THC REPRINT NO. 519 (£0.15)

King Edward's Hospital Fund for London

THE HOSPITAL CENTRE

- A QUESTION OF ATTITUDES -

(Second Series)

by

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An account of the second series of Attitudes Meetings held at the Hospital Centre from April 9 to November 11, 1970

- A Question of Attitudes -

Second Series

Introduction

The attitude a nurse has towards her (or his) patients is one of the most important factors influencing the standard of care those patients receive. But a nurse's attitudes to patients are influenced by the attitudes of staff (both senior and junior) to her and by her attitudes to them. Attitudes between staff and attitudes of staff to patients are, in reality, indivisible and both impinge on the patient. There is a steadily growing realisation that nurses' attitudes are important and this realisation is one reason why a series of meetings entitled 'A Question of Attitudes' was started at The Hospital Centre in October, 1968.

It was hoped that this group, representative of all grades of ward staff from nursing auxiliaries and assistants to ward sisters and charge nurses from psychiatric and general hospitals would, through discussion, reach a deeper understanding of their own attitudes to each other and to their patients. The end result, it was also hoped, would be an increased awareness of the importance of attitudes as a factor in patient care.

A report of these meetings, the first series, has been published by the Hospital Centre (THC Reprint No. 463) and readers can judge the results for themselves. But there is no doubt that many of the people who took part in the meetings are more aware of attitudes -- in themselves and in others. This awareness was one of the reasons why the planning group and the Hospital Centre decided to run a second series. Another reason lay with views voiced by people who took part in the first series. They said, in effect, "You must involve people at the top, people at all levels. Only if people at all levels are brought together will something be achieved." It was with this in mind that the second series was launched on April 9th, 1970. Those attending the second series were fully representative. They included all grades of staff: matrons, principal nursing officers, principal tutors, sisters, charge nurses, staff nurses and students. They came from an equally wide range of hospitals (24 in all out of the 37 invited to take part) and represented acute, general, teaching, mental, mental subnormality, children's and long stay.

This report, an account of what took place at six meetings, shows some of the problems that such a widely representative group of people faced when they came together to discuss a question of attitudes.

FIRST MEETING

The day began with an introduction from Janet Craig, assistant director at the Hospital Centre and a member of the group convening the series. (The convenors were an equally representative group drawn from those who had convened the first series of meetings and those who had taken part). Her welcome was warm and she had a special word of thanks for those administrators who had gone to such trouble to ensure the regular attendance of members of their staff. She stressed two main points: the group should regard the series as <u>their</u> meetings and the keynote throughout the whole series would be on informality. People at the meetings were not matrons, tutors or sisters; they were all nurses. "As nurses we're all together, we're all concerned about what is a nurse's attitude to patients. The important thing is for us to recognise ourselves as people."

The second point was the fact that the whole series of meetings was an experiment. The series was unique. Nobody had ever had a meeting on the subject on such a scale before. It was better, she said, for "nurses to discuss attitudes than for other people to tell us."

This was the second series of attitudes meetings. The first had proved so successful that those involved, almost unanimously, had suggested their continuation with a different group of people from a wider range of positions in nursing and a wider range of hospitals. (The members of the first group had ranked no higher than sister and charge nurse.) This group had been drawn from hospitals geographically adjacent to hospitals from which the people at the first series had come and this had been done in the hopes that discussion could go on out side the series with those already aware of the problems, already involved and anxious to spread the gospel.

Having set the scene Janet Craig then handed over to Dr. Tom Caine, consultant psychologist, Claybury Hospital, another convenor and another member of the former series, who was to be "Chairman" (in the most informal sense) for the day. He made two points. One concerned the amount of work that had already been undertaken in looking at attitudes of nurses - work which had shown, he said, "A tremendous divergence. We don't know why this should be." The second point concerned the attitudes of staff to staff. "Attitudes to patients," said Tom Caine, "are bound up with staff attitudes to each other."

He then outlined the programme for the day. This was to centre around two tape recordings, both disturbing, both likely to produce an emotional response. Both tapes had been chosen because it was important for us all to

face facts. A discussion period would take place between each tape and then the groups (the meeting had been divided up into nine fully mixed groups) would be free to discuss the tapes and the general subject of attitudes and report back, if they wished, later in the afternoon.

The tapes were one by the late Douglas Ritchie, author of "Stroke - A Diary of Recovery", and a tape-recorded version of an article entitled, "A Patient's Point of View" by Dr. D.F.E. Williams, which was published in The Hospital of September 1968. This is what the meeting heard:

Douglas Ritchie:

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

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

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

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

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

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

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

I did not go to a speech therapist until nine months after the stroke. She was in a Bloomsbury hospital and I was pushed there in a wheel chair. All this time I thought that the doctor and the hospital should cure me -

speech as well - and send me back to work; I could not for the life of me understand why they didn't do so. My wife did not have that simple idea but she thought they ought to try something instead of leaving me to die or live like a vegetable. So she haunted the hospital almoner and from her heard of the Medical Rehabilitation Centre at Camden Town. (None of my previous doctors had heard of it.) I was admitted to the Centre after two months on the waiting list. I worked hard. For eight hours daily I was kept hard at it - doing exercises for legs, arms and hands, and occupational therapy and speech therapy twice a week. I had expected to go to the Centre for about a month: I stayed 18 months.

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

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

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

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

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

Dr. Williams:

Commentary:

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

Doctor Williams:

"The army is not the only 'total institution' whose attitudes have been taken over by the hospital. There is a distinct trace also of the prison. We are 'sent' into hospital as we are sent to prison, and in both places we remain until we are 'discharged'. While 'inside' we are quite probably condemned to wear special clothing. If lucky, we may from time to time be let out on parole, but it is difficult to obtain permission for this.

During my second stay in hospital, I gradually realised that the only reason for my being there was to receive physiotherapy. The physiotherapists, however, only worked from Mondays to Fridays, and my treatment only took place in the mornings. There was nothing, therefore, to prevent my leaving the hospital before lunch on Friday and returning shortly after breakfast on Monday. My family were able and willing to collect me and bring me back by car. I put the plan to the physiotherapists, who saw no objection. I put it to the nurse in charge of the ward - there was no sister at the time. Her attitude was not encouraging. It would mean that she would have to admit me to the ward every Monday and discharge me every Friday - the book-keeping problem was difficult. It seemed odd to me that I should have to stay in uncongenial surroundings for some 70 unnecessary hours every week to save someone five minutes' writing in a register.

Nevertheless, the nurse promised to speak to one of the medical staff about it. I don't think she did, because as I remember it, I had to buttonhole one of the junior doctors myself to put my plan to him. His first reaction was that it would not be fair to the other patients. Why should I spend pleasant weekends at home when some of them were in plaster cases, or required to stay in to receive six-hourly doses of antibiotic? I don't think he began to see the queerness of this reasoning. What had fairness to do with poliomyelitis? Was he going to abandon the use of his legs and join me in a wheelchair to forgo the unfair advantage given him by his ability to walk? Was it fair that I should have to spend even Monday to Friday in hospital when other people were free to go home every night? Or were there two radically different classes of human beings: the healthy who were free to use their leisure time as they pleased, and "patients" who were kept segregated from the healthy and not allowed to bring disaffection into the wards by obtaining glimpses of how life was lived out there?

This feeling of imprisonment in hospital is no doubt irrational and possibly childish. But a patient, like anyone else, is irrational in many of his attitudes: and childishness is one of the results of hospitalisation to which I wish to return later in this paper. There are nevertheless things that hospital authorities could do to alleviate

these feelings. It is not enough that the patient should be free to leave the hospital when he wishes, with or despite the advice of the doctors: he should be seen to be free. Above all he should not be spoken about as if he were not free. Words like 'discharge' and phrases like 'allow to go home' should be deliberately avoided - even at the cost of everyone's seeming for a while to be mealy-mouthed. Doctors may give orders and instructions, if this is necessary, to their juniors and to the nursing staff; patients are not there to be given orders by them or permissions: they are to be given advice. They are not the doctor's servants: the doctors are theirs and should behave as such."

