvement, including more attention to relatives with a poor visiting record. The learners had shown greater support for the idea of mixing the grades of patients but had said that this would have to be in smaller units. There had been general expressions of reservation about the system of catchment areas for units because this could lead to an under use of beds; and about mixed sex units, although there was support for mixed age units provided they included quiet rooms for the elderly patients. The nurses had given a long list of the improvements they would like to see and had expressed support for the use of voluntary workers, provided they were properly organised. Finally, they had found that while the trained staff and nursing auxiliaries liked being called "nurse" the learners would mostly prefer some other title . One speaker from the Stoke Park group team said that they now felt that there was a value in the use of questionnaires because they could indicate both opinions and attitudes. They were now considering a similar exercise with the general public.

Teams were asked why they had recommended increased mobility of staff between the different types of wards. This might not be in the best interests of patients, who needed continuity of care just as children needed a permanent mother figure. New staff and new ideas could be beneficial, but there was no advantage in change for change's sake. Should the nurses be more honest with themselves and say that the reason why they needed to change around was because they could not cope with very difficult patients for very long periods ? There was nothing to reproach themselves for in this. Another question on how the teams had been selected, revealed that they were all nurses who were interested in the project and who had wanted to be involved. Indeed their whole hospitals had been interested and involved. Farleigh had had great support from the CNO down and thought that the whole hospital had been the team and that the team were simply the spokesmen for them. There had for example, been a 100 per cent response to the questionnaire. The hospital had been the subject of a public enquiry and so had had a problem of which all the staff were aware before they became involved in the project. Some of the other teams had apparently gone back to their hospitals after the meetings

to look for a problem, and had not been able to get their colleagues to see things in the same way. This reply provoked the more general thought that the nurses from general hospitals seemed to feel more threatened by having been selected to represent their groups than the nurses from psychiatric hospitals.

Priorities and titles

The need to make more community care facilities available to the mentally handicapped led on to a discussion of priorities and resources. A CNO said that he thought that the honeymoon period was over for the mental subnormality services. The DHSS was now gearing itself up to 1974 and was turning its attention to the needs of geriatrics. Another speaker thought that this reflected public attitudes. A local council had built a new marble entrance to its town hall at a time when its provision for the mentally handicapped was seriously below par. The Secretary of State had promised to put pressure on local authorities to do more for the mentally handicapped but there was no evidence that this had happened. A majority of the public did not care, so efforts should be concentrated on educating the council leaders because they were the ones with the power to effect change. This view provoked considerable discussion and disagreement. Other nurses felt that education should be directed at the general public both because they were the ones who put the council in power and could sway their views, and because it was no use getting the council to provide say two houses to handicapped ex hospital patients, if the general public were not prepared to have them living next door to them in the community.

The discussion moved on to the question of names and titles and how they affected attitudes. There were spokesmen for both the "formal" and the "christian name" approach and a general feeling that it was not possible to make a hard and fast rule on this. Patients and staff should be given the courtesy of being called what they wanted to be called, in the awareness that the element of choice could be one sided. Often the person in the superior position could choose what he would be called while the one in the inferior position could not. Moreover, titles did not signify relationship and did not necessarily increase the formality or informality of the working situation. Tom Caine questioned whether nurses were being called on to play an unnatural role and to act for the other staff and patients. Did this help ? Did it even matter ? Nobody seemed able to answer this and two nurses went on to ask whether familiarity did indeed breed contempt and reduce their control over their patients, or whether the use of a christian name might increase confidence and as a result, control. Again, there were no agreed answers but a feeling that whatever approach was chosen it had to be made clear to newcomers to avoid insecurity.

Finally, the teams were asked whether they planned to go on with their study of attitudes after this final meeting. The team from the Stoke Park Group said that they would. The West Suffolk and Isle of Wight teams said that they hoped to continue with informal monthly meetings to help them to get to know more staff members. The team from the St Birinus Group said that they hoped to involve other departments and the Cambridge team said that they hoped that the project would go on within their hospital but with another team. They felt they had gone as far as they could. This feeling was shared by the Portsmouth team who said that their PNO was very keen that the project should continue, possibly with the involvement of somebody from the local polytechnic to support a new team. They would like to share their experiences with the new team and then leave them to develop their own angles.

Comments from the central team

The day's programme closed with comments from the Hospital Centre project team, some of whom had been involved with the attitudes series from the start and some who were new to this study. Lucienne Arnott said that she had been interested to see the problems that had arisen within the various groups and the way in which they had resolved many of them. She felt very strongly that the burden of this study should not rest entirely on nurses. Eileen Skellern said that she had started the series with as little idea of what was to follow as most of the team members, and that in learning she had been filled with dread as to how she could relate it into the hospital where she was CNO. She would have liked more participation from the nursing auxiliaries who could look at the question without a professional training and perhaps an interchange of ideas with patients. She had learnt more than she had been able to give and she felt that, just as the teams did not know the sort of help they should ask for, so the Hospital Centre team did not know what sort of help they should offer.

