KFC 86/60

BLUEPRINT FOR THE FUTURE?

A one-day conference on a partnership scheme between St Bartholomew's School of Nursing and the University of London Institute of Education

Wednesday 17 December 1986

King's Fund Centre
126 Albert Street
LONDON NW1 7NF

KING EDWARD'S HOSPITAL FUND FOR LONDON KFC 86/122

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BLUEPRINT FOR THE FUTURE?

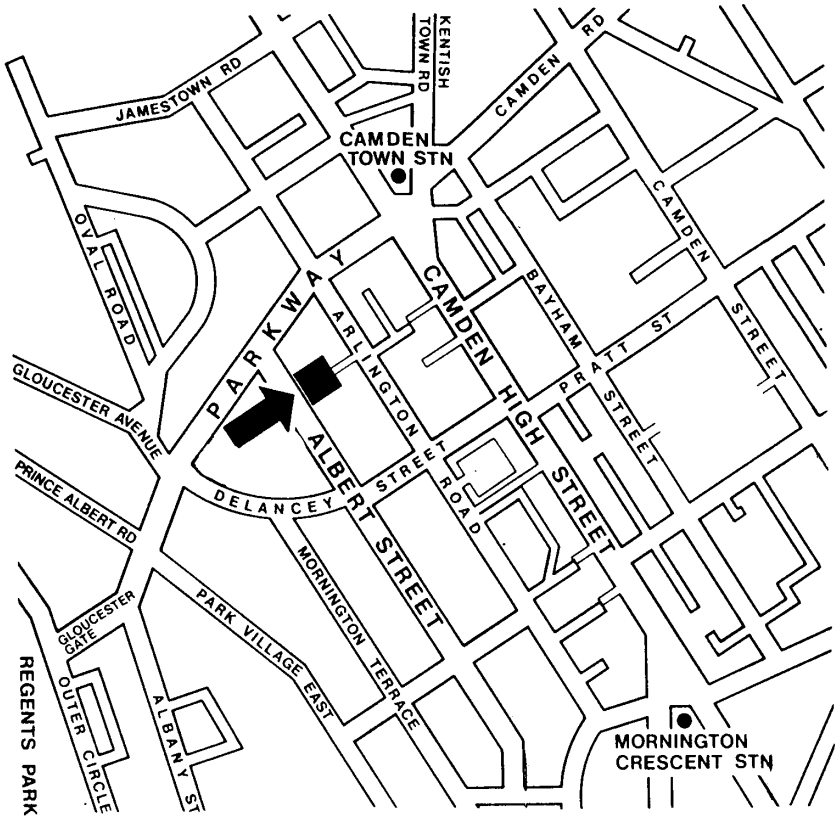
A one-day conference on a partnership scheme between St Bartholomew's School of Nursing and the University of London Institute of Education.
Chairman: Miss Hazel O. Allen, BA, SRN, SCM, RNT, Associate Director, King's Fund Centre.

Wednesday 17 December 1986

10.00	Coffee and registration
10.30	Welcome to the Centre. Opening Remarks. Chairman
10.40	Curriculum Development for Health Studies: A professional foundation for nurse teachers. Alan Beattie, Head of Health and Welfare Department, Institute of Education, University of London
10.20	Eight case studies in curriculum development presented by members of staff from St Bartholomew's Hospital School of Nursing
13.00	Lunch
14.00	Towards a climate of creativity: A strategy of innovation in one school of nursing Sylvia P. Docking, Director of Nurse Education, St Bartholomew's School of Nursing
14.40	Supporting curriculum change in nursing: Trials of an educational facilitator S. Evelyn Hide, Lecturer in Nursing Education, Institute of Education, University of London and St Bartholomew's School of Nursing
15.20	Tea
15.45	Plenary
16.15	Close of day

Receipt of this programme is confirmation that a place has been reserved for you and we look forward to meeting you on Wednesday 17 December 1986. Please bring this programme and the enclosed papers with you.

Thank you



King's Fund Centre 126 Albert Street, London NW1

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CURRICULUM DEVELOPMENT FOR HEALTH STUDIES:

a professional foundation for Nurse Teachers

paper for
BLUEPRINT FOR THE FUTURE?
a Conference at the King's Fund Centre
Tuesday June 3rd 1986

Alan Beattie
Head of Health and Welfare Studies
University of London Institute of Education

INTRODUCTION

In the past year, the connections between nursing education and the wider world of higher education have become a focus of widespread and lively debate, prompted by the RCN Commission Report in March 1985, the English National Board 'Strategy' proposals in April 1985, and by the UKCC Project 2000 Discussion Papers last autumn. One common and insistent thread of argument in this debate is that the reform of nursing and of professional preparation for nursing careers must be "education-led", in that forthcoming reform will demand a fundamental restructuring and rethinking of the frameworks for initial and post-basic education across the whole field of nursing. It is this prospect, I believe, that makes the particular form of collaboration that today's conference will examine of especial interest to the world of nursing education. Our focus, on partnership between nurse teachers and general educationists, should begin to highlight (I hope) ways in which educational expertise can be brought to bear in support of innovations in nursing and health care.

This is where I come in, so to speak. I am not a nurse or a nurse tutor, but during the past 7 years have enjoyed the privilege of working closely with colleagues from nursing education on several fronts in the Univesity of London and elsewhere. In the past few years, I have had to get used to being ascribed an identity as a general educationist, even though my own professional credentials lie in health sciences, health planning, and health education. In fact I want to argue in this paper that recent research and development in general education does indeed have a great deal to offer nurse educators, particularly the growth of curriculum development as a field of inquiry and practice. However, my own interests and involvements remain firmly in Health Studies, and I also want to argue that advances in this field provide another crucial frame of reference within higher education for nurse teachers.

What follows is intended to give substance to this argument, and I have divided my paper into two parts. In the first part, I will sketch out a brief narrative of the growing relationships between general education and nursing education as I have seen them and contributed to them over the past

7 years, from my own position in London University. In the second part, I will set out a number of "themes", a selective sampling of major directions in which (I believe) curriculum development in Nursing Studies and Health Studies can most usefully be pursued, and which can show the benefit of up-to-date awareness of advances in general education.

NEW OPPORTUNITIES IN NURSING EDUCATION

I became a full-time member of staff of London University in 1977. I had previously worked in cancer research for the MRC, in hospital planning for the DHSS, and in health service planning and health promotion/health education for City and East London Area Health Authority. My post in 1977 was that of lecturer and Course Director responsible for setting up what was then the first full MSc course in Health Education in this country (at Chelsea College, now Kings College). It was through students on that course that I first became seriously aware of the complex and diverse patterns of nurse education and of their enormous potential significance for health promotion and health education. In 1979, I moved across the University, to the Institute of Education, to become Head of the Department of Health and Welfare Education; and one of my ambitions in this new post was to seek to contribute to the development of educational opportunities for nursing and related professions (alongside our contribution to education for health and welfare in the school system and in informal adult and community settings). Now the Institute of Education had included nurse teachers among its students for a long time before my arrival - indeed several famous and influential figures in high places in nursing in this country are graduates of the Institute. But these were a very few robust individuals, who were not specially provided for, and who had to get whatever they could out of courses that were designed to meet the needs of teachers in the school system. When I joined the staff in 1979, I found numbers of nurse educators who had completed Dip.Ed. courses at the Institute, and who were keen to take their studies further, but who particularly wanted to focus on the application of curriculum development expertise to their own fields. In response to this interest, I established with the support of the Institute, a major new option in Nursing Education within the broad framework of an MA in Curriculum Studies. This permitted

students to undertake a full seminar programme, tutorials, 3 coursework assignments, a dissertation, and a 3-hour final examination paper all in Curriculum Change in Nursing Education, together with another seminar programme and a second 3-hour final examination paper in 'general' Curriculum Studies. This course began in October 1979 with 5 full-time students (and I can reveal that among those 5 were two of my colleagues today, Sylvia Docking and Evelyn Hide), with myself as Course Tutor. This course has continued to attract similar numbers of students each year since then. Most of them have come from general schools of Nursing, but we have had 2 Midwife Tutors, 2 Community Nurse Tutors, - and also 2 Physiotherapy Tutors.

The parent MA course (in Curriculum Studies) is popular and prestigious, attracting over 80 students each year, mostly senior educationists from schools, FE, or LEA's; and it has been of interest and importance to us to see how well our nurse educators have performed alongside of those other students. In fact right away in the first year, one of our group gained a Distinction (these are rare); and we have had one other since then. None of our students has so far failed or been referred, and both the staff from (general) Curriculum Studies and the External Examiners have commented regularly on the high standard of work achieved by the nurse educators. I should also perhaps mention that a further 2 of our MA students have had their disserations published in the RCN Research Report Series (Amalia Gallego 1983 and Sheila Hollingworth 1985).

I have long been firmly of the belief that systematic and sustained service links are crucial in higher education. To some extent these links can and must be built-in, through student-centred teaching and learning modes; but I have always sought also to build-in collaborative links with outside "centres of excellence" in nursing education which can provide for a steady traffic of ideas in teaching and research, and can act as a forum for exchange of views on 'good practice'. In the first two years of the MA we were able to use the services of Dr Will Bridge, then at the Joint Board of Clinical Nursing Studies as Co-Tutor. Subsequently, we developed official working links with The Institute of Advanced Nursing Education at the RCN, where Bobbie Miles was designated as our Liaison Co-Tutor. (Bobbie was a

Tutor at the RCN, and herself a graduate of the second year of our MA course). Our Joint Lectureship scheme with Barts to which Evelyn Hide was appointed 2 years ago, has made possible a crucial consolidation of this feature of the course. We were able to get this lectureship going with financial support from the Kings Fund and from the Trustees of St. Bartholomew's Hospital (each contributing 1/3 along with my own Institute). From this September, it will be funded for a further 3 years, on a 50:50 funding split between my own Institute and the Barts School of Nursing itself. I believe this is an important recognition of the value of the post.

One other feature of the course that I attach some importance to is that for the past 3 years we have been able to award Health Education Council Felowships to selected candidates, to support full-time study on the MA course. (This scheme also supports students from schools and from community contexts.) We use these Fellowships to give nurse educators an opportunity specifically to prepare themselves to undertake a major piece of curriculum development-work for health education within a nursing education establishment. Six out of the 16 Fellowship awards we have made in 3 years have gone to nurse educators; and 2 of those 6 have been members of staff at Barts, and they are both reporting their work in this conference (David Shaw, and Anna Barnfield).