Commentary:

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

Dr Williams:

"Let me do no more than to point to one common manifestation of authoritarianism which is to be found in hospitals - one which I find particularly offensive. I refer to the practice, common amongst senior medical staff, of calling male patients by their surname without the prefix 'Mr.' We tend to laugh at people who show themselves fond of being called 'Mr Robinson' or 'Mr Jones', or 'Dr Stickleback', and give themselves these titles when answering the telephone. This should not blind us to the real blow a middle-aged man may feel to his dignity when 'How are we today, Robinson?' trips condescendingly from the tongue of the consultant.

But nobody supposes that patients are going to start addressing the consultants as 'Stickleback', thought I should be <u>delighted</u> if somone were to retaliate in this way. Unfortunately, it is not only consultants who treat the patients with this lack of manners. A cousin of mine who trained as a nurse shortly after the war, tells me that student nurses at her hospital were forbidden to call male patients (except, I have no doubt, those in private wards) by anything more than their surname unadorned. She remarked that it was often all she could bring herself to do to call men old enough to be her father 'Jones' or 'Smith', but failure to comply with the regulation brought a swift rebuke from the sister. I can only hope that that distinguished hospital has in the last 20 years bethought itself of a little elementary courtesy."

Commentary:

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

Dr. Williams:

"Not all of us have the boarding school experience but all of us have been to a school of some sort. A newly admitted patient finds himself interpreting the complex relationships into which he enters by becoming a member of the hospital community. He finds himself in relationship to fellow patients, to nurses, to doctors, and immediately construes these relationships on the model of those which existed in the nearest approximation to the total social institution to be found in his previous experience, namely, the school. His own role is subconsciously assimilated to that of the child. There are conspicuous superficial similarities. He spends his time in a large room with 20 to 40 human beings in a similar condition. A little corner of this, containing a bed and a locker, is his own domain: he is instructed to keep this tidy as he was once urged to keep

his desk tidy. Meals are dispensed at regular intervals, not by a teacher, but by a ward sister who seems to occupy a position vis-a-vis the patients remarkably like that of a teacher vis-a-vis her class. One is scolded for 'not eating up' one's dinner. At the other end of the day one is scolded again for not having gone to sleep. This too, is reminiscent of childhood days, though for most people it is not of that part of childhood with which school was concerned."

Commentary:

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

Dr Williams:

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

The childishness of adolescent nurses may deprive patients of the sort of motherly care which could be a real comfort to them: it does not prevent these youngsters from adopting the scolding, 'Don't bother me now, I'm not going to take any notice of you' attitudes that mothers adopt towards their children. A middle-aged, or still worse and yet more commonly, an elderly patient is likely to discover after a few days in hospital that the word 'naughty ' has suddenly come back into use. Suddenly he is told that he is naughty because he has left his face flannel in the bathroom - or the like. It can come as quite a shock. In time however, this treatment becomes familiar, and familiarity brings further degradation. Constantly spoken to as a child, the patient begins to act as a child, to talk like a child, to think of himself as a child. I can well remember the period during my first stay in hospital after polio, when I was required to lie on my back at night, which seemed to make sleep impossible, and after an hour or two produced a great feeling of soreness. I could not turn myself over, and when my patience was exhausted, used to ring for the night-nurse to come and turn me over. This was a 'naughty' thing to do, but the relief and the possibility of an hour's sleep in

the new position was worth the grumbling and scolding. Eventually, however, the night superintendent came to disapprove strongly of this bell-ringing and had the bell removed. Still my patience was too weak, and I was reduced to crying 'Nurse' pitifully at intervals until I could attract attention. While doing so I can remember, as it were, standing outside of myself and noticing the childish tone of my voice, remarking that my behaviour was exactly that I would have shown when I was six or seven and wanted my parents to come to me after I had been put to bed. It was not pleasant to realise that one had been reduced to a state of childishness that one was unable to throw off.

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

A positive reaction

The reaction to both tapes was surprisingly positive. There was little of the aggression, little of the rationalisation which had been so evident, especially in response to the Williams' tape during the first series of meetings. This group generally, and with one or two exceptions accepted all that these patients had to say and got right down to cases. Reasons for the state of affairs shown in the tapes included the problems of communication with the patient. One member of staff, said a group spokesman, could tell him that he had had a stroke. Another would say that it was cerebral thrombosis. To professionals, the same thing. To the patient - conflicting diagnosis. A case conference in the wards, suggested this group, would decide what should be told to the patient and how it should be told.

People (including relatives) tend to talk about patients rather than to them. Nurses and doctors usually tell a patient about a treatment rather than asking if they may carry it out and giving a reason. They rarely say, "Would you like me to ...?" or "May I ...?" or "Please can I ...?" Instead nurses say, "I am going to give you an injection."

Suggestions for overcoming this kind of problem and for improving the interaction of staff with staff, and staff with patients included better selection, with use of psychological testing, regular changes of ward to overcome "the isolation of ward sisters" (recognised as difficult in this time of increasing specialisation) and the need for courses of training to include greater emphasis on interpersonal relationships.

This group also produced a comprehensive programme for follow-up which included group discussions, meetings with Student Nurse Association units, study days, conferences and the need to convince ward sisters of the importance of beginning each day with group discussions.

Laying on of hands

The second group to report back took the subject much more personally and spent a great deal of time "mulling round the problem and trying to become aware." They wanted people to feel what it was like to be a patient and considered that it would be helpful for staff members who had undergone operations to describe their experiences to other staff. There was, they felt, not only a need to allay patients' fears but also the fears of the nurses about what they were being called upon to do to patients. This might be overcome by nurses taking care to explain each procedure fully.

Communications with patients is not solely by word of mouth. The 'laying on of hands' (as in treating pressure sores) is one way of making contact at a very deep level, a very important way of letting people know you really care. "It was," said this group, "very important to imagine yourself at the receiving end of any procedure."

The third group looked almost exclusively at attitudes between staff and considered that these could only really be improved in the ward and that change and improvement would probably best come from student nurses. They chose the ward as the setting for improvement because, they argued, students were greatly influenced in their attitudes by ward sisters (some emerging at the end of their training more authoritarian than ward sisters ever were) and that because of this, attitudes should be based in the ward and on the ward sister.

This group, which also felt that volunteers could play a large part in changing attitudes for the better (by showing nurses exactly how they - the volunteers - talked to patients), were also worried about the reluctance shown by some ward sisters to allow nurses, especially students, to talk with patients. Why not? As one member of the group said, "We should talk to patients. I mean, they're people. Why shouldn't we talk to them?"

Change for the better?

Although, generally, groups showed on acceptance of the tapes and believed that the stories told by Ritchie and Williams were true, not everyone accepted that such things still happen. The fourth group was a case in point. They felt that things had changed, very much for the better,

that attitudes had improved. They felt that many nurses had benefited from the "authoritarian type of ward sister", that many had enjoyed this kind of training but that there was now not much need for it. They did, however, recognise the fact that pressures in hospitals (which can, of course,affect people's attitudes) were often used as an excuse.

A sharp difference of opinion made itself felt when the fifth group disagreed with those who believed that attitudes start in the wards and with the ward sister. They felt that change could only come from the top and filter down and held firmly to this view, despite the first group's explanation that what they really meant was that the ward was the best starting point for change, but certainly not the only one. The difference remained unresolved. The cross-talk went like this:

"The change of attitudes must come from the ward. It <u>will</u> come from the students."

"But the lead must come from the top."

"Then the pipeline must be blocked." (Applause)

Generally speaking the rest of the groups dealt with topics already outlined by others. Training, pressures on staff, the importance of staff to staff relationships and attitudes were all given fresh airings. There seemed fairly widespread agreement on the fundamental importance of the ward sister in creating, making and breaking attitudes and a general feeling that there should be genuine two-way communications between patients and staff, and staff and staff. One group summed up a very real problem when they said, vis-a-vis the patient suffering from a stroke, "He has to be educated as a child - the difficultly was not to treat him as a child."

The general discussion dealt with talking with patients and its inherent problems. Tom Caine said that people thought it was easy. It was not. It was often very much a matter of being a good listener. This, said someone else, was underestimating the student nurse. "The ward situation is such that a patient is anxious for someone to talk to him. It is the easiest thing for someone to get in there and talk."

Another: "Ithink that basically it's the patient who talks to the nurse, not the nurse who talks to the patient."

And the reply: "This is attitudes. Perhaps the nurse is inhibited."

Not everyone agreed that the tapes were gospel. One person got up and said, "There is no lack of communication between nurses and patients. Nurses know a lot of secrets about their patients."

