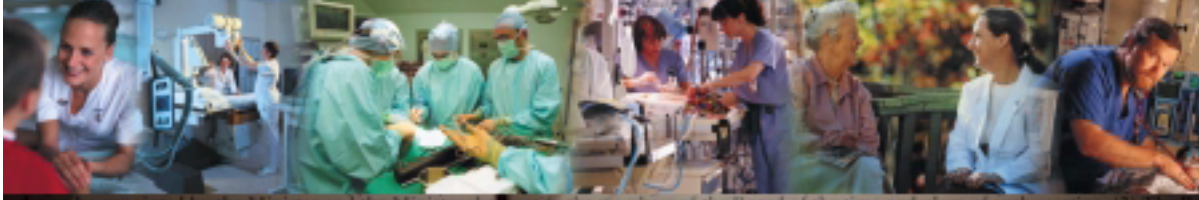
NURSING AND MIDWIFERY

IN IRELAND IN THE TWENTIETH CENTURY



JOSEPH ROBINS

Fifty Years of An Bord Altranais (The Nursing Board) 1950 - 2000

Nursing and Midwifery in Ireland in the Twentieth Century

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Message from President McAleese

I have great pleasure in sending my warmest congratulations and good wishes on the occasion of the 50th anniversary of the establishment of An Bord Altranais. At this important milestone of the organisation's establishment it is appropriate to reflect on the developments which have taken place in a profession which is rightly held in such high esteem in this country.

Any young woman or man who decides on a career in nursing enters an exciting, demanding world of life long learning. The past fifty years have witnessed dramatic advances in the healthcare area and nurses have been to the forefront of all new developments. By adapting to changes and acquiring additional skills and knowledge, nurses and midwives have made an invaluable contribution to improving standards of patient care.

As they grow strong, confident and proficient in that complex world of medical knowledge, they must always be mindful of the equally important world of warm human relationships.

I hope that in the years ahead nurses will continue to find deep personal and professional fulfilment in their vocations. I have no doubt that the nursing profession will retain the special place it has earned in the hearts of the Irish people.

I would like to congratulate everyone associated with An Bord Altranais and to wish you well in your endeavours.

Mary McAleese
President of Ireland.
November 2000

Contents

APPENDICES

Views expressed by the contributors are not necessarily those of An Bord Altranais.

Foreword

It is a great honour for me to be President of An Bord Altranais at this time when the Board is celebrating its 50th anniversary. The establishment of An Bord Altranais by the enactment of the Nurses Act 1950 was a decision to bring together the Central Midwives Board for Ireland, established in 1918 and The General Nursing Council for Ireland established in 1919. I am very aware that the regulation of nurses and midwives by statute has been in place for almost one hundred years and An Bord Altranais wishes to commemorate this by the publication of *'Nursing and Midwifery in Ireland in the Twentieth Century'*.

As we enter the 21st century we are witnessing the implementation of changes in the professions of nursing and midwifery in Ireland which will enhance and develop both professions. Regulatory, professional and employment issues are being comprehensively addressed and structures are being put in place to support nurses and midwives in their professional roles.

It is important for future generations of nurses and midwives and others interested in social history to have a reference point at this time in the development of the professions. Last year An Bord Altranais decided that an account should be written of the events and decisions which brought us to this point in the history of nursing and midwifery. This history is an acknowledgement by An Bord Altranais of the people, including nurses and midwives, who contributed so much throughout the century to the development of both professions. It is my hope that our generation of nurses and midwives will get inspiration from this account of the work and dedication of those who went before us. I hope that their courage and dedication will be

a model to guide us into the next century amid all the changes taking place.

An Bord Altranais has responsibility for the promotion of high standards in the education, training and practice of nurses and midwives. Quality care and patient focused practice is the hallmark of both professions. The history of regulation to date ensured that the public had confidence that such standards were underpinning the practice of the professional nurses and midwives they encountered. We nurses and midwives of this generation must use the empowerment conferred on us by that history to ensure that the highest standards of patient care continues to be the hallmark of both professions.

I thank Dr. Joe Robins for writing and editing this publication. We appreciate the experience, skill, expertise and knowledge of social history he brought to the task of writing and editing. I thank the nurse and midwife contributors who have documented their personal experiences and knowledge of their own disciplines and specialities in nursing and midwifery. I thank the staff in An Bord Altranais for managing the project and for delivering to the professions a quality publication.

Sheila O'Malley
President, An Bord Altranais

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Other Contributors

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and Ad Hoc Midwives Committees. Earlier she had been a member of the Board's Statutory Midwives Committee. She was a member of the EC Midwives Liaison Committee from 1972 to 1991 and was President of that committee for a period. She served as President of the Irish Nurses Organisation for a number of terms of office during the 1981 - 1991 period. She has been a member of the Joint Standing Committee of the Dublin Maternity Hospitals since 1998.

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Introduction

The President and Board of An Bord Altranais and its Chief Executive Officer, Eugene Donoghue, invited me to compile an account of Irish nursing in the twentieth century to commemorate fifty years of An Bord, 1950-2000. I was honoured to accept the invitation. During subsequent discussions about the scope of the project, it was decided that the book should comprise two parts. I would write a broad account of the development of nursing and midwifery services in Ireland from1900 to 2000 with particular reference to the social and administrative changes of the period, the growth of the health services, and the main impacts on the nursing profession of the statutory controls of An Bord Altranais. The second part of the publication would consist of a series of papers describing in more detail the changes that have taken place in nursing practice and education within the different disciplines during the period 1950-2000. A certain amount of duplication was inevitable since it was desirable that the account of the development of each discipline should stand on its own. All the contributors are nurses of standing invited by An Bord to participate. We hope that our joint efforts will be of value and give a picture of the changing face of nursing and midwifery during the century of radical change that has just ended.

I thank my fellow contributors for their co-operation and enthusiasm. I would like also to thank the various other persons who assisted me with information and views, notably Ita O'Dwyer, Johanna Barlow, Sister Columba MacNamara, Kathleen Keane, Una Doyle, Bernard Carey, Peta Taaffe, Joe Casey, Vincent Breheny and Eugene Donoghue. Gerry Donnellan was my main

guide to the working of the Bord and my chief facilitator in getting the work completed. Catherine Rooney made the resources of the library available to me and Toni Beegan, Hilary Flynn and Annette Lawrence also helped me. Jonathan Williams gave a professional finish to the script and Desmond Bell managed the publishing arrangements very effectively. I thank Sarah McCormack for helping me so competently to produce the final draft of the book.

Finally, I acknowledge the help given in obtaining illustrations by Mary O'Doherty, archivist, Mercer Library, the Faculty of Nursing RCSI, the Nursing Department of Tallaght Hospital, the Sisters of La Sagesse, Sligo, Sheila Armstrong and Eileen Musgrave.

Joseph Robins
October 2000

PART ONE

The Development of Nursing and Midwifery Services in Ireland 1900-2000.

JOSEPH ROBINS

Chapter One

The Irish Nurse in the Early 1900's

By the beginning of the 1900's nursing had become established as a reputable and highly respected profession. Florence Nightingale's work in the later Victorian period had sparked off radical reforms that had transformed the world of nursing. In Ireland, as in Britain, a body of trained nurses had emerged whose entry to the profession were being subjected to stringent scrutiny to ensure that they were of good stock, of high moral standards and of unblemished character. Training schools for nurses had been established in all the main voluntary hospitals and in the large general hospitals operated by religious orders such as the Sisters of Mercy and the Irish Sisters of Charity. It was the voluntary sector rather than the State-run institutions that was developing the quality and status of nursing and establishing the social standing of members of the profession.

Given the class distinctions of the period, the voluntary hospitals had particular attractions for young women of middle-class background who were contemplating a nursing career. The medical schools and the most distinguished members of the medical profession were associated with them. The main religious orders and the lay boards of managements and their benefactors came largely from members of the influential classes, thus giving a certain seal of distinction to employment in their hospitals.

During the earlier period of the century the development of outdoor nursing (later called district nursing) added to the social enhancement of the profession. Because of the sparse provisions for the sick poor outside the public institutions

of the period, voluntary charities attempted to meet some of the needs. Nurses who had been already trained in hospitals were selected by voluntary agencies, mainly Queen Victoria's Jubilee Institute for Nurses and the Lady Dudley Scheme, and given additional training to suit them for working in the homes of the poor. The Jubilee Institute was funded by the public subscriptions raised to honour the golden jubilee of Victoria's reign in 1897. The Dudley Scheme was established in 1903 by the wife of the then viceroy (lord-lieutenant), the rich and extravagant William Humble Ward, third Earl of Dudley. The Countess was noted for her brilliant "seasons" at Dublin Castle. The linkage with the viceregal court ensured that the nursing associations were perceived as fashionable charities. Because of their loyalist connections, both schemes attracted the support of the former ascendancy classes, in particular the "old county families ", who organised garden parties and other charitable activities to fund the local associations. The nurses employed by the associations provided services for the sick poor in some of the most deprived districts of the country, especially in the western counties. The poor gained; so, too, did the social status of the nurses themselves.

In many areas the carefully chosen district nurse became a familiar and highly respected personality pedalling around on her high bicycle. She was expected to wear her uniform at all times —

"dark linen frock, white apron, cuffs and collar, neat little bonnet tied with the dinkiest of bows."[1]

If she could manage it, she also provided care for persons who were in a position to pay for her services. A viceregal commission of the period looking at poor law reform in Ireland referred to the remarkable and unquestionable success of the Dudley nurses and of the "character and resource that enable them to discharge their lonely and laborious duty".[2]

But while the district nurse was a protégée of the local gentry, membership of the nursing profession was never a sufficient distinction to admit her into their family ranks. The novel *The Marriage of Nurse Harding* by Annie Smithson, herself a former nurse and campaigner on behalf of nurses, describes some of the social barriers in rural Ireland in the early decades of the twentieth century. Anne, daughter of a wealthy estate-owning member of the gentry, seeking independence, decides that she would like to be a nurse and approaches her father:

"Could I be a nurse, Daddy ?"

"You could not, never with my permission. No, no, Anne my dear."

So Anne elopes with the gardener's son to a life in an English slum. Her brother, heir to the estate, falls in love with Nora Harding, the local district nurse. She was not only a nurse but a Catholic to boot, so his mother resolutely puts an end to that romance.[3]

Outside the cities the public hospital services were almost entirely based on the poor law workhouses and the inadequate county infirmaries where there was little scope or inclination for the training of nurses and a reluctance on the part of the ratepayers to fund improvements in the quality of care. The poor laws stigmatised both the patients and their staffs. Until the 1920's there were only small numbers of trained nurses in these institutions. The staffs in the workhouse wards and associated units were mainly pauper assistants, often unmarried mothers, who were paid only a pittance but who welcomed a roof over their heads and the somewhat better than normal workhouse fare that they were given. The accommodation was spartan, and patients sought admission only as a last resort. A poor woman visiting her dying mother in a workhouse ward in 1909 complained to a district nurse about the miserable conditions she saw there:

"I saw the nurses, too, but they weren't right nurses, oul wans wid dirty necks and yallah strings to their caps"[4]

It was a common enough public image of the poor law nurse that survived until after registered nurses started to appear in the county institutions of the new Irish Free State.

Demands for the Registration of Nurses

As the importance of having a well-regulated nursing profession became obvious, it was accepted that there was a need for a centrally operated government system. In Britain, there were strengthening demands for the introduction of statutory controls to regulate and supervise the profession in general. A parliamentary select committee, established in 1904, received representations from various interests that the registration of nurses was desirable because "of the amount of illegality, immorality and scandal which at present continues undiscovered and unchecked."[5] While the state of Irish nursing in the early years of the twentieth century had serious shortcomings, it would have been unfair to ascribe to it the grosser defects of the British system. As already described, the quality of the nurses employed in the voluntary and religious controlled hospitals and in the district associations was very good.

While those providing the nursing care in the poor law institutions were mostly untrained and unskilled pauper assistants, it is unlikely that, as a group, they were deficient in basic kindness or of bad character. However, there were obvious benefits to be gained from the creation of a centrally supervised system. By the 1890's it was evident that the existence of a number of small, independent nurse training schools, lacking co-ordination, had obvious weaknesses and would be likely to benefit from the pooling of resources. This had led to the establishment of a central school, the Dublin Metropolitan Technical School for Nurses. The initiative arose from a meeting of prominent members of the medical profession and of matrons of most of the existing hospitals. The School was later integrated into the Royal College of Surgeons in Ireland. The cost of the School was shared by the participating hospitals. It existed from 1893 to its closure in July 1969.[6]

Shortcomings of Midwives

Whatever about the institutional nurses, there was good reason to be troubled about the quality of midwifery in Ireland. By late Victorian times and during the early decades of the twentieth century, the medical profession and others seeking to improve the pattern of public health were concerned about the continuing high rates of maternal and infant mortality. The unfavourable situation was blamed to a large degree on the shortcomings of midwifery, although there were other influences at work, such as diet, poverty and the hazards of an insanitary environment where the manner of transmission of infection was, as yet, inadequately understood. In 1901, the Dublin Sanitary Association reported that, on average, one-tenth of all Irish children had died during their first year of life during the decade 1889-99. It was a death rate that remained remarkably consistent during the earlier part of the new century. In 1915 there were 160 infant deaths per 1,000 live births in Dublin; although rates were lower in other parts of the country they were, by modern standards, alarmingly high. Maternal mortality, too, remained consistently high during the early years of the twentieth century, mainly owing to puerperal sepsis. From 1900 to 1915, six or seven mothers died annually per thousand live births; 576 mothers died in 1915.[7]

Historically, childbirth had always been regarded as a natural event unrelated to sickness. Midwifery was seen as a special and exclusive skill related to the event. The family home was accepted as the proper environment for birth and

there was no great demand for the provision of institutional accommodation for that purpose. The small number of maternity hospitals were viewed by their founders and supporters as being exceptional measures to help mothers in the dire conditions prevailing in overcrowded and squalid city tenements. In rural areas almost all women underwent their confinements at home no matter what their social class or living conditions. In many districts there had been a long tradition that, when the time came, the family called for the assistance of the local "handywoman", who was seen as the fount of all knowledge and skill as regards childbirth. Many of these women had inherited skills passed down through their family line. Their competence varied. But the generality of handywomen were ignorant, untrained persons, oblivious of the importance of hygiene and often carriers of infection from one woman to another. Yet their status in many communities went unchallenged. With the development of the poor law system from the 1840's onwards the local boards of guardians were encouraged by the central authorities to appoint trained midwives to the dispensary services. Despite considerable resistance by the guardians, largely on grounds of cost, there were 605 midwives in dispensary districts in 1905.[8] But the midwives were poorly paid and mostly untrained and this continued to be the situation for a long time. During the years of World War I the handywoman remained dominant in many rural and urban areas in Ireland. Even when there was a dispensary midwife available in a district, she would often be ignored, for many families were not prepared to flout tradition. A report from the Dublin branch of Carnegie Trust in 1917 expressed disappointment that the handywoman was still allowed to "practice her nefarious trade unchecked and to carry the germs of child-birth fever from one victim to the next".[9]

The First Statutory Provisions

The ravages of quack midwives were not a peculiarly Irish problem and in Britain statutory regulation of midwifery practice was introduced in 1902, including the phasing out of uncertified midwives. The provisions were not extended to Ireland. While the new legislation provided for the recognition of midwives trained in Ireland at the Rotunda and Coombe Hospitals and by the Royal College of Physicians in Ireland, rules subsequently drawn up for the regulation of midwives in the UK excluded the recognition of Irish-trained midwives.

Eventually, because of pressure from the College of Physicians, the government implemented measures for Ireland through the Midwives (Ireland) Act 1918. This established the Central Midwives Board to maintain a roll of midwives and to regulate their training, their admission to the roll and their removal from it if their conduct justified such action. The fact that the maternity hospitals charged a fee to their trainees made it difficult for working-class young women to secure entry to the profession. At this period, Holles Street Hospital required a fee of £22 from a trainee at a time when a labourer might earn £50 a year. The new legislation forbade women to describe themselves as midwives unless they were qualified to do so. It also made it an offence, habitually and for gain, for a woman to attend a childbirth other than under the direction of a doctor, unless she was a certified midwife. A Central Midwives Board of eleven members, of whom only four were women, was established by the Irish Local Government Board to oversee the operation of the new laws.[10]

The registration of other categories of nurses quickly followed. Separate bills were introduced in the House of Commons during 1919 to provide for the registration of nurses in the UK and in Ireland. The bills were similar and provided for reciprocity of recognition. The legislation was quickly implemented. The Irish Act provided for the establishment of the General Nursing Council for Ireland. It consisted of fifteen members, nine being nurses appointed by the Chief Secretary for Ireland, after consultation with nursing bodies, and six chosen after consultation with bodies with a special knowledge of the nursing and medical services. As a gesture to ascendancy circles, among the persons chosen was the Countess of Kenmare.[11]

Registration of Midwives

The first meeting of the new midwives board took place in October 1918 when its members unanimously chose Dr. Edward Coey Bigger as their chairman. Bigger, a medical inspector with the Local Government Board for Ireland, had been a member of the earlier viceregal commission on poor law reform and was prominent as an energetic campaigner for better public health provisions for mothers and children.[12] He continued as chairman until after the withdrawal of the British administration in 1922 and the establishment by the new Irish government in the following year of a reconstituted Central Midwives Board. Sir Andrew Horne, master of the National Maternity Hospital, was elected

chairman of the new board but died after only a few months in office. Senator Dr. Oliver St. John Gogarty, writer and wit, replaced him; but when his first term of office ended after a year, both Gogarty and Bigger contested the chairmanship. A majority of the board chose Bigger.[13]

Under the initial rules drawn up by the Board, training as a midwife would be for six months in all cases, except where nurses could show that they had served in a general hospital or as a Jubilee nurse. The hospitals recognised as centres were the Rotunda, Coombe and the National Maternity Hospitals in Dublin; Cork Lying-In Hospital; and Cork Maternity Hospital; Bedford Row Hospital, Limerick; and the Incorporated Maternity Hospital, Belfast. During the 1920's the training period for midwifery was increased to six months for trained nurses and to one year for candidates without nurse training. At the end of the 1930's, the training period for those not already trained as general nurses was increased to eighteen months. The training period continued to be extended. When the parliamentary secretary, Dr. Con Ward T.D., was introducing the Midwives Bill in 1943 (later Midwives Act 1944) he referred to the improvements in the midwifery profession, pointing in particular to the increased training period of two years.[14]

During the early years of the Board's work, the members gave considerable attention to the establishment of rules for midwifery training and practice, as well as sitting in judgment on the suitability for registration on the many practising midwives who had little or no formal training. The aim was to weed out the most blatantly inept. Throughout the early 1920's, in particular, the minute books often refer to instances of handywomen continuing to operate especially in some of the remoter districts. There were, for instance, complaints during 1922 about "a dirty handywoman" spreading puerperal sepsis in the Spiddal area but the Board accepted that "the elimination of this class cannot be affected all at once".[15] It was a slow enough process. By the end of the 1920's the Department of Local Government and Public Health was acknowledging that there had been substantial progress in reducing its activities despite the difficulty in rural districts of breaking with the traditions of the past. But a Kildare deputy, speaking during a Dáil debate in 1931, claimed that handywomen were doing a "roaring trade" in his constituency and that in some districts they were more popular than the properly trained nurses. In 1932 seven unqualified women were successfully prosecuted in County Mayo but the Department reported continuing difficulty in that county in securing adequate evidence, and some proceedings failed. There were occasional prosecutions in other parts of the country up to the end of the 1930's.[16]

The law continued to be strengthened. An amending act of 1931 removed a loophole which had left it open to an unqualified person occasionally to practice midwifery. From the beginning of 1933 the only persons permitted to attend a woman in childbirth were a doctor, a qualified midwife, or a person in training to be a doctor or a midwife. Midwives were given badges that clearly indicated that their wearers were midwives. A further Act of 1944 changed the constitution of the Central Midwives Board and strengthened its controls over midwives; under the new provisions, they could be required to attend post-graduate courses.[17] By now the work of the successive midwives boards, assisted by statutory provisions, had developed a clear definition of the role of the midwife and her professional relationship with the medical profession. Ethical issues had been resolved and disciplinary measures had been put in place. Occasionally, frictions arose between the midwives and the doctor. In1936 a medical member of the Board was concerned about the doctor/midwife relationship, claiming that many members of his profession was faced with "constant interference by the nurse in attendance which meant that the doctor in charge was to a great extent at the mercy of such nurses".[18] But the issue was not pursued and the allegation did not appear to reflect the attitude of the generality of doctors.

The efforts of the Board, especially from the 1920's to the 1940's, and the contemporaneous public health policies of the Department of Local Government and Public Health, created a reliable, professional corps of midwives, essential at a time of increasing recognition of the need to further the health of mothers and children. Nevertheless, by modern standards the toll of infant and maternal mortality remained disappointingly high throughout the period. At the end of the1920's the Department reported that" the problem of ensuring safety in childbirth remains unsolved". For every one thousand births, five mothers were dying in childbirth. A particularly sad social reflection of the times was that almost one-third of all so-called illegitimate children died in infancy. The high toll of infant death continued. During the mid-1930's the infant death rate was 65 per 1000 births but it was as high as 126 in Limerick City and 110 in Wexford Town. Despite the burden of their responsibilities, there was little advance in the employment conditions of the midwives during these years. During 1943 a medical member of the Dáil protested that midwives' pay was "a scandal". Their salaries were as low as £40 a year and many of them were "practising on the verge of starvation".[19]

Dr. Edward Bigger remained chairman of the Board until his death in 1943. He was succeeded in office by Dr. Ninian Falkiner, Master of the Rotunda Hospital from 1940 to 1947, who had achieved considerable stature for his clinical research in the field of obstetrics and gynaecology. Falkiner remained in office until the Central Midwives Board was dissolved in May 1951 to make way for An Bord Altranais. Shortly before it went out of existence, the Board defended the retention of the title "midwife". The Bill establishing the new Bord Altranais proposed replacing it by the title "maternity nurse". The members of the Board complained that they had not been consulted about the contemplated change and protested to the Taoiseach (John A. Costello) and the Minister for Health (Dr. Noel Browne). In the event, the Minister later amended the Bill and the old title was retained.[20]

Registration of General Nurses

The first meeting of the General Nursing Council for Ireland was held during February 1920 when Sir Edward Cooey Bigger, already chairman of the Midwives Board, was elected chairman of the Council. He continued to be unanimously re-elected to the post until 1934. With the advent of the first Fianna Fáil government in 1932, a general policy was adopted by the incoming administration of replacing many members of statutory boards by persons seen to be more sympathetic to the new regime. When a new council was appointed at the beginning of 1934, Dr. P. McCarville, one of the newcomers, was proposed as chairman. Bigger also contested the post and a majority of the council members voted in his favour. He remained in office until his death in early 1943. He was succeeded as an interim chairman by Angela Halbert, then matron of St. Vincent's Hospital, Dublin. When a new council was appointed at the beginning of 1944, Dr. McCarville was chosen unanimously as chairman, a post he continued to hold until the General Nursing Council of Ireland was dissolved to make way for An Bord Altranais under the Nurses Act 1950.[21]

Initially the Council established a register for general nurses with supplementary parts for male nurses, mental nurses and sick children's nurses. Provision was made for further supplementary parts if they were thought to be desirable. Where mental nurses were concerned, those who already held the certificate of the Royal Medico-Psychological Association were granted automatic registration, but some years later admission to the register required the passing of the Council's own examinations. The registration of mental

nurses was an important step in the reform of the care of the mentally ill; but there was still a long way to go in that direction. Mental hospitals continued to be seen largely as places of detention with many untrained staff. By the beginning of 1924, 2,373 general nurses had been registered and there were 633 mental nurses, 18 fever nurses and 16 sick children's nurses on the supplementary registers.[22]

Just as the Midwives Board had succeeded in reforming and disciplining the midwives, so too did the General Nursing Council succeed in setting standards for the recruitment, training and supervision of general nursing practice in Ireland at the crucial early period of health service improvement between the founding of the State in 1922 and the emergence of the first notions of the welfare state in the 1940's. During these years all training hospitals were subjected to regular inspection to ensure that acceptable standards of training and examination were attained and maintained in accordance with rules fixed by the Council from time to time. As in the case of the maternity hospitals, the general training hospitals required a relatively large fee from the student nurses. Effectively this meant that nursing became a middle-class occupation since the fee created an obstacle for those from poorer families. But, in any event, the religious orders and the boards of management ensured that those selected for the training schools were from 'good' families and likely to maintain the high status of the profession.