Our first initiative, then, in nursing education at the Institute was our MA course; but a year later, in 1980, I also made available a parallel specialist option in nursing education within the Institute Dip.Ed. course. This provides a 'degree-equivalent' qualification, and is an important bridge between initial nurse teacher qualifications and a higher degree. In fact it is an essential bridge for nurse teachers with the older Sister Tutors Diploma qualification; and even for those with the newer London University Diploma in Nursing Education, if they are not graduates, we normally recommend the Dip.Ed. route as a preparation which permits students to gain the full benefit of MA-level studies. This course also is one which I undertook to develop and to teach in its early days, but again in full recognition of the need to have a qualified tutor with service links in charge of it. This course has now become another major

responsibility of our Joint Lecturer.

The Dip.Ed. course has a similar general orientation to the MA, focusing on the Theory and practice of curriculum studies in general and in nursing education. One of the ideas that I have been exercised by recently is that of writing up this course as a set of "workbooks" which can support resource-based learning and provide for professional up-dating for nurse teachers. These materials could offer (I believe) a flexible and adaptable mode of study, emphasising active learning and "on the job" inquiry, and perhaps more capable of being tailored to the inservice needs of particular Schools of Nursing. Evelyn Hide and myself are currently carrying out a modest pilot study of these materials, negotiated with St. Georges District School of Nursing.

In addition to taught courses, we also try to encourage curriculum development in nursing eduction through supervised research degrees. The 12 research degrees completed in my department since 1979, have included 2 Ph.D's and 2 M.Phils in nursing education. (by Seta Durguerian, Dirk Keyzer, Irene Miles, and Cynthia Clamp). There are another 10 research students currently in the pipeline, and progress on two of these is reported in this Conference (Di Marks-Maran, and Eileen Inglesby). Similarly one of our funded research projects was a DHSS sponsored study of "The Role and Training of the specialist Family Planning Nurse", which was an evaluation of JBCNS course No. 900.

These programmes of research are a crucial backdrop to our taught courses, and they offer opportunities for us all (student and lecturers) to renew our awareness of the foundations of nursing education, (and of how these foundations are changing or may need to be changed).

In this survey of new opportunities in nursing education there is one other set of recent initiatives that I would like to mention, although it lies beyond my own Department. This is the work of the London University Department of Extra Mural Studies in its provision for the Diploma in Nursing and the Diploma in Nursing Education. This provision, represents, I believe, another striking example of the usefulness and importance of

curriculum development expertise in nursing education, and the work in our Department has benefitted greatly from a close association with the recent transformation of the two Extra Mural Diplomas.

I had myself been a University Examiner for the old Diploma in Nursing and for the Sister Tutors' Diploma; but from 1979 onwards I became involved in what were then the early days of validation and examination for the new versions of these Diplomas. During the 3 years that I have served as Chair of the Extra Mural Advisory Committee for the Diplomas in Nursing and Nursing Education, I have witnessed a remarkable expansion in the Diploma in Nursing scheme (which currently attracts over 400 students per year at 30 Centres across the UK), and a consolidation in the Diploma in Nursing Education (which attracts up to 60 students at 2 centres in London). Central to these changes have been, I believe, a marked growth in expertise, confidence and authority in dealing with problems of curriculum development, among the members of the subcommittees (the Curriculum Review Groups) which are responsible for detailed scrutiny of the operation of the two Diploma schemes.

A number of graduates from our own MA course play a central part in the work of review and revision of these two Diplomas. Frequently, when I have been in the chair at one of these subcommittees, and my colleagues get rough and tough about crucial matters of educational principle or curriculum theory that are at stake in this or that detail of wording in an examination scheme or a validation report, I have recognised myself being hoist with my own petard!

Most recently, we have established within the University a framework whereby holders of the new Diploma in Nursing can progress to a BSc Honours degree in Nursing Studies at Kings College, and I offer you this as a minor triumph of planned curriculum development in the University sector. Generally, what the new Diploma/Degree route illustrates is I believe something of profound long-term importance for the future of nursing and nursing education. This is the establishment of coherent frameworks which can provide opportunities for study and qualification, at every level from initial Diplomas to Degrees and higher Degrees. For nurses, the Diploma in

Nursing/BSc/MSc route is now at last beginning to be more widely available, not just in London University but through the CNAA; and for nurse teachers, a similar route (Dip N Ed/BEd/MA) has likewise been opened up, again both in London University and in the CNAA system. These opportunities will (I have no doubt) be in increasing demand as the 'Great Debate' in nursing and nursing education continues in the near future. Also the fuller and better provision of such opportunities will put a premium on advanced expertise in curriculum development among nurse teachers. The points at which such curriculum experitise can most usefully be brought to bear is the subject of the next section.

WAYS OF IMPROVING NURSING/HEALTH STUDIES THROUGH CURRICULUM DEVELOPMENT: 5 THEMES

The first section of this paper has offered a review of points at which nursing education and general/higher education are beginning to do more business together. In this second section, I will set out an agenda of themes which I believe merit attention as possible "ways forward" in these joint efforts. In selecting from the many areas of educational research and development that are likely to be of interest to nurse teachers, I have tried to strike a balance between the professional preoccupations of nurse teachers as represented in student work on our courses at the Institute, and theoretically informed speculation (what one might call "strategic guesswork") on my part, as to the areas in which current policy debates are most likely to place demands on nursing education. The 5 themes on my agenda are as follows:

1) advances in course planning and design
2) rethinking teaching methods
3) innovative strategies in course assessment and evaluation
4) new maps of nursing and health knowledge
5) moving into partnership

I will offer some brief comments on each of these themes in turn. In doing so, I want to illustrate a general line of argument about the contribution

that recent educational research has begun to make to nursing education. This is that the growth in critical reflection and systematic inquiry which it has led to, have brought about a recognition of a range of alternatives, of "strategic options" for nursing education. I believe that nurse educators have thus begun to confront what the Barts Symposium series calls "The Challenge of Choice". I will try to show also that a theoretical perspective on "knowledge and control", drawn from contemporary curriculum studies, is particularly useful in taking stock of these "choices" and the issues that they raise.

1) Advances in Course Planning and Design

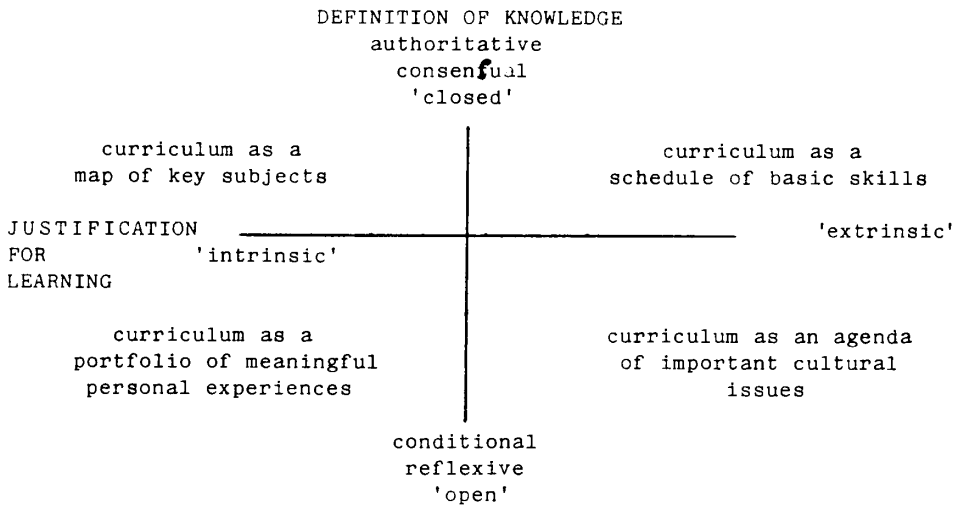
One important area of advance for nurse teachers has been to become aware of theoretical frameworks through which courses can be put together in systematic and coherent ways. The move from 'block' to 'modular' structures in SRN courses a decade or so ago represents I believe a significant breakthrough in this respect, as Mary Dunning's study (1981) of the experience of a School of Nursing which pioneered this scheme shows. In addition, as another study in the same School showed (Lovett 1980), the establishment of modular structure permits more deliberate 'mapping' and 'threading' of key subject-matter through the SRN (RGN) curriculum, and can encourage close attention to learning sequences or to integration of subjects, through explicit use of instructional theories.

Another significant advance in curriculum design is I believe seen in the new London University Extra-Mural Diplomas. As Shirley Orbell (1982) showed for the Diploma in Nursing, and as Sheila Hollingworth (1982) and Alan Myles (1983) showed for the Diploma in Nursing Education, both of these courses embody an explicit commitment to an "integrated" curriculum design, in which different areas of subject matter, practical problem-solving, and personal/professional experience are all brought together (with varying degrees of success). Thinking through curriculum design along these lines finds more assistance in sociological perspectives than in the psychological themes that support modular construction.

This provides a lead into a further, and highly promising line of work, which is to examine systematically the different models currently available for curriculum planning, and to inquire into their appropriateness in nursing education. Sue Studdy (1982) when she was in another job in another place, showed the usefulness of 'situational' and 'cultural' analysis in the design of post-basic courses; and since moving to Barts she has pursued these ideas for the case of the initial RGN curriculum (as her paper for this Conference shows).

Taking this thinking further, an idea which has begun to appeal to me is that of the "four fold" curriculum, whereby different, alternative approaches to the generation of curriculum (with their contrasting strengths and weaknesses) are brought together and "combined" in various ways to give a "higher order" structure to a course (see Fig. 1).

Fig. 1: The Four Fold Curriculum



Another colleague presenting a paper today, Di Marks-Maran, is currently investigating how far such an approach to curriculum design

works for the case of a post-basic course in oncology nursing. Another research student, Constance Martin is similarly examining the usefulness of this four-fold approach in the design of a post-basic course for practice nurses.

It occurs to me that ideas along these lines may be especially helpful or indeed essential in two directions of work that are in prospect. One is the design of common core/foundation programmes in initial course - as called for by all and sundry recently! (The RCN Commission, the ENB, and the UKCC). The other is the design of modular short courses of continuing education, of the sort envisaged by the recently announced "Health Pickup" sponsored by the NHS Training Authority. Both of these initiatives I believe will require bold, imaginative and creative curriculum planning, where the perils of outdated, simple-minded, "single model" approaches are abandoned, in favour of more complex, multifacetted designs.