There was enough conflict in this meeting to keep everyone stimulated and certainly by the end of the day there seemed no lack of willingness to take part. This, together with the general awareness of the fundamental problem of attitudes and its importance, augurs well for the rest of the series.

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SECOND MEETING

"We have been very superficial. We haven't got rude to each other. Attitudes have not come into it." This was how one participant summed up the second meeting of the series. In essence he was right. The day had been superficial. Attitudes as such had not been discussed. People had not been rude to each other. There had been no tension. But the meeting had jelled in a most encouraging fashion. People seemed immediately at home and although individuals may have been polite to each other the meeting as a whole had no hesitation at all in passing loud and derisive comment upon points it disagreed with. At times, though, it took on the air of the House of Commons in one of its more frivolous moods.

This is not to deny that some good and useful work was done. The whole day was spent working, under Tom Caine's leadership, on his questionnaires; the DI Preference Questionnaire, the Favour or Belief Questionnaire and the Attitude to Treatment Questionnaire. After filling them in, (an exercise which everyone seemed to enjoy), the groups sat back to discuss the Attitudes to Treatment Questionnaire in some detail.

The pros and cons of discipline

For groups to spend a lot of time debating questions that are meant to be answered by individuals on the spur of the moment may seem a waste of time but reporting back threw up some diverse views on several matters dear to nurses' hearts. A question of the pros and cons of discipline was one which almost all groups discussed. All agreed that discipline was needed, not all could agree on what discipline actually was. Some said, "imposed order"; others, "a question of personality"; yet another group said "discipline is an acceptable form of behaviour that benefits all in time of stress".

Uniform is another topic which brings nurses to the boil. One group wondered whether uniforms were worn to satisfy the vanity of nurses. Another group felt that uniforms added to the glamour of the profession but that they confused the patients. Nurses, they went on, "feel vulnerable and lack confidence without them." They were generally in favour of uniforms but against "caps and gowns", preferring "civilian clothing of a uniform nature".

Yet another question which must have been debated endlessly by mental nurses and less frequently perhaps by mental subnormality and general nurses is the one about whether or not nurses should conceal their personalities from the patients. A large number of people considered this impossible, something of a person's personality would always, they felt, show through. Another group disagreed in part. Nurses should not conceal their personalities from patients but many probably did

and such a thing was perfectly feasible. People had different roles - those at home and those at work. "People," they said, "change when they put on a uniform."

"That," said someone else, "is the different roles you play." "Are you suggesting," inquired another, icily, "that nurses are being Jekylls and Hydes?" No one was, apparently, merely saying that people adopt different roles for different occasions. This too caused disagreement.

One said, "This is normal behaviour, surely."

Another, "Your personality is always the same."

And one honest soul, "I refute that. You should see me on Monday mornings!"

This question of revealing personalities tied in closely with another on the degree of involvement with patients that is permissible to a nurse. Here a difference between mental nurses on the one hand and mental subnormality and general nurses on the other became clear. Mental subnormality and general nurses, it was felt, could become involved and could advise patients on courses of action. Mental nurses, whose patients were often trying to avoid responsibility, had to be far more careful.

An intellectual tangle....

Other questions looked at doctors, who should, by common consent, spend far more time with patients but who should never, ever, be regarded as gods; at ward administration (of which there is too much) and at the reading habits of nurses. This was occasioned by another question which asked whether it was a good thing for nurses to take "a great interest in theoretical matters, such as reading books of psychiatry in spare time." People generally felt that nurses should keep up to date but that spare time reading should be broadly based and that theoretical reading and discussions, especially in a therapeutic setting, could become sterile and that nurses could "escape into an intellectual tangle."

Should nurses "look out for trouble-makers in the wards and make sure that they don't get away with anything?" No, of course they shouldn't, at least not in the pugnacious sense of looking for trouble. But nurses should be aware of potential trouble-makers, whether patients or staff, in the sense of knowing the people in their wards. One group took an even more liberal line. They rather liked trouble-makers they said. Such people could be trouble-spotters or even reformers.

Nothing was said about attitudes

As these debates show, nothing at all was said about attitudes although group reports may have shown something of that group's (or that rapporteur's)

attitudes to the subject under discussion. But reporting back sessions took place in an atmosphere of cheerful irreverence in which groups were quite prepared to barrack each other or to join in a concerted groan of disapproval or cheer of acclaim. Mass disapproval was shown when one rapporteur gave the impression that he thought there were services available for all those in need. When told that there were still people who "fell between the professional stools," his answer, "This is not our job," met with cries of "Oooh!" and "Attitudes! Attitudes!" Cheers of acclaim greeted the rapporteur who described over-specialisation thus: "We take our itch to the dermatologist, our twitch to the neurologist, and, if all else fails, the whole lot to the psychiatrist."

People were cheerful and good humoured and the discussion was generally superficial. But after this had been pointed out by one group rapporteur, the meeting took a more determined line. It liked his suggestion that the next meeting should be a completely free discussion about personal relationships. Despite warnings that things were, perhaps, going too fast and that at least another two structured meetings were needed before they could cope with such open discussion, they voted unanimously in favour of the more adventurous step. The meeting really opened up at this point, rejecting with cries of "Out! Out!" the suggestion that groups should be reorganised and rejecting also a suggestion that students should have their own group. This suggestion, not made by a student, and not supported by any, was effectively demolished by a pupil nurse who said, "I've taken great delight in coming here and saying what I've felt."

So the programme for the next meeting on June 25th is fixed. The convenors, after prolonged debate, agreed that it should consist entirely of discussions about personal relationships. The time allowed for reporting back will be strictly limited, groups will be asked to choose new rapporteurs and Gordon Gutteridge will take the chair.

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THIRD MEETING

There were those who thought this meeting a success. There were others who considered it a failure. And no doubt there were several people who couldn't make up their minds either way. If the meeting was to be judged by the amount of discussion on attitudes which took place then it was a failure. Plenty of people used the word "attitudes" but always in the context of solutions to or reasons for problems. Nobody got up and said, "My attitudes are bad because..." Nobody criticised some of the attitudes which were expressed by members of the various groups. Nobody seemed able to begin to undertake the exploration of personal attitudes, either to colleagues or to patients, which is what this series is surely all about. It appeared that the majority of people were trying to find solutions to a problem before they had even discussed it.

Even so group and general discussion yielded some valuable insights into the effects of bad attitudes on staff and patients and, as always, some interesting examples of the attitudes of groups and individual rapporteurs. It also gave some general hospital nurses a glimpse of some of the seemingly intractable problems faced by their colleagues in mental subnormality hospitals.

A wide brief

The brief for the morning discussion was a wide one. Each group was to choose its own topic provided it centred around the problems caused by the attitudes of staff to staff. Groups were also asked to decide on topics for the fourth meeting to be held on July 22nd.

Reporting back revolved very much around the effects of attitudes on people. One group cited the problem caused by family groups in psychiatric hospitals where sometimes whole families of staff - "brothers, sister, wives, husbands..." - are employed. This, it was claimed, led to an "informal network" which could block communications and impede change. Someone else thought that changes of titles could lead to changes of attitudes. They gave, as an example, the case of relief nurses in one hospital who are now called the hospital "emergency team". This, apparently, has changed their attitudes.

Then there are the attitudes of seniors to juniors and of students to pupils which, if they are wrong, can have unpleasant effects. One group claimed that, "In one hospital 75% of the pupils left because of the superior attitude of students towards them." This group "had evidence" of senior staff encouraging such superior attitudes among students.

The problems in general hospitals are as nothing when compared with those in hospitals for the mentally subnormal. This was the opinion of another rapporteur who found it quite incredible that mental subnormaility hospitals sometimes tolerate inadequate staff simply because they cannot afford to lose them. This group also wondered why nurses are so afraid of criticism (they referred to Farleigh) and made a passing reference to nurse training which used, they said, to be "training by ordeal, a baptism of fire" but which was now gradually improving.

Doctors' attitudes ("room for improvement and much more teamwork needed") were once again criticised. Consultants were easiest to get on with, registrars and medical students the hardest. But this was partly the nurses' faults. They "inherited attitudes from the past of turning doctors into little tin gods." It seemed at one point that student nurses were subservient to domestic staff who had been in the ward for years. In mental hospitals, they added, students could even be subservient to a long stay patient who had worked in the kitchen for years.