Health Care in the Pre-war Years

Economically the period from the 1920's to the end of the 1940's was an impoverished period for the Irish public services. Agricultural prices, aggravated by the so-called economic war of the 1930's, remained depressed. There was considerable unemployment and emigration, government spending was kept to the minimum for the most essential services, and local authorities were determined to prevent any improvements that would lead to more local taxation. In the climate of the times, it was very difficult to bring about advances in the quality or availability of health care. Tuberculosis was rampant. Most of the population had to pay for the full costs of their health care; the poor, the 'public assistance class' as they were referred to in the social legislation of the period, were covered by provisions rooted in the former poor law.

Despite the difficulties of the times, there were some important

improvements in the health services. A system of county medical officers established a structure for developing and supervising a range of preventative services such as maternity and child welfare services, medical inspection for schoolchildren, and a range of sanitary provisions particularly directed at preventing the spread of infectious diseases. The growth of these services led to increasing numbers of public health nurses but the Department's approach was to encourage and assist the expansion of voluntary nurses services rather than add to the staffs of the local authorities. During 1934 there were only 33 public health nurses employed by local authorities, compared with 217 nurses working on outdoor services under the aegis of the voluntary nursing agencies. Most of the agencies received small subsidies from public funds. The majority of the voluntary nurses operated under the direction of the Queen's Institute and, to a lesser degree, under the Lady Dudley Association.[23]

The Impact of the Hospital Sweepstakes

As far as the hospitals were concerned, both the local authority system and the voluntary system were in a very run down condition by the end of the 1920's. The local authority system (of which the main element was the county hospitals) was to a large extent based on the reorganisation of the old workhouses; the accommodation of most of the voluntary hospitals was of eighteenth- and early nineteenth-century origins. Given the parlous state of the public finances, their early improvement would have been unlikely but for the appearance of the Hospital Sweepstakes.

The establishment of the sweepstakes by a group of voluntary hospitals at the end of the 1920's was a hugely successful initiative and a great boost to the impoverished hospital system during the hard economic times that preceded the years of World War II. The State took over the control and distribution of the sweepstake funds and they were applied both to the voluntary and to the local authority hospitals. The funds enabled considerable renovation and addition to most of the voluntary hospitals and the replacement of some of the county hospitals which were often based on old poor law institutions. In keeping with the practice of providing living accommodation for nurses at hospitals, the new building initiatives included new and extended nurses' homes, but the flow of sweepstake funds did not otherwise benefit the nursing profession to any great degree.

The several annual sweepstake draws generated great public excitement

because of the large sums paid to prizewinners. There was a colourful panoply associated with the events. It included music from an army band, the Commissioner of the Garda Síochána presided over the occasion, while uniformed nurses selected from the hospitals drew the winning counterfoils from a huge rotating drum. It was a coveted distinction for a nurse to be chosen to participate in the ceremony. There was little else to be gained. In the draw for the race for the Manchester November Handicap in 1931, the nurses who participated under the direction of Commissioner O'Duffy, received in appreciation of their services a free ticket for a performance in the Gaiety Theatre and a share in a box of a chocolates. And when the Irish Nurses Union, viewing the great flow of money into the sweepstake fund, asked for a grant to help establish a pension scheme for nurses, it was informed that expenditure of that sort was outside the scope of the sweepstakes. The requested scheme would have been modest enough. As Miss Smithson visualised it, should a nurse leave the profession, she would have "a nice little sum for a trousseau, or a nest egg if she is setting up for herself".[24]

While at all times there was general admiration for the work and commitment of nurses, and a universal acceptance that they were poorly paid for their services, government was slow, particularly during the 1940's to submit to the growing financial demands for more and better health services. As World War II came to an end, many Western countries, including Britain, were influenced by socialist notions and were expanding their health services to make them more easily available to all citizens. The concept of the welfare state was strengthening bringing with it worrying implications for those who believed that the State should limit its social provisions to the needy. Participants in a public symposium in Dublin during 1942 on the needs of Irish nurses expressed sympathy for them but some were reluctant to add to the cost of public services. Professor Michael Tierney, vice-chairman of Seanad Eireann, warned that "we are quite probably on the threshold of a new age which will be marked by a universal distrust of State intervention in any but a carefully delimited group of activities.… What it [the State] unfortunately tends almost to do is not to organise but to swallow up into itself every form of organisation with which it comes contact." He suggested that professional groups like nurses and doctors should best deal with their own needs without being drawn into the bureaucracy. Dr. John Shanley, President of the Irish Medical Association, effusive in his regard for the nursing profession "quieting the pains of childhood, steeling manhood and womanhood to endure the tortures of pain,

bearing with the exacting querulousness of old age, ministering, indeed, from the cradle to the grave", asked that they be given "more reasonable treatment and recompense". Other participants were more outspoken. Professor Mary Macken said that the nurses were "over-drilled" and underpaid, and the mildly militant secretary of the Irish Nurses Association (later Organisation), Annie Smithson, declared that they were being "scandalously" neglected.[25]

The Nurses Organise

During 1944 nurses employed by local authorities were on an annual scale of pay of £75 to £90. Voluntary hospitals, with less assured funding, often paid lower rates to their nurses and most of them had no pension schemes for their staff. In 1945, the Hospitals Commission reported that two-thirds of serving nurses were not then in pensionable positions. Historically, most members of the nursing profession were philosophically opposed to industrial agitation and would have found incompatible the notion of trade union membership and the occupation of nursing. A nurse complained in a newspaper in April1942, about "the utter impossibility of arousing trained nurses to take an interest in the crying needs of their profession and the absolute necessity for organisation".[26] Nevertheless, a small element of the profession had established themselves as a trade union as early as 1919 when they founded the Irish Nurses Union as a branch of the Irish Women Workers' Union. It was a brave initiative for the times for these twenty Dublin nurses and midwives. Later the organisation became an independent body and called itself, initially, the Irish Nurses Association, subsequently becoming in 1935 the Irish Nurses Organisation. While continuing to distance itself from taking on the full characteristics of a trade union, the Organisation was, in 1942, granted registration as a trade union with limited powers of negotiation and, with that status, continued to campaign on behalf of the profession.[27]

The mental hospital unions were organised separately. During the 1920's and 1930's there was considerable agitation about the conditions of staff of the district mental hospitals. There were a number of strikes. Because a number of unions were involved and because they had to negotiate separately with each individual hospital authority, most nurses and attendants decided to join the Irish Transport and Federal Workers Union. This led to negotiations with the Minister for Health and the local authorities concerned; and eventually, parity of conditions was achieved for all mental hospitals.[28]

In July, 1922, a small group of Dublin and Cork-based nurses established the Irish Guild of Catholic Nurses. The aims of the Guildwere "purely spiritual and social and shall endeavour to promote a feeling of good fellowship between all its members". With the passage of time, the rules were occasionally amended to have regard to the wider issues of ethics, education and other matters of professional concern to the members, but the Guild remained fundamentally concerned with the formation of spiritual values and was never involved in agitation about nursing conditions. By the 1960's the Guild had about 2,500 members.[29]

The most active campaigner on behalf of nurses from the 1920's to the 1940's was Annie M. P. Smithson, who was better known as a popular novelist than as a champion for the nursing profession. Trained originally in England, she returned to Ireland and became a Queen's Institute nurse. She joined Cumann na mBan and took part in the war of independence and later in the civil war on the republican side. She was always concerned about the advancement of her profession, serving as a member of the General Nursing Council from 1924 to 1942 and becoming secretary of the Irish Nurses Union (later Organisation) in 1929, a post she held until she took up fulltime writing in 1942. She died in 1948.[30]

The Health Services Grow

Whatever the fears might be on the part of conservative-minded politicians and members of the medical profession about the implications of socialised medicine, there was, during the immediate post-war years, an inevitability about expanding health and welfare provisions by the State. The first Minister for Health was appointed at the beginning of 1947. A White Paper and the Health Act of the same year laid down the basis for future change, distancing government policies from former public assistance attitudes and providing for wider and more equitable services. During the next decade there was special emphasis on preventative services in mother and child health and in regard to infectious disease. Free and reduced-cost hospital services became available for a larger segment of the population. A huge programme of hospital building was undertaken, financed largely by sweepstake funds. Both in the preventative and institutional fields larger numbers of personnel were required. Nurses were in greater demand as public health measures expanded and hospital beds increased. The establishment of new regional sanatoria gave rise to the need for

a new grade of nurse to care for long-term tuberculosis patients. The Department envisaged the training of several hundred women of assistant nurse status to meet the demand. The General Nursing Council was reluctant to create a new grade of nurse but eventually agreed to the opening of a register for sanatoria nurses and a special examination. The nurses were debarred from holding any post higher than staff nurse in a sanatorium. All the major sanatoria were recognised for training purposes.[31]

Other new nurse training needs and demands continued to emerge. The South Cork County Hospital, better known as St. Finbarr's Hospital, sought recognition as a training school exclusively for male nurses with a syllabus similar to that for general nurses, except that the subject of gynaecology would be omitted. A visiting committee from the Council regarded it as an unsuitable training centre because of the large number of chronic patients. By 1946 the Council was clear that there was a need to open a supplementary register for public health nurses but was awaiting clarification of detailed policy about the changes that were taking place. Midwifery training was being reappraised: the 1947 White Paper on Health Services envisaged the need to bring it more into line with general nurse training. As new centres for the care of persons with mental handicap developed it also became obvious that the skills required in them showed the need for specialised nursing in that discipline.[32]

It was becoming increasingly evident that the expanding health services had important implications for various aspects of the training and organisation of nurses. The General Nursing Council and the Midwives Board had served the profession well over the previous thirty years; but, in a time of major social change it was now necessary to put in place a new body to guide the future progress of nursing in Ireland.

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Chapter Two

Bord Altranais 1950-1970

The establishment of a separate Department of Health in 1947 had given notice that the health services were likely to have an increasing place in the public services. Likely future expansions, and the extent of the changes that had taken place in health care since the establishment of the General Nursing Council and the Midwives Board, made it obvious that there was a need for the updating of the statutory arrangements for the supervision of the nursing profession. This led to the Minister for Health deciding to replace both bodies and to the integration of their former responsibilities in revised and extended form in a new body to be known as An Bord Altranais (The Nursing Board).

Nurses Act 1950

When the proposed legislation setting up the new body came before the Dáil and Seanad during 1950, it became an occasion for discussion on various aspects of nursing in Ireland, many of them not strictly within the remit of the Bill. The Minister for Health, Dr. Noel Browne, introducing the proposals in the Seanad, emphasised that while the existing registration bodies had been performing competently, the wide changes taking place in the health services and their impact on the nursing profession required the replacement of these bodies by a new integrated organisation with additional powers. The Bill was

not treated as a political issue. It got a general welcome and there was little disagreement of significance. Much of the discussion related to shortcomings in the pay and the working conditions of the nurses, which,strictly, were not within the ambit of the legislation. Browne acknowledged that many of the criticisms were justified but he stressed that his own powers in that regard were limited. There was concern about the manner in which probationer nurses were treated. One deputy said that probationer were treated "more like a flock of sheep than anything else.... they are afraid to complain" and it was said that they were being locked up at ten o'clock at night. And there were criticisms that in the hospitals controlled by religious bodies all the plum positions were denied to lay nurses.[1]

The Act - the Nurses Act, 1950 - gave the nurses themselves a substantial voice in the regulation of their profession. The new body consisted of a board of twenty- three members, including ten nurses elected by their own profession, and six doctors drawn from designated specialties and from general practice. Provision was made for a special midwifery committee, thus for the first time, bringing into association the regulation of midwifery with other aspects of nursing.[2]

The Board Starts its Work

The first meeting of An Bord Altranais took place on 7 June 1951. It was formally opened by the Taoiseach, John A. Costello, acting in his temporary capacity as Minister for Health following the controversial resignation of Dr. Noel Browne. Costello withdrew after a brief speech and the Board then unanimously elected Dr. P MacCarville as its president; MacCarville had been chairman of the dissolved General Nursing Council. Dr. Falkiner was appointed chairman of the new Midwives Committee. When, at the beginning of 1953, Dr. MacCarville made it known that he did not wish to be considered for reappointment as president because of ill health, Dr. Falkiner was unanimously appointed to the office. Falkiner was re-elected in 1954 but his further re-election in January 1955 was contested by T.C.J. (Bob) O'Connell, a prominent Dublin surgeon and activist in medical politics. After a vote, O'Connell was appointed and he continued to hold office until the end of 1960.[3]

The added responsibilities of the new board required a strengthened administration. The two former registration bodies had minimal staffs and

occupied different premises. As an interim arrangement, Olive Meyler, who had had a long period of service with the former General Nursing Council, took over the operation of the business of the new body. Una Doyle, who had been secretary to the Central Midwives Board, became her assistant but continued to have the main responsibility for midwifery affairs. A post of chief executive officer was created and the subsequent advertisement attracted over a hundred applicants. A number of nursing organisations urged that a nurse with administrative experience should be selected but, in the event, the Board chose James (Jim) Keogh whose previous experience had been largely as the county librarian for Longford / Westmeath. He took up duty in July 1952.

The Board also decided that there should be a post of Director of Nursing, who would serve as its main professional adviser. There were seventy-two applicants for that post. A prominent matron was offered the post, but she subsequently turned down the offer because she regarded the proposed conditions to be inadequate. The Board later decided not to proceed with the filling of the post but instead to appoint an Education Officer as its senior nursing adviser. There was considerable competition for the office, which culminated in Roseanne Cunningham being appointed in 1955. She had qualified as a tutor in Edinburgh and her teaching career had been in St. Vincent's Hospital and in the Children's Hospital, Temple Street, Dublin. She was, recalled one of her colleagues, " an excellent person... dedicated to nursing". Later Kathleen Keane joined her as Assistant Education Officer and later still a number of other assistant education officers were added to the staff. When Roseanne Cunningham retired in 1975, Kathleen Keane was promoted to the post. Kathleen who had been trained in Guy's Hospital, London, received her tutor diploma at UCD and went on to become a lecturer and examiner for that course. She also worked in the National Children's Hospital and the Rotunda Hospital.[4]

One of the initial problems confronting Jim Keogh was to provide sufficient finance to keep the new organisation afloat. The Department of Health had made it clear that it would have to be a self-financing operation; there would be no government subsidy available. Under the previous arrangements, nurses registered with the General Nursing Council paid two shillings and sixpence (12.5p) annually but this would be an inadequate income for the new board. Keogh, with the agreement of his board, devised an arrangement under which a single consolidated fee was introduced. Thus, nurses became registrable for the rest of their career for a single fee.[5]

By 1953 the new Board had reviewed its broad rules for the training and registration of nurses. They prescribed a register consisting of separate divisions for general nurses, midwives, male nurses, mental nurses, sick children's nurses, infectious diseases nurses and sanatorium nurses. There was a supplementary division for those registered in the general or male divisions who had also passed an examination in tuberculosis nursing. Another supplementary division listed those already qualified as general or male nurses who had also passed an examination in orthopaedic nursing. The normal period of training for all the main divisions was three years, except for midwives and infectious diseases where the training period was two years. Where a nurse wished to qualify for registration on two of the main registers, she/he could undertake a shortened period of training for the second qualification. Over the subsequent two decades the infectious diseases and sanatorium divisions were closed, reflecting the marked decline in the incidence of tuberculosis and other infectious disease and the radical changes in their prevention and therapy. New divisions were added, notably those for mental handicap and public health nursing arising from the prominence given to these in the expanding health policies.[6]

From the 1950's onwards, more questions were being asked by the statutory authorities and by the public at large about the living environment and work regimen of nurses, particularly student nurses. The outspoken Donogh O'Malley, Minister for Health during 1965-66, criticised the traditional disciplines of hospital managements, especially the close chaperoning of the students by matrons and other senior nurses. Anne-Marie Ryan, in her account in chapter five of the development of general nursing, describes the rigid rules and constraints to which students were being subjected in the training hospitals during the 1950's and 1960's. But by now the attitudes of the nurses were beginning to change and, in many respects, the profession was moving away from the past.

Ethics and the Nursing Profession

The issue of nursing ethics became a sensitive matter within the Board during the 1950's. It stemmed largely from the controversial events surrounding the proposals to extend mother and child services, put forward by Dr. Noel Browne when he was Minister for Health from 1948 to 1951. Browne's scheme was opposed by the Catholic hierarchy as well as by powerful political and medical personalities, who saw it as a threat to the rights of the

family as well as an intrusion by the State into matters where it had no competence to act, such as sexuality, chastity and marriage. The organised medical profession also saw the scheme as heralding the destruction of private practice and the introduction of a full-time salaried state medical service. During the subsequent controversy, Browne was forced to resign and his proposals were dropped. However, during the following years, a new Fianna Fail government succeeded in implementing free services for mothers and children and in extending other free health services without any great controversy. But, from the traditional Catholic point-of-view, free services provided by the State continued to carry with them the threat of interference with the integrity of the family and the hazard of the imposition of unacceptable practices such as contraception and abortion. Nurses were seen as being in the front line in the defence of traditional family values and sexual relationships.

The Board looked in particular at practice guidelines for the growing numbers of nurses working in the expanding services for mothers and children. A group established by the Board to look especially at the manner in which a course for outdoor nurses (later categorised as public health nurses) might be devised, later concluded that such a course was likely to touch on issues of Catholic ethics. This lead to the president, Dr. Falkiner, and other representatives of the Board, arranging a discussion with Archbishop MacQuaid in June1954, which led to further discussions involving the Ethics Department of University College Dublin.