2) Rethinking Teaching Methods

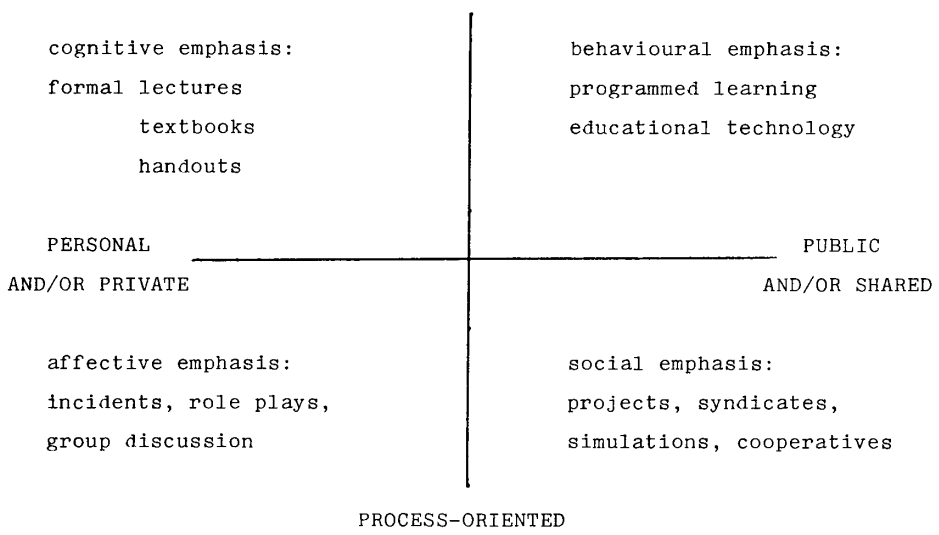
Another of the obvious breakthroughs in educational development in nursing has been the vigorous pursuit of alternatives to the traditional 'didactic' lecture/textbook mode of teaching. Perhaps the first alternative that was sytemtatically explored was that of educational technology, including programmed learning materials. The influence of this approach is still strongly apparent in many current Open University programmes, as shown by Chris Bithell (1984) for the OU Post-experience pack in "Rehabilitation".

Perhaps more prominent recently has been the increasing attention given in nursing education to affective, personal/interpersonal, and experiential learning modes. As Cynthia Clamp (1984) showed, "critical incident" reports can be an extremely valuable method for prompting learning in the attitudinal/affective area. But in this, as in all discussion-based group-work modes, nurse teacherss need a good deal of support and guidance as Judith Muir (1984) demonstrated - and as Terry Maunder and Janice Scott will show in today's Conference.

A further extension of teaching methods that has begun to capture the imagination of increasing numbers of nurse teachers is that of "shared learning". Various facets of this are being taken up rather rapidly these days - for example project-based teaching and cooperative learning in RGN courses (Bossino 1984), shared learning in multiprofesional groups in post-basic education (McKenzie 1984), and "learning contracts" as a basis for continuing education and staff development in support of innovations such as the nursing process (Keyzer 1985).

Here also the "challenge of choice" needs I believe some fresh and imaginative thinking. As Entwistle (1981) in particular has shown, effective education in problem-solving needs to be mixed, eclectic, in some respects unpredictable and perhaps even 'subversive', in the sense of constantly confounding student predictions .... . In a future where nurse teachers will themselves be working across diverse settings, such versatility and flexibility in teaching methods is likely to be inceasingly at a premium. And here also I find the notion of a four-fold approach helpful, as shown in another structural diagram (Fig. 2).

Fig.2 : Alternative Modes of Teaching



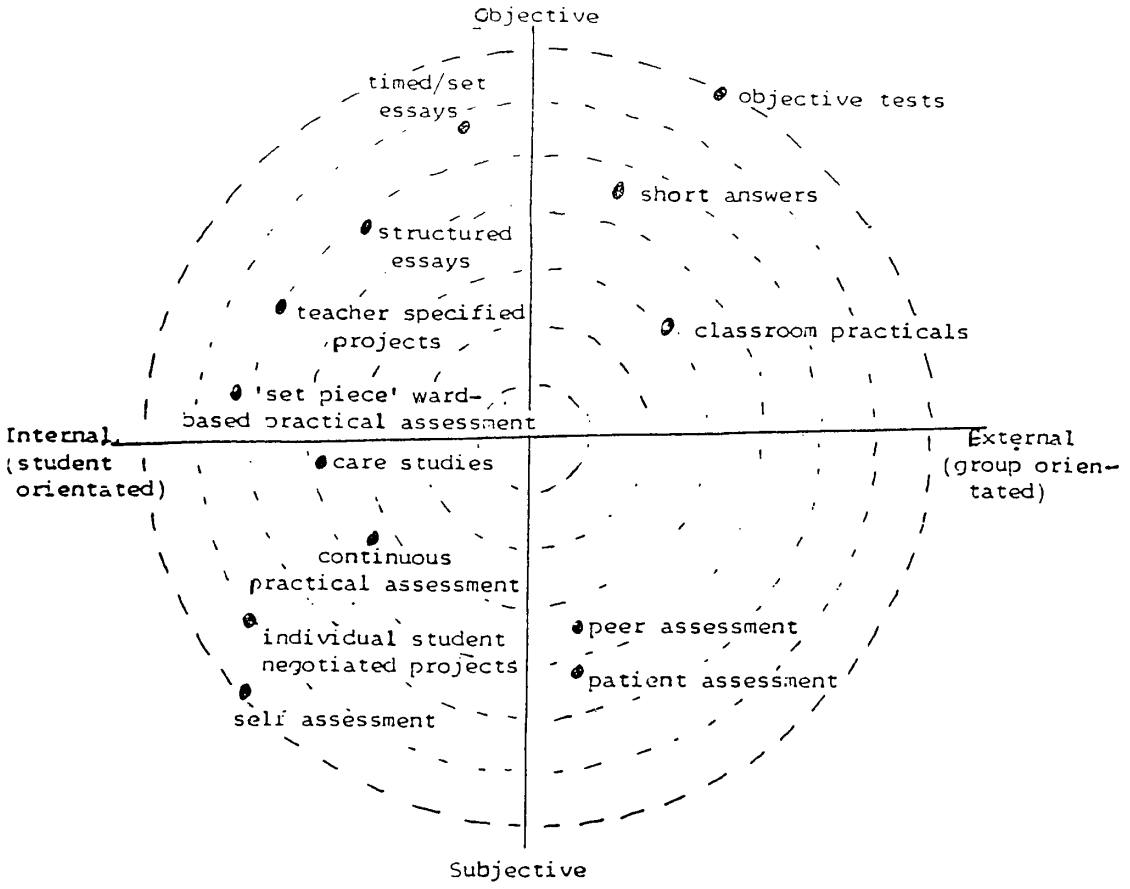
One of the most intriguing challenges for the future is to see how far the full range of methods and modes can be incorporated into teaching packages: and the work of Joan Ramsey and Tina Cheethams at the today's Conference (on a package on Child Care) illustrates I believe a way forward on this.

3. Innovative Strategies in Course Assesment and Evaluation.

Just as new approaches to curriculum design must be accompanied by rethinking of pedagogy, so also they demand innovation in strategies of student assessment and course evaluation. In the several different fields of nursing education, far too much in the way of assessments is taken-for-granted, and urgently needs rethinking and reconstruction - for example in RGN courses (Mary Chapple 1983), in Midwifery courses (Sandy Emery 1984), in Health Visiting courses (Sheila Twinn 1986). Clearly there are now some valuable initiatives which move away from 'set-pieces' and 'objective-tests' and which begin to assess higher level problem-solving skills - as Daryl Evans shows in her paper for today's Conference.

Pursuing once again the issue of the "challenge of choice", I would like to present another structural diagram which sets out the repertoire of alternative modes, methods, and tools of assessments (Fig. 3). This representation was arrived at in collaboration with a current M.A. student, Molley Bessent:

Fig. 3 Dimensions and Orientations in Modes of Student Assessment



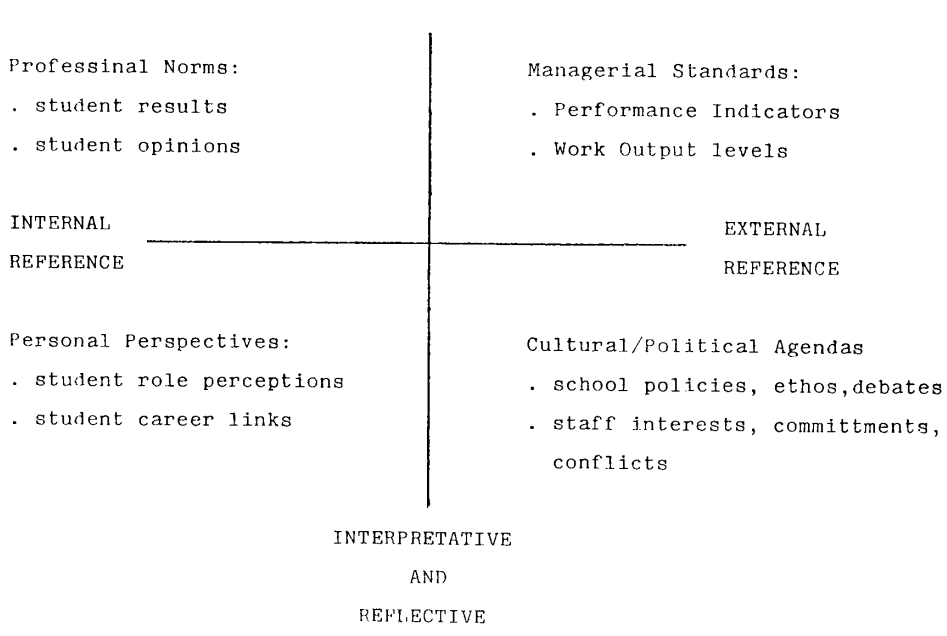
I believe a great deal more work will be needed in the near future in nurse education to devise more comprehensive and flexible strategies of assessment, and I cannot better a recent comment by Evelyn Hide (1986):

> "As nursing consists of many diverse aspects and skills, and as no one assessment procedure has been adequate to meet the needs of all aspects and parties concerned, it would appear that the answer lies in the judicious selection of assessment tools chosen from all four orientations."

