

## **Paper 2: 'Report on a tour of the United States of America, Canada and Australia to study psychiatric nursing, May 1960-April 1961'.**

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### **[Report to the Commonwealth Fund]**

This is, of necessity, a very brief report of an exceedingly full and profitable year spent in the United States of America, Canada and Australia. The trip was made possible through the generosity of the British Commonwealth for Nurses Scholarship Fund, who awarded me a scholarship in 1959, the Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and the S.E. Metropolitan Area Nurse Training Committee who granted me a year's leave, and helped to finance the journey. I enclose a list of hospitals and other agencies I visited, and will later prepare a detailed account of all that I believe to be of special interest to us in this country.

It is not possible or appropriate to give details of all the many people whose acquaintance I made during the year and who offered me hospitality, friendship and a host of memorable experiences. I should, however, like to thank them all here and to stress how much the private enjoyment has contributed towards the professional experience. It is, of course, impossible to understand the significance of a people's attitude to work, to sickness and to the profession without a love of its culture. Living in the U.S.A. for nearly a year meeting people in their own homes, meeting their families, sharing with them leisure and work, enjoyment and anxieties, has helped me to understand a little more about the U.S.A. than I had done before. I met people in all walks of life, rich and poor, white and coloured, young and old, intelligent and stupid. I met many people in no way connected with nursing and learnt a little about the way they view their health services and the nursing profession. I met doctors and other health workers, and nurses of all kinds - ranging from the newest students to those in top level executive positions, professional nurses, auxiliary nursing personnel, hospital staff and public health nurses, faculty and students in University and in hospital schools.

Meeting so many different people can be a confusing experience. Having formed some conclusion about the U.S.A., these promptly had to be revised in the light of new experiences. However, there is no short and simple way to knowing so large and complex a country as the U.S.A. I am profoundly grateful that I was able to spend so long in the U.S.A., and that I never felt I had to hurry. Time and time again when I stayed several days in the same hospitals I gained information during the last day of my stay only because during the early part my hosts and myself had had time to relax, to know each other well and to trust each other. I could not help reflecting on the arrangements I have seen for some of our overseas visitors and for some English nurses in the U.S.A. Whilst congratulating myself on my good fortune in having arranged a leisurely trip, I should like to make a plea to all who are concerned with arrangements of tours, to allow for fewer and longer visits. I should like to thank Miss Rowe and Miss Selby-Lownes for their help and Miss Deane for her part in smoothing my way on this side of the Atlantic.

My thanks are due to the American Nurses Association for their invitation to the Convention, and for arranging observation visits in New York, Washington and Baltimore. To the American Nurses Foundation, and particularly to Dr. Hardin, for giving me so much interesting information, allowing me to browse and for all the helpful suggestions. To the many nurses in the National League of Nurses for discussing with me nursing policy, standards, examinations and many other topics.

I am grateful to the Dean and faculty of Boston University School of Nursing for accepting me as a student and helping me to understand nursing education.

Most of all I should like to thank Mrs. K. Steele, Director of Nursing Services in the State Department of Mental Hygiene, for the tremendous help she has given me during the 3 months stay in California. Her constant help and support, her advice, and her introduction to nurses in other State Departments were of inestimable value to me. I should also like to thank her and Dr. Blain for doing me the honour of inviting me to serve as training consultant to the California State hospitals. I hope that they found their trust in me justified. For me it was of tremendous value to be invited into the hospitals, to be so warmly received and so completely accepted during my stay in California.

While I do not wish to detract in any way from the value contact with the A.N.A. has been to me, I should like to emphasise the advantages of contact with State Departments of Mental Health for any nurses who wish to gain information about psychiatric nursing in the United States. My own initial contacts were with the State Department of California, and thanks to Mrs. Steele I met nurses in the State Departments of New York, Massachusetts, Connecticut, Iowa, New Jersey and Washington all of whom were extremely helpful.

My first week in the USA was spent at Miami Beach, observing and participating in the Convention of the A.N.A. This was a very stimulating experience. The number of nurses present alone, made it a most impressive Convention. There were so many meetings going on simultaneously that it was difficult to choose the most interesting and worth while.

During my later visits to schools of nursing, in the U.S.A. I came to appreciate more fully the value of having listened to American nurses discussing their profession right at the beginning of the tour. Quite frequently, later, when I was inclined to be critical of nursing practice or nursing education, it was good to remember how seriously American nurses criticised themselves and how many different opinions I had heard expressed about every conceivable professional topic, during the week in Miami Beach.

When I first tried to formulate my aims and objectives, I put very high on the list my desire to find out how psychiatric nursing was incorporated in the basic comprehensive nursing course. Internationally a comprehensive training appears to be the aim and there are many people in this country who would like to see the end of the General Nursing Council's separate registers for Mental Nurses. Instead, they would like to see the student prepared in a comprehensive training for first level positions in all branches of nursing.

I had myself been concerned with providing students in general nursing with a short experience in the psychiatric hospitals. Having had serious doubts about the value of this, and no idea at all about the best way to introduce the student to psychiatry, I had hoped that in the United States, where this was no new idea, I would find clearly defined aims, well planned curricula, and sound evaluation of the psychiatric experience.