Why are seniors resistant to change?

Why are senior nurses sometimes resistant to change? Part of the reason, thought one group, could lie with the fact that they had been educated in a "passive fashion", that they felt inadequate and were not able to answer the questions put to them by junior staff. One group told the story of a young nurse who wanted to encourage a patient to start painting and who was met with the response, "No, you can't do that. Painting can only be done on a doctor's prescription." Another group told of the night sister who expected a nurse, (after only four hours in a completely strange ward, during which she coped with two emergency admissions to theatre), to know the names and diagnoses of all her 24 patients. The sister would not listen to any excuses and the nurse was severely reprimanded. Why does this kind of thing happen? Anxieties caused by Salmon, by patients who are demanding more explanations, by poor communications, by the fact that "a lot of staff are afraid to go to their superiors in line management with personal problems", were among the reasons put forward. Solutions included multidisciplinary conferences, the encouragement of teaching by senior staff and meetings in the ward. The appointment of a counsellor was also put forward but the group found it hard to decide on the qualifications needed for the job and finally settled for "some sort of personnel officer" who should "liaise between heads of departments."

Change and self-esteem

The problem of change, thought another group, turned on self-esteem. People often refused to accept a new idea because they believed, in their hearts, that

they should have thought of it first. People were also reluctant to initiate change because they might get labelled as troublemakers or because they lacked the authority to make their ideas stick and "stood to be reprimanded." In this group's view the registered nurses were not always accorded the authority they deserved. Why, they asked, shouldn't a nurse in charge of a ward decide on her own hours of duty? She was, after all, a responsible person. This feeling, that nurses were not necessarily competent simply because they were nurses led to frustration because the nurses considered that their expertise was not recognised. It needed full communications and "a good mix-up of the whole bang-shoot" to overcome the problem.

One group, in a commendably brief and honest report, summed up the whole day when they said, inter alia, "We found it easier to talk about inter-staff relationships than attitudes." So did everyone else, apparently.

In general discussion people went on to talk about the problem of "other staff" who caused resentment by taking away the nurses' interesting work and who compounded the offence by only working from 9 to 5, Monday to Friday. "Outsiders," said somebody, "often do the interesting jobs. Nobody comes along to do the work with incontinent patients." This (it was an attitude really) was roundly condemned by a tutor. "This is rationalisation. The interesting jobs are our patients. They are human beings who require the best care we can give as nurses. There's masses of work to be done if only our nurses knew how to do it." He went on to cite long-stay wards where it is still possible to see rows of patients sitting around and doing nothing, and concluded, "Isn't it time that nurses took this advanced role of psychotherapy that we talk, hear and write so much about? We haven't really begun to know what psychiatric nursing is all about."

Fighting words but nobody took them up or went into the reason why nurses resent "other staff", or why they permit rows of long-stay patients to sit around doing nothing. One or two people offered excuses. The conservatism of some charge nurses was to blame, said one - "Some charge nurses seem to regard our job as purely domestic servants." Another felt that "you can't do real psychiatric nursing in a large hospital," and was immediately attacked by someone else who was convinced that you could.

Yet another speaker, revealing an attitude which is fairly common among nurses, blamed the "increasing number of geriatrics." He said, "What hope is there for nurses to do the more advanced work when we have to do all this menial work. We should make the community keep these patients at home."

The attitude of the profession

The attitude of the nursing profession itself was put forward as a reason for poor attitudes in the ward. "Without the right person setting attitudes at ward level there is no hope of achieving the right attitude for patients," said one, and went on to criticise the fact that in nursing people who stay with the patient at the bedside are "looked down on." "We send our best people into administration and teaching. Why do we pay less to those who are nursing, who should be setting these standards? Should there be a separate career structure for people who want to stay in the wards? Do they not carry the greater responsibility?"

And so it went on with attitudes tucked firmly away out of sight. But there is no doubt that some people are ready for something more dynamic and stressful. When the meeting was asked to make suggestions for the next programme, one or two expressed their dissatisfaction at the way things were going. They wanted something much more open. "Why not," they asked, "question people on attitudes during reporting back? We should be rather more insulting. Or why not have a full-scale debate on two sides of a problem so that we get at what people <u>really</u> think."

This is what is needed. Reporting back will be axed for the next meeting and it is hoped that people will begin to get to grips with the problem of attitudes. After all, as people remarked this time, there are only three more meetings to go.

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FOURTH MEETING

There was a period during this meeting when I thought that my report would consist of four neatly folded but perfectly blank pages. Fortunately that didn't happen and the meeting eventually blossomed forth into what was the nearest thing to a discussion on attitudes we have had so far.

Jillian MacGuire took the chair and pointed out, right from the start, that we only had three meetings to go. We must, she said, get down and look at ourselves. We knew the problems but were talking as if it didn't concern us as individuals. To help us we were to have group discussions in the morning and a free-for-all, without reporting back, in the afternoon. People were to speak as individuals. "Just leap to your feet and say something! To give us a lead Jillian said the key paragraph of the report of the third meeting was the one, at the bottom of age 4 which began, "Why not question people on attitudes..." "Let's, she said, "try to be a little more on to people about their use of words."

Confessionals

Group discussion took up the morning session. Some groups apparently (and mine was one) were a dead loss, people finding it impossible to talk about attitutdes at all. Others were more successful, making a breakthrough right from the start, holding "confessionals" in which people remembered occasions when their attitudes had been at fault. One of the most effective groups was that in which Jillian joined. She reported back to set the ball rolling for the afternoon session.

Her group, apparently, had concentrated on relationships and attitudes and had talked about "games people play", the "look what you've made me do! kind of ploy. They had also talked about the use of "killer phrases" such as "I haven't time now" and "I wasn't here then" - phrases we all use to protect ourselves from entering into relationships with other people. They had gone even further and discussed shame, loyalty (frequently misplaced) and fear of physical contact with patients. In discussion, said Jillian, the group as a whole could either consider the use of verbal killer phrases or look at pairs of relationships to see the strategies and ploys used. She used the word confessional meaning the kind of learning process which can result when people force themselves to look inwards. "This must," she said, "Go some way to improve things - but it is a personal thing. It connot be introduced from above." Then she sat down and the long silence began.

The long silence

This silence, it must be admitted, was a ploy of the convening group. The idea was to let silence take its toll in the hope that increased tension would, sooner or later, force someone to say something pertinent and start a general discussion. It worked, eventually, but not in the way it was intended.

Silence there certainly was, a long silence broken by suppressed giggles, whispers and a rustle of sotto voce conversation. Gradually the noise level began to rise and quite soon groups were hard at it and instead of general discussion we had a continuation of the morning's programme. But the original idea worked in the end because, while it was obvious that some groups were perfectly contented to carry on talking (some about attitudes, some I suspect, about other things) one or two groups who had not been able to get to grips with the problem in the morning began to feel most uneasy. They felt, perhaps, that everybody else seemed to have at least some idea of the answers. They certainly felt cut off and worried by the fact that no-one was getting up and dealing with the subject. Eventually the tension broke and a member of our group, speaking for most of us, got up and said, "We keep on talking about attitudes but we never get controversial. We all look inwards, say we were wrong, everybody nods their heads and agrees and that's as far as it goes. We would be glad to hear of any controversy."

"We're all beginning to think we're perfect..."

He received immediate support from a member of a group which had gone quite a long way along the confessional road. "Eight out of nine in our group felt that they displayed wrong attitudes and then qualified their statements and made excuses. How many of us here have done something we shouldn't? We're all beginning to think we're perfect - the chosen few. It's about time we realized that we're only a representative sample from the Metropolitan area. Patients are complaining. Let's admit it."

And so it started. Not that there was much talk about attitudes as such but there was plenty of the old cut and thrust, advance and retreat, defence and attack. It was really a few "progressives" (for want of a better word) versus what the Communists would no doubt call the reactionaries. The former would listen impatiently to the latter and then ruthlessly force them to consider the fundamentals of their arguments, which were, all too often, merely excuses and escapes.

For example, the nurse who began, "I'm here because I'm full of misdeeds. That's why I'm here," went on to say that really we would get nowhere unless we studied that attitudes of doctors and unless they were persuaded to take

a more postive role. But, said one of the progressives, let's put our own house in order first. Once again we got blanket replies. Nurses are not perfect, they are only human, therefore they err. It is the public who want nurses to be perfect. And so on.