A very similar line of reasoning applies to strategies of course

evaluation, as the RCN Research Report by Amalia Gallego (1983) shows. Too often, even now, evaluation consists only of a normative exercise in establishing how well students have preforms on State Finals, or how much they like or dislike this or that component of a course; or alternatively, it consists only of attempts to establish "performance indicators", revealing how well tasks are carried out and how far this can be attributed to the course. These professional and managerial interests in evaluation are of course legitimate - but not enough. There is the whole area of student experience - their thought processes, their hopes, anxieties, and stresses, and their emerging sense of role, identity and career. And then there is also the institutional context to be taken into account - the school, its curriculum, its ethos, its internal debates and external pressures; and the staff and their perspectives and interests, and the way their career lines and interests intersect with (and sometimes conflict with) the agendas in the school. I can perhaps once again summarize the "challenge of choice" facing nurse teachers in this aspect of their work in a structural diagram.

Fig.4 Facets of Evaluation



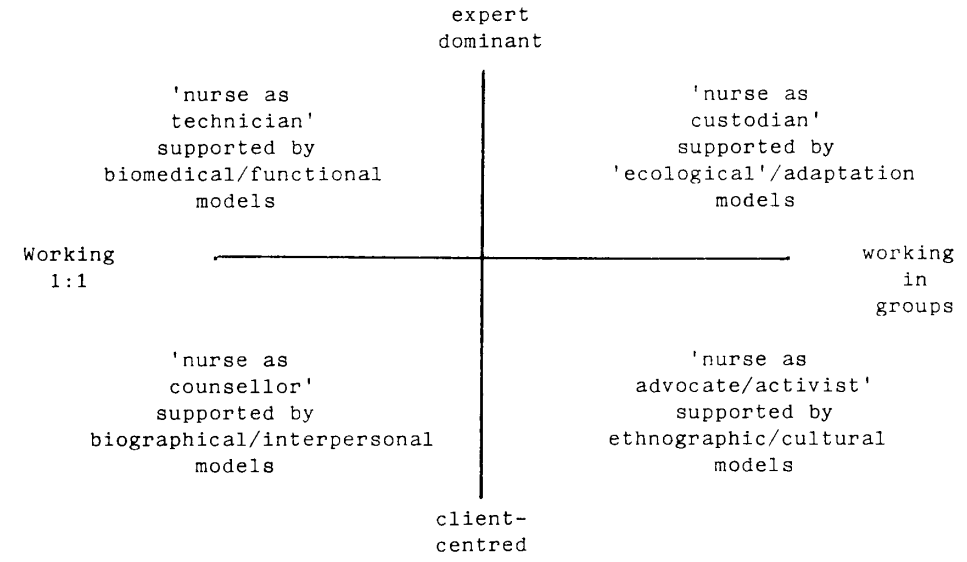
As the studies by Amalia Gallego (1983) and Sheila Hollingworth (1985) show, evaluation strategies which are multifacetted, sensitive, and fine-grained are within the competence of nurse teachers - but they are indeed tricky, fraught with risks, and downright exhausting! I believe this is one of the great challenges that must be faced by Schools of Nursing in the next decade or so.

4. New Maps of Nursing and Health Knowledge.

I suggested near the beginning of this paper that advances in Health Studies are an important frame of reference for curriculum development in nursing, along with advances in educational expertise in general. I believe this is because recent developments in the wider field of Health Studies makes a crucial contribution to current efforts to redefine and extend the knowledge base for nursing.

One of the most obvious growing points in nursing studies in recent years has been in the development of "conceptual models" of nusing, and I have been struck by the way in which the various alternative models each articulates a connection between nursing and the broader field of health - which is also nowadays marked by a proliferation of alternative models. Once again I believe a structural diagram may help to reveal the parallels between nursing models and concepts of health:

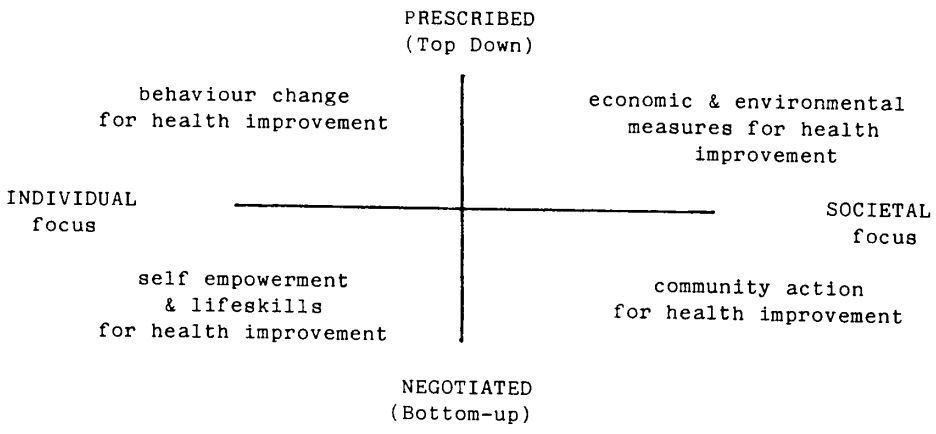
Fig. 5 Alternative Models of Nursing



This diagram can also draw attention to the essential and unavoidable conflicts between different concepts of nursing and of the nurses' role : each different concept represents a fundamentally different orientiation towards power and control in nurse/patient relationships. This repertoire is nevertheless I believe one which must be encompassed much more deliberately. UKCC Project 2000 Paper 6 'Facing the Future' argues that this will require a new emphasis on personal and social development in nursing education and much greater attention to moral and political awareness. Unless I am much mistaken, it is precisely this kind of scenario for the future that the attention to ethics in the Barts curriculum is a preparation for (as seen in Eileen Inglesby's paper to today's Conference).

A particular instance of these shifts in the boundaries of the nurses' role is the enhanced concern in nursing education with health education and health promotion. I sometimes wonder (as a non-nurse!) whether care is being left out of account altogether in the rush towards prevention ... . Two of the papers at today's Conference, by Anna Barnfield and by David Shaw, offer worked examples of the thinking through of a greater emphasis on prevention and patient teaching in connection with heart-heart and mental health. Yet again, I think a structural diagram is of assistance in staking out the choices that face nurse teachers in the health promotion field:

Fig. 6 Conflicting Strategies of Health Promotion



I hope nurse educators are not too bewildered to discover that just as they are getting used to the idea of accepting health education as a key component of professional preparation for nursing, it turns out that its all much more complicated and difficult than they had been led to believe (Williams 1984). But I cannot escape the view that nursing education should be engaging students in discussion and debate on the dilemmas raised by the nursing role in health promotion.

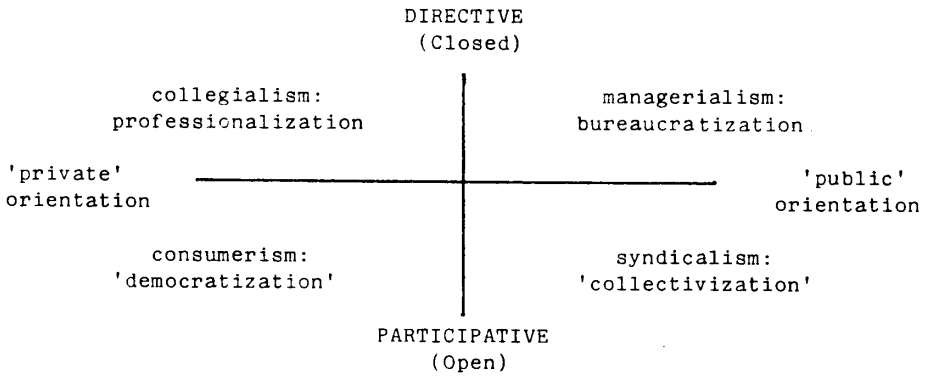
5. Moving into Partnership.

The whole of this paper, the whole of the day's Conference, the whole of the scheme of collaboration between Barts and the Institute of Education, and (it must seem sometimes at present) the whole direction of policy in nurse education in the UK is about 'moving into partnership'. It is easy enough to see why, as the great roll call of Reports in the last year and over the last 50 years has shown - nursing education has been for too long kept out of mainstream general/higher education, it has suffered as a result, and the time has (surely) come to arrange things differently. At this stage, as a way out of my paper, I merely want to pick up a general theme. Evelyn Hide in her paper today describes some of the role shifts and role conflicts her Joint Lectureship faces her with. And Sylvia Docking in her paper shows how she has tried to build structures in the School which can tap into and manage the creative potential of conflict. It is this theme of 'conflict' that I think merits some thinking through. I have no doubt whatever that the strategy of 'partnership' between Schools of Nursing and Institutions of Higher Education that have been envisaged by the ENB and by several RHA's and discussed by the UKCC is one that will lead to a great deal of conflict, and it will be a rude awakening for many (on both sides of the partnership). I think this needs to be faced, and indeed welcomed. It is the creative potential of this conflict that leads me to favour this strategy rather than the wholescale 'lock, stock and barrel' move into Higher Education favoured by others, such as the RCN Commission.

I believe that the experience, and explicit discussion, of different styles of accountability - in colleges, in hospitals, in clinics, in

community centres, in voluntary organisations, etc, needs to be given a central place in the nursing education of the future. I would summarize the issues likely to be encountered in "crossing the boundaries" in this way in one last structural diagram:

Fig. 7 Institutional Arrangements and Accountability



I suspect that serious thinking through of the alternative ways in which the work of the nurse (and other care givers) is regulated in NHS settings and beyond may be one of the most powerful means of preparing nurses of the future for a role as effective change agents. With this in mind, partnership between Schools of Nursing and Higher Education will serve to provide just such a juxtaposition of alternative institutional settings. But even more important, the academic freedom of the Higher Education environment (still real enough, however threatened and vulnerable) will allow the wider discussion of alternatives that is undoubtedly going to be essential.

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SUPPORTING CURRICULUM CHANGE IN NURSING; TRIALS OF AN EDUCATIONAL FACILITATOR

PAPER FOR:

KINGS FUND CONFERENCE ... BLUEPRINT FOR THE FUTURE?