Bill Kirkpatrick, a nurse whose concern had given rise to the first series of meetings, offered the teams a number of very fundamental questions and comments on their work. He pointed out that they had been talking about attitudes to clothes, clerks and other people rather than their own attitudes. Did they label people to keep them at a safe distance ? Did they learn from people or from the whole situation ? Why was finance always the first subject to be discussed ? Did it help nurses to care better ? Why did nurses need a role at all ? Was it because they worked in a situation of agony which could touch them if they did not maintain their separation from the patient ? He went on to point out that speakers had been talking about their nursing officers as "7s, 8s, or 9s". If they treated their colleagues as numbers, they were likely to treat their patients as cases. A team could have a relationship between

members and a clear leader without formal titles. He had seen progress during the series, despite feelings of depression within the teams and he thought that this sort of examination of attitudes could only help participants and their patients.

Hazel Edwards said that she had learnt a lot from the series. The teams' presentations had been good and she was glad that the nurses had been able to share their experiences. She felt that a link with local authorities was vital and that community nurses should be included in any future series as a first step towards the involvement of other types of staff. Bill Kirkpatrick pointed out that the drawing together of multi-disciplinary teams drawn from both the hospital and the community would demand even greater attitude changes from participants. Finally, Tom Caine said that he had observed reactions within the teams that he had also seen in psychotherapeutic groups. There was the same defensive reaction from people who felt themselves to be under attack or threatened with no means of support. He agreed with the nurses need for counsellors and supported their request for personnel officers. He suggested that nurses could learn from their colleagues who were working in a therapeutic community setting and from industry where they were organising sensitivity groups. Nurses should not, however, be left to undertake psychotherapy in hospitals without training or support.

APPENDIX I

A WARD DISCUSSION GROUP by Dora Frost

Last summer I was able to read two publications by the Hospital Centre * on the question of attitudes. I was most interested and fascinated by what I read. I was fascinated by the account of the discussions that had taken place and was impressed by the need for a change, or at least a modification in our attitudes towards each other and towards our patients.

I am a ward sister in an acute male medical ward of 26 beds and have been so for twelve years. The turnover is pretty high and we have a variety of cases from acutely ill coronaries to patients admitted for investigations, quite minor investigations sometimes. We have no coronary care or intensive care unit and intensive medical work is carried out in the acute ward. It is not unusual to have intensive care going on in a corner of the acute ward.

I have two consultants, one is particularly interested in cardiology and the other gastro-enterology, three house surgeons and one registrar. The nursing team consists of, apart from myself, two full time staff nurses and one part time staff nurse, and two part time nursing auxiliaries. The nursing team is fully augmented by student nurses. Numbers vary - sometimes four, sometimes as many as eight. We have two part time ward domestics.

Impressed

In the King's Fund reports * I was particularly impressed by the fact that as a result of frank discussion amongst varying grades of staff, attitudes could be modified. I wondered if it would be possible to perhaps modify attitudes on my own ward as a result of holding informal ward discussions, so I decided to initiate ward meetings.

The first problem to overcome was the time to do this. A ward sister is a particularly busy person in the centre of things, with very little time on her hands. This is the traditional concept of the ward sister and I think perhaps this is the first attitude to throw out and indeed, if these meetings are to be worthwhile then one has to make time for them. Wanting to do this badly enough means one has to find the time. Having made up one's own mind, then it is possible to carry it out. I have proved this.

* A Question of Attitudes (first series) THC Reprint No 463
and A Question of Attitudes (second series) THC Reprint No 519

Since the meetings started, I have held them in the ward once every two weeks with a few exceptions. They are held in the centre of the ward to enable the patients to gain our attention if needed. I tried to get discussion going, particularly on individual attitudes towards the patient, towards relatives, towards each other, but I found after a while that this did not really work and then gradually I discovered that the best way to get free uninhibited discussion was to leave the subject matter entirely to the nursing staff. I announce that at such and such a time we will be having a ward meeting and any topics they would particularly like to discuss, to make a note and bring it to the meeting. I find that in this way too, because of this stimulus, the nurses busy themselves about their tasks in order to be ready at a certain time for the ward meeting. At first, sometimes I felt I was an inhibiting factor. My presence seemed to dampen discussion. I was sorry about it, but nevertheless this appeared so. I soon overcame this problem by diplomatically absenting myself. It was not difficult to do - make a telephone call, attend to some ward business elsewhere and then just quietly rejoin the group a little later and by that time there was free discussion going on and several topics had been raised which were of value.