In order to study specifically the psychiatric affiliations, I felt the need to acquaint myself with many other aspects of nursing and mental health in the U.S.A.

It was necessary to find out what provisions there were for the mentally ill, both in institutions and in the community, how mental health and mental illness were viewed by the public in general, the patients, their relatives, and professional people in particular. The care of the mentally ill and the education of the people who provided care had to be looked at. Nursing education as a whole, not only its psychiatric aspects, had to be understood. To evaluate basic nursing education, it became necessary to learn something about the provisions for post graduate studies, the career opportunities in nursing and the problems relating to inter-

professional tensions between nurses and other health workers.

Nursing education cannot be properly understood without some idea of the general educational ideals and practices in the U.S.A., and nursing cannot be viewed without a knowledge of the people's expectations of and attitudes to doctors, hospitals and health services.

My terms of reference became so wide that obviously a year was not enough to answer all my questions. My initial problem, the integration of psychiatry into the comprehensive nursing training was the one which in the end received least illumination, and I became increasingly interested in the education of those people who gave nursing care to patients. but who were not, in fact, nurses - people called aides, or attendants, or technicians in different states!

A year turned out to be too short a time to learn enough about nursing in the U.S.A. It is, however, I believe, the maximum time during which I personally could have remained sufficiently detached to be a visitor and so gain the kind of information I was seeking. If I had stayed any longer, I would have become involved in nursing problems and could have felt that I belonged to the U.S.A.

A year, I think, is also almost too long to try and remember what conditions are like in one's own country and to compare objectively what one sees with what one remembers. I found it very hard at times to prevent my memory playing tricks on me.

Towards the end of the year, I could only remember the best of what I had known in Great Britain and even that took on a rose-coloured hue. I had to remind myself, quite forcefully, that I had found plenty to criticise in this country, and that my desire to travel had been fostered by my discontent with conditions as they were.

Throughout my stay in the U.S.A. I attempted to visit hospitals which had something of value to offer, and to talk to people who were well informed and had new ideas for the future. I did not go out of my way to see the worst. On the other hand, my American hosts made no attempt ever to restrict my visits to showplaces. They allowed me free access to all their facilities, invited me to all their discussions and conferences, and, frequently, deliberately showed me those aspects of their provisions about which they were most worried or concerned. In all I believe I saw a very fair cross section of hospitals and clinics and spoke to a very representative sample of people.

Perhaps the most startling difference between American nurses and British nurses is the easy unembarrassed way in which American nurses allowed me to see not only what they thought good, but also what they thought bad, the way they included me in discussions and meetings in which their shortcomings or their staff problems were being discussed.

I spent approximately one-third of my time in the U.S.A. in California, as the guest of the State Department of Mental Hygiene. During this time I visited 6 mental hospitals, 4 hospitals for the retarded, 1 University clinic and 2 community clinics. I spent considerable time discussing mental health problems with the staff of the Department of Mental Hygiene, with nurses at the Public Health Department, and with Members of the faculty of the University of California in San Francisco.

My main interests were in the provisions for the mentally ill under the Short-Doyle legislation, in the standards of care in the hospitals I visited, and in the in-service training programmes for all the staff in the hospitals.

About one-third of my time was spent at Boston University where I enrolled as a special student in the

School of Nursing. There I had the opportunity to gain first-hand knowledge of masters and doctorate courses in psychiatric nursing. I had the opportunity to meet student nurses from a variety of schools, participate in the clinical experience of students and to gain experience of University life in the U.S.A. During this time I paid particular attention to nursing research, particularly in the psychiatric field.

The rest of my stay in the U.S.A. was spent on observation visits of short duration to hospitals and schools of nursing in Chicago, Iowa, New York, Baltimore, Washington D.C., New Jersey and Hawaii. During this time I tried to get a varied picture and to see especially places which were in some way unusual or even unique.

At the end of my tour I spent a short time in Canada, too short to appreciate the special features of Canadian psychiatric problems. I had a very interesting time in all the hospitals I visited, and would like to take the opportunity of thanking all concerned, and particularly Miss McColl, for the arrangements and for their hospitality.

In Australia I visited several hospitals in Sydney and Melbourne, and on my return journey I spent a most enjoyable morning in the Woodbridge Hospital, Singapore.

Every one of the hospitals and schools I visited deserves a detailed description and evaluation. In this report it is only possible to give an overall view, and to discuss some of the general observations and conclusions.

## **COMMUNITY CARE**

There is a growing awareness among professional people in the U.S.A. of the need to decentralise mental treatment. In some areas, particularly in the West, psychiatrists believe it to be better for the patient to be treated outside mental hospitals, but this is not a universal opinion. Many analytically orientated psychiatrists treat their patients in hospital for long periods when hospitalisation as such did not appear to me to be of benefit.

However, an attempt to stop the building of large hospitals and to provide a variety of local clinics and treatment facilities is gaining popularity.

In the past there have been few enormously large mental hospitals - the largest I visited has 8,500 beds, there are larger ones. Patients and their relatives travel hundreds of miles and obviously it is impossible, under such conditions, to provide effective aftercare, to give help to the family or to encourage the patient to maintain contact.