JUNE 3rd 1986

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DEPARTMENT OF SCIENCE AND HEALTH AND WELFARE EDUCATION

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WITH ST.BARTHOLOMEW'S SCHOOL OF NURSING.

SUPPORTING CURRICULUM CHANGE IN NURSING; TRIALS OF AN EDUCATIONAL FACILITATOR.

On September 1st 1984, I was appointed to the post of Lecturer in Nursing Education in the University of London Institute of Education in collaboration with St. Bartholomew's School of Nursing. The post had been created to:

> "promote new academic initiatives in the education of nurses and nurse tutors, linked to long-term programmes of development within both collaborating institutions."

My job Outline consisted of the following:

> " ROLE
>
> The Lectureship is a joint appointment between the University of London Institute of Education and St. Bartholomew's School of Nursing. The Lecturer will be responsible for advanced teaching programmes for nurse educators and nurse practitioners; and will be expected to initiate and carry out curriculum research in te nursing education field.
>
> General Responsibilities will be:
>
> - to assist in the development, planning, and examination of nursing education options within the Diploma of Education and MA courses.
> - to teach, tutor and examine these course options
> - to undertake curriculum research in nursing education
> - to establish links between the Institute of Education and the School of Nursing
> - to assist in the development of a research-based curriculum
> - to act as an advisor to nurse teachers interested in carrying out research
> - to foster research-mindedness within the school of nursing
> - to serve as a resource person in matters related to research in nursing education
> - to facilitate the continuing education and professional development of nurse teachers and nurse practitioners

- to contribute specialist advice, teaching and curriculum development in specific areas of the nursing curriculum"

The University was looking for a qualified nurse teacher with experience and interest in educational research who could improve the traffic in ideas between the University world and the Health Service world. The School of Nursing was looking for an agent of change and for a means of increasing the ways in which theory could inform practice. In this way it was envisaged that many of the requirements of each insitution would overlap, the debates within the School of Nursing informing the content of the courses at the University and vice versa.

As it was an experimental post, the following additional special responsibilities were included:

- "to explore problems of innovation and evaluation in programmes of professional development for nurse teachers and nurse practitioners

- to assist in the review and further development of this joint appointment, and its significance for collaboration between Institutes of Higher Education and Schools of Nursing "

Almost two years on, this symposium provides me with the opportunity to formally review this appointment, to stand back for a moment and reflect on what has been achieved and to examine possibilities for future development.

THE TRIAL

My roles and responsibilities have fallen into three main divisions.

1 Teaching and supervision at the Institute of education.
2 Research to support curriculum change in the School of Nursing.
3 Collaboration between the School of Nursing and the Institute of Education.

Teaching and Supervision at the Institute of Education.

At the University I have taken on responsibilities as Tutor in charge of two courses; the Nursing Education Option in the Diploma in Education, and the parallel option in Nursing Education in the MA in Curriculum Studies. On the Diploma option, I revised the 'study guide' and produced a bank of reading lists for the course, I run seminars, coordinate a visiting speakers programme, and supervise student essay work. I have been officially appointed as Examiner to the Diploma.
On the MA Option, I have similarly revised the course outline and produced a comprehensive set of detailed 'Reading Lists'. I run seminars, supervise student essay work and undertake supervision of dissertation work, jointly with the Head of Department, Alan Beattie.

A particular focus of my work on the MA option has been to develop for the third term, a one term course on teaching decision-making, nurse-patient communications, and nursing ethics as a vehicle for advancing teaching and learning in an area that is of particular interest to me and to the Department of Health and Welfare Studies. I have been officially appointed as examiner to the MA Option.
In addition I have helped to establish links between the Department of Health and Welfare Studies and other initiatives in nursing within London University, namely the Diploma in Nursing run by the University Department of Extra-Mural Studies. Currently I am a member of i) the Curriculum Review Group, ii) a validator of the course and iii) Chief Examiner for Unit 2 of the Diploma (in succession to Alan Beattie). One further project is the production of teaching packages for the professional development of qualified nurse teachers designed to bridge the gap between initial nurse teacher training courses and higher degrees. I am involved (with Alan Beattie) in piloting these at the moment at St. George's District School of Nursing.

Research to Support Curriculum Change in the School of Nursing.

On appointment it was envisaged that my work in this sector would fall into three major areas: acting as a consultant to support a long term programe of curriculum innovation; contributing to teaching programmes by the development of teaching packages; and acting as a research advisor. To this can now be added: carrying out research, and staff development.
In connection with curriculum innovation in the School of Nursing, I joined staff groups working on curriculum development. I have become a full working member of the assessment group developing strategies for continuous assessment.
I offer assistance to the ADNE and Senior Tutor responsible for the design of the new curriculum, as a "sounding board" for their ideas, and as a researcher. The need for this research function has arisen from the curriculum model proposed (that of "situational analysis") which depends on review and evaluation as key components of the developmental process. In fact my role as evaluator of the new curriculum is integral to its research and development. Moreover, as this approach to curriculum planning is novel in nursing, the lack of worked examples necessitates considerably more research and a greater reliance on theory than is commonly found in curriculum innovation in nursing. To date the research I have undertaken includes-:

1 Mapping the role of the nurse using the Delphi technique. (ongoing)
2 Analysis of curriculum documents. (completed)
3 Analysis of School of Nursing documents. (ongoing)
4 Identification of the strengths of the teaching staff. (completed)

Embodied within the curriculum proposed is the concept of "self evaluation" and the "teacher as a researcher." Therefore, as the evaluation proceeds, we envisage that my role will change from one of research to one of staff development and facilitation. In parallel with this, my key relationships within the school are likely to shift from the curriculum planners to the staff involved in post-basic and inservice education.

As regards the production of teaching packages, I have produced a "child care" teaching package in conjunction with a Senior Tutor in the School of Nursing. A new development is that two packages (namely "Mental Health Education" and "Patient Teaching Post Myocardial Infarction") have been produced specifically for St. Bartholomew's School of Nursing by MA students at the Institute of Education. Other MA students have produced more packages for other Schools of Nursing eg for "small group teaching" which can also be used by the school.
As research adviser, I have helped to reconstitute the Nursing Research Committee at St. Bartholomew's and have become a member of it. I also advise on projects carried out by others within the school; I advise members of the School of Nursing on their academic development and draw on the services of the school members as "research assistants" for all the work that I undertake. I also join temporary groups formed to look at specific problems.

Collaboration between the School of Nursing and the Institute of Education.

The collaborative nature of the post has been particularly fruitful, and the academic cross traffic between the two institutions continues to expand. Members of the School of Nursing conduct seminars with the students of the Institute of Education, and members of the academic staff of the Institute of Education participate in INSET study days held in the School of Nursing. It is expected that the need for this kind of study day will increase as the new curriculum moves forward to implementation.
In my position as Lecturer in the University, I have access to leading authorities in educational research and I have been able to discuss with them the research which I am undertaking at St. Bartholomew's School of Nursing. These links have also revealed that the Delphi project is of wider interest in the world of nursing research (eg during Project 2000 at the UKCC). The link between the Institute of Education and St. Bartholomew's School of Nursing has already developed a remarkable momentum of collaborative research and development work. It is striking to see the wider interest that is being taken in this project.

Early In my appointment, a secretary at the Institute of Education said to me "I have just typed a paper on what you do - it's not possible." She may be right, but looking back it is gratifying to realise that I have in fact made some inroads into every area specifed in my job outline. But although there is little doubt that the job has been challenging, demanding, exciting, and stimulating and I would not wish to change it, there have been problems which I would like to talk about. Interestingly they have primarily been ones which were envisaged and which we attempted to avoid. Perhaps they are inherent in a joint appointment and cannot be avoided.
One set of problems concerns workload, and they relate mainly to working in two places and to serving two masters, in this case two masters who, as the head of a school of nursing and the head of a university department, have themselves, to a great extent, been appointed for their vision. No matter how hard I try to organise my

time, it seems that whenever I have planned to work in one place it becomes essential for me to be in the other. The workload can so easily become excessive and, of course, the only work that it appears possible not to take on is that which is the most interesting.
A further problem relates to the conflict between long term and short term priorities. For example an obvious long term priority is to publish reports on the work in progress. Bolam (1974) complains that

> ".....what we lack is any detailed knowledge of the ways in which such people (change agents) actually help teachers in schools...."

This joint venture provides nursing with an opportunity to contribute to the knowledge Bolam seeks. But in a post such as mine, immediate needs and short term priorites constantly drive out that slower cycle of "contributing to the knowledge base."
Another set of problems relate to the role of "consultant" within the School of Nursing. Dean (1975) writes of the role of the consultant

> "there is a need for a consultancy service, for someone to turn to, whose experience is wider, to be seen as a peer to be talked with on level terms."

This requires treading a delicate path between maintaining impartiality while working with and building up trusting relationships with all grades of staff. To err on the side of impartiality is to run the risk of not being seen as a member of the School of Nursing staff; to err on the other side is to run the risk of having my role of independent "outside" consultant (eg in curriculum evaluation) being called into question or compromised.
I think these problems perhaps represent the perils facing an individual in any pioneering job; and perhaps they will find their solution in further organisational development that can give more weight to "positional structures for collaboration" and be less dependent on the "personal" initiative of a solo (or solitary) practitioner such as I have been. I see this future development of collaborative structures as follows:

Holt (1980) argued that while the school itself must analyse its curriculum position and redefine it, it needs connections with professional knowledge and expertise. I was appointed as one of those connections in the school and I am perhaps what Havelock saw as

> "a new type of agency ..... manned by people - 'knowledge brokers,' 'linkers,' 'change agents'.....who can work in the middle between research and practice."

But what Havelock had in mind was a whole team not just a one person agency.
Likewise Hoyle (1973) has suggested the development of professional centres with four functions: Linkage, support, consultancy and in-service education for teachers.
The Institute of Education has considerable experience in providing such a professional service for teachers in the general education

system and I perceive a need for such centres for nurse teachers. My vision for the future is that through many more experimental joint posts such as mine, Schools of Nursing and University or Polytechnic departments will be able to move towards the setting up of such collaborative centres for nurse teachers, perhaps on a regional or subregional basis.