Are nurses encouraged to criticize their seniors? Someone said, "If you go and say something to a sister or charge nurse, they say, 'I've been here for 30 years. What do you know about it?" (A perfect example of the killer phrase). Others agreed. There were, for example, at least three students in the room who said they had asked seniors two or three times for advice and help and who had been rejected. Theiranswer, in effect, had been, "You're here to work."But others disagreed. They spoke of regular meetings with matrons and student and pupil nurses at which the juniors were "encouraged to ask questions." "Yes," said someone else, "but you have to help people to ask the right questions. That is a fundamental fact of management. Too many meetings are matron on a dais telling nurses what's already been decided and <u>then</u> asking for questions." But in some hospitals, apparently, the reverse applies and one pupil nurse said that she felt she could comment and criticise, even her seniors. Of course, she would warn them first. "If you're going to crucify one particular sister, you should say, 'I'm going to criticise you. You'd better <u>be</u> there!"

<u>Time-worn excuses</u>

But gnerally it seems as if such meetings are more of a formality than a reality. People kept trotting out the old time-worn excuses. Lack of time in general hospitals was one of them. But, as some pointed out, general hospital wards aren't busy <u>all</u> the time. And even when meetings are held, they are of little use if the opinions of those who take part is never heeded. This attitudes meeting was a case in point, as someone pointed out. It had asked for student opinion and then rejected it. But many people felt that even with such shortcomings, meetings in hospitals were at least a beginning.

All the talk about meetings in general hospitals led one psychiatric nurse to doubt the validity of meetings held in psychiatric hospitals about which psychiatric nurses are so proudly vocal. He said, "This kind of meeting is what in psychiatric hospitals we're constantly saying we're doing, but how many of us can really say we know the meaning of it? You are highlighting our falsehood." And another, "We are as guilty as the rest."

The meeting really remained superficial, with a few hammering at the barriers, a few more defending them and a large number of the uncommitted sitting tight and saying nothing. Each time a real point was made, each time

someone sought to discuss atitudes or self-examination, they were met with accusation such as, "But have you got your own house in order?" as if such a comment was relevant. It was this kind of thing, this attitude of impenetrable defence, which led one member to say, "I would suggest that attitudes expressed so far can be called a killer strategy." He was dead right and very frustrating it was, too.

But at least people were openly and with some frankness, either attacking or defending. They were not, at long last, sitting smugly around and talking platitudes about management, communications staff ratios and the like. At least some people felt obviously agressive or defensive and showed it.

What next?

What will happen next is anybody's guess. The major drawback to these meetings is the fact that they take place at such long intervals, giving people time to cool off, to retrench, to forget. The "trigger" which sparks off heated discussions need re-cocking by the time that the next meeting comes round and even then frequently misfires.

It would be a shame to lose so much valuable ground and perhaps next time people will be prepared to begin fairly near where they left off. The convening group, meanwhile, will do its best to find a suitable trigger mechanism to help them to do so.

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FIFTH MEETING

Few of those who have regularly attended the series can imagine that a real, (as opposed to a superficial) discussion on attitudes is at all easy. At the four previous meetings people had skated around the subject. People had circled it, warily. An attempt to break into this circle was made, with some success, at the fifth meeting.

David Boorer, in the chair, gave a resume of the failure of previous meetings. Reasons for this, he felt, included a belief that attitudes could be discussed rationally, without heat or emotional overtones. But attitudes were complex, more than intellect was involved. To change attitudes demanded a change in learning, emotion and action.

During the series most attempts really to talk about attitudes had come from those most junior - people who knew the least and felt the most. Senior officers can talk - and have talked - glibly about attitudes and the need for change. But they are under no real obligation to do anything about it. They are not forced to review their attitudes because no-one, patients or staff, will tell them that their attitudes are wrong. Junior nurses, on the other hand, see their mistakes around them all the time and once they have become aware are forced to take action.

Reasons for failure

There may be other reasons for the failure of the series to get to grips with the problem. Perhaps, said David Boorer, the 'mix' of people at the meetings was wrong. Perhaps the seniors have deterred the juniors. Perhaps the seniors know too much for their own good. Perhaps they can think of too many reasons for not doing something. They assume they know all the answers. But they don't, of course. They are caught up, often inextricably, in the minute details of day to day administration.

Junior nurses may see things more clearly - and they are frequently right. Change, it has been said, cannot come from the bottom, it must start at the top. This is both right and wrong. People at the top cannot make things change but they can allow change to happen. This is painful but essential. It means liberating junior staff, who are full of ideas. It means listening to them and taking action on what they say. It means giving up power and authority. It means that seniors must lay themselves wide open to their critics.

In any discussion on attitudes, said David Boorer, pain is essential. In the meetings so far, there had been no real anguish. The third element is action. But this must be preceded by painful doubts and by conflict.

This theme was taken up by others who had been involved in both series of attitudes meetings. One, a newly promoted staff nurse, said "You hear a lot of comment from junior staff. I have not heard one say, 'This is the reason for doing something.' Attitudes are terribly wrong."

Another 'old hand', herself an administrator, thought that selfishness was a problem. "It's what I want all the time." "If," she said, "we want a service for our patients, we have to adjust our attitudes."

"I won't become hard"

And so the meeting swung into action. Some attempts were made, right at the start, to escape once more, this time into a discussion on what exactly is a right or wrong attitude. But it tapered off and led into a consideration of why it is that nurses, once they don a uniform, cease to be people. This angered one person who attacked the whole idea that nurses must never get involved with patients. Her remarks are worth quoting. "Why," she asked, "do you put a uniform on and stop treating patients as people ? I was told that nursing will harden you. I said, 'No. It won't. I can respond, get emotionally involved. Why shouldn't I get involved ? I am concerned for that patient and his relatives. I am prepared to get involved, to get hurt. I didn't come into nursing for a 9 to 5 job. I wanted a 24 hour job. I won't become hard.' I have seen younger nurses who can cut themselves off. They shouldn't. You've got to become involved -- got to get right down to the basis of living. As soon as sister says, 'You're not to become involved', I just walk out."

This led to a brief discussion on involvement and what it means and who says that nurses are not to get involved. Is it, as Tom Caine asked, the result of official pressure ? Yes, said the nurse, it is. It also led to a discussion about who the nurse takes her troubles to. Some seniors are concerned about this and wondered if they were the last to hear of a nurse's problems. Perhaps they are. Some seemed to feel that it was all right so long as a nurse took problems to the person she felt best suited to deal with them or to listen. Others, however, believed that they were at fault and had not made it plain enough that they were available and interested. And this led to the question, put by Tom Caine, "How close would you allow them to come ? Would you know their names ? Would you allow them to call you by your Christian name ?" Some said yes, some said no and cited discipline as the reason for not permitting this familiarity. As always, some people took the question to extremes and failed to see the implications behind it. It is, as Tom Caine said, "A fundamental attitude. It limits how close you will allow people to come. If you limit this you limit communication. You cease to be a person and become a figurehead. If you allow them closer you will facilitate communication."

Tom Caine's refusal to allow people to escape this point led to some acrimonious comment about psychologists in general and him in particular. "The trouble with that chap," said one exasperated senior nurse (who later claimed that he was 'only stirring things up') is that he's too interested in theorizing and not interested enough in people who do the job." "The service" he concluded angrily, "is full of people who yap." This was a totally unfair comment about Tom Caine, who is deeply involved with the practical problems of nursing, but an interesting example of how disturbing some people were beginning to find this meeting. And this question of first names is fundamental because their use or otherwise does proclaim an attitude and does enhance or diminish communications.

Emotional involvement

We returned for a time to a debate on the question of emotional involvement. Is refusal to get emotionally involved with the patients (and the phrase itself carries emotional overtones) due to a genuine desire to protect the nurse from the problems she may meet ? Is it due to the fact that an emotionally involved nurse has no-one to turn to with her own troubles ? Or is it, as one senior nurse suggested, simply a question of expediency - a time-saving factor. We lack the time to explain, the time to get involved and therefore we do not. He cited a recent visit by the Hospital Advisory Service to his own hospital and quoted a phrase from their report which said, "It is difficult for patients to be anything other than patients in this hospital."