In February 1955, the Board's new president, T.C.J. O'Connell, told its members that the Catholic hierarchy was taking a considerable interest in the content of lectures being given to all student nurses on the subjects of ethics and psychology. O'Connell, with the Chief Executive Officer, Jim Keogh, and Education Officer, Roseanne Cunningham, had been involved in "prolonged" discussions with Monsignor Horgan of the Ethics Department of University College Dublin about the nature of these lectures. The outcome was that the Monsignor had, with the approval of the Archbishop, compiled a draft syllabus for the teaching of ethics and psychology and an accompanying memorandum which had been submitted to the Board. The proposal sparked off considerable discussion among board members. Some of them were concerned about the possibility that the examination papers would be corrected by the hospital chaplains. O'Connell assured them that any papers on these subjects would have to be corrected by examiners approved by the Board on the

recommendations of the hospitals. After prolonged discussion, the arrangements put forward by the Monsignor were accepted. The appropriate questions to be set for Protestant nurses was referred for his views to Dr. Barton, Protestant Archbishop of Dublin.[7]

In April 1956, Monsignor Horgan told the Chief Executive Officer that the Archbishop was consulting the other members of the Catholic hierarchy on the choice of lecturers. The Monsignor anticipated that they would not necessarily be hospital chaplains. The Archbishop had also made it clear that nurse tutors then participating in a series of lectures in ethics and psychology for medical students at University College, Dublin, would be unacceptable to him as lecturers in these subjects. O'Connell had continuing discussions with Horgan and, eventually the latter made it known that the "ecclesiastical authorities" wished that the lecturers chosen were to be appointed by each training hospital but only after approval by the local bishop. Some members of the board were angered by this directive and by the interference with its right to choose its own lecturers. But, in the event, the Board acquiesced in the views of the hierarchy and directed the training hospitals to consult with the local bishop. Monsignor Horgan later submitted the names of fifteen priests who had been nominated as lecturers and Archbishop MacQuaid himself nominated Rev. Dr. O'Doherty and Rev. Dr. Martin as lecturers for the nurse training course at the Dublin Metropolitan School for Nursing. For his part, the Protestant Archbishop, Dr. Barton, designated two doctors to give lectures to the Protestant nurses at the Adelaide Hospital.[8]

It was not the end of the matter. In a follow up to the previous directive, Monsignor Horgan then sought an assurance on behalf of the hierarchy that the Bord would not carry out a "State " examination in the subjects of psychology and ethics. Again, some of the members were extremely indignant about the pressure being put on them in relation to the conduct of their examinations. The minutes show that, in particular, the matron of St. Patrick Dun's Hospital, Miss Chambers, took a continuing stance in defence of the board's independence of action. There were long arguments at the Board but it was eventually agreed that there would be no centrally conducted examinations on the disputed subjects. However, the Board informed the hospitals that no objection would be raised to the locally designated lecturers conducting their own examinations on the subjects. This recommendation was directed at all training hospitals, Catholic and Protestant. While this was acceptable to the Catholic hierarchy as far as it went, further pressure from

Monsignor Horgan led to the Bord requiring all examination candidates to submit a certificate that they had participated in lectures in psychology and ethics.[9]

While these arrangements appeared to satisfy the Catholic authorities in general, a prominent Cork educationalist, Rev. Dr. E. Hegarty, felt that his Church superiors had not gone far enough. Dr. Hegarty had been chaplain to the Cork branch of the Irish Guild of Catholic Nurses and had developed and delivered lectures on medical ethics for student nurses in the Cork area. Throughout 1957 he carried on a correspondence with the president, T.C.J. O'Connell, demanding that there should be a formal paper in ethics and psychology as a required element in the Bord's examinations. Hegarty's demand was fuelled by the fact that many student nurses were ignoring the informal lectures on ethics and psychology and failing to submit the required certificate of participation in them, a situation that led to the board threatening to refuse participation in final examinations in the absence of such a certificate. Dr. Hegarty continued his campaign and the Board eventually sought the guidance of Monsignor Horgan who, in reply, said that the hierarchy was not then prepared to pursue the matter to the extent demanded by Dr. Hegarty. This did not appease him. Heated correspondence between Hegarty and O'Connell continued during 1958. It was ironic that O'Connell himself, and the hospital with which he was mainly associated, St. Vincent's Hospital, Dublin, was probably the least likely to flout Catholic moral standpoints. The brief minutes of the Board do not conceal his exasperation with Hegarty. In November 1958, they report him as informing the members that a particular letter from Hegarty contained "a number of most unjust and inaccurate accusations" and he sought the agreement of the board members to the submission of the entire correspondence to the Bishop of Cork. But, later, having had second thoughts on the matter, he decided that the most prudent attitude would be to ignore the persistent Cork man. Dr. Hegarty continued to be deeply involved with the issue of medical ethics. In March 1968, he was tragically killed when an Aer Lingus Viscount on a flight from Cork to London crashed off Fishguard.[10]

The issue of the role of Bord Altranais in relation to nursing ethics did not surface again for a considerable period. The Nurses Bill, introduced by the Minister for Health, Barry Desmond, in 1984, provided for many revisions in the operation of the Board. One of its sub-sections declared that "it shall be a function of the Board to give guidance to the nursing profession generally in all

matters relating to ethical conduct and behaviour". Dr. Rory O'Hanlon, the shadow minister, opposed the sub-section on the grounds that it would interfere with the hospitals "in relation to their character and ethics". The issue was put to a vote of the Dáil and a majority agreed that the sub-section should remain part of the Bill. When, later, the Bill came before the Seanad, opposition speakers again objected to the sub-section but the minister's view prevailed.[11]

Training of Psychiatric Nurses

The pioneering legislation of 1919 had included provision for the registration of nurses trained in the nursing and care of persons in mental illness. However, the public perception of mental hospitals at the time was that they were places of confinement and detention rather than places of therapy. By and large this was an accurate perception of the regimen of these hospitals which prevailed into the mid-century. Since there was an absence of effective therapies, the registration of mental nurses gave little impetus to the improvement of nursing standards or to any significant increase in their numbers. For a long time, many of the staffs continued to consist of untrained attendants. Suitability for recruitment was judged to a considerable degree on the physical attributes of the applicants and on their capacity to restrain. Furthermore a tradition had grown up in some hospitals that members of existing staff families were favoured in the filling of places. During the 1940's and the 1950's new methods of treating mental illness emerged that gradually transformed the care of persons with mental illness. Psychotherapy, requiring the establishment of a close therapist-patient relationship, developed as a method of understanding and treating the patient. The introduction of a number of important drugs, particularly in the chlorpromazine group, made a major impact on the treatment of some of the most serious psychiatric conditions. The new therapies made it essential that there should be a body of professionally trained nurses to implement them.[12]

But change was slow. As late as 1951, Dr. Joseph Kearney, Inspector of Mental Hospitals and a member of Bord Altranais, reported that half the staff of Kilkenny Mental Hospital were without nursing qualifications. Other hospitals showed a similar pattern. While all the mental hospitals had been designated as training centres, the Board became increasingly concerned about the quality of psychiatric nurses being produced by them. When the members looked at the examination results from the hospitals in June 1957 they found

them "very disturbing". Problems were arising from the fact that the students had a poor standard of general education; there was difficulty in getting them to attend lectures; and an absence of suitable tutors in mental nursing did not help. The Board's Education Officer found that the main difficulty was in getting the students to think of themselves as students. They placed greater importance on the employment aspect than on studying. Reports from the resident medical superintendents supported these views. The superintendents were unable to improve the training of their staffs because of the absence of tutors and textbooks and also because of the difficulties of organising lectures during working hours, off-duty leave and the high level of social activity among the students.[13]

When the Commission on Mental Illness established by the Minister for Health reported in 1966, it found that there were still serious shortcomings in the quality of nursing in the mental hospitals. A fairly high percentage of the students was failing to pass their examinations, mainly because they were unable to achieve a 50 per cent pass mark in the written parts. The Commission recommended that Bord Altranais should move towards the eventual integration of general and psychiatric nurse training. The Commission was generally critical of Bord Altranais' stewardship of the training of mental nurses and recommended a more forceful approach to the improvement of standards, an intensification of its inspection system, and the removal from the list of training schools of those not reaching acceptable standards within a reasonable time. The Commission also strongly recommended that students for mental nursing should require a high standard of general education, minimally an Intermediate Certificate.[14]

The Board subsequently subjected the training of mental nurses to more rigorous supervision and it had the result that even fewer students than in the past were passing their qualifying examinations. In January 1971, the Board members were concerned about the high percentage of failures. In the Dublin and Clonmel district hospitals, 68% of the students had failed: the best results were in Ballinasloe, where only 30% had failed. There were clear deficiencies in the standards of teaching in some of the hospitals and the Board decided that there was a need for further inspections in the hospitals. It was also clear that there was a need for a clarification of the responsibilities of psychiatric nurses as a result of the growth of community psychiatric services and movement towards greater integration in other health services. During 1972 a working party established by the Department of Health helped to clarify the role of the role

of these nurses outside the institutional environment. At this time the psychiatric nurses themselves were strengthening their trade unions and becoming one of the strongest pressure groups within the health services. The Psychiatric Nurses Association, with an initial membership of 500 in 1970, had increased it to over 2,000 a decade later.[15] Policies imposed by the unions with regard to insistence on promotion by seniority and on the segregation of male and female nursing were for a long period deterrents to improvements in psychiatric nursing.

From the 1970's onwards change in psychiatric nursing practices was gradual, but fundamental, as policy in the psychiatric services became focussed on the rehabilitation of long-stay patients and on the development of services within the community for the acutely ill. Ann J. Sheridan's study in this volume (chapter eight) describes the transition in psychiatric nursing that took place over the subsequent decades as the traditional long-stay psychiatric hospital faded into the background.

Public Health Nurses

The former General Nursing Council had discussed from time to time the importance of establishing a training scheme and formal qualification in outdoor nursing (later public health nursing). As preventative services expanded especially in school medical services, immunisations, maternity and child health, there was a strengthening case for the introduction of such post-graduate training. Because of fears about the cost implications of the expanding health services following the Health Acts of 1947 and 1953, and the fact that the government was holding a tight rein on public spending, the Department of Health was reluctant to embark on additional expenditure on the training of health service personnel. However, An Bord Altranais, from its initiation, had no doubt about the urgency of getting a special course up and running for nurses working in the community. During 1954, a group established by the Bord under the chairpersonship of Margaret Reidy, nursing officer of the Department, recommended a syllabus for a six-month course. The Bord accepted the recommendations and, in turn, invited the Metropolitan School for Nursing, the Queen's Institute and University College Dublin, to undertake the course as an alternative to the Bord itself operating the scheme. Over the subsequent two years the board minutes show that variations of that scheme were contemplated but, effectively, nothing positive emerged from these ideas.

Apart from the cost implications, one of the difficulties in establishing a course was the absence of a clear definition of the duties of nurses working in the community. The nature of the demands on the service was in a state of change as preventative services broadened. Furthermore, an important influence on the nature of non-institutional nursing was the reducing demands on domiciliary maternity services as more women opted for hospital confinements Towards the end of 1956, the Minister for Health, Thomas F. O'Higgins, announced his intention to abolish the existing grade of public health nurse and to replace her by "an all purpose nurse who would combine certain public health duties with domiciliary nursing and midwifery". Members of the board had varying views on the announcement; some of them regarded it as " a retrograde step".[16]

Nurses already serving as public health nurses were particularly alarmed about the development. In December 1957, representatives of the Bord and of the Department had a meeting lasting four hours, which looked in detail at the organisation of the outdoor services. The outcome was that a guarantee was given that no serving public health nurse would lose her post and that in each county at least one post of superintendent public health nurse would be created. Eventually, during 1958, the Minister decided that all nurses already designated as public health nurses or carrying out broader duties as district nurses would be put into the one classification: public health nurses. By now there was a clear acceptance about the urgency of establishing a comprehensive training course for public health nurses. Recommendations from a steering committee of the Bord recommended the secondment from Dublin Corporation of Eithne Mattimoe, superintendent public health nurse, as the course's first tutor. It would last six months, the first one starting in October 1959. Sixteen nurses, already working in the community, participated. Shorter courses were held for those who had five years' experience or more. A new public health nursing division of the register was established. Further courses followed in later years, eventually culminating in the introduction in 1972 of an extended course lasting a full academic year with three months' supervised practice.[17]

The activities of the voluntary nursing bodies responsible for creating the original district nursing services in Ireland were gradually phased out. The training programme of the Queen's Institute was discontinued in 1967 and the Lady Dudley Nursing Scheme ended during the 1970's. Nurses employed by the two bodies were absorbed by the local health authorities.[18]

Community health services expanded during the 1980's in keeping with the emphasis being given to providing care in a family setting, rather than within institutions. The demands on public nurses grew. A full-time public health nursing adviser, Deirdre Fitzsimons, was appointed to the Department of Health. A new senior grade of public health nurse was established. There were various official reports and analyses looking at the role of public health nursing, but increasing curbs were put on personnel expansion owing to the economic climate until the advent of the more affluent nineteen nineties.[19]

Sheila Armstrong's study in this volume (chapter seven) charts in more detail the development of public health nurse practice and education since the 1950's under the influence of the expanding emphasis given to community health services. By the end of 1996, 1,400 public health nurses were employed by the health boards.

The Recognition of Mental Handicap Nursing

Little specific attention had been given to the caring needs of persons with mental handicap before the 1950's. Stewart's Hospital, Dublin, had been established for that purpose in 1879. In 1926, the Daughters of Charity transformed a former workhouse school at Navan Road, Dublin, into St. Vincent's Home for children with mental handicap. By the end of the 1940's the only other special accommodation in that category were centres opened by the Brothers of St. John of God in Blackrock, County Dublin, and by the Brothers of Charity in Lota, Cork. Most persons with a mental handicap were living with their own families without any services being provided for them; others were being admitted to mental hospitals, often to poor, overcrowded conditions, and were receiving no specialised care.

A feature of the years immediately following World War II was the increased consciousness of human rights and needs, particularly where disadvantaged and minority groups were concerned. In Ireland, as elsewhere, many social issues came under closer scrutiny. Among the disadvantaged groups, persons with mental handicap became the object of greater public concern than in the past. This increased recognition led to a greater provision of special accommodation and other services and the introduction and expansion of new categories of specialised personnel to provide the required skills. They included nursing. Hitherto, much of the nursing care in the expanding centres fell on the shoulders of the members of the religious communities from these centres. As

the numbers of residents grew, there was increased dependence on untrained assistants. In May 1955, following pressure from parent groups, the Department of Health asked Bord Altranais to consider the need for a special training course in mental handicap nursing. The Bord accepted the need for a three-year course and in 1959 the first training schools were opened under the aegis of the Daughters of Charity at St. Joseph's, Clonsilla and by the Brothers of St. John of God at Drumcar, County Louth. Twenty-two students were enrolled in the initial courses: a number of other training schools followed. The Bord established a new register for those who qualified; it accepted certain persons who had already had three consecutive years working in mental handicap nursing.[20]

The initial approach to the training of the newly established discipline of mental handicap nursing was largely related to the custodial policy of the times, namely large numbers of persons being cared for in a traditional institutional setting. Since little attention was being given to the individuality of the resident, the emphasis, albeit a compassionate one, was basically concerned with providing care in a comfortable setting, with relatively little importance given to development and emotional issues. Fintan Sheerin's study in this volume (chapter nine) describes the subsequent evolution of a more informed and optimistic approach to the person with a mental handicap. The recommendations of a special government commission in 1965 offered new insights into the needs of mental handicap and led to the broadening of the range of services provided. Later came the concept of 'normalisation' as an aim of public policy to help all persons with a mental handicap towards integration in normal society to the greatest degree possible. Sheerin traces the impact of these policies on the discipline of mental handicap nursing. He sees special challenges in regard to the role of that discipline in the future and envisages the need for a fundamental reappraisal of its present orientation from the biomedical to the social-developmental-educational model.

Maternity Nursing

With the establishment of Bord Altranais in 1950, policy in regard to the training and education of midwives became the responsibility of its statutory Midwives Committee. It was an eight-member committee which was reconstituted on a five-yearly basis. Dr. Falkiner became chairman of the new committee, an office that he would hold until the beginning of 1969. He was

followed in office by Professor Alan Browne, who had been Master of the Rotunda Hospital from 1960 to 1966. Professor Browne held the post until he was succeeded by Dr. Joseph Alvey, National Maternity Hospital, Dublin, in 1980, who remained in office until early 1984. He was followed by Dr. George Henry, Master of the Rotunda Hospital, the last chairman of the committee.[21] When the Nurses'Act 1985 established a new constitution for the Bord, it did not provide for the continuance of a statutory midwives committee, but it increased the midwifery representation of the Bord itself. Subsequently the Board appointed an ad hoc midwives committee, which undertook a continuing review of midwifery education and practice.

By the 1940's the issue of maternal and infant health had become one of the major concerns in the expanding health services. The persisting high level of deaths of mothers and infants influenced the strengthening view of the medical profession that hospital deliveries were safer than home deliveries. Mothers themselves were accepting that view and stimulating a demand for hospital beds. It became public policy to provide maternity units in county hospitals and in selected district hospitals; there were considerable extensions to the Dublin maternity hospitals. But old practices were slow to die. Even as late as 1957 there was concern among members of Bord Altranais about the continuing existence of "handywomen" in poorer areas of Dublin City and in some rural parts. At the beginning of the war years about half of all births in the Dublin area were taking place in hospitals; but births in the provinces remained, to a large degree, domiciliary-based. With the ending of the war there were considerable additions to all categories of hospital accommodation. During 1957, a total of 57,168 births took place in hospitals and homes, compared to 18,100 domiciliary births. Ten years later the domiciliary births had been reduced to 4,139. By 1977 there were only 265 domiciliary births, most of which were probably in emergency circumstances, as compared with 68,627 in institutions.[22]

The movement of maternity confinements into hospitals and homes posed problems for the well-established methods of training midwives. Rules drawn up by the Central Midwives Board during the 1930's had required each trainee to receive instruction in the supervision of not less than twenty pregnant women and to witness not fewer than ten labours. As domiciliary births declined, the requirement to be present at ten district births was reduced to five. When the number of domiciliary births continued to decline, the Board became concerned during 1957 about the impact that reducing access to

domiciliary experience was having on the education of the trainees. A deputation went to see the Department to urge the provision of additional funding to improve the training arrangements. It was told that it could not be provided. By 1958 the midwifery training hospitals were reporting that they were failing to get the necessary number of district cases for pupil-midwives and the Bord waived the requirement. Gradually the Board developed the view that there were hazards associated with domiciliary births and that the best place for them to take place were in a hospital or maternity home. In December 1976, when a member of its midwives committee, Johanna Barlow, proposed a motion urging the promotion and encouragement of domiciliary midwifery it led to a long discussion which culminated in her colleagues unanimously rejecting the motion. A plenary meeting of the board took a similar view.[23]

The paper of Ita O'Dwyer and Ann Louise Mulhall in chapter six below describes in more detail the changes which have taken in midwifery practice and education during the period 1950-2000.

Nurses Bill 1961

When the Nurses Bill 1961 was first published in April of that year it appears to have been prepared without prior discussion between the Minister (Sean MacEntee) and his department and Bord Altranais. The then president, Dr. Andrew Whelton, was indignant to learn that the contents had been published in the newspapers without consultation with the Bord. This was a consequence of the political climate that existed between Sean MacEntee and the organised medical profession. The former president, T.C.J. O'Connell, who had not put himself forward for reappointment to the post in January 1961, but who remained on the board, had been an active campaigner on behalf of the Irish Medical Association and a vigorous opponent of the health services policies of the Minister. The contents of the Bill, in general, were of little significance. They were mainly concerned with changes to existing legislation seen as desirable in the light of experience. But the Bill had one provision that was very controversial as far as the Board members were concerned. It would end the arrangement whereby they elected annually a president from their membership and replace it by a provision under which the Minister himself would appoint future presidents for the full five-year period of office of the Bord.[24]

A majority of the members was opposed to the proposal and sent a deputation to the Minister to express their views. MacEntee refused to alter the

Bill. As the legislation progressed through the Dáil and the Seanad, there was sharp conflict on the issue of the appointment of the president. The Minister defended his proposal on the basis that it was not a good principle to have an annual rotation of the office. Opposition members thought otherwise. They argued that it was a bad principle that the Minister should appoint the president of a professional body. Underlying the debate was the opposition view that the Minister was using the legislation to obviate the emergence of politically troublesome chairmen. T.F. O'Higgins, the shadow Minister for Health, thought it "highly undemocratic" and another member said that it was "the fuehrer system" of making appointments. In the event, the provision remained in the Bill and it was enacted in the Nurses Act 1961. The first board constituted under the new provisions held its initial meeting in February 1964 under the presidency of Dr. W.F. O'Dwyer, who had been appointed by Sean MacEntee. O'Dwyer's appointment had a pacifying effect on relations between the Minister and the Bord; one of the consequences was that staff were given a pay award which had been delayed by the earlier hostilities between O'Connell and MacEntee. Billy O'Dwyer was regarded as a good president who managed his board well. The arrangements for the appointment of president remained unchanged until the Nurses Act, 1985, restored to the Board responsibility for selecting a person for that office from its own members.[25]

Policy in regard to Enrolled Nurses

From time to time the Board considered whether enrolled nurses should be formally recognised in Ireland. It was usually raised in the context of Irish girls who had qualified in Britain as state-enrolled nurses seeking to secure employment in Irish hospitals. State-enrolled nurses in Britain were a product of harder economic times when the authorities there enacted legislation to enable the introduction of a second level with a shorter training programme and lower entry criteria. The basic education requirements and training programme set for such nurses would not meet the criteria for state-registered nurses. The Bord remained consistently opposed to the introduction of a special register for them on the basis that such an initiative would unnecessarily dilute the quality of nursing in Ireland, particularly at a time when there were long lists of applicants awaiting places in the existing training hospitals. This position was accepted by the European Commission as the result of an individual case raised with it.[26]

Nurse Tutors

Despite the changing provisions over the years for the pre-registration training of nurses, the generality of tutors involved in the implementation of the various curricula had not themselves been formally trained in tutorial skills. A small number had secured qualifications abroad but, although a high standard of teaching had been achieved in the nurse training schools, there was a growing recognition of the desirability of having a formal tutor course in Ireland.

Following discussions between the Bord and University College Dublin, the College agreed to provide a diploma course for tutors starting in October 1960. A similar course was held subsequently every second year until 1977 when it became an annual event. From 1960 to 1975 the course was under the direction of Roseanne Cunningham, Education Officer of the Bord. Following retirement, she was succeeded by Judith Chavasse, previously principal tutor in Dr. Steevens' Hospital, who became full-time Director of the Department of Nursing Studies in UCD in 1975. When she retired in 1994, she was succeeded by Pearl Treacy, who was appointed the first Professor of Nursing at UCD.

In 1964 the Board added a supplementary division to the register to give formal recognition to the tutors. Those eligible for inclusion were tutors who had a recognised diploma or certificate from a university or from a college of nursing. Persons with not less than five years' experience as a tutor could also qualify for inclusion.[27]

In 1979 Judith Chavasse secured the approval of the UCD authorities and of Bord Altranais to the inclusion of the midwifery option in the tutor course. The impact of this development is described in the paper on midwifery by O'Dwyer and Mulhall in chapter six.

Occupational Health Nursing

The first occupational health nurse was appointed as early as 1890 by Arthur Guinness and Co. The first formal course in this discipline was held by An Bord Altranais in 1976 when there were twenty-two participants. Similar courses followed in 1980, 1984 and 1985. In 1987 nurses wishing to work in occupational safety and health were able to participate in a multidisciplinary training course initiated by the Department of Labour. An Bord Altranais organised and directed the course. The theoretical input took place at

University College Dublin, with practical placements arranged throughout the country. The course continues at UCD without any involvement by the Board.[28]

Other Post-registration Training

From the late 1960's onwards there was an increasing demand among nurses and nurse managements for courses and training opportunities to further the post-registration development of the profession. The rapid expansion and growing specialisation of the health services and the advent of the health board system created a need for more information among the many professionals in the services who found themselves working in an increasingly complex environment where, for instance, legal and management issues were becoming more important. Among the early training initiatives was the introduction by the Institute of Hospital and Health Service Administrators, in association with the Dublin Vocational Education Committee, of courses in health services administration. The main driving spirit behind these courses was Colm Collins, secretary / manager of the Coombe Hospital. The courses were held in the College of Commerce, Rathmines.They were hugely successful and, while devised mainly for administrative personnel, many of the participants were nurses. At about the same time the Institute of Public Administration was extending its range of part-time and full-time courses, and nurses were involved to an increasing degree.

The inauguration of the Faculty of Nursing in the Royal College of Surgeons in Ireland in 1974 was a major contribution to the expansion of continuing education for nurses. The main inspiration behind its founding was Mary Frances Crowley, principal tutor in the Royal Victoria Eye and Ear Hospital, Dublin, who became first Dean of the Faculty from 1974 to 1979. Others prominently associated with the initial establishment of the Faculty included Roseanne Cunningham and Annie Kelly, Matron of St. Laurence's Hospital, Dublin. By 1979 there were one thousand nurses undertaking postgraduate courses of the Faculty, some of an innovative nature such as Intercultural Relationships and Anthropology. Later many new programmes were introduced with National University of Ireland accreditation and by 2000 thirteen higher diploma programmes, three bachelor degree courses and a master's degree were being offered. In 1998, Seamus Cowman was appointed the first professor of nursing at the College. He had worked as an education

officer at Bord Altranais and had been previously principal nurse tutor at James Connolly Memorial Hospital, Dublin.[29]

Judith Chavasse's paper (chapter eleven) traces in more detail the development of postgraduate education in recent decades.