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TOWARDS A CLIMATE OF CREATIVITY ... A STRATEGY FOR INNOVATION IN ONE SCHOOL OF NURSING

PAPER FOR:

KINGS FUND CONFERENCE ... BLUEPRINT FOR THE FUTURE?

JUNE 3rd 1986

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DIRECTOR OF NURSE EDUCATION

ST.BARTHOLOMEW'S SCHOOL OF NURSING

TOWARDS A CLIMATE OF CREATIVITY ..... A STRATEGY FOR INNOVATION IN ONE SCHOOL OF NURSING.

Introduction

When I first became DNE in April 1981 the partnership between my school of nursing and higher education began. It may not have been obvious at that time but looking back my primary concern in 1981 was to create an ethos of creativity and professionalism in the school in order to bring about radical curriculum changes. By creativity I mean that as a school we would develop the capacity to generate, try out, evaluate and adopt new ideas and practices. This seems to be what the Government report, The Development of Higher Education into the 1990's, (1985) is also saying when it describes the reason for the existence of institutes of higher education. This report says that higher education institutions exist for three reasons: scholarship, research and teaching. I believe that this is what creativity is about. I perceive that this sort of creativity in a school is the first step to taking on the values, beliefs and practices of higher education. Any partnership between a school and higher education requires this sharing of values, beliefs and practices. A total shift in ideology is probably impossible for a school working within a bureaucratic health service but a definite shift towards the values, beliefs and practices can and must be achieved if any sort of partnership is to happen.

A creative approach in a school can only be brought about by people. One of my strategies, therefore, was to encourse questioning, initiative, individual autonomy, openness towards people and problems,

constructive management of conflict, reflective and evaluative approaches to teaching and collaboration and sharing between colleagues regardless of position in hierarchy. Secondly, I sought to appoint new teachers who wished to engage in these same activities. Change is more likely to be achieved if these two conditions exist.

The focus of this paper is threefold:-

1. What partnership with higher education means.
2. The creative development of teachers as a means to building a partnership with higher education.
3. Making radical curriculum changes through partnership.

What partnership with higher education means.

To me partnership with higher education has two dimensions. Firstly partnership is about an ideological shift. A school can make such a shift by encouraging questioning, initiative, knowledge building, professional autonomy and accountability, research mindedness and so forth. As a school works towards these it is taking on some of the values, beliefs and practices of higher education. This can happen without any affiliation with any particular institution. The partnership here is between a school and a particular value and belief system. I would suggest that this is the first partnership towards which all schools of nursing should aim.

Then we can look at the second type of partnership - a partnership with a particular institution in higher education.

This can take many forms:-

1. Several teachers in the school reading for diplomas, first degrees and higher degrees at that institution.

2. Teachers from the school participating in teaching sessions at the institution and vice-versa.
3. Resource sharing in the form of expertise and knowledge.
4. Joint production of curriculum materials.
5. The school serving as a place for educational theory from the institution to be tried out and the school bringing a touch of the real world of work to the institution.
6. Joint appointments between the two.

To summarize partnership I would say that one dimension is the partnership between the school and a particular value and belief system. The second dimension is the partnership between a school of nursing and a particular institution.

The creative development of teachers.

If the school of nursing is to function within an ethos of creativity reflectivity, initiative and so forth - then some sort of teacher development is necessary. Part of this is the individual responsibility of the teacher and part is the responsibility of the head of the school.

Our school of nursing approached creative development of teachers in a variety of ways, some of which are similar to activities which are carried out in higher education but some of them are not, but perhaps should be.

Firstly we encourage teachers in the school to continue their own education by reading for diplomas and degrees. We also devolved curriculum development activities down to small task groups. This provided the opportunity to work fairly autonomously and to take on responsibility and accountability for particular activities. Authority in these groups is based upon expertise rather than hierarchy. This also became a trust building exercise because individual task groups were working on behalf of the school as recognized experts in particular areas. Another strategy for building knowledge and trust and for sharing professional ideas and innovations was through the creation of regular departmental meetings outside line management. The running of these meetings is shared by the teachers and the agenda is initiated through suggestions from teachers to an agenda committee.

At least once a year the school puts on a seminar/study day for itself. This is our day. Students in study block on that day are given independent work to do while all the teachers attend the in-house study day. Individual teachers within the school present academic papers to their colleagues and the day consists of presentation of papers and workshops. These study days are a time when teachers present some of their own curriculum development work and where ideas, problems, successes and other change issues might be discussed. Some of the study day topics have been:

Nursing process and the curriculum

Ethics and the curriculum

Our colleagues from the Institute of Education participate in these.

Our continuing education department runs a national annual symposium for nurse teachers which we call the Challenge of Choice. The planning team for this event includes both teachers in the school and colleagues from the Institute of Education. Our policy is that teachers in the school are invited to present papers at this symposium.

A creative school can only function constructively if there is openness and trust and the quality of the relationships is good. Creativity is not only about innovating new ideas, it is also about taking risks. People will only take risks if they feel comfortable. Part of the schools development therefore, involved providing personal and interpersonal skills workshops for teachers in order that we can become more self aware and to relate better to each other.

Our most recent activities are concerned with research. This includes carrying out research as part of our curriculum planning process. Teachers in the school are assisting with this research. Some teachers are involved in their own individual research projects. We have recently organised a series of study day workshops for the school to explore ways of becoming research minded and of incorporating research into teaching.

These are just some of the activities of the school which are directed towards developing the knowledge and skills to work within an ethos of creativity.

I do not doubt that many schools are engaging in such activities. The point is that in order to make the required ideological shift for a partnership with higher education requires an environment of creativity, openness and exploration of ideas and that teacher development is necessary for this to happen.

Making radical curriculum change through partnership with higher Education

Radical curriculum change in nursing can only take place when the teachers have developed the knowledge, skills and values of creativity and the organisation provides the climate for change to happen.
This is one reason why effective change takes so long to happen.
The first few years of a massive curriculum change attempt will be spent on preparing the organisation and the people within it. Partnership with an institute of higher education can help.

The Institute of Education at the University of London provides the theories and expertise about curriculum, and our school of nursing uses these to develop and change educational practice.

Many of our teachers undertake higher degrees at the Institute, use our school for their data collection and implement their research findings, new knowledge and ideas into their teaching. I would like to make the point that other teachers either have or are reading for degrees in other institutions. This is necessary in order for a school to have a healthy balance of specialist knowledge and expertise. It also allows alternative views and ideas to be brought into the school which makes for healthy and often lively debate.

Curriculum studies is a highly sophisticated and developing area of study. Nursing education has traditionally looked to nursing for it's educational programmes. I believe we must look to education as well as nursing for our future educational programmes. This is why we have chosen the Institute of Education for our partnership. Through this partnership we realise that curriculum planning in nursing education must be based on curriculum planning models rather than nursing models, and that nursing models are only part of the content within a curriculum.

In making our radical curriculum changes we appointed Sue Studdy, a graduate of the Institute, to co-ordinate curriculum development in the school. She has created a curriculum planning model which we are using for our radical curriculum change.

For the moment the culmination of our partnership with the Institute of Education is in the joint appointment and the curriculum activities surrounding this appointment.

The post is a joint lectureship in nursing studies between the Department of Health and Welfare Studies, The Institute of Education and the St.Bartholomew's School of Nursing. It was established in September 1984 and Evelyn Hide was appointed. The post is concerned with research and with the assisting of the school in it's long term programme of major curriculum and organisational change. Evelyn will describe her post in detail in her paper and the activities in which she has been engaging on behalf of the school.

The radical curriculum changes to which I have referred are a result of partnership with a particular institution, the Institute of Education at the University of London as well as the partnership with the values, beliefs and practices of higher education in general. Many of our curriculum changes are happening because the people making them are creative, questioning, open, reflective and evaluative. They have this partnership with the ideology of higher education without necessarily being personally linked to any institute of higher education.

The case studies being presented in the afternoon will be from some teachers who have direct links with the Institute of Education as well as other teachers who have no such links. What they have

in common, however, is a personal partnership with the values and beliefs of higher education.

Conclusion

Once the organisation and the people within it take on board the ideology of higher education they are in a position to form partnership links with specific institutes, colleges or universities. One can argue that if a school forms a direct partnership link with an institute first and waits for the values and beliefs of that institute to "rub off", there is a danger of the school of nursing entering the partnership on unequal footing and being taken over by the institution of higher education. True partnership is about equal sharing and this can only happen if both the school of nursing and the institute of higher education are working from the same value system.

Education is the foundation of excellence in nursing practice. The trite words we use to describe professionalism in nursing include those such as "accountability", "autonomy", "research mindedness" and "research based practice". These will only be achieved through education rather than just training.

Schools of Nursing should always be in the business of producing safe and skilled practitioners. Taking on board practices of higher education - scholarship and research - alongside teaching should not detract from this product. It will, in fact, enhance the product.

I believe that schools of nursing should enter into partnership with higher education. This partnership will enable teachers to more

actively and positively influence nursing practice and meet the future demands of the profession.

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BLUEPRINT FOR THE FUTURE?

Eight Case Studies in Curriculum Development

KINGS FUND CONFERENCE .... BLUEPRINT FOR THE FUTURE?

Eight Case Studies in Curriculum Development

Many teachers in the School of Nursing are involved in major curriculum developments. Seven such developments will be presented. They represent curriculum developments in both basic and post-basic nursing education and also represent major total curriculum innovations as well as innovations in parts of the curriculum.

Included in these case studies are examples of various dimensions of the curriculum such as curriculum design, curriculum planning, innovative assessment and evaluation strategies and teaching methods, new maps of health knowledge and teaching packages.

The case studies will be presented as market place poster sessions. This means that the various teachers will display material related to their particular curriculum development and will be available to explain, discuss and answer questions which arise. The participants on the study day will be free to move from session to session as they wish and spend as much time as they like at each display.

We believe that the case studies which are being presented demonstrate the exciting outcome of fostering creativity in a school through partnership with higher education.