Decentralisation and provisions for community care take many forms. I have seen day hospitals, psychiatric wards attached to general hospitals, out-patient facilities and special clinics for alcoholics.

Public Health Nurses are becoming increasingly concerned with their role in psychiatric work, and are studying psychiatric nursing in post-graduate courses. They are involved in research projects, attempting to see what help they can give before, during and after a mental illness. Psychiatric nurses are being used as consultants by public health nurses, and there are some interesting projects to help psychiatric nurses to learn the principles of consultation. Dr. Gerald Caplan in Boston in particular has developed this idea.

Psychiatric social workers on the other hand do not appear to concern themselves at all with the community or the social effects of psychiatric illness. They prefer to do "case work" with individual patients or to conduct group therapy. I found it difficult to distinguish their function from that of the

psychiatrist or the psychologist.

Community provisions depend to some extent on special legislation being passed. This is necessary to provide the money and also to make it possible to provide treatment without recourse to the usual laws. In California the Short-Doyle Act has made it possible for the local communities to plan psychiatric facilities in connection with the community hospitals.

I saw two such clinics. These are centres for out-patients, are responsible for education of the public as well as providing in-patient facilities.

The ward in San Mateo was one of the most interesting units I visited. It is in some ways, similar to an observation ward in this country in that it has to accept all emergency admissions. About one-third of the patients remain in the ward for up to 90 days for treatment, the others are transferred to other hospitals within a few days. It was amazing to see the improvement effected in a very short time as a result of the wonderful atmosphere of the ward, the enthusiasm of all the staff - medical and nursing, and their very high degree of skill.

Group therapy was used and all the staff being kept fully informed. All doctors were present at morning report, all staff met during the morning, and all details of treatment were fully discussed. The ward was open, patients acted as receptionists and kept the door under observation. The kitchen was freely accessible to all patients, who made coffee and helped themselves to nourishment from the refrigerator.

Nurses did not wear uniform.

Many of these features were observed in other hospitals too. I mention it here because it impressed me, particularly in view of the very serious disturbance of all the patients on admission and the tremendous improvement observed.

The problem of involving the community more in the treatment of patients and organising quicker discharge and better follow up is highly complex. It is different in each state, partly because of the geography, partly because of the different laws which apply in each state to the compulsory detention of patients, partly because the provisions of mental health services are intimately connected with politics. Each state approaches its problems differently, but the deep concern about the problem is universal.

On the whole I thought the laws relating to mental disorder restrictive. States vary in the extent to which they adhere to application of their own laws and in some states, patients are being admitted without formality to wards in general hospitals or to day hospitals.

The extent to which politics enter into decisions about the care of the sick was a surprise to me. Many professional appointments are made on political grounds and changes in staff follow on the election of a new Governor. This affects planning of all the facilities for the mentally ill, but in particular, community care.

## MENTAL HOSPITALS

I saw a very large number of hospitals, all of which were newer than most hospitals in this country, some were brand new or not even completed. Hospitals are generally much larger than we would consider desirable. The very large ones are not favoured by the Americans themselves, but they apparently do not consider 3,000 beds too large, and are constructing wards for 60 patients even now.

On the whole, bedroom facilities are good. bed spacing better than in many English hospitals. A lot of attention is paid to kitchens and dining rooms.

All hospitals have excellent gardens, in every hospital attempts are made to provide hairdressing facilities, washing machines. All patients have access to iced drinks, coffee and tea at all time.

The day rooms are small, overcrowded, uncomfortable and drab and on the whole least thought is given to the patients' sitting-rooms. Chairs are very uncomfortable in rows along the walls or in front of the T.V. set. This lack of attention to day-room facilities is very much in keeping with the Americans disregard for sitting-room comfort in their own homes. Plans for improvements rarely concern the sitting-rooms.

Bathroom and toilet facilities seemed poor in comparison with the very high standards which Americans are accustomed to. There is no provision whatever for privacy. Even now toilets are being built in new hospitals without seats and with no doors at all. In some hospitals patients wash under cold running water at a communal wash-basin.

There are very excellent laboratories; clinical rooms; most elaborate arrangements for dentistry; chiropody; X-ray and every conceivable physical investigation and treatment. All hospitals have central supplies for sterile equipment and most have central linen rooms.

A very high percentage of beds is set aside for medical and surgical illnesses. I did not succeed in finding out why so many should be required but two possible explanations offer themselves:

- 1. Most hospitals would like to be accredited by the American Medical Association, by the Psychological Association, the Dental Association, etc., or they have just achieved accreditation. To do so there must be a wide range of experience available to resident students; and it seemed that this determined the provision for sick beds.**
- 2. It is easier to obtain the services of physicians, surgeons, dentists, pathologists etc., than psychiatrists. Because the state hospitals have no link with other hospitals, they must employ their own specialists in every field, and must then find them enough work!**

Most states allow more generous provision of nursing staff in the medical and surgical wards and it may be in the patients' interest to house as many as possible in these parts of the hospital.

The hospitals are generally divided into at least three areas:

- 1. Acute treatment wards i.e. admission wards and acutely disturbed wards.**
- 2. Continued treatment wards. i.e. long stay wards**
- 3. Medical and surgical wards.**

Some hospitals have separate facilities for geriatric patients and for children.