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Chapter Three

Bord Altranais: after 1970

In a number of ways the years from the 1970's to the end of the twentieth century represented broadening horizons for the nursing profession. In effect, the period marked the ending of most of the traditional features of Irish nursing. Membership of the European Union removed much of Ireland's social and economic isolation, integrated many aspects of Irish life with those of its continental partners, and tied the country into the harmonisation policies of the Union in regard to many occupations, including nursing. While university education did not become a requirement of Union policy, third-level education for nurses had already become inevitable because of the growing scientific, technological and social advances affecting nursing practice. The old apprenticeship method of training ended. With it went the manner in which candidates for training were selected. The fitness to practice of registered nurses was subjected to closer scrutiny; registration became a matter for annual renewal.

Nurse Presidents

Given the radical changes in the nursing profession that would take place during the last thirty years of the century, it was appropriate that the post of president of Bord Altranais should be held by a nurse.

When Professor Billy O'Dwyer's long period as presidency from January 1964 to December 1978 came to an end, he was succeeded by Johanna Barlow, the first nurse to be president of the Bord. She was appointed to the post by the Minster for Health, Charles J. Haughey, after having been nominated by her board colleagues. She had already been a midwife representative and had been on the midwives' committee. Active in local politics as a community councillor on Dublin Corporation, Mrs Barlow became an alderman and was a Corporation nominee on the Eastern Health Board. She persistently argued the merits of home confinements, a view not shared by the majority of her Bord Altranais colleagues. She served as president until December 1983. Johanna Barlow was followed by Sister Columba MacNamara, appointed in January 1984, by the then minister, Barry Desmond. She had previously served as an ordinary board member elected by the profession. Two years later, following the implementation of the Nurses Act 1985, she was reappointed president for a five year period, this time by her board colleagues. Sister MacNamara was respected as an independent-minded woman during times of controversy notably when the question of the establishment of a central applications bureau was under consideration. She was Matron (Director of Nursing) of St. Michael's Hospital, Dun Laoghaire for thirty-six years.

Ita O'Dwyer, Director of Midwifery and Nursing, Coombe Women's Hospital, followed as president from 1992 to 1997. She had had a long association with Bord Altranais as a member of its board, as well as being a member of various committees, notably the Statutory Midwives Committee, the Ad Hoc Midwives Committee, the Nurse Education and Training Committee, and the EC Midwives Liaison Committee. During her presidency, the Bord published one of its most important reports, *The Future of Nurse Education and Training,* 1994.

Sheila O'Malley became the last Bord president of the old century and the first one of the new when she was elected by her colleagues to serve from 1998 to 2002. She had had considerable experience as a public health nurse, working in rural and urban areas of County Wicklow before becoming a superintendent public health nurse under the Eastern Health Board. Since taking up office she as represented the profession in Ireland at a number of regulatory international conferences.[1]

Chief Executive Officers

Jim Keogh retired in October 1982 after a long period of office that began in July 1952. He had been involved in all the important developments in relation to the training and education of Irish nurses during those thirty years and had participated as an Irish representative in many international conferences. During the 1980's he had an important part in the making of arrangements with the Middle Eastern Arab states for the training of student nurses from these countries in Ireland. It was a difficult period that required considerable travelling and a sensitivity to political and cultural differences. The outcome was that the authorities concerned sent a large number of students for courses of training in Dublin hospitals. They came from the United Arab Emirates, Qatar, Bahrein and Iraq. After retirement Jim Keogh, maintained an interest in the work of the Irish Council for Overseas Studies. He died in early 1999.[2]

Noel Daly was appointed Chief Executive Officer in November 1982. He took up this post before the introduction of the new Nurses Act 1985 and he managed the introduction of new regulations and procedures arising from the legislation. He was Returning Officer for the first election under the new legislation that provided for elected nurses to have a majority on the Board for the first time. New computer systems were introduced to maintain the register, and various projects got underway to modernise the regulatory systems. Noel Daly was formerly Adult Education Officer for County Meath Vocational Education Committee and Head of Education and Training in the Health Education Bureau. He is a graduate of University College Galway, where he was conferred with a Bachelor of Arts; he also has a Masters Degree in Adult Education. Noel Daly left An Bord Altranais in 1988 to take up a position in the computer industry.

Eugene Donoghue joined An Bord Altranais in November 1988. Previously and for over ten years, he was employed both as Education Officer and Head of Education and Training in the Health Education Bureau. After the Bureau ceased operations, he transferred to the Department of Health as Assistant Principal attached to the Health Promotion Unit. Eugene Donoghue worked for a number of years as a teacher and guidance counsellor with County Carlow Vocational Committee and also worked as an addiction therapist in Brooklyn State Hospital, New York. He has served on committees of the European Union, Council of Europe, and the World Health Organisation. Eugene

Donoghue is a graduate of University College Cork where he was conferred with a Bachelor of Arts. He received a Higher Diploma in Education from Maynooth University and a Masters' Degree in Educational Psychology from Manhattan College, New York. Eugene has undertaken numerous management and business courses during his career. He is currently directing the affairs of An Bord Altranais through a period of major change in the nursing profession.

Gerry Donnellan became Deputy Chief Executive officer in 1981 and still holds that office. He had previously held various posts in the local authority service and in the Mid-Western Health Board.[3]

Education Officers

Roseanne Cunningham's role as the first Education Officer of An Bord Altranais has been referred to from time to time in this account and she was one of the great strengths of the organisation during its earlier decades. Appointed in 1955, she retired in 1975 and was succeeded by Kathleen Keane, who was promoted to the office of Chief Education Officer in 1981.

Kathleen Keane retired in 1995 after a long service, during which she oversaw the transition of nurse education and training from the traditional hospital base to the registrar/diploma programme linked with third-level education. She had a considerable input into the implementation of the European Union directives on general nursing and midwifery. She also represented the Bord on many other international events. An active member of the Irish Guild of Catholic Nurses, she was president of the European region from1982 to 1986, as well as becoming the first president of its associated international committee, Comité International Catholique des Infirmiéres et Assistance Medico-Sociales

Kathleen Keane later received a papal award, *Pro Ecclesia et Pontifice* in 1986. Adding to her distinctions is a Foundation Fellowship of the Faculty of Nursing in the initiation of which she was involved. Yvonne O'Shea followed as Chief Education Officer. She had previously been deputy director of nursing at St. James's Hospital.[4]

From the early 1980's a number of new education officers and assistant education officers were appointed by the Board: Hilary Marchant, Sheila Armstrong, Eithne O'Donnell, Vincent Breheny, Catherine Shine, Maria Neary, Seamus Cowman, Breda Smith and Adeline Cooney.

European Union Requirements

Nurses, like many other occupational groups, became subject to the European Union's directives. Irish representatives of the profession with their colleagues from the other member states were the main element in the arriving at the directives and recommendations approved by the Council of Ministers. The discussions on working out a mutually acceptable policy on general nursing went on for several years. The main Irish representatives were Dermot Condon, Oliver Hogan and Dr. Niall Tierney from the Department of Health, and Kathleen Keane, Chief Education Officer, and Bridie Walsh, a member of the board, from An Bord Altranais. To some extent it had been anticipated that when the national representatives came together from the different countries to compare the qualities and the skills of their respective nurses, inequalities in existing standards were likely to emerge and that the challenge to harmonisation would be to bring all national groups to the same acceptable level. If there were pre existing notions about deficiencies in some countries, in the event, it quickly became obvious that all member states had already achieved admirable standards of nurse training. In so far as there were differences between the national groupings, they sprang from varying social structures and practices and political policies patterned to meet their own needs.

Two general nursing directives, 77/452/EEC and 77/453/EEC, were eventually approved by the Council and became subject to implementation by member countries in June 1979. The directives aimed to provide mutual recognition of the formal qualifications of general nurses. They required the extension of general nurse training into obstetrics, paediatrics, geriatrics, psychiatry and community care. Nurses' interests in Ireland, like their EU colleagues, welcomed the directives as a very important advance in the development of their profession.[5]

Despite the merits of the directives, it was not the best of times, economically, for bringing the training of nurses into line with the requirements of the EEC. The extension of training areas would add to the costs of the hospitals, including the recruitment of extra staff, at a time when there was a dire shortage of funding for the care of their patients. While the training hospitals were prepared to put the new arrangements into operation, the Department of Health insisted that there would be no additional money available for the purpose. The implementation of the directives became a

prolonged issue. The Minister for Health, Eileen Desmond, told the Board in early 1982 that students then in training would have the length of their placements in obstetrics, psychiatry and community care services reduced. A few months later, the secretary of the department, Dermot Condon, accompanied by a number of his officials, came before a meeting of the board to emphasise that there would be no additional funds for the implementation of the directives that year. He suggested that the individual training hospitals should see what could be done within their available resources. That meeting was followed by a tripartite discussion between the Department, the Irish Nurses' Organisation and An Bord Altranais to consider what measures might be possible. Over the next few years the directives were fully implemented, despite the continuing shortages of health service funding.[6]

The harmonisation of midwifery qualifications was subject to separate discussions. The chief Irish representatives were Kathleen Keane and Dr. Niall Tierney. The European Union's directive of January 1980 laid down the conditions for the mutual recognition of training and formal qualifications in midwifery. In summary, the directive required full-time training in midwifery for three years, or two years for a person who had already a formal qualification as a general nurse, or eighteen months for a person with a formal qualification as a general nurse followed by a year of professional practice. Bord Altranais decided to accept the terms of the directive. Not all the maternity interests in Ireland were happy about its contents. The particular model of midwifery training chosen in Ireland was the two years full-time course following registration as a general nurse. The Board's own midwives committee urged that an eighteen months' course be sufficient and said that this reflected the views of most of the tutors in maternity training units. But the members of the Board maintained the view that reduction to eighteen months would, in effect, deny Irish midwives freedom of movement within the European Union. Two years became the requirement.[7]

With the implementation of the general and midwifery directives, a number of European Union advisory committees was established to oversee and review them from time to time. Members of the board and management of Bord Altranais and representatives of the teaching hospitals and of the Department of Health participated in these committees. No EU directives were applied specifically to psychiatric nursing, mental handicap nursing or sick children's nursing, but movement within these classifications of nursing were subjected to what were known as general systems directives. Sick children's nursing became

a post- graduate qualification and ceased to be the subject of a separate register. While psychiatric nursing did not become subject to EU intervention, there were important advances in its training requirements. During 1972 a Department of Health working party recommended improvements in the nursing personnel of the district psychiatric hospitals. They included a requirement that trainees should have a Leaving Certificate or its equivalent, an interview to assess suitability, closer monitoring of training programmes by Bord Altranais, the establishment of regional training schools, promotion on merit, rather than on the long-standing basis of promotion of seniority, and the introduction of a new staffing structure headed by a principal nursing officer. These recommendations were gradually implemented. In 1986 there were changes in the training programme, reflecting the concepts of de-institutionalisation, normalisation and quality of life. By now there had been a significant change in the gender balance of psychiatric nursing. About two-thirds of all registered psychiatric nurses were female, compared with the traditional pattern of an equal balance between the sexes.[8]

Report of Working Party 1980 and Nurses Act, 1985

The European Union directives, the Working Party of 1980 and the Nurses Act 1985 were interrelated and together transformed the traditional features of Irish nursing.

By 1975 accumulating demands for the reform of the nursing profession in Ireland and the anticipated impact of European Union policies gave rise to the establishment by the Minister for Health of a widely representative working party to take a critical look at the education, training and grading structure of general nurses. Chaired initially by Anne Lavan and later by Bridin Tierney, two prominent members of the profession, the Working Party reported in 1980 and became one of the key documents of the period in the formulation of policy. Its recommendations included a revised hospital grading structure and more management grades in nursing: matrons should became directors of nursing with greater emphasis on the management of services; An Bord Altranais should establish a fitness to practise committee to advise, admonish or censure nurses and, in the last resort, remove a nurse from the register. The report also recommended the ending of the traditional practice under which nurses, in effect, remained registered for their lifetime and its replacement by a live register requiring annual re-registration. An Bord Altranais should be more

actively involved in continuing education, and its membership should be increased to facilitate this.[9]

A long consultative process followed the publication of the report of 1980. Many committees and studies increased the work of the Bord enormously. Bridin Tierney was appointed Research Officer, a new post, and took up duty in March 1981. She had had a very varied career, starting as a graduate in languages; she later trained as a nurse and qualified as a tutor on the first course for tutors at UCD. She worked for the Medical Missionaries of Mary in Nigeria before returning to set up the School of Nursing at St. Kevin's Hospital (later St. James's Hospital). In Bord Altranais Bridin Tierney was responsible for carrying out a number of important assignments, notably the development of the Nursing Process, a system for the planning, delivery and evaluation of care to each individual patient; and a study of stress in Irish nursing.[10]

Eventually, in June1984, John Donnellan T.D., Minister of State, on behalf of the Minister for Health, Barry Desmond, brought the Nurses Bill 1984, before the Dáil. It proposed implementing many of the recommendations in the report. The Minister said that there were far-reaching implications in some of the remaining recommendations which would require further examination by the proposed new Bord Altranais. These issues included the introduction of common basic training, the reduction of the number of training schools and the question of university education.

The Bill was subsequently enacted without significant change as the Nurses Act 1985. It established a new Bord Altranais. It was designated the competent authority to implement the nursing directives of the European Union and its membership was increased from twenty-three to twenty-nine to reflect more accurately its expanding role. It provided for the election by the nurses themselves of seventeen nurses drawn from the various classifications of nurses. Twelve persons would be appointed by the minister, including a number of members of the medical profession, representatives of health board and voluntary hospital managements, persons from the broader education field and two persons representing the public interest. Among the new responsibilities of the Bord was the establishment of a central applications board to process all applications for nurse training and the appointment of a Fitness to Practice Committee which would sit in judgment on the fitness to practice of a nurse because of professional misconduct or physical or mental disability. And the president and vice-president were to be elected by the board members and not by ministerial selection.[11]

Selection of Students for Pre-registration Training

One of the most radical changes in the development of the nursing profession in the late twentieth century was the manner of recruiting entrants to the profession.

Traditionally the training hospitals selected their own student nurses. It was an integral part of the apprenticeship manner of training in which the trainees learnt the skills of nursing from their experienced colleagues while taking part in the work of the wards. A candidate seeking a place in a training hospital applied directly to the hospital concerned, supported by information about her /his education, work experience and references as to good character. If the applicant met the requirements as to education and age prescribed by the General Nursing Council and by its successor, An Bord Altranais, it then became a matter for the individual hospital to choose the successful candidates for the available places. The choice was usually made following an interview by a selection board established by the hospital authority which would normally include an independent member. But the final choices were always made by the hospital itself usually acting through its nurse management. In latter times, Bord Altranais insisted through its rules of training that directors of nursing maintain ultimate responsibility for student selection and training.[12]

The apprenticeship system of training was an excellent one at a time when the skills and required experience were simpler and could be acquired largely within the hospital wards. And it was argued that the manner of choosing trainees was appropriate to the apprenticeship system since students could be matched to the characteristics of their trainers and to the demands and the culture of the training hospital itself. The huge advances of scientific knowledge and technology of recent decades gradually transformed that situation and made inevitable radical changes in nursing education and with it the manner of choosing entrants to the profession.

By the 1970's strong criticisms were being voiced about the arrangements for young persons wishing to gain admission to the training hospitals. With the introduction of free secondary school education, increasing numbers of students had the necessary educational basis to qualify for admission to third-level colleges or to professional training courses such as for nurses.. Many sought acceptance as trainees at the training hospitals: those looking for places were considerably in excess of available vacancies. There were criticisms of the methods of selection: they were not always independent or open to public

scrutiny. Even when student selections were made in an equitable manner, the fact that each training school had its own selection machinery meant that many students had to travel to interviews at various hospitals in order to have a chance of getting place. When the Working Party on General Nursing reported to the Minister for Health in 1980, among its recommendations was the creation of central applications bureau where all applications for entry to nurse training schools would be processed.[13]

This recommendation was widely, but not universally, welcomed. Some of the training hospitals saw it as an attack on their traditional independence of choice and a threat to their own long-established cultural and ethical values. An Bord Altranais strongly favoured the establishment of a central selection system which would operate under the aegis of the Bord, supervised by a committee consisting of nominees of the Bord and of the lay administrations of the health boards.[14]

When the reconstituted Bord Altranais met for the first time in September 1986, it reiterated the earlier decision to proceed with the establishment of a central applications board (CAB) but within a few months the Chief Executive Officer was reporting that many of the hospitals were objecting to the proposals to assign students to them from the central body. In the following months the board's representatives had many discussions with the varied interests and the Board decided in February 1987 to establish the machinery of the bureau. A committee was formed which consisted of a number of members of the Board and thirteen other persons to be nominated by the employing authorities and second-level schools. In liaison with the Central Applications Office, which was processing Leaving Certificate results for entry to third-level courses in general, prospective candidates for nurse training were invited to submit their applications to the CAB. Twenty thousand applications were sent to secondary schools and individuals, and six thousand completed applications were returned.[15]

The main opposition to the concept of a central selection machinery came from three hospitals: St. Vincent's, the Mater and the Adelaide. In May 1987, Sister Columba MacNamara, president of the Board, and a number of its members took part in a meeting with the Minister for Health, the Secretary of the Department and the three hospitals. No agreement emerged from that discussion. By now it had become a political issue. Barry Desmond, when Minister for Health, had supported the views of the Board on the establishment

of the CAB. A new government in early 1987 saw a change of minister. When the new Minister, Dr. Rory O'Hanlon, met the Board members, he emphasised that he was in agreement with the establishment of a central board. And he accepted that it was undesirable that perspective students should have to apply individually to a large number of training schools in their quest for a place. But he said that he and the government held strongly to the view that employing authorities had the right to select their own trainee nurses. The Board, he suggested, might have a representative on each selection board to ensure that no irregularities took place. He referred to the particularly strong views of the three hospitals and urged that a compromise arrangement be arrived at to obviate the threatened legal proceedings.

Following the Minister's intervention, the members of the Board decided that they "should attempt to have further meaningful talks" with the interests concerned. There were more discussions between the Board and the disagreeing hospitals which culminated in the Board taking the line that it would not make the additional concessions that were being sought. The representatives of the hospitals made it known that they would refuse to discuss the issue further. At the same time the chief executive officers of the eight health boards were expressing their own reservations about the Bord Altranais plans. It was a state of stalemate.

In the circumstances, the Board decided to suspend the operation of the scheme and in July 1987 all fees were returned to the applicants.[16]

But after a lapse of some months there was a further round of talks involving the Board, the Minister, the hospitals in general and the health boards. The culmination of these talks was that Noel Daly, the Chief Executive Officer, was able to inform a Board meeting in May, 1988, that there had been in agreement in principle to the operation of the Central Applications Bureau as a "clearing house" for all applicants for nurse training; and that all applicants would be guaranteed an interview. The Minister had indicated his agreement to this approach. Following this development, a majority of the chief executive officers of the health boards said that they were prepared to accept the original scheme for the central bureau. The Board decided that the voluntary teaching hospitals also would be given the choice of accepting the scheme as originally offered or merely using it as a clearing house.[17]

These proposals did not proceed. Other events in relation to the selection and training of student nurses would eventually dictate the method of processing applications. The introduction of a pilot registration/diploma

course at University College Galway in 1994 led to the establishment of a centralised applications system involving the Western Health Board and the Department of Health. As other third-level centres and schools of nursing implemented similar training arrangements, a revised centralised system, the Nursing Applications Centre, was introduced with the participation of the Department of Health, the Local Appointments Commission and Price Waterhouse, the management consultants. The National Federation of Voluntary Bodies Providing Services to People with a Mental Handicap set up a separate national applications centre for the centralised selection of students for the schools for mental handicap. The latter centre operated from 1990 onwards.

At the end of 1998 Bord Altranais launched the Nursing Careers Centre, aimed primarily to promote nursing as a career and incorporating the work of the Nursing Applications Centre. A broadly based advisory committee was set up to guide its work, and a full-time careers officer, Christine Hughes, was appointed to co-ordinate recruitment and promotion activities. In 1999 there were over 5,500 applicants for the 781 places in general nursing and 201 in psychiatric nursing. There were 624 applicants to the centre for mental handicap recruitment for the 160 places available. However, the Commission on Nursing was not happy that administrative efficiency could be fully achieved by these selection arrangements and recommended that the Central Applications Office, which processes other student applications for third-level education, should take over the application system for all pre registration nursing education. This recommendation was accepted and the transition was being planned at the time of writing.[18]

The Live Register

In accordance with the Nurses Act 1985, the Board introduced a live register in 1987. It was a huge undertaking. To accommodate this work and the other extended responsibilities arising from the new legislation, the Board acquired its present spacious headquarters in Fitzwilliam Square. It was also necessary to install computer technology costing £300,000. Within a few months 28,000 applications were received for inclusion on the register and most of the nurses then working had been registered and had paid the new retention fee. Some nursing interests raised issues about the level of fees but by the end of 1991 the system was operating smoothly and 42,705 nurses were then on the register.[19]

Fitness to Practice Committee

The Fitness to Practice Committee was established towards the end of 1986 as provided for in the Act of 1985. It was made up of twelve board members, of whom ten were nurses, the other two being a medical practitioner and a representative of the general public. The purpose of the committee was to investigate complaints against nurses and, if it considered it warranted, to hold an enquiry into the fitness of the nurse to practice. It was always contemplated that requiring a nurse to undergo the rigours of the Committee would be a very exceptional process and that the disciplining of members of the profession would, ordinarily, be a matter for the employer concerned. In the event, as anticipated, only a small number of cases came before the Committee. The Board's president, Sister Columba MacNamara, said in her annual review in 1988 that the work of the Committee was "proceeding in a way which has won the respect of nurses... [it] is peer judgment". During 1989 seven complaints against nurses were received: only in two cases were formal enquiries held. In 1990 eight complaints were received: there were four enquiries. Over the following year there were seven complaints and four formal inquiries. During the first five years there were fifty-four applications for inquiries which lead to eighteen formal proceedings culminating in four nurses being struck off the register and three others being subjected to lesser penalties. Ita O'Dwyer, in a report prepared after her term as president ended in 1997, praised the competent and compassionate manner in which the Committee was discharging its responsibilities.[20]

Discontinuance of Basic training in Sick Children's Nursing

During the 1990's an important change took place in the long-standing provisions for the training of nurses for the care of sick children. A separate register for sick children's nurses had existed since the establishment of the registration system in 1919. While there had been children's wards in most general hospitals, the only centres offering training for direct entry to the sick children's nurse register up to the 1950's were St. Joseph's Hospital, Temple Street, and the National Children's Hospital, Harcourt Street. To meet the population needs of the developing south- western fringes of Dublin, to which many inner city families were transferring during the pre-war years, the Catholic

Archbishop, Dr. Byrne, initiated the establishment of a new children's hospital, Our Lady's Hospital for Sick Children, Crumlin by purchasing a site in 1938. The war held up the progress of building but the new hospital was opened in 1956. A school of nursing was established in it providing direct entry to the register for sick children's nurses.