Case Studies

1. Selecting and using a curriculum planning model

   Susan J. Studdy
   Assistant Director of
   Nurse Education

2. An Innovation in a Post-Basic Oncology Nursing Course:
   A Negotiated Curriculum

   Diane Marks-Maran
   Tutor

3. The Development of an Ethical Component within
   the Curriculum

   Eileen Inglesby
   Clinical Teacher

4. Teaching Mental Health Education in the Basic
   Programme for General Nurses

   Anna Barnfield
   Tutor

5. The Preparation of Student Nurses for their
   Health Education Role

   David Shaw
   Tutor

6. Learning and Teaching Strategies I & II

   Terry Maunder
   Tutor

   Janice Scott
   Tutor

7. The Production of a Teaching Package for
   the Child Care Component of the
   General Nurses Curriculum

   Joan Ramsay
   Senior Tutor

   Tina Cheetham
   Senior Tutor

   (Joan Ramsay and Tina Cheetham are now Senior Tutors
   at the Hospital for Sick Children, Great Ormond Street).

8. Assessing Problem-Solving Skills

   Daryl Evans
   Senior Tutor

SELECTING AND USING A PLANNING MODEL

In 1985 a decision was taken to plan a new RGN programme. In my role as curriculum co-ordinator my first task was to consider whether a curriculum planning model would be helpful to our purpose, and if so, which model should be used.

The criteria developed for the selection of a curriculum planning model, together with a detailed description of the cultural/situational analysis model and its application in nurse education, are presented and discussed.

Curriculum planning is a deliberate, planned, purposeful and highly complex activity involving a detailed consideration of a number of elements. A curriculum planning model helps to clarify the elements and procedures involved, the interrelationship between them and whether they should be accomplished in a particular sequence, as well as giving structure and a necessary sense of direction. A model also provides a momentum for action, encourages decision making and critical analysis and assists in an explanation of how the curriculum is being developed. (Skilbeck, 1984).

Furthermore, it helps the planner to focus on the whole curriculum and to view each stage of the development in this context. For these reasons the decision to use a model was taken and three were considered:

- The objectives model
- The process model
- The cultural/situational analysis model.

Criteria for the selection of a model were developed, and the cultural/situational analysis model was selected.

This approach to curriculum planning has been increasingly acknowledged as an alternative to the objectives and process models in general education, mainly due to the work of Lawton (1973; 1975; 1983) and Skilbeck (1976; 1984). Both of these

educationalists have developed their own model, each emphasising different aspects of curriculum planning.

An eclectic model which I have developed using aspects of both Lawton's and Skilbeck's work is presented and discussed.

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AN INNOVATION IN A POST-BASIC ONCOLOGY NURSING COURSE: A NEGOTIATED CURRICULUM

This presentation will be about an innovation in curriculum design for a post-basic oncology nursing course. The innovation is about putting into practice a curriculum planning model using a framework described by Beattie(1986) based on concepts about how knowledge is structured and who has power and control over decisions as described by Bernstein (1971).

The curriculum model explores the way curriculum decisions are made and who controls curriculum decisions. Using the model, I have identified ways of sharing power and control over the structure of knowledge so that curriculum decisions are made through negotiation with teacher and students. This shared decision-making through negotiation includes decisions regarding content, teaching methods, course assessment strategies and evaluation. The research I am doing towards an M. Phil. at the Institute of Education is an illuminative case study of this negotiated curriculum. It examines the use of the curriculum model, using learning contracts and critical incidents as a way of identifying issues which are important to the students and explores the way in which personal and interpersonal skills development enables students to identify and negotiate their learning needs for oncology nursing.

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THE DEVELOPMENT OF AN ETHICAL COMPONENT WITHIN THE CURRICULUM

This display is concerned with the place that ethics should hold within the curriculum. I hope that it will emphasise the universality of ethical decision making and show its importance to extend beyond that which is 'merely academic'.

'Nursing' ethics are commonly seen as a subsidiary of 'medical' ethics - more specifically as the role nurses play in 'medical' ethics. Issues which are often covered within lectures and seminars on 'nursing' ethics are those which make headline news: abortion; euthanasia; transplant surgery; in vitro fertilisation. These issues and others which are commonly termed as 'medical' ethics are, of course, relevant to all nurses but are not central to the everyday practice of most nurses; nor should they be seen as the core material for the ethical input to the curriculum.

I believe the danger of presenting ethics solely as 'headline issues' is that one may miss the everyday ethical decisions that nurses make - decisions that they may not even see as ethical because they are not publicised as being such. The more obvious decisions might involve telling patients the truth, patient's choices about care and confidentiality. Less obvious examples might be decisions regarding priorities of care for patients or whether a nurse decides to believe an elderly lady who is generally reluctant to mobilize when she says she is not up to walking to the sitting room that day.

It may seem as if these parameters are large enough to include most decisions that a nurse might encounter and indeed this view is not as extreme as it might at first seem. An ethical decision is <u>any</u> decision that is based upon the decision maker's beliefs about what is right or good. Most decisions that nurses make concerning patient care are based upon what they believe to be best (or right) for the patient. One does not need to be an expert in moral philosophy to make ethical decisions but one must understand what it is that one believes and values.

If we view ethics as being as much about individuals' values as it is about theories and moral philosophies' then its position within the curriculum must logically change to occupying a central role rather than the peripheral one that it commonly holds. This might mean basing a curriculum upon the moral, personal and social development of the learner nurse or spiralling a developed ethics content throughout an existing framework. The mechanics of this integration must depend, however, upon the curriculum structure and beliefs upon which it is based.

TEACHING MENTAL HEALTH EDUCATION IN THE BASIC PROGRAMME FOR GENERAL NURSES

The workbook presented during the 'market place' session of today's conference is a guideline for an introductory WORKSHOP on the use of values clarification strategies to help teachers of nursing to clarify their own values about mental health education.

The need for such a workshop grew from the findings of my research into the teaching of mental health education in the curriculum of the programme leading to registration as a general nurse in my own school of nursing.

In 1980 the Health Education Council carried out a survey into schools of nursing to discover what teaching was carried out to prepare student nurses for a role in health education. The response rate to their questionnaire was 43% which could form the basis of speculation with regard to the degree of importance attached to the subject by schools of nursing. From those who did reply it was discovered that:

> "responses ... indicate little involvement with mental health".
>
> (Health Education Council 1980 p.70)

In my own school of nursing this finding was not supported by the research I carried out. What the research did indicate was that mental health education was included in the curriculum in a form and content under a number of other titles. I would suggest that this can only lead to confusion in a form of education which is itself complex and will lead to failure in presenting this part of the curriculum:

> "in a form that is open to critical scrutiny, and capable of effective translation into practice".
>
> (Stenhouse 1975 p.4)

A number of conclusions were drawn from the research but two of them were identified as fundamental to curriculum development and lead to the construction of this workshop.

The first conclusion:

That there is a need for a forum to facilitate the clarification of the constructs: mental health

Mental Health Education for Teachers

The long association of mental health with mental illness has probably influenced the thinking of a majority of teachers as it has the general public. To some extent the research asked teachers to disconnect mental health from mental illness and connect it with 'education', this in itself caused questionning, confusion and uncertainty. However, the research alone was not the only factor that may have caused these processes, as attempts to associate 'mental health education' with 'psychology' indicate that they were already underway.

It is clearly unrealistic to proceed with curriculum development until teachers themselves are clear about the nature of mental health when it is no longer referenced to a concept of mental illness; and consequently there is a need to become clear about the nature of mental health education.

The suggested structure of this forum is available in the guideline for the workshop, which can be found in the section titled 'Mental health education'.

The second conclusion:

That there is a need to recognize the value positions which underpin the understanding and practice of mental health education

The evidence demonstrated that a majority of teachers teach the aspects of the curriculum they consider mental health education in relation to patients from within a biopathological paradigm of health; and in relation to students from with a biopathological and biographical paradigm. (Please see the four paradigms of health (mental health) in the display.) These two paradigms contain values that conflict with each other, as well as conflicting with the values in the ecological and ethnographic paradigms.

Curriculum development in relation to mental health education, and development of the skills to teach it are seen as dependent on teachers being provided with an opportunity to address themselves to these conflicts and clarify their own values.

I designed the workshop using one theory of values clarification (Raths el al. 1966 and Kirschenbaum 1977) demonstrating how it can be used to aid teachers to clarify their values about mental health education.

The workshop is perceived as facilitating two processes: the first, allowing teachers to address the conflicts, perspectives and values assumptions raised by the research; the second, being a step towards a clearer conceptualisation of what the content and process of mental health education should consist of in an education programme for preparation as a general nurse.

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THE PREPARATION OF STUDENT NURSES FOR THEIR HEALTH EDUCATION ROLE

My presentation will address the problems of introducing a health education component into the nursing curriculum. Such an undertaking must be seen as problematic for the following reasons:-

1. Designing and implementing a health education curriculum forces us to address some fundamental questions about the kind of health education role nurses should adopt, their relationship with other health care workers and indeed with their patients/clients.

2. There is likely to be a lack of fit between existing illness-orientated hospital-based curricula and some of the basic tenets of health education.

3. Many nursing curricula do not equip students with the knowledge, skills and attitudes which are necessary pre-requisites to developing health education skills.

4. It is questionable whether the majority of nurse teachers have developed the necessary knowledge and skills to implement a health education curriculum. It is certainly true to say that there is very little documented research to guide teachers in this respect.

5. We have yet to develop satisfactory means of assessing and evaluating a health education curriculum.

These problems were illuminated by the work I did while reading for my MA at the Institute. Using Skilbeck's Model for School Based Curriculum Development, I carried out a critical review of the newly introduced health education curriculum within my own school. Having identified the problems outlined above,

I then proceeded to make a small contribution to the field.

My contribution was to take the form of an experimental workshop in which various experiential teaching methods were tested and, in particular, a live patient simulation exercise was designed and tested. In order to give the workshop focus, I decided to centre it on the area of my own clinical interest which is post-coronary health education.

This classroom research was not intended to produce a definitive teaching methodology, but to offer a contribution to the pool of resources from which teachers can draw materials and ideas. It was, however, only a very small contribution in the sense that it was concerned with only one area of the health education curriculum, i.e. post-coronary health education. There is clearly a good deal more work to be done, and it is my conviction that the majority of teachers in the school be involved in this work. I drew a great deal of inspiration from the original work of Lawrence Stenhouse, and later work by John Elliott and Clem Adelman. They envisaged a style of curriculum development which is fed by and accessible to individual teachers. This approach to classroom research is borrowed from the social-anthropological tradition and therefore tends towards a qualitative methodology. Within this paradigm the teacher becomes more systematically self-conscious about what is happening in the classroom, he is more likely to engage in experiment, self-criticism and the sharing of experiences with colleagues. This also opens up some exciting ideas for the development of a professional/democratic model of educational accountability.