All hospitals have good recreation rooms, many have bowling alleys, sports grounds. All have workshops and O.T. departments. All have canteens and shops.

## PATIENT CARE IN MENTAL HOSPITALS

It is important to emphasise that nursing care is, in most instances, not given by nurses; but by people in other categories.

Nurses on the whole are not interested in psychiatric nursing. In the larger mental hospitals I have only seen nurses in the sick wards or in administrative or teaching posts. Some of the small wards attached to community clinics were staffed by nurses and in some of these the quality of care was excellent.

In most hospitals care is given by people who call themselves "Aides", "Attendants" or in California "Psychiatric Technicians". In some places attempts are made to train attendants as "Practical Nurses" or to employ "Licensed Vocational Nurses" in mental hospitals.

The terminology varies from state to state, so does the quality of care given. Some hospitals are able to recruit excellent people. Some gave a very good inservice training.

On the whole the patients are extremely well cared for, and I think we have much to learn from the American approach to inservice training. It was of interest to me though to observe that the comprehensive basic education which students receive is of no value whatever to the psychiatric patient. Nurses simply do not return to nurse and patients are in the hands of others, who receive a specialised training in the care of the mentally sick.

I was very favourably impressed by the general atmosphere in most of the hospitals I visited. Although doors are rarely open and it would probably be more difficult for American patients to leave hospital than it is for patients here, there was a tremendous feeling of freedom within the hospitals.

One hospital for the criminally insane, Atascadero in California, was an extreme example of how maximum security arrangements could be compatible with total freedom inside the hospital.

There is a noticeable absence of petty restrictions on patients. Routine is adapted to individuals, patients and staff are relaxed and relationships between staff and patients are cordial. In the grounds one sees large numbers of patients happily engaged in games or conversations, or going about their business. Even where patients are sitting about unoccupied, the feeling is relaxed, not apathetic.

This is, of course, not universal - there are some wards where patients are apathetic or where restrictive rules exist.

Morale is lowest, I thought, in the geriatric wards and in some of the children's wards, highest in the hospitals for the retarded and in acute treatment units.

Most mental hospitals are almost completely staffed with "aides, technicians or attendants". There are practically no domestic workers, aides carry out domestic work and often some of the maintenance work in the hospital. They also act as drivers if patients have to be transferred or picked up from another hospital or even for taking visitors to the station.

There are some occupational therapists, some "rehabilitation workers", but the use of occupational therapy was not impressive. Quite frequently occupational therapists, like social workers and psychologists, function as psychotherapists.

There are "Volunteers" in most hospitals. Their function and usefulness varies greatly.

Food services are nearly always completely taken out of the hands of the nursing personnel. I have great doubts about the wisdom of this in psychiatry where food often has great significance to the patient. It may be that the giving and receiving of food is of less symbolic importance to Americans than to us.

## TREATMENT

Psychiatric practice in the U.S.A. is much more influenced by psychoanalytic theory than it is in this country. Doctors have a long period of "residence" when they learn psychotherapy, but as far as I could ascertain, very little else. Physical treatment is strongly condemned at the moment as "old fashioned" and out-of-date. Drugs are used widely but not very scientifically as nursing observations on the effects of drugs are not available to the doctors.

Most doctors I have met are not really interested in hospital practice, they use it solely to become qualified for private treatment. It seems that hospital care suffers because so few doctors are interested in the life their patients lead when they are in hospital. Nursing care, consequently, is planned only in relation to individual patients, and not on the whole with a view to ward or hospital organisation.

In California there is a growing interest in the therapeutic use of the hospital environment and of the hospital community. It was most exciting to participate in the planning and discussion of the various schemes. Patient government, ward meetings of various kinds, patients' committees, patient organised newspapers, all aspects of what they call "Therapeutic Community" are being experimented with. The interest in this was awakened by a visit of Dr. Maxwell Jones and our concept of "Social Psychiatry" has great appeal. In the East on the other hand, the emphasis is very much more on psychotherapy and there is very little evidence that the role of the nursing staff has been thought out by the medical profession.

In all hospitals there are innumerable staff meetings - these are used more or less profitably in different places. Quite universally, nursing personnel are welcome to all case conference or team meetings and on the whole they participate well. I was surprised that as a visitor I should have had such free access to all conferences, many of which would have been very confidential in this country. At all staff conferences, clergymen of all denominations take part.

In many hospitals nursing staff did not wear uniform, in all of them the position of uniform was being discussed. It is widely believed that nurse-patient relationship is better if nursing staff do not wear distinctive clothing. Everyone is concerned about the fact that uniform tended to increase authoritarian attitudes. I was surprised that this was a problem to Americans, and I have remained unconvinced that the problem is solved by abandoning uniform, especially if the patients wear a kind of uniform in the shape of hospital clothing. It is good though to see nursing staff examining their attitudes so closely.

Some hospitals make very full use of ward clerks. Cardex system of record keeping is widely used. I was surprised that wards managed to find enough work for ward clerks and yet nursing staff were still busy writing.

Doctors give very detailed orders which appear to need endless transcribing. Often times I would have felt insulted had I been the nurse to receive such detailed orders.