The three schools remained the sole training centres for that group of nurses until the 1990's when it was decided to terminate their programmes. The decision to discontinue the three years direct entry training programme arose largely from the expanding skills and knowledge expected of all nurses and from the difficulties in securing employment by persons who had been trained only in children's nursing. The three-year course was replaced by a shorter post-registration course and became the only manner in which a nurse could obtain a formal qualification in sick children's nursing.[21] Later in this publication (chapter ten) Antoinette Kelleher and Eileen J. Musgrave trace in more detail the progress of sick children's nursing in Ireland in recent decades and explain the changes that have taken place.

Scope of Practice

The overall scope of nursing and midwifery practice in Ireland has traditionally been defined by legislation, national and local policy and guidance. An individual nurse or midwife's scope of practice has been defined by registration education that he or she has received. This means that the range of roles and responsibilities that a nurse or midwife has been authorised to perform has been confined to those included in the syllabus of training for their particular discipline of nursing or midwifery. Additional skills have been attained by participation in education programmes for which they have received certification. It became increasingly clear that this is neither an efficient or effective way of developing the competence of the nursing and midwifery professions in the interests of quality patient care. Nurses and midwives need to be able to develop their professional practice in a way that is flexible and responsive to patient and service need. To achieve this the emphasis of regulation of scope of practice in many other countries has shifted to individual and professional accountability for competent practice with organisational and national support. In recognition of this need for change An Bord Altranais in 1998 initiated a project entitled *Review of Scope of Practice for Nursing and Midwifery.*

The project aims were to review issues surrounding scope of practice for nurses and midwives in Ireland and produce guidelines to the professions on determining scope of practice. The project team consulted widely with nurses and midwives and other professions allied to nursing. Public submissions were called for, participative workshops were held, a large-scale survey of the professions was carried out and focus group meetings with key stakeholders took place. The Interim Report of the project (An Bord Altranais, 1999) indicated that nurses and midwives felt that decisions about their scope of practice had in the past often been unplanned and reactive, made without due consideration. They indicated that what was needed was guiding principles that would be broad and empowering to guide decision making in relation to issues of scope of practice.

The Scope of Nursing and Midwifery Practice Framework was published in April 2000 (An Bord Altranais 2000). This framework provides a consideration of the principles that should underpin decisions about the scope of nursing and midwifery practice. Particular emphasis is placed on the individual accountability of the nurse or midwife in determining his/her competence to perform roles. It provides a basis for local and national review of roles and scope for expansion of nursing and midwifery practice in a flexible and effective manner.

When she introduced the *Framework,* Sheila O'Malley, president of An Bord welcomed it as a timely initiative that would be of immense value in facing the challenges of midwifery and nursing in the new century.[22]

Move into Third Level Education

As the twentieth century moved into its last decade it had become inevitable that the education of nurses would transfer to the university level. The notion had been around for at least thirty years, much discussed and argued about, but, for much of the time, not taken too seriously among the decision-makers. From the government viewpoint it would be very costly. In any event, there was a broader popular view that change would have made an unacceptable impact on the deeply rooted manner in which nurses were selected and trained. The old, amiable image of the kind, caring and compassionate Irish nurse unselfishly tending the sick patient, undistracted by ideas about management, information technology or academic abstractions was too valuable to be set at risk. To many persons, student nurses appeared to be in their proper milieu in the hospital

ward rather than on the university campus. But change was unavoidable. The demands of prevention and therapy grew, the acceptance of a holistic view of the individual's ailments, scientific and technological advances, the shift from institutional to community care, all required new knowledge and skills. Tradition, sentiment and economic reasons could no longer be valid excuses for retaining the old order of things. Various Department of Health and Bord Altranais studies confirmed the need for change. In 1994 a pilot registration/diploma course was introduced at University College Galway following an arrangement with the Western Health Board; by 1998 similar arrangements had been implemented for all schools of nursing. The comprehensive Report of the Commission on Nursing, 1998, pushed the development a stage further by calling for the creation by 2002 of a four-year programme of pre registration nursing education at degree level in third level institutions. By 2000 a Nursing Education Forum established by the Minister for Health was examining the arrangements for the transition. The changes proposed are dealt with in more detail in chapters five to twelve.

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Chapter Four

A Summing Up

The end of the twentieth century is an appropriate moment in time to ask - how fares the nurse and the midwife today?

The emergence of the occupation of nursing in the first instance sprang from the acceptance of illness and infirmity as unavoidable factors of human life and from society's anxiety to ameliorate these conditions. The occupation grew in importance as civilisation became more complex as the role and value of the individual grew. Emerging religious philosophies, notably Christianity, stressed the obligation to charitable works for one's fellow beings. In time, as medical knowledge expanded and as the control of disease became increasingly the concern of states and rulers, nursing came to be seen as a necessary, but not always respected, public occupation. Social change and scientific advances in the nineteenth century made inevitable the need for a well-trained and disciplined body of nurses. Florence Nightingale's sense of humanity and determination set in motion the growth of such a force. The consequence was that the new twentieth century ushered in the almost universal acceptance of nursing as not only a highly respected profession but as a vocation, an activity to which one had been called by God.

Have the expectations of the century been realised? To what extent has the status and role of the nursing profession grown in importance in the environment of the hundred years of remarkable change that followed? The answers are clear. Nursing emerges at the end of the century as a hugely

enhanced activity, larger in numbers, greater in skill, an essential element in the great volume of social provision for the sick and the infirm. Some would feel that along the way the sense of vocation has diminished. In any event, for most of the century the notion of vocation was cynically exploited by those in authority as a justification for not giving nurses just recompense for their services. But, whatever the inspiration, at all times nursing remained an extremely popular choice of career as the services for the sick and infirm grew in volume and complexity. The statistics are striking. In the early 1920's, with the initial statutory registration systems well established, there were about 4,000 nurses on the various registers. By the end of the 1990's there were almost 50,000 nurses on Bord Altranais's live register, of whom about 33,000 were in active practice. Nurses had become by far the largest professional group working within the public health services. During 1996, when there were 65,755 persons (wholetime equivalents) employed in these services, 27,264 of them were nurses.[1] Despite that situation, in the booming economic climate prevailing in Ireland in 2000 when this account was being completed, some health service managements were having great difficulty in filling vacancies for nurses. It has been necessary to meet the shortfall by securing the services of foreign nurses, an extraordinary reversal of the long-standing situation where many Irish nurses sought employment abroad.

In the period under review in this book, the professional knowledge and the skills of the nurse and the midwife have expanded enormously. This has been especially so during the fifty years from 1950. The contributors to the second part of this publication describe in some detail the changes that have taken place in practice and training under the guidance and the supervision of An Bord Altranais. The changes have been extraordinary and have produced a group of high quality professionals meeting the requirements of a very advanced health service. Their education has moved into university level. The improvements in education and in the quality and broadening skills of nursing in general have not only enhanced its status within the caring professions but have increased the self-esteem of nurses. The profession has become more assertive and independent in attitude and is now moving towards acceptance as an autonomous profession, rather than continuing to be perceived as a subordinate appendage of the medical profession. The first independent nurse specialists are already developing. Under chairperson, Judge Mella Carroll, the recommendations of the comprehensive Report of the Commission on Nursing (1998) range across the future role, structure and education of the profession

and provide timely guidelines for the new century. The report has as its subtitle *"A Blueprint for the Future"* and has many important implications for the present organisation and operation of the profession. But it is outside the remit of this account to attempt to evaluate the report's ideas for the future.

Political changes in the island of Ireland have had benefits for the nursing profession, as well as for many other aspects of life. The new government of Northern Ireland, the creation of statutory cross-border authorities, the closer association of the different cultures North and South, have created a more united island. Joint meetings between Board members and executive staff of An Bord Altranais and the Northern Ireland Board for Nursing began in 1994 and four meetings have taken place since then. These meetings concentrate on sharing information between the Boards about developments in the nursing and midwifery professions in the respective jurisdictions. Joint collaborative projects are undertaken, including the establishment of an All Ireland Research Scholarship Fund and the joint organisation of an Annual Conference for nurses and midwives North and South. Both Boards are continuing to identify issues and tasks suitable for collaboration, which will enhance opportunities for the professional development of nurses throughout the island.

Looking ahead, Geraldine McCarthy's paper (chapter twelve) envisages nurses playing a greater leadership role in health care policy and challenging medical knowledge and dominance. In recent decades the profession has been involved to an increasing degree in the policy and decision-making machinery of the health services. The nurses themselves had perceived some of their earlier involvements as mere tokenism. Nursing representatives have been elected by their colleagues to the local health boards since their establishment in 1970 but given the size of the boards and their strong political orientation and priorities, it has been difficult for the small nursing voice to be heard. At the central level, nurse participation over the years in the many commissions and working parties relating to the health services established by the Department of Health (and Children) provided a more effective input into policy decisions. But for many years the only nurse adviser in the Department of Health was Margaret Reidy; she was later joined by Marjorie Deegan. These advisers also served on An Bord Altranais where they were regarded as valuable contributors. Deirdre Fitzsimons's appointment as a public health advisor has already been noted and there were shorter-term appointments in relation to psychiatric and mental handicap nursing. But despite these appointments, the nursing voice did not always carry a great deal of weight in the higher echelons of department policy-

making. Acceptance of the case for greater participation by the nurses in policy formation came in 1997 with the establishment by Minister Brian Cowan of a nursing policy division to ensure an integrated and strengthened nursing function within the Department. Recommendations by the Nursing Commission led to an expansion in its role. Since 1998 the division has a chief nursing officer, Peta Taaffe, formerly director of nursing at St. James's Hospital; she is supported by a team of nurse advisers, including a researcher, drawn from the main disciplines.

To an important degree, the discipline of the general body of nurses, previously influenced by their employing authorities, has been replaced by the requirements of trade union membership and the collegiality of that membership. This account has described earlier the manner in which, for decades, nurses, encouraged by their employers, distanced themselves from active trade union membership as antipathetic to the profession of nursing. Until recent times many nurses were not members of unions; many others, although in membership, were lukewarm when it came to adopting union stances. That situation has now changed radically. In October 1999, when the unions representing the profession called an all-out strike in support of a demand for better conditions, the nurses responded almost unanimously. By then there were almost 25,000 members of the Irish Nurses Organisation, the largest nursing union;[2] in addition most psychiatric nurses were members of the Psychiatric Nurses Association and there were also large groups of nurses in IMPACT (Irish Municipal, Public and Civil Trade Union) and in SIPTU (Services Industrial Professional Technical Union).

Even if the sense of vocation is less apparent and if the traditional ways of recruiting and training have become facts of history, there is no evidence that the quality of commitment of the profession to its caring role has diminished. In closing this account of nursing in the twentieth century in Ireland, it is necessary to salute the particular contribution of religious communities to the care of the sick and the infirm. The radical reduction in recent decades of the large numbers of religious involved in nursing has been a social loss that has removed from the caring services a large body of individuals who brought special qualities of dedication to their work. But if the Irish nursing force is now almost entirely a lay one, it remains unchallengeable in its ethics and in its sense of humanity.

Obviously the practice of nursing has been important in the immeasurable reduction of society's burden of mortality, pain and illness in modern times. It

would be naive to attempt to apportion the share of the health and social gain to which the art of nursing might be credited. The contributions of the other caring professions have to be taken into the reckoning and the many social, scientific and technological influences which have improved the well-being of the individual. But it is clear that, in terms of public perception and public experience, the use of nursing skills has become an enormous element in contemporary society's apparatus for maintaining health, coping with ill-health, and mitigating many of the more distressing hardships of vulnerable humanity. In so far as the progress of human health can be measured, Ireland's national vital statistics for the last half-century contain important indications. Life expectancy for males at birth increased from 64.5 to 73.0 years during the period 1950 to 1995. For females it increased from 67.1 to 78.6 years. The overall mortality rate declined from 11.7 to 8.5 per 1000 population during roughly the same period. Infant mortality which had stood at 68 per 1,000 births in 1947, was 6.2 in 1998. Maternal deaths are now a rarity.[3]

To an important degree the practice of nursing and midwifery in the twentieth century has contributed to the creation of that picture.

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PART TWO

The Development of Nursing and Midwifery Services in Ireland 1950-2000.

Chapter Five

General Nursing

Anne-Marie Ryan

This chapter aims to unravel some of the issues that influenced the maturation process of contemporary general nursing in Ireland as we attempt to embrace a graduate profession. It will explore issues related to changes associated with autonomy, responsibility, education and organisation of care, while acknowledging the significant issues that have shaped the current professional position of general nursing.

Registered General Nurses in Ireland

Registered general nurses have always accounted for the majority of registrations with An Bord Altranais. An Bord Altranais kept a register of general trained nurses (those entitled to use the initials R.G.N.), with separate divisions for male general nurses (R.G.N. (M.) until the passing of the Nurses' Act 1985 when the one division of the register pertained. Male registered general nurses have always been a minority group in Ireland. The numbers are steadily increasing, with 1,222 males on the general register at the end of 1998[1] compared to three male general nurses on the register in 1949.[2] On 1 January 1959 the number of nurses on the general register was 8,525, with 22 male registered general nurses.[3] The numbers of nurses have subsequently increased over the years to 40,518 registered general nurses on the active file of An Bord Altranais in July 1999.[4]

1950-1960: Legislative Change

The Nurses' Act 1950 provided for the establishment of one Board to replace the General Nursing Council and the Central Midwives Board. This new board was called An Bord Altranais and was established as a statutory body responsible for the education and registration of nurses, including responsibility for disciplinary procedures.[5] This was heralded as "hope for the future" by Margaret Reidy, Nursing Officer, Department of Health, in a winter series lecture organised by the Irish Nurses Organisation (INO) in November 1949 to members of the profession.[6] Many changes were to ensue as a consequence of this Act.

Advances in Hospital System

Direct and indirect influences on the practice of nursing occurred through the control of such prevalent diseases as pulmonary tuberculosis and pneumonia, and treatment for chronic sepsis following surgery. The greatest change was to the structure and scope of the hospital. Largely as a result of the availability of funds from the Irish Hospitals Sweepstakes many new hospitals were built, and others renovated, between 1930 and 1970. It was reported by Roseanne Cunningham, Education Officer, An Bord Altranais, that hospitals had "changed from drab, congested- looking buildings to spacious well lighted, uniformly heated products of modern architecture offering special departments for investigations and treatments, up-to-date operating theatres and amongst other amenities day rooms for patients and their visitors".[7] Medical research and advances of practice, especially in the prevention and curative treatment of disease, called for nurses to acquire a wider knowledge of the needs of the individual in sickness and health. Specialist hospitals for patients diagnosed with tuberculosis and cancer, as well as hospitals for the elderly were built, requiring "a new approach in the preparation of the nurse undertaking this special type of work".[8] The World Health Organisation drew up a blueprint for a rational approach to the problems of basic nursing education in 1955 and made recommendations for the selection of students and the financing of education. The need for "research, reassessment and change", with "an accent on health", was identified for consideration by all countries.[9] These changes were to affect Irish nurse education from 1960.

General Nursing as a Career

Nursing in Ireland in the 1950s was a popular career choice among middle-class women. It was portrayed as a vocation and a profession and was revered by many as exemplified by Rev. Meehan, a librarian at St. Patrick's College, Maynooth, in a lecture to nurses organised by the General Secretary of the INO in 1949. He suggested "Nursing stands at the zenith of its prestige now in Ireland." He posited two reasons for this: "the womanly character of the profession and its vocational character both, which hold good whether nursing be undertaken as a permanent career or a prelude to marriage".[10] These were the virtues that were sought in all prospective student nurses, as evidenced by the following: "In selecting candidates for our Schools of Nursing we must make every effort to choose only those who have the personal qualities needed in nursing: girls with the interest in other people and a highly developed mothering instinct".[10] This was further supported by Roseanne Cunningham who suggested in 1959 that there were two essentials required of the nurse in order to carry out her functions: "quality" or "the desire to serve, adequate intelligence and a pleasing personality," and the other was "qualifications that merited her for registration and professional recognition".[12] The majority of candidates were selected through meeting the above criteria, a positive reference and an ability to pay a training fee to the general school. The fee ranged from £50 to 200 guineas depending on the hospital plus the trousseau the nurse brought with her in the form of uniforms, shoes, veils, coat/cape, sheets, blankets, books and ancillary items, according to a list provided by the hospital. In the 1950s and 1960s in some instances it was more expensive to send a daughter nursing than a son to medical college.

Structures for Nurse Training

The education of nurses was conducted in schools of nursing over a three-year period, but some hospitals required the nurse to stay for a further year on the salary of a third-year student nurse as a donation for her training. The additional incentive to 'staying on' was obtaining the hospital badge.

In 1959 there were thirty hospitals training general nurses through a three-year programme of instruction. To be approved for training, a hospital had to have a minimum of a hundred beds, follow a detailed syllabus from An Bord Altranais and include evidence of provision for teaching staff, accommodation

and facilities available to student nurses.[13] Although these were the minimum criteria for the approval of a school, inspections by An Bord Altranais ensured the quality of the settings and practices for training.

Many calls for change in the education and training of nurses occurred through the years. At a symposium on the nursing profession and its needs, Professor Michael Tierney, Vice-Chairman of Seanad Eireann, called for diploma level education for nurses in 1942.[14] The difficulties he suggested with implementing it were financial but he believed the means existed to surmount this difficulty. It was reported in 1950 that prominent nurses in the Irish Nurses Organisation and An Bord Altranais supported this educational initiative. There was a questioning of the basic training and its adequacy to meet the needs of a changing social structure.[15] University authorities at this time were sympathetic to developing courses for nurses but the obstacles of finance and accommodation stood in the way of doing this.[11]

The Moral Stability of Nurses

The methods of managing nursing through the decades have reflected societal expectations and influences. The concern of nursing management was the efficient running of the hospitals and the maintenance of a strict moral code for nurses. An example of this is reported by Dr.Cohen of the University of Leeds who declined to be a co-signatory of the Minority Report of the Working Party on the Recruitment and Training of Nurses, since he was critical of the "outmoded course of discipline to be found in many hospitals" and considered that a "complete overhaul of the disciplinarian regime is as urgent as the introduction of a selection procedure for senior nursing posts."[17] Dr. Noel Browne, the Minister for Health at that time, continued the theme in an address to the Annual General Meeting of the Irish Nurses' Organisation in 1949 when he stated: "Sometimes I hear arguments put forward that girls have not the high moral standard or sufficient discipline in local institutions. When local representatives have said these things to me I replied that they were impugning the characters of their daughters."[18] The image Irish general nursing represented both within and outside the workplace was an issue for discussion in the nursing press. It was suggested that "with a combination of religious customs on the one hand and, on the other, an unexciting economic life, one arrives at the existence of a corps of nurses whose high moral development could not fail to impress us." [19] This image was perpetuated by the training and conditions of employment of the general nurse.[20]

Learning the Practice of Nursing

The passing of the Nurses' Act 1950 led to many changes in the organisation of education for nurses, including the appointment of an Education Officer, Roseanne Cunningham, in 1955 to An Bord Altranais.[21] The Bord Syllabus of Course of Instruction from 1 September 1956 outlined the content of the programme for the practice of nursing and indicated that "Particular attention should be paid to those matters which are of everyday practical use to the nurse while tending the sick. It is more important that the nurse should be able to recognise those symptoms and signs which indicate the onset of trouble than that she should be conversant with the pathology of the disease."[22]

The syllabus outlined many duties in relation to domestic ward management which included cleaning and household management tasks. The patient-centred activities included general care of the skin of the patient confined to bed. The duties of a first year nurse were associated with bed-making and its accessories. The nurse was required to take and record temperature, pulse and respiration rates, administer oral medicines, apply poultices and lotions, administer enemata and observe/measure excretions, perform simple ward dressings, care for a patient after anaesthesia and prepare and serve meals, including feeding helpless patients. In the second and third years, the nurse was required to administer injections and perform more complex dressings, baths and treatments. The nursing of heart cases and of respiratory diseases[23] reflect examples of an objectified approach to provide care that mirror medical practices that involve the nurse as assistant.

The topic of ethics, as opposed to the subject, appeared in the early Syllabus of Courses of Instruction (1956). The indicative content for the topic was "care of general health, body, hands, feet, hair, clothing, ventilation, sleep, recreation."[24] Lest the impression be given of a loose ethical concern for the development of nurses, this was far from the case. The issues of ethics and psychology were mentioned in the 1956 Annual Report of An Bord Altranais where it states that lecturers for these subjects "must be appointed in consultation with the appropriate ecclesiastical authority for the diocese in which the Training School is located".[25] It was, however, decided that it was not necessary to hold a formal An Bord Altranais exam in the subject, but local exams could occur.

The nursing staff of any hospital that wished to be involved with nurse training in 1955 had to comprise a matron, sister-tutor, and adequate numbers

of ward sisters and staff nurses. The recommended ratio of staff nurse to patients was 1:15, of students to patients 1:5 and of sister-tutors to students 1:40.[26] The organisation of nursing management was hierarchical, with senior management having much power and control of staff and resources. The medical colleagues, who relied upon the nurses' judgement and interventions with patients in their absence, held senior nurses in high esteem.