"My attitude has been revolutionised"

Looking back over these last few months, there is no doubt at all in my mind that my whole attitude towards the nursing care and the approach to paraplegic patients in particular, has been revolutionised. I was most impressed by the account of the tape recordings given in the Hospital Centre's account of a patient who had recovered from a stroke and who was able to recount his experiences and his extreme frustration at the treatment he received during the time he was unable to communicate. This has made me and my nursing staff terribly aware of the need to bridge the communications gap between us and more of these patients. I find it heart warming to see the nurses sitting down beside this type of patient and painfully and painstakingly making the first links, the first communications with these patients.

A young man had a stroke which affected his right side and unfortunately also his speech. A young student nurse persevered very hard with this patient and was thrilled because the first word he eventually managed to say was her name. This was a young nurse from overseas, the West Indies, and I can still picture the enormous pleasure in that girl's face to realise that this patient's first word was her name. That particular patient made enormous strides and he recovered his speech very much more quickly as a result of efforts on the part of the nursing staff who in turn had a deeper understanding of his needs. We were also able to bring in his wife who helped. She spent a lot of time with him and eventually he went home almost fully restored and certainly very independent. We have been able to repeat this in

other patients in similar situations.

Our approach towards so-called difficult relatives has been helped by informal discussion. I recall one patient, a boy who happened to be mentally subnormal. He was frightened and most introspective and apprehensive, very difficult to help and we worked together and discussed this particular problem and ways in which we could help this boy, and in fact as a result of the meeting together and deciding our policy, our approach and our attitude towards this young man improved. We were able to help and support him during the time he was with us.

All grades of staff

I decided to open the meetings to all grades of staff, domestics included. I found truly that relations between staff can be improved by discussions of this sort. There was some friction between the junior nursing staff and the domestics and it turned out that the domestics were very annoyed with the fact that the nurses were putting the dirty crockery into the kitchen in a most haphazard fashion after they had collected it after a meal. In turn, I discovered that the student nurses themselves were resentful of the fact that they had to collect the ward's dirty crockery. This was not only discussed in an informal meeting, the nurses expressed their feelings quite forcefully that they felt this was a non nursing duty and that they should not be required to collect dishes. The domestics in their turn, pointed out that if they spent most of their time getting ready to wash up because things were collected untidily, then they had no time left in which to do the washing up properly and that in fact they too were short of time. I was most interested indeed to hear, as a result of discussion, the nurses realised that if they did not collect the dirty crockery then as things stand at present, there was no one else to do this, so nobody would. They also realised that if they did not do the job properly, then in turn the domestics would not be able to do their job properly and on time. In turn, the domestics fully accepted the nurses resentment at having to do a task that was not strictly speaking a nursing duty and they shared every concern and sympathy for them. As a result, there was no doubt about it, the atmosphere between the junior nurses and the domestics had improved enormously and instead of working against each other, they started to work together happily and amicably and I decided that that was one minor friction which was completely resolved as a result of honest and open discussion.

So far, I have not been able to involve any of the medical staff in these group discussions but I am hoping to do so in the near future. We have just had a change of housemen and we have three very nice individuals and I hope very much to be soon able to involve at least

these junior doctors in ward discussions.

Criticism

No other wards have copied our example as yet. One or two of the other sisters are rather interested in what we are doing. We keep a minute book of our discussions and the students are encouraged to read back over these meetings and to read points of topics which have already been discussed. We make a note also of any action taken as a result of our discussions. I find even as the individual in charge, I must be prepared to take sometimes, quite hard criticism. I am developing quite a thick skin I think! For instance, at our last ward meeting there was a very bold statement when I returned from answering the telephone, to the effect that a patient entering the ward must be acutely depressed as soon as he gets inside. I must say, I swallowed hard when I read this point noted down in the minute book. I am rather proud of my ward and I hope there is a very happy atmosphere in it. However, on questioning and as a result of discussion, I discovered that the accusation was to the effect that the curtains are rather dingy and could do with renewal, the paint work is peeling in many places and the ward could do with at least a good wash down. This, I felt, was a very valuable and fundamental criticism and one that could do with an airing and we had some first class discussion around patients impressions on first entering the ward.

One student nurse recounted something she had noted in another ward. It was a busy surgical ward and all the beds were full. Suddenly, another emergency appeared on a trolley through the ward doorway. And the student nurse witnessed this particular incident. The nurse in charge, with this emergency admission suddenly thrust upon her, immediately reacted with "Oh, my goodness me! What are you doing here ? Who sent you ? Where have you come from ? I haven't got a bed for you. I don't know where we're going to put you!" The student nurse pointed out that this sort of reception was far more damaging and demoralising to a patient than arriving in a ward where perhaps the decor was a little dingy, but the human reception was bright and warm. They decided that it was not a cheerful fabric that mattered, it was the cheerful and welcoming faces of the nursing staff that was more important.