People at the top in nursing feel very insecure. This was made plain in the discussion following a suggestion from a principal tutor. He said, "How do we develop the potential of youth ? What developing role are we playing at the moment ? We all have faulty attitudes. We can all moralise. Are we in fact allowing them to express themselves fully ? Are they allowed to challenge our programmes at the end of each block and study day ? Are we asking them, 'What would you do ?' Do we have places on education committees reserved for learners ?"

People began to swap stories about senior nurses covering up staffing deficiencies during official visits and then someone said "There is far more resistance to change at the top than anywhere else." Others told of remarks like, "There are no bad attitudes," and someone else said "If you create these attitudes the nurse in the wards will take it out of the patients." And this led to a remark that much of the tension would be reduced if the top nursing administration advised the HMC properly. People were really escaping from the main point and the meeting was brought back

into line when someone else said, "We can't keep passing the buck up and up and up. Nobody's accepting responsibility."

But it takes courage to be wrong and it appears that many people at this meeting believed that senior nurses lack that courage. One cri de coeur went like this, "If only they would tell us why the answer is no. If only they would tell us why." This apparently simple request obviously upset some people who, as always, tended to take it to extremes. "If," said one, "the immediate response to any order is Why ?, we are getting to a state of anarchy. I strongly resent being asked why. If they do the job and come to me afterwards and ask why I am prepared to answer them." Another was more honest, "Let's face it, quite often we say 'No' without any reason. We say it because we simply don't know." And another, "We should face up to the fact that explanations are only grudgingly given."

A personal attack

This debate appears innocuous on paper, but in fact was a personal attack on junior nurses. This was the culmination of several requests for students to speak up and tell their seniors what they thought and the result, with some admirable exceptions, was personal attack rather than reasoned debate on the points the students had raised. Student views were varied. One said "We get what we deserve in that we don't ask why enough." Another, "But when you do ask why, you get the answer, 'You're not here to ask questions - you're here to do as you're told." And in answer to the question why don't students speak up came the reply, "Because I'm not allowed to become emotionally involved. We lose the power to communicate, the power to respond." That this debate was upsetting there is no doubt. How much so can be gauged from the remark made by a principal tutor apropos students with things to say. "Empty vessels make most sound. I have often found that the most vocal student verges on the psychopathic."

The morning session ended on this rather unhappy note. It seems sad that senior nurses, who, after all, were constantly asking students for their views, should have reacted so aggressively. Many of them were aggressive and many felt threatened. There is no doubt about that. Sotto voce comments from the back of the room about some vocal students and, surprisingly enough, about the pupil nurse who wanted to get involved with her patients, showed this. Phrases like 'trouble-maker' and 'wouldn't like to have her in my hospital' showed massive insecurity at the very least. But they were also in the nature of a compliment to the junior nurses concerned.

Unlike many previous meetings where a natural break led to the steam going out of the discussion, this one started the afternoon session exactly where it had left off during the morning, with a discussion about why senior nurses find it so hard, often, to accept the critical comments of their juniors. Reasons for this included jealousy at the training they receive, the wide gap between the young and

the old and the mending of this gap by "really courageous programmes of in-service training." But this was not generally accepted. People felt that there were other reasons for what Janet Craig described as "a battle between seniors and juniors". Tom Caine said that many of the criticisms made by juniors were not justified, but that the important thing was that the juniors think they are. As the discussion wore on some administrators were ready to admit they were at fault, that they should listen. But it gradually became clear that, in attitudes meetings generally, those in the most senior positions tend to be criticised. As Janet Craig said, "In the last series it was the sisters who were getting it. It seems to me that whoever's senior is getting it. Is it that we just find fault with seniors ?"

The communications gap

Perhaps it is, as someone pointed out, that communication gaps appear higher in the ladder as people get more senior. When she was a student (and attending the first series) it was ward sisters she found it hard to communicate with and it was ward sisters she tended to criticise. Now, being a staff nurse, she finds the gap exists with administrative staff. Others felt the blame lay with the ward sisters, with the administration and of course, with that old problem the nurse training school and student needs versus the staffing needs of the hospital. This degenerated into a tutors versus administrators conflict and in turn to a debate on who should, or indeed, can, teach attitudes. Is it the tutor ? Is it true, as one tutor claimed, "I could have students eating out of my hand - until they go into the wards, then they're completely changed." Is it the ward sisters ? Do they 'teach' attitudes by precept and example ? Or is this an impossibility ? Will, in fact, seven sisters have seven totally different sets of attitudes ? Is the "great secret to put yourself in the patients' place and treat them as you would like to be treated ?" For whom is the hospital run ? For staff ? Or for patients ? Or does the final answer lie with the whole question of nurse training ? Is it regarded as a necessary evil by some, the whole answer by others ? Does the answer lie in dropping the masquerade of nurse training as it is now and concentrating solely upon service to patients, or should we face two years of chaos and remove all students from our hospitals immediately ? These were some of the questions asked. Certainly, the meeting was free enough to listen without too much anxiety to sad stories of neglect, to a senior nurse telling of nurses he had heard talking to elderly patients like this, "If you don't keep your hair straight, I'll smack your

bum." This incidentally was an effective riposte to the nurse who had earlier claimed, "We don't discipline patients."

And so the meeting drew to a close. Inconclusive ? Yes, in the sense that nobody had drawn any hard and fast conclusions. But heartening for the convenors because people had, to some extent at least, shed their armour and expressed their real feelings. Even the naked aggression that some had expressed towards their junior critics was valuable because it showed just how wide and uncomfortable the gap is between theory and practice of communications. And it is as well that this meeting did come to grips with some of the problems because it was the last chance. The next meeting will be far more formal and designed to allow discussion between those involved in the series and representatives from RHBs on the kind of future action to take place.

A success

But this meeting was a success. Although late in starting, this group achieved a great deal on this final day. One or two people at least seemed to have gained something from it. "Haven't these meetings made you more aware ?" (In response to a question about what had been achieved) "I've got a lot more opinions." "We may not have established what an attitude is -- but certainly I've found out the need to change attitudes." And perhaps most significant was this final piece of dialogue. "But I don't know how to change attitudes." "Nobody here can tell you. But the revolution's on! "

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SIXTH MEETING

The sixth and last meeting in the second series set out to look at three things: the effect (if any) that both series has had on hospitals in the four Metropolitan regions, the value of the series to those who attended and future action. To facilitate regional reporting, the room was arranged geographically according to the four Metropolitan regions.

Three of the four regions, the North East Met., the South East Met., and the North West Met., submitted reports based on questionnaires of one kind or another. The reports (appendices A, B and C) are attached. An individual view of the meetings by a student nurse from a mental subnormality hospital is attached as Appendix D. The South West Met. did not conduct a survey as such and impressions of the value of the series was reported by some of those from the region who had taken part. The comment, generally, was favourable - people feeling that they had gained something from attending the series if only in terms of a heightened personal awareness of attitudes and their importance. But where impact upon hospitals, upon those outside the "unreal world" of the attitudes meetings (as one participant put it) was concerned, people were less sanguine. Quite a bit of follow-up action has been taken but many people met a blank wall.

Follow-up action

Reported follow-up action ranged from staff meetings, group study days, plans to do research into the attitudes of student nurses to pupil nurses, multi-disciplinary meetings, and involvement with hospital chaplains. It may be, as someone said, preaching to the converted or at least to the interested but "You've got to start somewhere and hope to drag the others in."

A structure - or not ?

A common point of criticism, highlighted by people speaking for the North East Met. region, concerned the lack of structure common to all the meetings. Many people obviously felt happier with a clear lead as to the subject under discussion and felt that such leads (exemplified by the Ritchie and Williams' tapes) helped discussion to keep to the point. Criticism was also voiced about the apparent lack of leadership - one group reporting its surprise at the discovery that there was actually a group engaged in planning these meetings. There is an irony about this comment that was pointed out by Jillian MacGuire. People in the first series, she said, had felt that the planners had identified themselves too strongly and in the second series the

planners (by this time a much larger group) had tried to overcome this. The meetings, she said, were not an attempt to conduct research but an attempt to get people to look at themselves. "People at the end of meetings have come to realise that attitudes are not something one can settle once and for all at one meeting."