## INSERVICE TRAINING

There is a widespread belief in the U.S.A. that training on the job is wrong, that it is educationally unsound and undesirable, and that it is only necessary because at the moment there are educational deficiencies to be remedied. Training is regarded with contempt as opposed to education which is greatly esteemed.

Having, observed the excellence of some of the inservice training and the poor standard of some of the education, I have become more enthusiastic than ever about training people while they are doing the work

for which they are being trained.

In particular I became very excited about the first rate training given to the "Psychiatric Technician" trainees, in California. People of the very highest calibre are being recruited and within the first year are given 300 hours instruction before taking the Civil Service examination. The syllabus, the plans of instruction and the educational methods used, produce what I would call excellent "psychiatric nurses". Many hospitals take in new recruits every month and the training programmes in operation at anyone moment would put many nursing schools here and in the U.S.A. to shame.

All hospitals have a "Director of Nursing Education". Sometimes she is responsible to the Director of Nursing, sometimes responsibility for service and education is strictly divided. It appears that one cannot say which of the two practices is to be preferred without taking into account the people involved.

In all cases the director of nursing education is responsible for the education of all nursing staff, not only the new technician trainees. At any one moment there is some kind of educational programme for every level of personnel. I was impressed the way new personnel were introduced to the hospital and with the universal interest in learning more about the job. It seems excellent that someone is specifically appointed to take an interest in the professional development of all.

If I were asked for the greatest single impression, I would stress the eagerness of all the technicians to learn more, and to keep informed of new ideas. Their willingness to try out new methods and to discuss with each other the progress they were making. This attitude, in my experience, is often confined to students in this country. That it perseveres seems to me due to the appointment on the staff, of a person whose business is education for all.

## NURSING ORGANISATION

I may have given the impression, until now, that all the exciting things in psychiatric care can take place without nurses being involved. This is my impression except that the "directors of nursing" and the "directors of nursing education" I met were, in fact, nurses of outstanding ability. So were the nurses in the State Departments responsible for nursing services in the mental hospitals. The U.S.A. is indeed fortunate in having nurses of such quality available for senior positions.

At the present moment, much as I should like to work in some of the State hospitals I have seen I would rather be a technician or aide than a nurse, as the work I find satisfying is performed by them.

In California, technicians are now licensed and the job carries full opportunity for promotion. Several of the assistants to the directors of nursing are technicians. In order to be eligible for promotion, technicians must take progressively more advanced examinations, and must show evidence of further study.

Technicians seemed to be well paid. Working conditions are good. A 40 hour week is universal and on the whole the technician can choose on which shift she wishes to work. Both male and female technicians work on male and female wards.

There is no equivalent position to that of our ward sister or charge nurse.

Although one technician occupies a charge position in the ward, this carries less responsibility and authority than the ward sister's post. There is less centralisation of information. The doctor retains more executive functions and there is always a supervisor for an area.

There is no hierarchy among the staff on the ward.

Although technicians have a great deal of satisfaction in their work, the position of technicians as a profession is, at the moment, uncertain. There is no recognition for them outside the state, even within California it may be difficult to find a job outside state service.

Nurses who are responsible for the success in creating the training scheme are uneasy in the professional relationships.

## THE PATIENT'S DAY

One of the most valuable experiences for me was to be in the ward, not in uniform, with nothing in particular to do, and to gain some insight into what life in a hospital is like. I was very much struck by the fact that even the best organised hospital life is meaningless for the patient. However full the programme, the patient's life consists of waiting. Waiting to see the doctor or waiting until someone makes some demand on her. It is difficult to see what motivation patients have to get up in the morning if the day has nothing to offer. Very frequently nursing staff had conceptualised very well how hospital life was meant to help the patient, but this was not experienced by the patient. It is my intention to see if patients here have a similar experience.

## NURSING EDUCATION

Nursing education in the U.S.A. is sufficiently complex and controversial to cause difficulty in understanding, even among American nurses. Other people in the health profession are very ignorant of the nursing curriculum, and of the various grades of nurses. I was present at a staff meeting in one hospital when nursing education was explained to doctors, occupational therapists, social workers and others, who seemed very surprised at the situation.

1. It is possible to study nursing in a Diploma School, by taking a 3-year course in a hospital school of nursing.
2. There are college courses of 3, 4, or 5 years duration leading to a Bachelor Degree in Arts or Science.
3. There are 2-year courses at Junior Colleges, leading to Associate Arts Degree.

Nurses graduating from any of these courses are eligible to become Registered Nurses.

In addition there are Licenced Vocational Nurses, in some States called Practical Nurses, with a shorter education.

Diploma Courses and Degree Courses of nursing all follow comprehensive curricula, covering all the basic sciences required for nursing, including sociological and psychological subjects. Clinical experience covers medical and surgical nursing, obstetrics, paediatrics, psychiatry and public health.

All schools of nursing are run as educational establishments with a teaching staff much larger than in our schools.

The students enrol in the school and are not members of the hospital staff. The school arranges their course, their timetable and their clinical experience and, wherever possible supervises their clinical practice.

Students pay for their education. In some diploma schools the hospital pays the student a small amount for their services in their senior year.