Conditions of Employment

The Nursing Officer of the Department of Health, Margaret Reidy suggested to nurses in 1950 that they were "living in an interesting era" exemplified by

a) Up-to-date equipment has somewhat lessened the drudgery of nursing,
b) Nurses have more leisure,
c) Salaries, if not all they might be, have certainly improved,
d) Fear of unemployment has vanished,
e) For the girl with ambition the profession offers wide scope and interest and the opportunity of leading a full and varied life.[27]

Nevertheless, nurses did work a 96-hour fortnight and attend lectures in their own time.[28]

Hospital-based general nurses were renowned for their lack of political awareness. This was brought to the nurses' attention by the Minister for Health, Dr. Noel Browne, in 1949, when in an address to the annual general meeting of the INO he stated: "The apathy of the nursing profession surprised me...you nurses have made little effort to help me to help you. Nevertheless I shall continue in my efforts to ensure that members of the nursing profession shall enjoy the conditions of service and the status they deserve."[29] Dr. Browne further said that nurses required living quarters; facilities for recreation and the first 'experimental' nurses' home was built in Galway as a model.[30] Throughout the 1950s many more nurses' homes were built, and more than half the hospitals in the country had such a facility in 1963. In many hospitals not alone was living out discouraged but obstacles to it were retained, in the form of broken off-time and charging for meals at the daily rate for four meals, even when only one may have been taken. A practice that was also used during this period was of sub-letting the room of a nurse while she was on holiday.[31] There can be no doubt but the general nurse during the 1950s experienced many contradictions associated with terms of employment, but there were medical

innovations; the advances in chemotherapy and advent of the artificial kidney in 1958 brought with them the promise of opportunities for development of practice.[32]

1960-1970: The Nurse's Place in the Health Team

In an address to the third meeting of the Irish Matrons Association in 1960, T.C.J. O'Connell, President of An Bord Altranais, stated, "the trained and experienced nurse was just as important as the trained and experienced doctor. She must take her place in the team whose work is dedicated to the welfare of the patient."[33] This theme was developed when O'Connell suggested that "the modern nurse finds herself having to deal with a multiplicity of new techniques and treatments which have arisen in the tremendous advances in medicine and surgery which have taken place in the last ten years."[34]

Working in a changing environment gave the nurse an expectation of educational change through a university-based programme. This was realised for the nurse tutor in 1960 but the nurse at the bedside lived with the promise of change.[35]

There was a call at the annual general meeting of the INO in 1960 for "job analysis of the nurse."[36] While a study was conducted, in a Belfast hospital, with the object of "obtaining the most effective use of staff and equipment," it was reported, in the *Irish Nurses Magazine,* that an examination of ritualised practices could effect a change that would lead to a more patient-centred approach to providing care. This demonstrated that a 44 hour working week was manageable. The practice of waking patients at 5 a.m. to dress their beds was no longer necessary since it was possible to bath patients and administer enemata in the afternoons.[37]

Nursing Structures

A study by Pauline Scanlan in 1962 entitled *Nursing Education in Ireland: Background, Present Status and Future*.[38] and a follow-up study in 1968 demonstrate a marginal improvement in nurses work patterns and structures. Scanlan's initial study and the 1968 study reported by means of a questionnaire, on the structures and practices of nurses in 41 of 73 hospitals that provided training in Ireland. The findings of this latter study in which seventeen general hospitals, mainly from the Dublin area, participated, illuminate a picture of the structures, practices and lives of nurses throughout the 1960s.

The organisation and control of nursing services in Ireland was largely under the authority of the Church. National government mainly provided the source of funds for the general nursing programme throughout the country. Both religious and lay employees staffed the majority of the hospitals, and managerial positions were held by religious staff. This influenced the ethos and environment in which teaching and learning occurred, as was illustrated by the library resources that were available to students: the library stocked current nursing journals and religious magazines, but there were professional works in only a few hospitals. The influence of the Church was strong in Ireland's hospitals as it was generally at that time.[39]

In the late 1960s the general nursing management services were under the direct control of a matron, night superintendent or night sister, who monitored ward and departmental unit sisters, who supervised staff nurses, and subsequently the nursing student. The matron managed the total nursing service maintaining personal files of prospective and actual employed nurses and the progress of the sick in the hospital; she was also involved in non-nursing duties associated with housekeeping. Her responsibilities also extended to the selection of students in the school of nursing and she was accountable to An Bord Altranais for the education and training programmes. Matron in many institutions was a strict disciplinarian who censured erring nurses through ward allocations and by restricting off-duty freedom.[40]

Students as Employees

A pragmatic approach to the education and training of nurses was supported by the student's legal status of becoming an employee. The effect on the student was that the service needs of the institution took priority over teaching/learning. The student was on the lowest rung of a rigid hospital hierarchy where a great deal of her time was occupied in repetitive tasks, starting with cleaning and domestic duties before being allowed to progress to patient-based responsibilities. It was suggested in the study conducted by Scanlan [41] that, in the main, students learnt the art of nursing from more senior students. Registered nurses and students performed many non-nursing duties. These duties included among others: moving furniture for cleaners, carrying meal trays, standing in for the front door porter when he was engaged in other duties, as well as the cleaning tasks in the kitchen, such as defrosting the fridge, cleaning and polishing cutlery and seeing to the kitchen before breakfast and

lunch. The nurse therefore performed a pivotal role in the hospital where she was required to adapt and undertake a wide range of activities as the situations demanded, including leaving the classroom to perform an activity in the wards.[42]

Ward Duties

Nursing activities were always referred to as 'duties' and as such were performed to contribute to the greater good. Ward sisters were responsible for the nursing and general care of the patients. Ward sisters noted in interviews in 1967-1968 that, with improvements in treatments and investigation procedures, activities in their units had intensified. They stated that many of the old procedures of douching, poulticing, and various therapeutic baths were no longer employed, but these duties were replaced with nurses engaged in charting and monitoring drips, observing for side-effects of drugs, blood dialysis, special diets, feeding by Ryle's tube, inhalations, fluid balance and defibrillation.[43] It was suggested that patients were becoming more informed and were looking for explanations on treatments and medicines. The environment in which nursing care was being given was also improving and becoming more mechanised, with defibrillation machines, arrest trolleys, electric food trolleys, bleeps, patient call bells, medicine trolleys and kardex filing systems. The sisters noted that that they were desperately busy and short-staffed. They said that they could spend their days engaged in activities such as writing, sorting admissions, answering phones, ordering stores, filing charts, completing diet slips, ordering domestic and pharmacy supplies accompanying doctors on their rounds.[44]

Living-In

All student nurses were required to 'live-in' in the nurses' home during training,[45] bar one hospital which introduced an option element to living in the nurses' home after two and a half years of training.[46] Only some homes provided a bedroom for each student. Many senior nurses lived in a room or a flat in the nurses' home. Difficulties arose on the retirement of these ladies who over the years had become institutionalised and inexperienced in managing normal household affairs. As a consequence, some nurses retired to live in a nursing home. In most hospitals nurse-teachers lived in the residence. Students in the

main were not involved in a student organisation or association, despite the emergence of a student section of the INO in 1960.[47]

Each student worked on average an eight-hour day shift and a ten-hour night shift. Night duty ranged from a total of 24 weeks to 52 weeks in the three-year training period with an average of thirty weeks worked. Scanlan reports that annual leave ranged from 21 days to 36 days, with an average of 27 days off per year per student.[48]

Student nurses of that period recall being called at 6.00 a.m. in the nurses' home, to dress, tidy their room, go to mass and have breakfast before going on duty at 7.30 a.m. A uniform inspection could occur before going on duty reflecting a military custom inherited by hospitals. Another practice was to waken nurses on night duty to dress and attend a midday lunch. Inspection of nurses' bedrooms was a frequent activity and nurses were checked in their bed in some hospitals by the night superintendent/sister. Monitoring student and staff nurses' off-duty activities was achieved by requiring nurses to sign a book for a 'late pass.' The late-passes were strictly regulated such as for the night before a day off. There were restrictions also as to how many late passes a nurse could take in a month. In some institutions a key was required and this necessitated queuing up to see matron on the morning involved, thus missing breakfast and queuing again the next morning for its return. The practice also prevailed of asking permission to take annual leave noting the address where the leave would be taken and the name of someone at that address. Most hospitals operated a one-day-off-a-week roster. In some institutions students were held accountable for the replacement of breakages during these duties.

Call for Improvements

An address in 1965 by Donogh O'Malley, Minister for Health, called for an improvement in the life of a student nurse. He suggested a 90 hour working fortnight, inclusive of lecture time; block study periods of eight to ten continuous weeks in the first year of training and five to six weeks in both the second and third years as well as avoidance of 'split shifts' where possible. He also urged the elimination of night duty during the first six months of training, and where possible, during the month preceding the examinations for An Bord Altranais, and its limitation to two months each year. Among his other proposals were the removal of the additional year's service requirement following training; adoption of a modern simplified uniform, where this had

not already been done; reasonable freedom during off-duty periods; good student-management communications; and the increase where necessary of the number of tutors to provide a ratio of one tutor to thirty students.[49] It appears from the documentation of that period that the recruitment and retention of staff was problematic, yet practices that today would be interpreted as bullying persisted. The INO made recommendations for change to An Bord Altranais following its annual general meeting of 1967 and a letter received in November 1967 from An Bord suggested that, "it was not aware of any general dissatisfaction regarding the present basic training course."[50]

Improved Conditions

Pay and conditions of employment following a major campaign were revised in the 1960s with increases in pay and allowances granted for working in theatre and on night duty. In 1968 it was reported in the *Irish Nurses' Journal* that working hours were fixed at 90 hours per fortnight, which was then revised to 85 hours per fortnight.[51] A superannuating pension scheme for all nurses was established in 1968, including nurses working in voluntary hospitals.[52] Change in conditions of service occurred slowly for general nurses, because they were mainly a compliant workforce. At the end of the 1960s, nurses began to examine the unique contribution of nursing to the maintenance and achievement of health, especially in the expanding role of the profession.[53]

1970-1980: Social Change

The 1970s saw much social and legislative change in Ireland. In such a female- dominated profession as general nursing, the influence of the social and economic climate of Ireland cannot be underestimated. In 1974 women at work were afforded equal pay with men for like work, but this highlighted the problem in general nursing of an almost exclusively female workforce, where injustice of pay differentials existed between male and female nurses. Another significant issue for women was that until 1977 they were obliged to resign a permanent position in the workplace on marriage. This was seen as a particular injustice, especially damaging to the morale of the general nurse.[54]

New Structures

Nursing practice during the decade remained functionally orientated, and practising nurses were busy with tasks and procedures, leaving little time to reflect and question their own practice. The president of the INO, Maureen McCabe, called for a College of Nursing and ultimately a Nursing Studies Unit in the university for post-basic education.[55] In 1972 some nurses renewed the call for a university-based education and a College of Nursing including Judith Chavasse, Ita Leydon and Brigin Tierney.[56] The training of nurses in management was supported and facilitated in 1971.[57] The call for the further development of education and training was answered by The Royal College of Surgeons in Ireland, set up a Faculty of Nursing to develop post-basic nurse education in 1974. Mary Frances Crowley was the founding Dean and with a Board of the Faculty, she developed many modular type courses in a wide variety of nursing and allied skills including a Fellowship in Nursing in 1982. The profession warmly welcomed this initiative.[58]

European Links

With Ireland's entry into the European Economic Community (EEC) in 1972, it became necessary for Irish nurses to comply with two general nursing directives that were agreed by the Council of Ministers in June 1979. The directives for nurse education were devised to allow for mutual recognition of certificates in general nursing and to facilitate the employment of Irish nurses throughout the other member states.[59]

The Syllabus of Course of Instruction (1956), outlining nurse training, remained unchanged until the European Union Directive (77/ 453/EEC) was implemented in 1979. A new syllabus was introduced based again on a systems approach to providing care, augmented by basic sciences and social sciences. This syllabus required all nurses to receive twenty-six weeks' theory of instruction in "blocks" of 4-6 weeks during the training period and to experience specified allocations to particular clinical environments.[60]

Duties and Role of the Nurse

The role and duties of the general nurse were becoming more specialised, with nurses undertaking short courses in theatre, neurosurgery, ophthalmic,

intensive care and urological nursing.[61] Nurses were legitimately trying to establish their place in the health care team. An editorial in the *World of Irish Nursing* called for "the nurses to be the authority on nursing care and nurses must channel their efforts towards health, including health education and care and the provision and control of care"[62] Problems were identified of nurses taking on roles for which they believed they were inadequately qualified including specialist areas of practice of I.C.U., giving I.V. injections, taking blood specimens, over the phone prescriptions and diagnosis, and the role of the anaesthetic nurse.[63] Representations were made to the Minister of Health seeking financial support for nursing research and arguing in favour of the creation of the post of principal nurse tutor and open competition for senior nursing posts met with success.[64] A major review of the role of nurses in the health services and health services management was agreed and began in 1975 when the Minister for Health established a Working Party on General Nursing.[65]

1980-1990: The Working Party Report

The Working Party report in 1980 was to affect substantially the structures of nurse education and training. It made sixty six recommendations related to hospital grading structures, community nursing services, nurse teachers, specialist nurses, non-nursing duties/support staff, hospital design and planning, nursing advisor posts in the Department of Health, role of the nurse at health board headquarters, entry to nursing, An Bord Altranais, nurse training schools, organisation and assessment of basic education programmes, common basic training and continuing education.[66]

A survey and attitude study was conducted on behalf of the Working Party.

This report was wide-ranging and many of its recommendations subsequent influenced developments. The importance of education was a central theme throughout the report, which recognised the changing responsibilities of the nurse from purely providing support in curative services to the need to develop a more preventative and educative role.

The Clinical Learning Environment

The report identified a number of problems about the demands the service needs of the hospital placed on the education and training of student nurses.

This included the obstacle of developing a modular training system that would reduce the gap between theory (what is learned in the classroom) and practice (what is actually carried out in the clinical areas). The dominance of the hospital's service needs also led to problems in balancing the staffing requirements of the clinical areas with the need to provide educational opportunities for the student nurses. Because of these problems the Working Party realised that the education and training of the student nurses should achieve a balance between practice in the clinical area and learning within an educational setting.[67]

Several recommendations were made to achieve this balance. The report suggested that clinical learning objectives be identified to allow the student to achieve their learning needs in the practice setting, thereby helping to reduce the theory-practice gap. However, the real issue of the students providing the bulk of the service needs was not tackled. No reason was given for not dealing with this issue, even though it had been highlighted as necessitating change earlier in the report. However, in the climate of the health services in the early part of the 1980s the financial implications of replacing the service contribution of student nurses with qualified staff may have had far-reaching implications for government budgetary policy at the time. Therefore, the students' main role, following the publication of the Working Party Report, was to meet the service needs of the hospital and not their own educational needs. The apprenticeship system remained firmly in place for the next decade.

Nursing Activities

A study to examine nursing activities was conducted by the Working Party where a list of tasks or activities was distributed to 90 staff nurses, asking them to record their activities during one week. The findings of this survey indicated four distinct patterns of work activity. These were patient-oriented activities, such as giving injections to patients; decision-making activities; such as ordering supplies; doctor-assisting activities, such as taking blood samples; and housekeeping activities such as cleaning and tidying. Staff nurses indicated that they were involved in tasks associated with daily living activities where they helped patients to bathe, feed and move. They also engaged in the technical nursing activities of administering medications and treatments, bandaging and performing dressings, observing/recording/monitoring, setting up equipment and performing initial resuscitation of a patient. The other activities of staff

nurses included nurse/patient communication, clerical and domestic tasks and a category entitled 'other activities' of attending to a dead body, the disinfection/sterilisation of equipment, escorting patients, collecting specimens, and preparing equipment for other members of the healthcare team. Nurses at this time were dissatisfied with the range and amount of time they perceived they spent on non-nursing duties.[68]

A difference between the activities of ward sisters and staff nurses was highlighted in the study and in the diary features of nurses reported in journals.[69] The ward sister was seen to perform more skilled or administrative-type tasks, while the staff nurse engaged in the housekeeping aspects of nursing. An interesting finding of an attitude survey that was commissioned by the working party from the Institute of Public Administration relates to nurses' suggestion that some regimentation was necessary to enable the hospital to run smoothly. They suggested that while nurses should devote as much time as possible to their patients, they should not get too friendly. Visitors were felt to be quite disruptive to the hospital routine. It can therefore be assumed that structure and routine remained important in the lives of nurses.[70]

The Work Ethic

The hierarchical management structures and values, built from a vocation culture, resulted in nurses' lives being controlled by rules, routines and regulations. Students needed to learn these rules in order to survive and feel comfortable in the classroom and the ward. There was a heavy dependence on students to provide labour. This created a work ethic in which the student learned to work quickly, look busy and pull her weight.[71] The student quickly realised that she was a worker with responsibilities for which she was accountable to her superiors. Students learned that it was necessary to gain knowledge of the routine, do the physical work and react less to individual patients needs. This led to students accepting their tasks without questioning. Sitting down and talking with patients was seen as not working which students learnt to overcome by administering a drink or giving a patient some other physical care. Students also learnt how to juggle good theory with acceptable practice. They thus learnt very good adaptive systems. Tracey called for an exposition and discussion of this hidden curriculum since it can militate against implementing change in attitudes and behaviours.[72]

Research and the Nursing Process

There was awareness amongst nurses throughout the decades of a need for nursing research. In 1981 a Research Officer, Brigin Tierney, was appointed to An Bord Altranais and throughout the 1980s she set about disseminating documentation and presenting the nursing process as an approach to managing nursing care in twenty-two centres.[73] The nursing process is a patient-centred approach to organising and providing care and was to challenge the task allocation system. In task allocation duties were performed according to seniority of the nurse within the ward team and the perceived status of the task. The nursing process required the nurse to assess, plan, implement and evaluate the total care for an individual patient.

Relationships and Support

Relationships between grades of nurses were perceived differently. The perceived availability of the matron and the fear engendered by her also varied between hospitals. Staff nurses reported the most tension in relationships. The Working Party report highlighted the stress nurses experienced.[74] In 1984 the Research Officer of An Bord Altranais received funding to conduct a study entitled 'Stress in Nursing'. The findings of this study, which supported the hypothesis, were not published for five years. An Bord Altranais set up an experimental Professional Guidance and Welfare service in 1987. The evaluation of this service found the brief too broad and unwieldy, and while it was recognised as a valuable service, it caused disquiet as a conflict of interests was identified between it and the role and function of the Fitness to Practice Committee.[75]

1990-2000: Changing Practices of Nurses

A further study to examine the activities of students and staff nurses Beaumont Hospital, Dublin was conducted in 1994 using non-participant observation. The study's framework was based on some of the activities of daily living as described in the Roper, Logan, Tierney model of nursing care, with the additional categories of specific nursing treatments and procedures, teaching and learning, cleaning/housekeeping, clerical, miscellaneous and personal. The findings indicated that nurses were involved in specific nursing

treatments and communication activities 52% of the time. Direct patient care activities associated with the activities of daily living were observed 28% of the time. Teaching and learning activities, clerical duties and cleaning and housekeeping activities were each observed about 5% of the time. It may therefore be construed that nurses over the years have increased the amount of time they spend on patient-related activities and less on non-nursing activities. This study also asked staff nurses to identify the grade of staff they believed should undertake each activity in an acute general hospital situation where there were no student nurses on duty. The study identified 128 activities performed by nurses. Nurses' opinions were divided as to who should or should not undertake these activities in the absence of a nurse. A majority of the sample (60%) suggested that a nurse or a doctor should always perform 59 activities from the list. The scope of activities witnessed by virtue of this study indicates that information technology, technology, and pharmacological interventions affected the nurses' role, necessitating special observations and assessments. This study also made suggestions regarding work to be done by care attendants as a consequence of the reduced numbers of student nurses in the workforce.[76]

Future of Nurse Education and Training

An Bord Altranais, following a culmination of research, consultation with the profession and an expert group, in 1994 published *The Future of Nurse Education and Training*.[77] It mooted a common basic training course to include a common portal of entry for all nurses which would lead to registration in general, psychiatric, paediatric or mental handicap nursing following a three-year course. The first two years of the course would be followed by a third year of "intensive training in the division of nursing in which the student at the commencement of training, would have indicated the intention to register."[78] However, this was superceeded by the report of *The Commission on Nursing: A blueprint for the future (1998)*[79] and the pilot registration/diploma programme which commenced in 1994 as a response to an initiative of the Department of Health and Children.[80]

Links to third-level institutions

The general nurse registration/diploma programme began as a pilot programme in Galway in 1994 and heralded "the beginning of a radical change

to the system of nurse education and training in Ireland."[81] This model of education saw an increase of the theoretical component of the programme from 40 weeks to 59 weeks, with the student receiving a non-means-tested grant, supernumerary status in the clinical area, bar a 14-week period in third year, and receiving one-sixth of the content of the nursing programme from subject specialists in the third-level institution. This student of nursing, though based in a hospital, was exposed to some of the experiences offered by third-level education.

Continuing Professional Education

An examination of continuing professional education for nurses was conducted and subsequently published by An Bord Altranais in 1997.[82] Investment in this initiative was seen as supporting quality patient care and the future of the health services. The changing role of the nurse, encompassing advanced levels of clinical expertise, enhanced practices associated with health promotion, research and management, required educational support and organisational change. This report examined the issues of access, accreditation and career development of nurses and the necessary supporting structures. One such structure, acknowledged by the report and the Health Strategy,[83] was that nurses should be involved in policy-making. Influenced by that recommendation a Chief Nursing Officer, Peta Taaffe, was appointed to the Department of Health in 1997.[85]

The Commission

Nurses had experienced extensive changes in the delivery of services and in training, and as a consequence of a threat of industrial action a commission on nursing was established by the Minister for Health, Michael Noonan, following a recommendation from the Labour Court.[85] The report of the subsequent Commission on Nursing 1998 examined the role, promotional opportunities and education of nurses and one of its recommendations called for the transfer of pre registration nursing education into third-level institutions at degree level.[86] This four-year programme includes a period of twelve months, continuous clinical placement as a paid employee of the health service and is due to commence for all pre-registration programmes in the academic year of 2002. A Nursing Education Forum was convened to prepare a strategy for the

implementation of this programme. In order to effect this transition of education to third-level institutions, An Bord Altranais issued Requirements and Standards for Nurse Education Programmes in 1999 to provide guidance to third-level institutions and health care institutions for the development of flexible, innovative and, practice-oriented registration programmes.[87]

Conclusion

General nursing in Ireland has grappled with immense changes during the last fifty years. The education and training of the general nurse, the management structures she works within, the organisation of the care she delivers have transformed as a response to a changing health care and social environment. Although the structures and processes surrounding the provision of care have altered, the central concern of general nurses "to help those in need"[88] has remained constant and this unifying principle links the past with the present while providing a solid foundation for the future.

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Chapter Six

Midwifery

Ita O'Dwyer and Ann Louise Mulhall

Introduction

The Republic of Ireland is one of the safest places in the world in which to give birth with the lowest maternal mortality rate and the second lowest infant mortality rate.[1] A significant element in this success is the standard of midwifery practice. The midwife occupies a central position in the provision of maternity care in Ireland and is the most senior clinician present at 72% of births.[2] The provision of maternity care in Ireland is underpinned by the key principles underlying the Health Strategy: equity, including access, quality of service and accountability.[3] This chapter describes the history of midwifery practice and of midwifery education and training in Ireland between 1950 and the year 2000. It considers the skills, responsibilities, education, training, organisation of midwives and maternity care.