Fundamental problems

Inevitably, I suppose, discussion centres on occasion around the sort of problems that face us working in this particular acute ward. The problem, for instance, of caring for the patient who is deeply unconscious, who is not going to recover and whether it is right to pass a

naso-gastric tube and perhaps prolong his life by a few days, or just to give him the hour to hour attention that he needs, turning him, tending to his eyes, his mouth, his pressure areas and the like, and letting nature take its course. With this, the problem of resuscitation arises - whether it is right to resuscitate certain patients or whether we should leave them to die naturally and in a dignified way. These problems we cannot resolve amongst ourselves. They are not entirely nursing problems, but these questions have been raised during the last few weeks upon the ward as a result of these discussions. The problem of resuscitation is one that I shall have to take further. It is a problem very much uppermost in the minds of the young student nurse, particularly when they are left in charge of the ward at night and it is obvious that we must be prepared to give them some definite guidance on this subject.

I would not like to give the impression that discussion of this type cures all illnesses on the ward, or that they dramatically alter our attitudes towards each other and the patients, but one thing I do know is that discussion and frank appraisal like this can make quite a considerable dent into this problem of attitudes.

Meetings of value

I find these meetings beneficial to me and other members of my staff find them of value. I feel, or sincerely hope, that as a result our patients and their relatives and visitors have benefited. It is worth while continuing and I feel that this is something that any ward sister would gain from if she were prepared to give the time and the energy and the thought to initiating such a group on her own ward.

I warmly recommend this type of discussion to anyone who is really concerned about people whether they are patients or visitors, or whether they are our own colleagues who work alongside us each day.

APPENDIX II

NURSES ATTITUDES TO PATIENTS AND ASSESSMENT OF NURSES IN TRAINING

PORTSMOUTH GROUP HMC

Mrs C Davies	Nursing auxiliary
Miss C A Featherstone	Student nurse
Miss M Mulcahy	Student nurse
Mrs L A E Male	Sister
Miss B A Waldron	Enrolled nurse
Miss B K Wren	Departmental sister
Chief nursing officer	Miss R Worsley
Principal nursing officer	Miss L Topley
Principal nursing officer	Miss V M Watts

ST BIRINUS GROUP HMC

Mr J R Arnhold	Staff nurse
Mr R Brough	Charge nurse
Mr D W Johnson	Nursing officer
Miss M Martin	Pupil nurse
Chief nursing officer	Mr K Wright
Principal nursing officer	Mrs M Clarke

STOKE PARK HMC

Miss C Ashmore	Student nurse
Mr D Bacon	Pupil nurse
Mr C Hawkins	Charge nurse
Mr V Poegal	Nursing officer
Mr N Richards	Senior nurse
Mrs J Taylor	Ward sister
Chief nursing officer	Mr S G Badland
Senior nursing officer (admin)	Mr N A Williamson

UNITED CAMBRIDGE HOSPITALS

Mrs J A Burnett	Staff nurse
Mrs E O Dunstan	Clinical teacher
Miss K Politowski	Pupil nurse
Miss J Jenkins	Senior nursing officer
Miss L E Welch	Student nurse
Miss D M Wharton	Nursing officer
Chief nursing officer	Miss O M Bonner

WEST SUFFOLK HMC	
Miss R E Armstrong	Nursing officer
Mrs K E Harris	Student nurse
Mr M Johnson	Charge nurse
Miss S Melluish	Student nurse
Miss D S Walker	Midwife sister
Chief nursing officer	Miss I M Clark
Senior nursing officer	Miss P M Cooper
ISLE OF WIGHT GROUP HMC	
Mrs K Daniell	Nursing officer
Mr Steele	Ward sister
Miss Paine	Staff nurse
Mrs Langridge	Ward nurse
Mrs Matthews	Nursing auxiliary
Miss M Williams	Student nurse
Chief nursing officer	Miss M Pilbeam
Senior nursing officer	Miss A Evans
UNITED BRISTOL HOSPITALS GROUP	
Farleigh Hospital	
Mr B Forster	Nurse
Mr B J Moyse	Charge nurse
Mr T S Bishop	Student
Head of nursing services	Mr H F E Hope

APPENDIX III

NURSES ATTITUDES TO PATIENTS AND ASSESSMENT OF NURSES IN TRAINING

THE HOSPITAL CENTRE

Central Team

Lucienne Arnott	Nurse
David Boorer	Nurse/Journalist/PRO
Tom Caine	Psychologist
Janet Craig	Nurse
Hazel Edwards	Nurse
Bill Kirkpatrick	Nurse/Priest
Eileen Skellern	Nurse
Paul Sommerfeld	Student of Organisation Research