All courses I saw were very carefully planned. School brochures are most elaborate, very detailed, giving not only all the facts about the school, but also detailed course outlines. All schools have curriculum committees, enrolment committees, library committees etc. There is a lot of thought devoted to the development of the curriculum, to the logical progression of learning and to the integration of the various subjects. Students' health is well supervised, all schools have complete health services available. Counselling services for all students are considered to be of utmost importance and students get every help and assistance with personal problems as well as difficulties in studies.

All schools select their students with care, though the standard required for admission differs in different schools. All schools attempt to provide, in addition to a nursing education, a broad general education. There is great variation in the extent to which they succeed in their objective.

The aims of all basic nursing courses is to prepare the student for first level position in any branch of nursing. It is assumed that the student will later take advanced courses in specialised forms of nursing, and also in administration and teaching.

At the present moment there is strong disapproval among American nurses of Diploma Schools of Nursing. It is felt that some of these schools use the students for service and that the students' needs are subordinate to the needs of the patients. This sounded familiar to me, yet I must confess I saw no evidence of the students' needs being overlooked. In fact many of the diploma schools I visited appealed to me very much. In some of the Catholic schools, in particular, students seemed to have an attitude of enjoyment in giving service, which seemed most refreshing.

To understand the American disapproval however, one must see nursing education against the general educational climate which prevails.

It is the ambition of every parent to send the children to college and of every child to go to college. The whole nation is feverishly trying to solve the problem of how to provide enough schools, find enough teachers, and secure enough money for every school leaver to have a college education. Why this should be desirable was not at all clear to me, and it certainly seems an impossible undertaking in view of the tremendous growth of population. The desire to go to college is very closely linked with the idea of democracy and equality, at the same time it represents more even than material goods, the need for status and recognition. Few of the people I met are genuinely seeking knowledge for its own sake, the important thing is to "be well prepared" by having the necessary degrees.

A report of the State of New York recently published states that by 1970 80% of all school leavers will need college places. The report goes on to discuss how this can be achieved, but does not question at all whether this should be so.

Clearly if 80% of all school leavers go to college, colleges must provide courses in every kind of subject and must be the places where people prepare for their jobs. Most nurses must be recruited from among the 80% at college, and there is therefore no room for apprentice-type courses. It looks as if diploma courses will have to cease to exist. 2-year courses at Junior colleges and degree courses will provide two levels of preparation.

The 2-year courses seemed to me a very exciting new development. The students I spoke to were very determined to give bedside care and showed great understanding of the need for skilled nurses who chose

to carry out practical nursing duties.

With so many schools of nursing in existence, it is obvious that there is very wide variation in quality of instruction. Competition for places in the best schools is tremendous. This is even more serious in graduate schools of nursing. In order to gain admission, students must show evidence of having attained very high marks in their previous studies.

Grades and examinations are terribly important to students. The anxiety about grades seemed to interfere with their ability to take full advantage of educational opportunities and the competitive spirit which prevails in schools of nursing inhibits cooperation among the members of the class. The necessity to do well in examinations also discourages students from trying anything really difficult.

Although courses are planned in great detail some students end up with surprisingly chaotic knowledge having obtained their degrees in part-time studies over many years and in different Universities. Every course entitles the student to a certain number of credits which can be collected in a quite haphazard manner. Many of the courses resembled evening institute courses or refresher courses of the kind organised by the R.C.N.

The advantage of schools of nursing being independent of the hospital and run as real educational establishments are tremendous. The students enter University with students in other departments. Many courses are shared, the social life, campus activities, clubs and academic interests of the University are available to nursing students. Standards expected from them are the same as for other students. Library facilities are excellent. The faculty is big enough to enable teachers to specialise.

Post-graduate students provide the necessary stimulus for advancement in the profession and research methods and attitudes are introduced early in the students learning.

Some of the teaching I saw was rather poor. This is partly due to the lack of well organised teaching courses. Partly it is inevitable, because of the very large numbers of teachers required.

Lectures and classes take place throughout the students course. There is no block system or study day system. There are some classes every day, more in the beginning, fewer later, and sometimes classes are held in the hospital ward.

The clinical experience is planned to give the student progressive knowledge and understanding. This does not always work out in practice. For example, paediatrics is introduced early because it seems logical to learn about children first. Psychiatry comes late because the contact with mental illness appears to require a certain degree of maturity from the student. In fact, however, she may meet severely ill or dying children and very disturbed mothers in the early part of her experience which proves to be much more traumatic than the psychiatric problems she'll meet later.

Great care is taken that the practical learning is well supervised by clinical instructors and that repetition is avoided.

The result seems to be unsatisfactory. Students have very limited experience, lack self-confidence have far too few examples to fall back on when trying to apply theory.

I have become more convinced than ever that clinical instructors are not the solution to the problems of ward teaching. Students who have been instructed by clinical instructors only have never really observed nursing. I have discussed this with many students and asked them to describe to me good and bad nursing

they have seen. They have not seen any nursing at all. They have only experienced their own efforts under the supervision of an instructor. They have no model at all, and, therefore, no aim for themselves. Worst of all they have never experienced the satisfaction of having been part of the ward team, of having been useful, of a job well done.