Definition of a Midwife

The definition of a midwife as recognised by the World Health Organisation is:

> A person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in

> midwifery and has acquired the requisite qualification to be registered and /or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postnatal period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women but also within the family and the community. This work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.[4]

This definition highlights a complex and specialised role. By emphasising these aspects related to prevention, the execution of emergency measures, the detection of abnormal conditions, the carrying out of deliveries on her own responsibility, it highlights the degree of autonomy and independent practice afforded to the midwife.[5]

The number of midwives registered with An Bord Altranais at the end of 1998 was 15,211 including nine male midwives.[6]

EDUCATION

Earlier Developments

The earliest formalised initiatives in midwifery education in Ireland were in the Dublin Lying-In Hospital (Rotunda) in 1773,[7] the Coombe Lying-In Hospital in 1836,[8] the Royal College of Physicians in Ireland, and Sir Patrick Dun's Hospital(1868).[9] The first regulatory recognition of midwifery training in Ireland was granted to the three former institutions under the 1902 Midwives Act.[10] The Coombe Lying-In Hospital, Dublin and Erinville Hospital, Cork, were accepted by the Central Midwives Board in London as recognised training schools for midwives in 1904. Commencing with the Midwives Act for Ireland 1918 and the setting up of an Irish Central Midwives Board, there was a series of midwifery legislation regulating entry to, duration and content of midwifery training. The regulation also dealt with experience

required in hospital and on the district, the conduct of examinations, and the approval of training institutions. In 1944 the first mention is made of the appointment of sister tutors; the lack of qualified midwifery tutors presented a serious problem. Efforts made to recruit qualified midwife teachers from abroad met with little success notable exceptions being the appointment of Rita O'Mahony in Cork and Delia Casey in Galway, who also served as a member of the Midwives Committee (1955).[11]

The contribution of expert clinical midwives, who combined a clinical role with joint appointments as approved tutors, is recognised, these included Sr.Fidelis (Galway), also a member of the Midwives Committee of An Bord Altranais, Maureen McCabe (Coombe Lying-In Hospital) and Margaret O'Sullivan (Erinville Hospital,Cork).[11]

In 1950 two programmes of training and education of midwives were approved:

A direct entry programme of two years duration with a part 1 examination at the end of 18 months and part 2 examination six months later. The last direct entry programme was provided in the Rotunda Hospital in 1959.

A years' midwifery training programme for Registered General Nurses and Registered Sick Childrens Nurses (since 1944) with a part 1 examination at six months and part 2 at end of one year.

Institutions approved

Prior to the establishment of An Bord Altranais, the institutions approved for pre- registration training were Rotunda Hospital, Coombe Lying-In Hospital, National Maternity Hospital, Incorporated Maternity Hospital in Belfast (until 1922), the Cork Lying-in Hospital, the Cork Maternity Hospital, Bedford Row Hospital in Limerick[12] and Our Lady of Lourdes Hospital in Drogheda (1942). From 1950 to 1970 application were received and approved by the Midwives Committee for midwifery schools for The Family Hospital Curragh, Portiuncula Hospital, Ballinasloe (1970s), St. James's Hospital, Dublin (1965), St. Munchin's Hospital, Limerick (1960), Central Maternity Hospital Galway, (later the Regional Hospital Galway), Bon Secours Hospital, Cork (1958) and St. Finbarr's Hospital (1955) Cork.[13]

Inspection

Under the Nurses Act 1950 each training school was inspected by the Midwives Committee who would make a recommendation for approval to the Board. These institutions were inspected again as necessary. Regular inspections of schools commenced in 1978 and the process was regulated by the Nurses Act 1985 when each school was inspected every five years. This contributed to the enhancement of standards and was a source of considerable support to midwifery training schools and student midwives. *Criteria for approval and inspection of Schools of Nursing /Midwifery* were adopted in 1988 provided for revised guidelines.

Post Registration Education and Training

In 1956 Professor Eamon de Valera first mooted the provision of training programmes for nurses and midwives in neonatal care[13] and the National Maternity Hospital (1966), Coombe Lying –In Hospital (1986) and the Rotunda Hospital (1990s) were approved by An Bord Altranais to provide courses in special and intensive nursing care of the newborn.

In the mid 1970s the first consideration was given to the provision of programmes for the education and training of midwives to become teachers of preparation for parenthood programmes.

The annual midwifery refresher courses organised by the Irish Nurses' Organisation continued to provide a valuable forum for midwife education and practice updating. Minutes of Midwifery Committee meetings clearly indicate the pivotal role in these initiatives of the Dublin maternity hospitals and their midwife and obstetrical staff. On the basis that sound midwifery education is the key to improvement in midwifery care, the above developments have enhanced the reputation of the Republic of Ireland as a safe place in which to give birth.

Midwifery Tutors

During the early 1970s the possibility of the establishment of a midwifery tutors education programme in Ireland was being pursued by Professor Eamon de Valera, Roseanne Cunningham, Education Officer An Bord Altranais, and Anne Young, St. Kevins Hospital, Dublin. A commercially sponsored

scholarship was established to enable midwives to undertake the Midwifery Tutors Diploma in the Midwifery Teachers Training College in High Coombe near London.[13]

In 1972, following Ireland's entry to the EEC, the implementation of the EEC Directives relating to the liberal professions, including midwifery, became compulsory. It was recognised that midwifery registration programmes within Ireland would require amendment. The availability of competent approved midwife tutors within all training schools was essential.

In 1979 Judith Chavasse secured approval to include a midwifery option in the Nurse Tutors Diploma programme in UCD. This programme was accepted by An Bord Altranais as the recognised qualification for midwifery tutors. The establishment of this course was seen as a major development in midwifery education in Ireland. This initiative, to be successful, required the support of the voluntary maternity hospitals and health boards. Since the programme was going to be located in Dublin, the matrons, masters and principal tutors in the Coombe Lying-In Hospital, the National Maternity Hospital and the Rotunda Hospital were invited to participate in it. The full co-operation of these hospitals and St. James's Hospital with this programme was granted, together with access to the hospitals for clinical and classroom teaching purposes. This strategy promoted a concept of student midwife teacher education to the clinical staff, including midwives and student midwives in these hospitals. Six midwives, Cecily Begley, Vaun Currin and Ann Louise Mulhall (Coombe Lying-In Hospital, Dublin), Catherine Flanagan (Bons Secours Hospital, Cork), Sr Brenda Knox (Our Lady of Lourdes Hospital, Drogheda) and Nora Mansell (St. Finbarr's Hospital Cork), successfully completed the first programme (1979-81). This first programme was established and led by Ita O'Dwyer (St Munchin's Hospital. Limerick). Sr.Triona Harvey, Medical Missionaries of Mary, was later appointed full time lecturer to the course.

Single Period of Midwifery Education and Training

In 1970 the single period of midwifery training was introduced following consultation with the training hospitals. A review was undertaken of the syllabus for the theoretical and clinical experience requirements, including district experience of four weeks. Midwifery tutors and senior midwives and obstetricians were now involved in the clinical, oral, and written Bord Altranais examination at the end of the year's course. Students were still required to obtain a certificate of proficiency in gas and air analgesia before registration.

Impact of EEC Directives

The nursing and midwifery directives that followed Irish entry to the EEC had an important impact on midwifery training. This was recognised in the report of the Working Party on General Nursing 1980 which recommended that the syllabus should be revised "to prepare the midwife to function in an extended role and should include an in-depth study particularly in relation to counselling, principles of health education, parentcraft, psychological and emotional problems of parents, inter-personal relationships, mental handicap including its causative factors, genetics and medical ethics."[14]

EU Nursing Directive 1977

The EU Nursing Directive (77/452/EU) required that education and clinical experience in maternity care be provided for each student in general training. It was subsequently agreed this would be of three weeks' duration. It would incorporate secondment to an approved maternity hospital or unit.

EU Midwives Directive 1980

European Union Directive 80/155/EU, article 4, defined the activities of a midwife as follows:

Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

- to provide sound family planning information and advice.
- to diagnose pregnancies and monitor normal pregnancies and to carry out examinations necessary for the monitoring of their development.
- to prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk.
- to provide a programme of preparation for parenthood and a complete preparation for childbirth, including advice on hygiene and nutrition.
- to care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means.
- to conduct spontaneous deliveries including, where required, an episiotomy and in urgent cases a breech delivery.

- to recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor, and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus.
- to examine and care for the newborn infant, to take all initiatives which are necessary in the case of need and to carry out where necessary immediate resuscitation.
- to care for and monitor the progress of the mother in the post-natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant.
- to maintain all necessary records.

Midwifery education and training in Ireland is provided in accordance with these directives and

- ensures that, through a planned programme of theoretical instruction and clinical experience, that the midwife, at the point of registration, can give skilled care on her own responsibility to the mother and baby during pregnancy, labour and the post-partum period
- enables her to undertake the activities of a midwife, as listed above in article
- enables her to fulfil the role of the midwife, as described in the International Confederation of Midwives' definition of the midwife.[4]

Three modes of entry to the profession are recognised by the EU Directive 80/154, article 2, as follows:

- Full time training in midwifery lasting for at least three years' either subject possession of a diploma, certificate or other evidence of formal qualifications giving the right of admission to university or higher establishment, or, failing this, attesting an equivalent level of knowledge, followed by professional practice of two years duration for which a certificate shall be used.
- Full-time training in midwifery lasting for at least two years' duration, subject to possession of a diploma, certificate or evidence of formal qualification as a nurse responsible for general care.
- Full-time training in midwifery lasting for at least 18 months, subject to possession of a diploma, certificate or evidence of formal qualification as a nurse responsible for general care, and followed by professional practice of one years' duration, to allow for freedom of movement.[22]

In 1983 Ireland commenced midwifery programmes following option 2 students being employees.

In 1989 An Bord Altranais organised a two-day workshop on curriculum development in midwifery for midwifery tutors, facilitated by Sr Triona Harvey (UCD), Mary Uprichard and Ann Murphy(Northern Ireland).

Advisory Committee on the Training of Midwives

The Advisory Committee on the Training of Midwives was set up to monitor the implementation of these EU Midwifery Directives. An Bord Altranais was represented on this committee by Kathleen Keane, Chief Education Officer and Eithne O'Domhnaill, Education Officer. The committee's third report recommended that:

> Arising from its deliberations on the content of midwifery training the Advisory Committee emphasises the importance of promoting midwifery as a research-based profession. The midwife should be able to appreciate and critically evaluate research studies and apply research findings to her clinical practice as relevant. Research should therefore be an element of midwifery training programmes and research findings should be reflected in the teaching of midwives".[16]

Research awareness was added to the syllabus at the next review.

The Coombe Lying-In Hospital, in association with An Bord Altranais, provided a three day workshop on teaching research in midwifery and nurse education programmes in June I993 for midwifery and nurse tutors.

A research scholarship scheme was established by An Bord Altranais in 1991. This scheme administered by Eithne O'Domhnaill, Education Officer ,awarded 60 scholarships and committed over £30,000 in funding to nurses and midwives between 1991 and 1997. In 1995 a research development strategy committee was established to review the development of nursing and midwifery research and make recommendations. In 1997 the Board announced the provision of doctoral scholarships to the value of £42,000 per annum for three years. These developments were consistent with An Bord Altranais's policy on continuing education, research and professional development for nurses and midwives.[17]

The Commission on Nursing recognised the importance of research in midwifery and welcomed An Bord's initiatives in this field and recommended that research funding be made available through the Health Research Board specifically for nursing and midwifery research.

The Future of Nurse Education and Training in Ireland

The Bord Altranais report, *The Future of Nurse Education and Training in Ireland* (1994) made six recommendations in relation to midwifery education and training:

1. Article 2 of the EU Midwifery Directives 80/154/EU should be used to provide flexibility in the approval and validation by An Bord Altranais of programmes of midwifery education and training.
2. Midwifery education and training programmes should have academic accreditation.
3. A new curriculum should be developed for the new midwifery registration programme.
4. Programmes of midwifery education and training should be located in colleges of nursing and midwifery and should be under the direction of a qualified midwife teacher.
5. The EU recommendation (111/D/5159/2/89) on continuing education of midwives should be implemented.
6. The EU recommendation (11/f/5122/4/90)) on midwives and research should be implemented.

These recommendations provided a framework for the future development of midwifery education and training.

Midwifery tutors attended the annual Bord Altranais Nurse Tutors Conferences in Dublin and in 1996 attended the workshops for teachers and examiners facilitated by Professor Peter Jarvis (University of Surrey) on behalf of An Bord. [17]

Academic Accreditation of Midwifery Registration Programmes

In 1995 the first academically accredited basic midwifery education and training programme commenced. This was organised by the Schools of Midwifery, Coombe Women's Hospital and the National Maternity Hospital, in partnership with the Department of Nursing Studies, University College Dublin. Midwifery students following successful completion of the two-year programme, qualify for registration with An Bord Altranais and are awarded a Higher Diploma in Midwifery from the third-level institution. This initiative received the approval of An Bord Altranais. Over the next three years, following

the Coombe model, the five remaining schools of midwifery established similar programmes with their linked universities. The midwifery education programme provided by the Schools of Midwifery at the Rotunda Hospital and Our Lady of Lourdes Hospital in Drogheda was validated by the University of Dublin (TCD), the College of Midwifery Cork linked with University College Cork, the School of Midwifery Regional Hospital Galway with University College Galway, and School of Midwifery Limerick with the University of Limerick.

In early 1997 An Bord Altranais initiated a process of alignment of the Bord Altranais examination structure and the university examination systems. An Bord commenced new forms of co-operation and conjoint arrangements between itself, the National University of Ireland and its constituent colleges, University of Dublin, University of Limerick, National Council for Education Awards and the Department of Education and Science. At local level, partnership structures are being put in place among An Bord Altranais, the Schools of Midwifery and third-level institutions. In July 1999 An Bord Altranais issued *Requirements and Standards for the Midwife Registration Education Programme 1999* as guiding principles to manage this transition.

Nurses Rules 1988, and subsequent amendments, make provision for third-level institutions to carry out assessments of student midwives and to enable them to develop their own curricula, including assessment systems based on a syllabus provided by An Bord Altranais. A Validation Committee was appointed by An Bord Altranais.

Extension of Duration of the Theory Time

An Bord Altranais has approved the extension of the theory time in the two-year midwifery education programme for registered general nurses from 13 weeks to 26 weeks and has reviewed the syllabus/ indicative content of the programme.

Direct Entry Programme

As recommended by the *Report on the Commission on Nursing 1998* and An Bord Altranais's *Report on the Future of Nurse Education and Training in Ireland 1994*, the Department of Nursing and Midwifery, University of Dublin, together with the Rotunda and Our Lady of Lourdes in Drogheda were

approved by An Bord Altranais to commence the Direct Entry Midwifery Education and Training Programme. This three-year Higher Diploma programme commenced in June 2000.

Developments in Degree and Higher Degree Programmes for Midwives

By the end of 2000 developments in post-registration education for midwives included an MSc in Midwifery provided by the Department of Nursing and Midwifery, Dublin University and an MSc in Midwifery from The School of Nursing and Midwifery, University College Dublin and from the Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland. A primary degree programme in midwifery is also available in UCD.

PRACTICE

Midwifery practice is directly influenced by many factors, including legislation, health policy, demographic trends, professional education and knowledge and the regulation of midwives. Midwifery practice and maternity care in the 1950s was focused on the reduction of maternal and infant mortality from approximately 100 maternal deaths in 1949 to an average of less than one per year in the late 1990s. This was a rate equivalent to 120 maternal deaths per 100,000 births in 1951, as compared with 1.2 in 1993,[18] and an infant mortality rate of 54 per 1000 live births in 1949 as compared with 6 per 1,000 live births in the 1990s.[19] Now fifty years later the focus of maternity care is on the reduction of morbidity, with increasing emphasis on evidence-based practice and clinical effectiveness. It gives considerable importance to the provision of women-centred care to ensure that the woman and her partner are active participants in planning their own care.

Another notable change over the past half-century has been the virtual disappearance of home births; such births have dropped from 1 in 3 in the early 1950s to only 4 in 1,000 births in 1998.

Regulation of Midwives and Midwifery Practice

Following the implementation of the Nurses Act 1950 and the dissolution of the Central Midwives Board, a Statutory Midwives Committee of An Bord Altranais was established. This eight-member Committee was reconstituted every five years, in accordance with the Nurses Act 1950. While this Act did not describe the role and function of the Midwives Committee, the minutes of its meetings indicate that the committee was concerned with the education and training of midwives at pre- and post-registration levels, the regulation of practice and the conduct of midwives prior to the implementation of the EU Directives [20]. The Committee was concerned to ensure the maintenance of reciprocity of midwives registration between the UK, Northern Ireland and the Republic of Ireland.

Under the 1950 Act, each midwife was required to "give notice to the Local Supervising Authority of her intention to practice annually. The Local Supervising Authority was the County Borough Council or Board of Health."[21] The responsibility for this supervision was usually delegated to a nominated midwife officer.

Under the Nurses Act 1985 the newly constituted Bord Altranais was established to "provide for the registration, control and education of nurses and to provide for other matters relating to the practice of nursing".[22] This Act required the midwife who is not employed by a hospital or maternity home to notify to the health borad his/her intention to practice. The supervision of practice outside of institutions became a duty of the health board. The responsibility of this supervision is usually delegated to the superintendent public health nurse of the health board.

While the Act did not provide for the establishment of a statutory midwives committee, the midwifery membership of An Bord Altranais was increased to include midwives elected in the following categories:

a midwife engaged in administration

a midwife engaged in clinical practice

a midwife engaged in the education and training of midwives.

An Bord Altranais established an Ad Hoc Committee to review the regulation of midwifery practice. The activities of the committee (1986-91) and (1991-97) included

- Preparation of draft rules of midwifery practice forwarded to the Department of Health 1987 and 1997.

- Preparation of Guidelines for Midwifery Practice adopted by An Bord Altranais 1990 and 1994.
- The giving of advice to An Bord Altranais on the administration of pethidine to women in labour.[23]

The Midwives Committee 1997 included co-options to represent third-level institutions. Its activities include advising An Bord Altranais on the

a) development of a direct entry midwifery education and training programme
b) extension of the duration of the theory time in the shortened programme
c) review of the Scope of Practice for midwives
d) other issues in relation to midwifery practice including a review of the Guidelines for Midwives. [24]

The Commission on Nursing: a Blueprint for the Future 1998 recommends that the Nurses Act 1985 be amended and entitled The Nurses and Midwives Act. The Commission further recommends the establishment of a separate Statutory Midwives Committee. This committee would have the power to draft the scope of midwifery practice, subject to Board approval.

As well as the Nurses Act 1985 and the EU Midwives Directives 80/154/155 /EU, the practice of the midwives is also influenced by other legislation, including the Births and Deaths Registration Acts (Ireland 1880), Notification of Births Acts 1907 and extension 1915, Registration of Stillbirth Act 1994, the Misuse of Drugs Acts 1977 and 1984 and the Misuse of Drugs Regulations 1988.

An Bord Altranais Rules

The clinical practice of midwives in the 1950s was based in a variety of locations, including 671 dispensary districts, hospitals - some with district services and public and private nursing homes; a number of midwives were engaged in private practice.

An Bord Altranais (Midwives Division) Rules E or F, known to midwives as " the midwives rules", identified the main issues of clinical/regulatory concern and the statutory duties of the midwife and applied from the 1950 to 1985.

Rule E regulating, supervising and restricting within due limits the practice of midwives, and defining the emergencies in which a midwife shall call a registered medical practitioner to her assistance. This rule identified:

The general duties of a midwife with particular emphasis on the prevention of infection, the restriction within due limits the boundaries of professional practice, the administration of drugs including recording same in the midwife's register of cases.

Duties to the child included resuscitation, the promotion of breast feeding and notification to the local supervising authority "in each case where it is proposed to substitute artificial feeding for breast feeding."

Responsibilities regarding deaths and stillbirths and the preservation of all records.

Rule E further required sending for medical and "in all cases of illness of the patient or child or of any abnormality occurring during pregnancy, labour or lying-in" and when there was "a rise of temperature to 100.4°F for twenty four hours or its recurrence within that period or a rise of temperature above 99.4 of on three consecutive days, a steady rising pulse rate, ophthalmia neonatorum or inflammation above, or, a haemorrhage to the navel"

Rule F required that a midwife must not employ an uncertified person as her substitute, must notify the local supervising authority of her intention to practice in the January of each year has responsibilities under the Notification of Births Acts towards live births and stillbirths.[26]

This regulatory framework had a significant and positive influence on the practice of midwives and on the improvement in the standards of maternity care.

Dispensary Midwives

Dispensary midwives encountered some difficulty in their professional practice and were still attending a considerable number of patients during confinements in their own homes, despite the trend towards hospitalisation. The total number of cases attended in the districts from which data were collected in one study was 10, 434; at least 164 dispensary midwives attended more than 30 patients each during the year ending June 1951. A midwife in Monaghan cycled 800 miles in the year and a midwife in Limerick averaged 45 miles per case. " Few midwives owned motor cars or auto–cycles." They were not paid travelling expenses.The economics of providing this service were:

Midwives salaries £100- £200 plus allowances of £40 per annum.
Cost of a car (8hp Ford) being

cost price	£355/0/0;
cost of tyre	£5/14/0;
cost of tube	£1/1/0;
taxation	£12/0/0;
petrol	1/11 (per gallon);
oil	10d (per pint);

with the average running costs of 30 shillings to £2 per week.[27]

Eileen Hennessey (1955) lecturing to the Midwives Refresher Course describes postnatal care as follows:

> … the patient is transferred to the puerperal ward (after a minimal period of 1 hour post delivery), she is made comfortable in the semi-recumbent position…patients who gave positive Wasserman and Khan reactions and those with rhesus negative blood containing antibodies are now allowed to breast feed their babies. The mother is advised to move freely in bed. On the morning following delivery she is allowed to sit out for bed making. An aperient is given on the second morning and the patient is taken for a short walk in the ward. Escorted by a nurse she is allowed to visit the bathroom on the third morning. Provided the mother and child are satisfactory they are discharged from hospital on the seventh or eighth day. They are then visited by the district staff for a further three days, longer if necessary.
>
> … all puerperal patients are swabbed twice daily as a routine. … In cases of first and second degree lacerations... the patient is swabbed three times daily until the sutures are removed. The sutures are kept dry with spirit … and are removed on the sixth day.