In the course of the presentation I shall be happy to discuss my research in detail, and to discuss issues arising from any of the problem areas identified above.

LEARNING AND TEACHING STRATEGIES I

This presentation will be concerned with the use of experiential learning techniques in the classroom. As a teacher primarily involved with the psychiatric unit of learning of an RGN curriculum, I have both created experiential exercises and used ones from other sources to explore a variety of subjects.

Experiential learning occurs when a learner engages in a particular activity, reflects upon it and extrapolates useful insights which can be put to practical use. If employed as teaching strategies, experiential techniques enable learners to examine their feelings, behaviour and attitudes; such techniques have developed from learner-centred philosophies of education and social sciences such as humanistic psychology and sociology. Learning can occur through experiences (such as role play) or from previous experiences applied to a situation in the present; insights drawn from experiential learning can facilitate personal and interpersonal skills and foster self-awareness. Unlike lessons where didactic teaching methods are employed (which may involve learners passively receiving information), the learning that takes place in lessons that are facilitated using experiential techniques is more self-directed: Knowledge and control are not vested totally in the teacher. Specific techniques that I have employed include role play, sculpting, fantasy and games; fuller explanations of these terms will be found in the books and articles recommended in the reading list.

The use of these techniques in the psychiatric unit of learning represents an innovation for several reasons. Prior to the current

programme, the emphasis in terms of content tended toward didactic methodology in the context of biopathological paradigms of mental illness. Content and methodology has changed in emphasis to explorations of feelings, attitudes and psychiatric nursing skills, enabling learners to experience a wide variety of activities and consider other paradigms of mental health/illness. Since learners explore theories and skills through participation and sharing of experiences, peer group teaching occurs. Learners are able to practice nursing skills in the safe environment of the classroom before putting them to use in the clinical area. Self-directed learning is enhanced since the programme is negotiable and experiences (which rely less on informative interventions) must necessarily be supplemented by reading. Teachers and learners are able to share more in the interpersonal dynamics of the classroom, especially since experiences are continually evaluated. Learners are thus involved in personal, interpersonal and social development throughout the unit of learning. I am indebted to my colleague, Ms A M Barnfield, who has shared with me in facilitating these developments. I have, in addition, employed these techniques in the whole RGN curriculum. The main feature of the presentation will be participation in an experience used in the classroom to convey a particular sociological theory.

Visual aids will include a reading list, poster(s), handout on evaluation of learning and handout on facilitator learning.

My colleague, Ms J V Scott, will be facilitating a concurrent presentation (see separate abstract). Each demonstration will take place in a separate area.

LEARNING AND TEACHING STRATEGIES II

During the afternoon, I will facilitate a session, exploring the art of questionning.

Mr T Maunder will be facilitating a concurrent presentation (see separate abstract). Visual aids will be shared, but each session will take place in a separate area.

This presentation will explore experiential techniques used in both personal and interpersonal skills development, for it has become apparent that the use of didactic teacher centred education strategies are not enough in the development of the professional nurse.

> 'Maturity, responsibility, insight and the ability to cope with stress in oneself and others cannot be learned by just watching and listening'.
>
> (Briggs, 1974. Section 253 p.80)

Research points to carers inability to communicate effectively or develop a therapeutic relationship with their patients/clients. Nurses, when faced with a situation which threatened their authority ensured that they removed themselves from the 'danger area' (Stockwell 1972). As a consequence, both nurses and patients have suffered because nurses have learnt survival skills, based on anxiety and stress.

As teachers, we have a dual responsibility; not only to facilitate the development of interpersonal skills but also to increase the learner's ability to support themselves and each other. For in increasing a learner's ability to communicate effectively, we increased their contact with the patients/clients pain.

In acknowledging this two-fold responsibility the communication skills programme initiated in introductory course will spiral through the RGN course, concurrently with the development of personal skills eg increased self awareness and positive regard; relaxation techniques, time management.

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THE PRODUCTION OF A TEACHING PACKAGE FOR THE CHILD CARE COMPONENT OF THE GENERAL NURSES CURRICULUM.

When Tina Cheetham was appointed as Paediatric Tutor at St. Bartholomew's School of Nursing her main remit was to re-organise and develop the Paediatric component of the General Nurse Training Course there. In this venture she worked closely with Joan Ramsay, Senior Tutor. As they progressed it was realised that much of what had been learned as a result of their innovatory work would be valuable to a much wider field than St. Bartholomew's School of Nursing and that a means of dissemination should be found. As part of the dissemination strategy it was decided to produce a teaching package which would eventually be published. On examination of published paediatric teaching packages, they (the packages) appeared to concentrate mainly on the psycho-social aspects of child care. This, although in many ways laudable, seemed to leave large gaps in the paediatric component of the general nurses curriculum. It was decided therefore, that the package should be "issues based", a strategy through which we believed that the essential knowledge base and skills foundamental to child care could be identified while enabling the student to appreciate its conditional nature. It was also decided that it was important that the package should enable the student to be provided with "meaningful personal experiences" to which they could relate.

In this way we believe we have produced a balanced package which provides the students with broadly based introduction to the fundamentals of child care.

ASSESSING PROBLEM - SOLVING SKILLS

This presentation will outline a strategy which has been designed to assess the level of problem-solving ability attained by student nurses. The Problem Solving Case History can be used at any stage in the RGN Programme for learning diagnostic purposes as well as for summative assessment of learning. It has been developed by the St.Bartholomew's School of Nursing following the work of Rowntree (1977) and Boreham (1977), and will be used as part of an overall strategy of assessment which runs through the RGN Programme.

The school set up a Student Assessment Curriculum Working Group with a remit to review the then current system of theoretical assessment and to devise a new system. It was believed that any new system should be based on such innovations as a more student centred approach, formative as well as summative assessment, emphasis on the Competencies now required of a nurse and inclusion of problem solving skills.

A system of seven assessments was devised, placed at strategic points throughout the course. These seven consist of varied methods of assessment, including Problem Solving Case Histories of different designs placed at the ends of the first, second and third years. Following devolution of the examination management to individual schools of nursing, the seventh and last assessment has become the Final Examination.

The new assessment system is flexible and capable of evolving along with the current development of a new curriculum. In particular it seems that the Problem Solving Case History, because it is essentially an assessment of cognitive levels, can be adapted to assess these levels within the context of varying aspects of the curriculum, and varying expectations of the students overall development.

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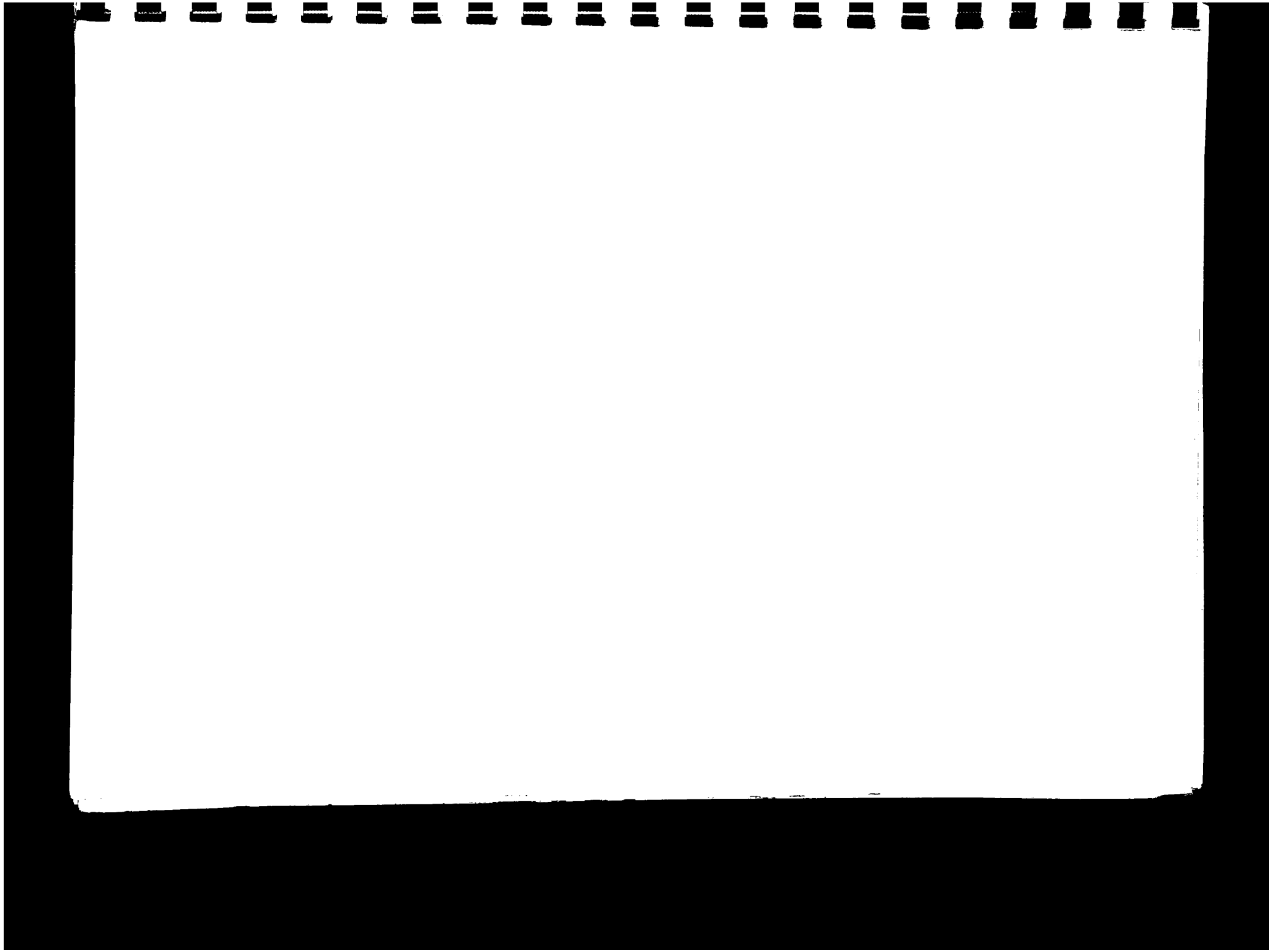

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