The question of whether or not meetings should be structured was discussed by Tom Caine. In his view the unstructured method is the best one because, "one can learn by psychotherapeutic methods." Jillian MacGuire supported this. In the planning for the first series, she said, consideration had been given to providing group leaders, experienced people. But it was very easy for a group to become dependent upon its leader. "It's only when you face a blank that you realise it's your responsibility and it's only then that the group develops."

A waste of time

But despite these comments there are still people for whom the whole exercise seemed to have been a waste of time. One said, "I am extremely dissatisfied with the way this meeting is going. We seem to have been discussing the same things as we discussed at the first meeting. I suggest a show of hands to indicate whether our attitudes to patients have improved. If many say "Yes" then the meetings will have been a success." He was to repeat this plea at intervals throughout the day.

The meeting generally did not stick too closely to the subject of attitudes, and spent much time discussing the organisation of the meetings and reasons for the selection of certain people. How for example, were junior nurses chosen ? Some were worried about this and wondered if they had been selected because their attitudes were thought to be wrong. Many of those responsible for selecting people to attend reported, reassuringly, on this and basically selection proved to boil down to choosing people who could contribute and report back.

Some criticism voiced at the apparent lack of interest shown in the attitudes project by some regional nursing officers was taken as an indication of the low priority they gave to this kind of nursing problem. One member of the planning group told of being asked to write a report for her RNO. This had to be vetted by her matron before being sent to the RHB. (Why ?, someone asked). She had never received an acknowledgement. Some present felt this was straying from the point, others that it was germane to the general discussion because "this incident has built up an attitude of resentment in the person affected." The morning session ended on this rather inconclusive note.

Attitudes research

Mrs Winifred Raphael, present at the meeting as an observer, began the afternoon by describing two pieces of research in which she has been engaged - the Rcn survey which compared the priorities of patients with the priorities of those who look after them, and the King's Fund's Patient Satisfaction Study. Both surveys showed what a gap there often is between the views of the staff and those of the patients. A general

discussion on these pieces of research then followed and led to the conclusion that research into attitudes needs to be two-pronged: a study of nurses' attitudes to patients and vice versa. Such research should be conducted by a neutral body. It was interesting, said Mrs Raphael, that patients have many misconceptions about nurses. They think, for example, that nurses work a ten-hour day and only get £10 a week. This led someone to say "We don't like to be honest with ourselves. Some of us like this pitiful situation. We like people to be sorry for us. Personally I prefer money."

Future action

Janet Craig brought the meeting back to the point when she asked about future action. Tom Caine wants to run a small group of 12 to 15 people, in order to discuss attitudes in greater depth. People were asked to let him know if they wished to take part. Janet Craig said that the people involved in the first series had asked to meet up with those who took part in the second series. Did people think this was a good idea ? Taking silence as consent she said she would arrange these meetings. They have now been scheduled for 30th March 1971 and 28th April 1971.

This really ended a fairly scrappy and inconclusive meeting, but it was one which showed that the question of attitudes is important, that some of the people who attended recognised as much and that some follow-up action at local level is taking place. How effective or widespread this is is anyone's guess. But it may well be, as the speaker said at the end of the Fifth meeting, "The revolution is on."

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APPENDIX A

NORTH EAST METROPOLITAN REGIONAL HOSPITAL BOARD

Four Hospital Groups were represented at the Hospital Centre Conference on A Question of Attitudes.

All except one felt that these conferences had been of value and achieved the objective of provoking self-examination. One set of representatives felt that many of the suggestions made for improving attitudes towards patients, relatives and staff, had been taught and practised in their particular hospitals for many years, e.g. addressing patients by their proper name. This led to some degree of complacency in discussions with other conference participants whose experiences were so dissimilar. Often factors influencing the responses of this group were:

(a) too much time elapsed between conferences and continuity was lost

(b) too much time spent formulating what a discussion group should discuss leaving little time for analysis of specific problem areas.

ACTION TAKEN BY 3 GROUPS

1. Regular staff meetings being organised and implemented
2. Free discussion on problems of attitudes with individuals in immediate working environment
3. Discussions in Schools of Nursing between:
   Conference participant and teaching staff
   Conference participant and student nurses
4. Circulation of summaries of conferences to Senior Nursing Staff.

Action Planned for Future

1. (a) Separate staff meetings of equivalent grades where individuals feel free to voice their opinions

   (b) Follow-up meetings for representatives from all grades

   (c) Immediate circulation of information arising from meetings to all staff.

2. Use of the two tape recordings made by patients and used at the conference to open discussions on attitudes at Staff Nurses and Sisters Study Days.

SUGGESTED BY A STAFF NURSE

Regular multidisciplinary (Medical Staff indluded) meetings.

Discussions on 'Attitudes' to be an integral part of nurse training from the day she enters the Nursing School.

J. Woodward

MED/N
Ext. 71 (Int)
29th October, 1970.

APPENDIX B

REPORT submitted by C.I. Crichton, Hellingly Hospital, Hailsham, on behalf of the Nursing Officers of the South East Metropolitan Regional Hospital Board, in respect of nursing personnel who had attended the series of discussions on "Attitudes" organised by the King Edward's Hospital Fund for London.

From a total of thirty questionnaires despatched to participants within the S.E. Metropolitan hospitals, 24 completed replies were received, 3 were returned in respect of members who had joined the armed forces and untraced, and 3 failed to reply. The 24 comprised 4 student nurses, 2 state enrolled nurses, 2 staff nurses, 1 charge nurse and 1 ward sister, and 14 tutors or senior administrators, of whom one had gained promotion since commencement of the series.

Methods of selection had been made principally by senior administrators (16) 2 had been elected by their tutors, 2 had submitted themselves for representation, and four invited by the "Jet Set", but only 12 knew why they had been selected, and these were all in the hierarchy category, which would indicate poor communications systems. Again only 9 replies suggested that the series was to promote improved attitudes towards patients, colleagues and others, and these, too, applied to senior nurses. Those in training, or up to charge nurse and ward sister level, with but one exception, ignored this question. One attended the first series of talks, though up to 4 had been invited to the last two discussions, and within the second series the vast majority had to forego one attendance due to annual leave; work had detained only two.

"Goqd" was the general criticism of the talks, general concensus of opinion expressing better understanding of human relationships and appreciation of other peoples' problems. For some such stimulation had evoked a change of personal attitudes towards colleagues and patients, and revision of hitherto routine patterns of conduct.

Most people would have welcomed greater frequency of meetings, rather than monthly or bi-monthly arrangement, and several said the continuity of group discussions was disrupted by members' absences.

Communicating the discussions within hospitals had applied mainly to senior nursing personnel, the others having received little, if any, encouragement to relate events to administration, education, medical or other departments, but all appeared to have voluntarily discussed the talks amongst their colleagues in the immediate work situation, and from the replies, only one Hospital Management Committee has become involved with the outcome of the series (Hellingly).

Analysis of the questionnaires determined that learners should have had greater representation in numbers, as the entire complement was overwhelmed by senior nursing personnel, and the non-committal replies from that small section made this point evident.

Emerging from the talks, four hospitals have pioneered programmes on attitudes within their own sphere. 1 mental subnormality hospital (Leybourne Grange) had devised a "communications project" for its students, as well as showing films on the "Importance of Communications" and to "Improve Relationships". 1 general hospital (Brighton) had submitted a questionnaire to nurses, and another mental subnormality hospital (St. Augustine's) arranged a project, but this was not specified. Only one hospital (Hellingly) appears to have formulated an entire programme involving members of all disciplines to be attended by members of the Hospital Management Committee, to be held at six weekly intervals, the first commencing this month

(November 1970). Selected topics have been introduced to provoke frank exchange of ideas, to culminate in greater understanding of our common objective in our daily work, namely, "patient care".

To summarise, the talks at the Hospital Centre have been most acceptable, though specific topics selected for every day's discussions would have been beneficial. Groups could have been smaller, and several mentioned that other disciplines would have been welcome participants, particularly the medical fraternity, whom several opined were unaware of our problems, and many participants obviously regretted that they, in their work area, have been given no opportunity to commence any projects of a similar nature. Many regret the conclusion of the talks at the Hospital Centre, and appear to have devised a fresh approach to their immediate problems, most indicating their desire to see similar discussions within their own environments.

APPENDIX C.