Much as I like the organisation of the classroom instruction and the planning of clinical experience, I should like the practical experience to be the responsibility of the ward sister. In psychiatric wards it seems particularly inappropriate to have students for a few hours per day, if the students are in no way attached to the ward or involved in the life of the patients. Supervision by a clinical instructor can only be of use in this situation if the instructor spends enough time in the ward to become almost a member of the team.

## PSYCHIATRIC EXPERIENCE IN THE COMPREHENSIVE COURSE

There is some variation in the amount of time students spend with patients in different schools, and in the extent to which they take part in the events of the ward.

Theoretical work is extensive and it was surprising how much they managed to learn in so short a time. There is strong bias in all schools in the way psychiatry is presented and much of what is at best hypothetical is presented dogmatically as factual. Most schools are psychoanalytically orientated, even where the hospital has strong opposite bias. Some schools use Sullivanian theory. In San Francisco great emphasis is placed on "disturbed communication" in psychiatric illness.

Examinations are so constructed that the students are expected to classify information into 'right' and 'wrong', where this is totally inappropriate. Very few schools take the trouble to teach students to state their references or to know whose theory they are quoting. I found this surprising in view of the very careful annotation of text books. It was interesting to see the tremendous influence of Hildegard Peplau on all schools of nursing. Dr. Peplau's book "Interpersonal Relations in Nursing" is treated with the reverence only the Bible deserves.

The film "Nurse Patient Relationship" is shown everywhere. In the film a nurse helps a withdrawn patient by entering into a very special relationship with the patient. The effect the film has had on schools of nursing is tremendous. The special relationship - called everywhere a "ONE to ONE relationship" - is now considered to be the essence of psychiatric nursing and in many schools it is the only thing now being taught.

In the extreme form, the student is told that during her period in the psychiatric ward her sole duty lies in finding a patient with whom to form a relationship.

The student is left to make her own choice, find her own way of approach and decide for herself how often to see the patient, in what circumstances and what to do with her.

At least weekly the student discusses with her instructor, in detail, the inter-relation between herself and her patient, special attention being paid throughout to the student's.

Feelings. The student learns to recognise her own feelings of anger at being rejected, pleasure of being liked, need to be popular, fear of failure etc. She understands how her feelings influence the patient, how feelings find expression, how she can deal with her own emotion. She prepares carefully for separation from the patient.

I was impressed with the skill of some instructors in helping students to examine themselves. These instructors state, quite frankly, that the only purpose of the psychiatric affiliation lies in providing the student with a pause during which she learns about herself.

This is thought to be valuable in helping the student to grow and mature. I think if it is well supervised, it also helps her to understand the mechanics of emotional involvement and gives her skill in entering into involvement without harm to herself.

I was completely unable to find out how this is supposed to benefit the patient. Indeed I found no reference in all this to what was happening to patients while a succession of students formed relationships with them. At no time did I hear the relationships discussed specifically in connection with the patients' needs or difficulties. No student or faculty member was able to tell me what specific benefit they expected a patient to gain, and what special forms of relationships seemed indicated by the patient's condition.

The patients themselves and the psychotherapists seemed blissfully unaware of the impact of this relationship which the student thought to be so important.

I do not feel entirely critical of the "one to one relationship". It seemed a useful way to ensure that emotional involvement is taught and not left to chance. In this country we sometimes either believe that involvement should be discouraged, in which case the student feels guilty when she does become involved, but receives no help. Or we encourage involvement, without, however, proper safeguards for the nurse. American nurses are aware of the problems created by involvement and try to deal with them.

I do not think, however, that this is the only thing that should be taught and I am left wondering about its relevance to psychiatric nursing or to nursing in general.

At the end of her experience, the American student is in no way equipped to function in a psychiatric hospital. I am not convinced that she is better equipped to nurse elsewhere because of the psychiatric experience she has had, but I am assured this is so.

The instructors concerned with teaching students during the psychiatric experience hold themselves responsible for changing students' attitudes, for promoting sympathetic understanding of patients, for personal development and for creating sensitivity to social and psychological difficulties. They also invariably feel they must teach the students about growth and development before they can begin to teach psychiatry.

It was surprising to see that the gulf between psychiatry and the rest of nursing is as great in the U.S.A. as it is here, and that after years of inclusion of psychiatry in the curriculum there is allegedly still so little understanding of psychological problems among those who work in surgery or medicine.

#### ADVANCED STUDIES, MASTER DEGREE PROGRAMMES, DOCTORATE.

The purpose of the basic comprehensive course is to prepare the student for first level positions in nursing. All specialisation and advanced knowledge is meant to be taught in master degree programmes.

I enrolled at Boston University as a special student, to participate in such a programme. It would be totally misleading to compare this with advanced degree study in this country. Rather one should think of the master degree as the equivalent to a post certificate course. My colleagues in the master programme were wholly ignorant of psychiatric nursing. In 18 months they were to learn some theory of psychiatry, psychology and related subjects, and they spent approximately 8 hours per week in clinical experience in

the hospital. Of this about 4 hours per week were to be spent in a one-to-one relationship with a patient. A little experience in conducting group discussions was also included and a short piece of research work was to be carried out. The students with a master degree in psychiatric nursing are then considered specialists. Some of them later work in psychiatric wards, but most of them find teaching posts in University schools of nursing.

The result is that psychiatric nursing is being taught by people who have never done it and the patients are being cared for either by totally unprepared nurses or by aides.

In the few wards where I saw really first rate psychiatric nursing, the people concerned told me that they had acquired their knowledge by trial and error and by conference / discussions in the ward in which they were working. Their course had not prepared them, except in the most general sort of way, by giving them the background education. Some master programmes have a slightly broader base, but the general trend is the same.

Because nursing is taught in Universities and most schools of nursing have attempted to become full University Departments it is necessary to have a University faculty which is as well qualified as in other departments.

All University departments have at least some professors who hold doctorates and consequently there is great pressure in nursing to find some people capable of taking higher degrees.

All University departments have at least some professors who hold doctorates and consequently there is great pressure in nursing to find some people capable of taking higher degrees. Courses are only just developing and everybody is aware of the difficulty in finding suitable content.

Research is an important aspect of advanced work. There is certainly no shortage of suitable candidates for the courses, if and when they are developed.

## RESEARCH

I took part in many seminars on research methods in nursing, and paid particular attention to any research projects in which nurses were involved.

The fact that at all levels, nurses are taught to investigate nursing problems is most exciting. Instead of being expected to do things the way they were always done, just because they were always done that way, nurses are taught to plan research projects and to submit everything they see to critical examination and evaluation. It was astonishing how accepting hospitals are of students who come into the ward to carry out research.

The actual quality of the research seemed on the whole rather poor. Much of what is called research really does not deserve the name. In the long run, however valuable findings can only be made if people are prepared to look. The quantity of research and the general enthusiasm for it should bear fruit in the future.

## MALE NURSES

There is a shortage of male nurses in the U.S.A. Most schools of nursing do not take male students. Some schools will accept male students, but have very few. The only schools which have a sizeable number of male students are schools situated in mental hospitals. I saw three of these, two in New York State and McLean Hospital in Boston. These schools appeared very good to me, but are not looked upon with favour

in the U.S.A.

## CANADA

I spent much too short a time in Canada to form any opinion of the Canadian psychiatric hospitals or nursing education in Canada.

The few days spent at Montreal and Toronto were most stimulating and I enjoyed the very high level of discussion which took place and the excellent teaching I was able to observe.

I am deeply grateful to Miss McColI for the tremendous trouble she has taken in making arrangements for my visit. The time spent in the offices of the Canadian Nursing Association and in the offices of the Nurses Association in Toronto was greatly appreciated.

I was particularly glad to have the opportunity of meeting Miss Helen K. Mussallem who had recently completed a report called "Spotlight on Nursing Education". Miss Mussallem had directed a pilot project for the evaluation of Schools of Nursing in Canada.

The report she has written is one of the most interesting documents I have ever read. Many of its findings are relevant to nursing education in this country, and the criteria used for evaluating schools of nursing merit special notice. Detailed study of the report is strongly recommended.

## CONCLUSIONS

Many of the impressions of the last year are still waiting to be sorted and properly digested. I saw many excellent examples of teaching and nursing which will need to be thought about before some of what I learnt can be applied.

Three main points have mainly occupied my thoughts:

1. The general pressure to adopt comprehensive training worries me all the more, now I have seen it in operation in the U.S.A. It is not at all clear what precisely psychiatric experience can contribute. Attention to the students own development should be possible in any ward and at any time of her training. Knowledge about patients emotional problems can be gained at any time. Special knowledge about psychiatrically ill patients cannot be gained in a short time. Psychiatry tends to attract people who may not generally be interested in nursing and who would be lost to the profession if the separate register is given up. The psychiatric patient certainly does not gain from this. I found the manner in which students were introduced to psychiatric wards most disturbing. Large numbers of students coming together, leaving within a few weeks disrupt the ward. I do not see how this could be avoided in this country if all students were to have psychiatric experience.
2. I became tremendously interested in the training of other nursing personnel. The scheme for technicians in California in particular would serve as an excellent model for training of psychiatric personnel. At the moment it is relevant to our planning for enrolment. Should the mental register be closed we might have to think along the same lines as the United States in training people who are not nurses to do the job. Inservice training for all staff was of great interest.
3. While I was not entirely impressed with nursing education in the U.S.A., I was very envious of the ability to attract very highly intelligent people into nursing. It seems that the fact that nursing is studied at a University makes this possible. There seems to be less discouragement of the brightest in the U.S.A. In the schools of nursing the brightest students receive all the encouragement and stimulation they need to do well and progress rapidly. Parents and schoolteachers seem less prone

to dissuade the brightest pupils from entering nursing. In the hospital they have scope for their ability and enquiry is encouraged. Whatever the shortcomings of nursing are in the U.S.A. at present, there seem to be enough first rate people in nursing to remedy these in the future. It seems while we may be rightly proud of present standards of bedside nursing in this country, our system does not encourage future leaders to enter nursing now. Some way must be found to recruit and retain at least some of the University type of student into nursing without losing our advantages of training.

Recommended citation format

Altschul A. 'Report on a tour of the United States of America, Canada and Australia to study psychiatric nursing', May 1960-April 1961. IN 'A Festschrift for Annie Altschul', 2001: 44 pars. Online UKCHN. Available at: <http://www.ukchnm.org/> [Accessed: 24 August 2222].