PRELIMINARY ANALYSIS OF THE FOLLOW-UP QUESTIONNAIRE TO THE 'ATTITUDE DISCUSSION DAYS'

Number of questionnaires sent	82	
Number of questionnaires returned		52
Number of questionnaires not returned		30
		82

Questionnaire was sent to nurses working in the following areas...

Clinical, all grades	46
Administrators	20
Educators	16
	82

Questionnaires were returned by nurses working in the following areas...

Clinical, all grades	27
Administrators	16
Educators	8
Not ascertained	1
	52

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Table One — Sex

Male	17
Female	35
	52

Table Two — Grade

Untrained	1
Pupil	0
Student	6
S.E.N.	4
Staff Nurse	4
Sister/Charge Nurse	12
Asst. Mat., A.C.M.N., N.O	4
Sen. Asst. Mat., S.A.C.M.N.	1
Dep. Mat.,D.C.M.N., S.N.O	1
Matron, C.M.N., P.N.O., C.N.O	10
Educators, all grades	8
Not ascertained	1
	52

Table Three	Type of Hospital	
	General	9
	Psychiatric	6
	Mentally Handicapped	2
	Teaching	1
		18

Table Four	Change of Job	
	Yes	3
	No	48
	Not ascertained	1
		52

Table Five	Change of Title	
	No	48
	Yes	3
	Not ascertained	1
		52

Table Six	Those selected	
	Head of nursing services	27
	Teaching Department	2
	Self Selection	4
	Other	15
	Not ascertained	4
		52

Table Seven	Why selected	
	Knows the reason	26
	Does not know the reason	22
	Not ascertained	4
		52

Table Eight	Reasons for selection - i.e. to improve attitudes	
	Patients	3
	Colleagues	3
	Others	20
	Not ascertained	26
		52

Table Nine — Attendance 1st Series

Sessions

1.....2	3
3.....4	1
5.....6	5
7.....0	4
attended 2nd series	41
Not ascertained	3
	57

Table Ten — Attendance 2nd Series

Sessions

1.....2	4
3.....4	12
5.....6	23
7.....0	0
Attended 1st series	16
Not ascertained	2
	57

Table Eleven — Attendance both Series

1.....2	7
3.....4	13
5.....6	28
7.....0	4
Not ascertained	5
	57

Table Twelve — Reasons for not attending

Illness	11
Pressure of work	11
Own decision	0
Discouraged	0
Other	9
Combination of 1,2,3,&4	1
Did attend	8
Not ascertained	12
	52

Table Thirteen	The Value of the Meetings
Very good	12
Good	24
Fair	12
Poor	1
Neither good or bad	0
Some good, some bad	0
Not ascertained	3
	52

Table Fourteen	Increased insight into attitudes
Own	40
Others	5
Patients	0
Not ascertained	7
	52

Table Fifteen	Form of future Meeting
No change	22
Change	24
Not ascertained	6
	52

Table Sixteen	Some suggestions for change
Nurses only, of same grade	4
Smaller grouping	4
Multidisciplinary groups	4
Different rooms	1
Meetings to be held closer together	5
More leadership	2
More structure	8
Continue meetings in hospital groups	9
Other	0
Not ascertained	15
	52

Table Seventeen — Discussion on attitudes initiated by others

Ward team	10
Administrative	2
Educators	4
Medical	0
H.M.C.	1
Others	9
Nil	0
Not ascertained	18
	44

Table Eighteen — Discussion initiated by participant

Yes	1
Nil	8
Ward Team	11
Administrative	0
Medical	0
Educators	6
H.M.C.	0
Others	10
Not ascertained	16
	52

Table Nineteen — Attitudes referred to in general discussion

At work	7
Away from work	7
Other	34
Not ascertained	4
	52

Table Twenty — Have any projects been started

Yes	13
No	30
Thinking of starting	4
Other	0
Not ascertained	5
	52

Table Twenty-one	Stage of any projects started
Discussion	15
Project just started	3
Completed	0
Other	0
No project started	30
Not ascertained	4
	52

Table Twenty-two	Any special problems in starting projects
Yes	16
No	14
Other	2
Not ascertained	20
	52

Table Twenty-three	Special kinds of problems
Passivity	1
Fear of discussion	1
Unwilling to accept ideas	1
On the defensive	4
Educational gap	3
No help from Head of Nursing Services	2
Became complaint sessions	2
Too abstract	1
Salmon	1
Personal difficulties	1
Not ascertained	35
	52

Table Twenty-four	Definite steps suggested for future meetings
Multi-disciplinary groups in hospitals	18
A definite structure	6
Guidance from the Hospital Centre Team	3
Need for a Project Officer	1
More support from R.H.B.s and G.N.C.	2
A definite statement of purpose of the meeting	1
Wider publicity	1
Other	1
No ideas for future meetings	4
Not ascertained	15
	52

Table Twenty-five — Other general comments

Groups of hospitals to be involved	3
Too much reminiscing	1
More need to be kept informed	3
Interesting - stimulating	5
Of immense value	14
Good food	1
Psychologist failed	1
No other comments	7
Not ascertained	17
	52

APPENDIX D

A NURSE'S VIEW

Like so many others, I approached this opportunity of conferring with fellow workers with some trepidation. How, by conferring, could we solve any of our problems in the subnormality field? Most presses seem to delight in turning the spot-light on our difficulties and problems - problems which we, more senior in this field, watched grow and grow about us, helpless to avert or avoid. Our pleas to reduce numbers, for more equipment, more pairs of hands, more cash - and so many other 'mores' - were all unheeded. Why were the presses so silent in those far-off days.

We are constantly being made aware of the fact that our attitudes must change. How we long for the opportunity to change at least some of them. If only we, or someone, could produce a solution!

Recently I surveyed my position as a charge nurse working 42 hours a week, in a ward of 54; training others, administration duties, supervising domestic work, clerical work, and all the other non-nursing duties that we are all too consciously aware of - allowed me to devote 3½ minutes per day to each of the 54 patients.

I give you these examples to emphasize our problems as charge nurses. We are condemned as non-progressive 'stick-in-the-muds', for not changing our attitudes. With such frustrations, I hope someone will bear with us.

How well I understand the people who have said to us in Subnormality - 'I couldn't do your job' or 'I wouldn't have your job for a pension' or similar denunciations. It is so much more than a job - it certainly takes more of oneself. Our patients are with us for a much longer time than are general or mental ones. Each one is an individual, with all the little sidelines of personality, which all need to be understood before any attempt can be made at teaching or training. They are as children and in so many cases will remain so for the rest of their lives, a major point which is so often overlooked, particularly when dealing with aggressive or violent adults. Training them as children has so many pitfalls. Patience and tolerance are tested to the extreme, daily. One must accept that, depending on the degree of subnormality, it requires twice as much effort on the part of the nurses than if they were normal children - i.e.it has taken me two years to teach a patient to write and recognise his name, but to see the pleasure and pride registered on his face when he signs for his pocket money is worth every effort.

The charge nurse with the long-stay patients becomes, without any doubt, the father-figure, so to delegate this position would, in itself, be a deprivation for the patients - how they need a father-figure.

We are sometimes blessed with as many as four staff on the ward and one would think, as did I, on the face of it, a golden opportunity to discuss, or perhaps even change, attitudes. And so we met over the (is it illegal) "cuppa". 1 S.E.N. having a particularly trying day with his chronic asthma, 1 N/A Russian, although very cheerful - extremely limited vocabulary, 1 Malaysian student of Chinese origin, his English perfect, his fourth day in England, his first day on duty, and 1 ward orderly, a Spaniard with no knowledge of the language apart from 'yes' or 'no', which he used, ad libitum, right or wrong.

However, attitudes were discussed (I think) and we set out our plans to further the changes. Full of hope for progress I was then presented with details of staff for the next day. With me, there was to be another charge nurse, noted for his inactivity, and one of those rare breed - a student nurse, taken away from his sheeted ward to make up the number (Where do we go now?).

To all of you - the people who wouldn't do our job - you should try to look beyond the incontinent patient in the corner, or that one whose nose needs wiping and who will persist in talking to you. Let us make a start at 'changing attitudes'. Try to remember that, there, but for the Grace of God - and chromosomes - go I!

I would like to express my sincere thanks to the organisers for the wonderful effort that they have made toward Changing Attitudes. Deep down we all realise that as a result, attitudes must change and of course for the betterment of our patients.