Reference is made to the management of complications of the puerperium, including phlebo-thrombosis, thrombo-phlebitis, phlegmasis alba dolens, puerperal sepsis, "rare in recent years and the desirability of a six week visit to the post natal clinic is stressed"…[28]

Towards Hospital Confinement

The continuing trend towards hospital confinement was accelerated through the late 1960s, in 1973 85% of births took place in hospital, 14% in private maternity homes, and 1% were domiciliary or home births.[29] This change can

be attributed to social and medical factors, together with the introduction of the Maternity and Child Health Services (Amendment) Regulations, 1956, allowing, in many cases free hospitalisation. The demise of the role of the domiciliary midwife was heralded. The impact upon hospital accommodation was considerable, causing earlier post-natal discharge. Staffing problems developed arising from the possible loss of status for training schools, owing to the requirement that student midwives gain domiciliary midwifery experience which was not likely to be available. Anxieties were raised. Would student numbers be reduced? Would midwifery training schools close? Would the reciprocity of midwifery training and registration between the Central Midwives Boards in the United Kingdom and An Bord Altranais be at risk? These were challenging times for midwifery practice and education, particularly in the context of the aim of reducing the mortality of mothers and babies and of seeking improvements in the quality of their lives.

Elements of Practice
Parenthood Programme

As recipients of maternity care (rather than users of the service) even in the early 1950s women were reluctant to articulate their needs. Even in the 1960s professional carers - doctors and midwives - tended to adopt the attitude that patients/women "shall be allowed to…". Preparation for parenthood programmes within the public maternity services had commenced and were beginning to address the psychological, psycho-social and information needs of mothers/parents-to-be.

The *Survey of Standards of Midwifery Care in Ireland* (1980) revealed the concerns of the patients. An analysis of those surveyed (N = 1,600) showed that the principal fears about labour were:

Pain as the major worry for	52.0%
Prolongation of labour	13.0%
Fear (unqualified)	22.7%

Fifty per cent attended preparation for labour classes and 84% considered these helpful. Twenty-seven per cent had their husbands present during some part of labour and in hospitals where husbands were not permitted, 42.4% of the patients/clients wished that their husbands could have been present.[30]

The midwifery tutors, matrons, clinical midwives and physiotherapists combined in a particularly effective fashion from the mid-1970s to develop

preparation for parenthood programmes nationally and programmes for the preparation of teachers of such programmes. The contribution in this development of midwives Teresa Power, Ena Gurhy, Joanna Fitzgerald, Anna Monaghan, Ita O'Dwyer, Mary. Appleby, Marie Finnegan and physiotherapists Kay Marshall and Margaret Lawton was both significant and sustained. This heralded the acceptance by midwives that the educational element of their professional roles was important to the health and welfare of mothers, babies and families. From 1981, the written paper in An Bord Altranais's examination for midwives frequently featured a question on this subject, thereby ensuring further study and teaching of preparation for parenthood.

Family Planning

The teaching of family planning by the midwives reflected attitudes prevalent within Irish society at the time. Fertility control was viewed essentially as the woman's responsibility.

Throughout the 1960s, 1970s and early 1980s the emphasis was on teaching natural methods of family planning. Following legislative change and the availability of "artificial" contraceptives, family planning education and practice became more comprehensive. The first post of family planning midwife in a maternity hospital was established in 1973.

Relief of Pain in Labour

Relief of pain in labour, although recognised as an advantage to any woman in labour since Queen Victoria's satisfactory experience with the use of intermittent inhalations of chloroform during the delivery of her seventh child in 1853, was the subject of increasing interest and study in the early 1950s. Related developments in midwifery practice included the administration of inhalation analgesia through An Bord Altranais's approved apparatus:

- the Minnitt apparatus to administer nitrous oxide and air by face mask in conjunction with uterine contractions.
- Trichlorethylene (Trilene), administered on the same principle (not approved by the Minister of Health for use by midwives unless under medical supervision)
- Entonox (nitrous oxide 50% and oxygen 50%), approved in 1968 and currently approved.

In 1973 An Bord Altranais approved the procedure of perineal infiltration with local anaesthetic prior to episiotomy, and in 1983 the procedure of perineal repair was included in the clinical experience requirements of student midwives.

Begley's study of the incidence of episiotomy and her follow-up study challenged and continues to challenge midwives to review the evidence base of their practice and resulted in a marked decrease in the rate of performance of episiotomy.[31]

In 1981 An Bord Altranais issued *Guidelines: the midwives role in epidural block* and in 1993 issued *Midwives role in epidural analgesia,* which included the midwives' involvement in the maintenance of continuous epidural analgesia.

Technology

The 1970s featured the introduction of advanced technology into midwifery practice: ultrasonography was introduced as a diagnostic monitoring tool, with particular application to ante-natal diagnosis involving the feto-placental unit. Fetal heart monitoring (cardiotocography) became an almost essential procedure for women in labour (excluding those with special circumstances).

During the following decade the increased emphasis on the use of technology and innovations in obstetric practice including fetal blood sampling, induction of labour, active management of labour, increased use of epidural block, increased incidence of instrumental and operative delivery, earlier post-natal discharge, a decline in breast feeding impacted upon the practice of midwifery and the midwifery profession considered the question "whether midwifery?" These same issues had arisen simultaneously in the United Kingdom.

The Midwives Committee of An Bord Altranais so ably chaired by Professor Alan Browne and including Joanna Barlow, the first Nurse/Midwife President of An Bord Altranais, Eileen Gray, Matron Rotunda Hospital, and Ita O'Dwyer, Principal Tutor, St. James's Hospital Dublin, conferred with the statutory midwifery bodies in England and Wales, Scotland and Northern Ireland to discuss the role of the midwife and then published a paper entitled *The Role of the Midwife* in February 1983. The purpose of the paper was "to re-emphasise the professional responsibility and accountability of the midwife and to draw to the attention of other members of the team an apparent tendency to under-utilise her skills". This insightful publication states "on examination of

the midwife's sphere of practice, it can be seen that the midwife's role, particularly in the socio-psychological aspects of childbearing, is complementary to the doctor, whereas in the areas of clinical/technical skills there is an overlap of roles with the doctor. It appears to be readily acknowledged that the midwife is responsible for the care of normal childbirth, but perhaps one of the main threats to the execution of that role is the practical application of the philosophy that childbirth is only normal in retrospect. This has become increasingly evident with the change from home to hospital confinement and the application of more scientific knowledge and technology to the care of the majority of pregnant women both in the prenatal and intranatal period."

This paper concludes:

"In view of the need to provide optimum care for mothers and babies to reduce perinatal and neonatal mortality rates; utilise scarce resources, manpower and financial; and retain midwives and enable them to fulfil the role for which they are trained. It makes good sense and is in the interests of effective use of scarce resources that all concerned co-operate to ensure that midwives' skills are being utilised to the full for the benefit of mothers and babies wherever maternity care is given …"[32]

Surely this was a prophetic statement when viewed with Y2K vision!

Towards 2000

From the mid 1960s the outcome of pregnancies for many families has been dramatically enhanced by scientific and medical progress. This has included the use of Anti-D for rhesus-sensitised mothers, screening of all newborn babies for metabolic disorders, facilitating early and effective management, improved diagnosis and management of the clinical and gestational diabetic and her baby, of cardiac and renal disease, of ante- and post-partum haemorrhage, pre-eclampsia and eclampsia, ante-natal fetal surveillance and developments in neonatology. Furthermore enhancements in the general nutrition of the population and the promotion of folic acid use to prevent neural tube defects in babies led to improved perinatal outcomes.

The education and practice of midwives embraced all these concepts, and professional practice developments during and since that time include:

- Development of neonatal special and intensive courses (approved by An Bord Altranais from 1966).

- The procedure of neonatal metabolic screening and the management of families with an adverse diagnosis.
- Training in the use and interpretation of cardiotocography.
- Advanced training in neonatal resuscitation.
- Critical care in obstetrics courses (approved by An Bord Altranais 1999).
- Promotion of "baby-friendly" hospital initiatives, including implementation of the recommendations of the Department of Health and Children *A National Breast Feeding Policy for Ireland* (1994).
- Training in bereavement counselling and support for couples following miscarriage, stillbirth and neonatal death was introduced into basic and continuing midwifery education programmes. The need for this training was further emphasised by the findings of research by Brady et al[33] into the needs of couples following stillbirth and by Mulhall et al[34] and Jackman et al[35] into the needs of couples following miscarriage.
- Developments in specialist fields of practice, including ultrasonography, clinical liaison in the care and management of drug-abusing mothers/parents, risk management, clinical audit, neonatal transfer and transport, cervical screening, home (domiciliary confinement) and an early post-natal transfer to home for mothers and babies.

The Commission on Nursing, in considering professional development issues in midwifery recognises the absolute importance of continuing education to the quality of services offered to patients and families and to the development and growth of professional midwifery. The Commission's recommendations fashion the agenda for midwifery development for the next decade.

The health care needs of specific groups within our society require special consideration in providing midwifery care. These groups include women with disabilities, teenage pregnancies, drug misusers, socio-economically disadvantaged mothers, HIV positive mothers, immigrants/refugees and mothers/parents with pregnancy loss. Greater sensitivity is required in the provision of maternity care to mothers within these populations and care must be given in an equitable and quality driven manner.

There is no doubt that the next century will present hitherto unconsidered challenges for all. Developments in assisted human reproduction, genetic

1st Joint Meeting c1950, An Bord Altranais, Central Midwives Board, England & Wales, Central Midwives Board, Scotland and Joint Nursing and Midwives Committee, Northern Ireland.

An Bord Altranais / National Board for Northern Ireland – Joint Conference 1996.

First Fellows of the Faculty of Nursing, RCSI conferred 7th December 1982 with members of the Board of Faculty.

Nurses at Sweepstakes Draw in the 1960's.

An Bord Altranais staff photo on 9th November 2000.

Miss Sutton, Matron (1906-1918) St. Vincent's Hospital, Dublin.

Nurses Station, The Adelaide & Meath Hospital incorporating The National Children's Hospital.

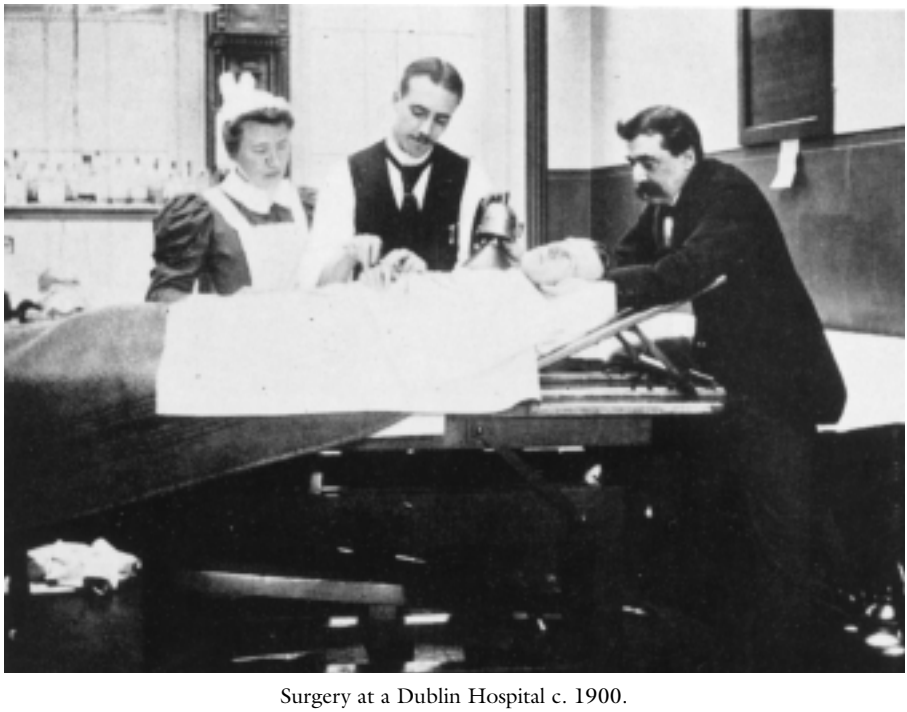
Public Health Nurses 1960.

Public Health Nurses 2000.

Coombe Women's Hospital, Dublin.

Paediatric Intensive Care Unit.

The Open Air Ward, Dr. Steeven's Hospital, c. 1900.



Surgery at a Dublin Hospital c. 1900.

Annie M. P. Smithson, Nurse, Novelist and Campaigner, died 1948.

Sisters of La Sagesse, Cregg House, Sligo c. 1960.

Nurses in Class, Adelaide Hospital c. 1950.

Sligo General Hospital, School of Nursing students awaiting conferring of Diplomas at St. Angela's College 1999.

St. Finan's Hospital, Killarney.

Johanna Barlow, First Nurse President 1979-1983.

Sister Columba McNamara, President 1984-1991.

Ita O'Dwyer, President 1992-1997.

Sheila O'Malley, President 1998 -

engineering, fetal medicine are now raising fundamental ethical issues and confronting scientists, policy formulators, lawyers, clinical professionals and humankind in general.

Midwives are required to be more analytical, more thoughtful, more responsive, more understanding and more able to offer women appropriate, sympathetic, sensitive, realistic advice and skilled care,[36] thus achieving the optimal outcome of pregnancy and childbirth for each individual mother.

Effective midwifery practice is and will remain the key to safe motherhood.

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Chapter Seven

Public Health Nursing

Sheila Armstrong

The public health nursing service is accepted as a vital component of the community care programme in every health board. This service, which provides a preventative and domiciliary clinical nursing service, has evolved through the integration of statutory and voluntary services dating back to the nineteenth century.

The first piece of legislation governing the practice of nursing in the community was the Poor Relief (Ireland) Act 1851. This Act obliged local authorities to appoint midwives to assist district medical officers in the provision of district midwifery services. This service was augmented by district nursing services provided by a number of voluntary organisations. They included the Little Sisters of the Poor, The Irish Sisters of Charity, Mercy Sisters, the Queen's Institute 1887, known as Jubilee Nurses and the Lady Dudley Nursing Scheme 1903. Both the Jubilee Nurses and the Lady Dudley Nurses were involved in the development of the child welfare and school health service between 1907 and 1915. The Lady Dudley Nurses worked mainly in the West and the Jubilee Nurses in the East and Midlands.

District Nurse Service

Training for district nurses was established in Dublin by Lady Plunkett in 1876; the Queens Jubilee Nurses were also trained in Dublin. During training the Jubilee Nurses were obliged to be resident in a house in St. Stephens Green which served as their home and their college. The inscription over the door read "District Nurses for the Sick Poor". On completion of the course, a written examination was undertaken and this was sent for correction to the Queens Institute in England. Jubilee Nurses became well known and highly respected figures throughout the country. Their bicycles, with a basket in front and a carrier at the back to accommodate their nursing bags, were very recognisable; they were given to the nurse by the Jubilee Committee, which administered the financial side of the service. The wearing of uniform was quite strict. This consisted of a blue uniform dress with studded collar, a white starched apron and a black belt, black shoes and stockings. Over this they nurses wore a navy blue coat and hat. Since a significant amount of time was spent on the bicycles most nurses wore a cape. The Committee did not supply uniforms; the nurses themselves had to buy them.

All the district nursing services were being provided during a time of great poverty, housing was poor and overcrowded, and water supply and toilet facilities were often shared by a number of families. The hardship endured by patients' families in ensuring that hot water was available to the nurse, both to attend the patient and also a separate basin in which to wash her hands was never underestimated by the nurse. The nurse were very conscious that this water often had to be collected and carried up several flights of stairs but had to be insisted on, to ensure an acceptable standard of hygiene for the patient and to prevent the nurse from carrying infection from one patient to another. Many of the patients were suffering the same chronic illnesses as occur today, e.g. multiple sclerosis, strokes, chronic lung conditions, but the medicines, equipment and methods of managing these patients were not as advanced as they are today.

Chronic infection of the lower leg was a major problem for patients and constituted a large part of the district nurse's caseload. It was the late 1970s before curing varicose ulcers became an option. Before that, the nurse's objective was to reduce pain and discomfort for the patient while endeavouring to prevent the ulcer extending or becoming infected. Medical research, and the development by pharmaceutical companies of scientifically proven methods of

diagnosing and treating these ulcers, has contributed significantly to changing the nurses' objective to one of cure. During 1950 the district nurses also attended patients suffering from tuberculosis, giving them their injection of streptomycin, ensuring that they took their other medications by mouth, and encouraging a good standard of nutrition and hygiene. Patients were referred to the nursing service from a variety of sources, the majority being referrals from general practitioners, the Jubilee committees and pharmacists.

The district nursing service and the present-day public health nursing service have played, and continue to play, a major role in the success of the immunisation programme. Their contribution to promoting immunisations and to allaying the anxieties of patients regarding possible side-effects attributed to vaccines cannot be over stated.

Improvements in living standards have undoubtedly reduced the mortality from infectious diseases, but immunisation has also played a large part in the reduction of disease incidence. The following table highlights this adequately.

Reduction in mortality and disease incidence after the introduction of Immunisation

	Last year before Immunisation			After Immunisation		
Disease	Year	Deaths All Ages	No. of Cases	Year	Deaths All Ages	No. of Cases
Diphtheria	1939	2,133	47,061	1996	0	12
Tetanus	1960	32	Not available	1996	0	8
Pertussis (Whooping Cough)	1956	92	92,410	1996	2	2,387
Measles	1967	99	460,407	1996	420	5,613
Tuberculosis	1952	10,590	48,093	1996	420	5,859

Sources: Office for National Statistics and Public Health Laboratory Service

Since the district nurse was also the appointed midwife for the area, she was on call twenty-four hours a day. One retired Jubilee nurse assured me that apart from a maternity case, she would rarely be called after 10 pm. These calls could be for a first-aid treatment e.g. a cut or burn or for some of the childhood illnesses such as measles. This retired nurse actually recalled having her name flashed on a local cinema screen requesting her to return home where a nursing call was waiting for her.

Growth of Nursing in the Community

The notification of Births (Extension) Act 1915 brought about Exchequer grants to health authorities which were used to employ nurses to visit mothers and children under five years of age to promote their health and to refer them for medical diagnosis and treatment when necessary. It was 1924 before the school health service was initiated, though it had been legislated for in 1919 under the Medical Treatment of Children (Ireland) Act 1919.[1] Both these services influenced greatly the recruitment of additional nurses to work in the community; these nurses were known as public health nurses and were qualified general nurses and midwifes. These were in addition to nurses providing services under the voluntary organisations. Nurses were also employed to do relief duties for the public health nurses and they were usually recruited by the public health nurses themselves to cover their work while they were on leave. The 1956 Health Act was the instrument used to facilitate the amalgamation of all these nursing services to bring about a comprehensive public health nursing service; and most of the nurses serving in the community became registered public health nurses during the 1960s.

Training of Public Health Nurses

Training for public health nurses was developed in the early 1960s. Short courses of two months' duration were arranged by An Bord Altranais for existing public health nurses and for other nurses who were being upgraded to the grade of public health nurse. An Bord also developed courses of six months' duration for nurses who were general registered nurses and midwives and who wished to become registered public health nurses. On successfully completing the course and state examinations, a nurse was eligible to have her name placed on the public health nursing division of the register of nurses and to seek employment by a health authority. The training and regulation of public health nurses was continued by An Bord Altranais, working conjointly with the newly appointed health boards. The boards seconded course leaders to the course and provided fieldwork placements for students to allow them to gain practical knowledge and the skills necessary to enable them to work with individuals, families and groups in the community. While these courses were being facilitated by An Bord Altranais the health boards subvented nurses undertaking the course and guaranteed them employment as public health

nurses when they were duly registered. As the wealth of knowledge and skills required to work in community were identified, the course was extended in 1972 to nine months' duration and in 1981 to a full year.

At this time the superintendent public health nurses were discussing with various representative bodies, including An Bord Altranais and University College Dublin, the need to move the course to a third-level college, with the objective of improving and developing the curriculum for the course and achieving international recognition for the qualification. From the beginning of these discussions, University College Dublin was supportive of this development and interested in moving the course to the Department of Nursing Studies UCD. The college, however, was constrained by lack of space in UCD until1986, when accommodation became available and the course was transferred to their Department of Nursing Studies under the directorship of Judith Chavasse. The course continued to be of a calendar year duration, and entry to the programme required current registration on the general and midwifery divisions of the register of nurses. A Diploma in Public Health Nursing has been awarded by University College Dublin since 1987 and University College Cork since 1994.

Development of Services

These continuing developments in the education and training of public health nurses greatly facilitated the development of district nursing services, as envisaged and encouraged by successive Ministers of Health since 1956. To further encourage the development of a comprehensive district nursing service, in 1966 the Department of Health issued a policy document stating the aims of the service and giving directives for its continuing development.[2] The aim stated was that public health nurses should be available to individuals and families throughout the country and the nurses' duties should include the following:

- Assisting medical officers at clinics.
- Domiciliary nursing.
- Home visits to the elderly.
- Follow-up of at risk children.
- After care of patients discharged from psychiatric hospitals.
- Care of mentally handicapped children at home.
- Health education.
- Child welfare clinics and the school health service.

This document also states that the aim should be to integrate the district nursing service with the general practitioner and hospital in-patient and outpatient services. The guidelines given by the Department of Health to the health authorities was that the ratio of public health nurses to population should be 1:4000. How realistic was this ratio, given the extent and the diversity of nursing duties constituting a public health nurses caseload? Until the development of the General Medical Services in 1972, which gave a choice of doctor and chemist to public patients, the majority of patients were referred to a public health nurse through the general practitioner. These general practitioners were appointed as dispensary doctors and salaried by the health authorities to provide services to those unable to pay for their own medical care and treatment. This brought about close working relationships between the general practitioner and the nurse and greatly contributed to the planning of good patient care. The public health nurse, however, in addition to domiciliary nursing duties also had duties, in relation to child welfare and the school health service.

Domiciliary Nursing Conditions

During the period prior to 1972, domiciliary nursing duties was very labour intensive. Contributing to this were poor and overcrowded housing conditions, difficulties in having hot water and clean bed-linen available for the patient, and lack of equipment. The nurses often contacted the Saint Vincent De Paul Society to help families with the additional needs and expenses arising from caring for the sick at home. They would also contact the housing department of Dublin Corporation to make a case for improved housing, particularly when this was, in their opinion, contributing to the poor health of the patient. On top of these difficulties nurses did not have disposable supplies and equipment available to them. They had to sterilise syringes, needles and forceps. This was done either by boiling or leaving the instruments standing in an antiseptic solution. The patient or relatives had to wash the bandages and make them available for reuse by the nurse when next she called. The lack of disposable incontinence wear necessitated old sheets being cut and used to place under the patient as draw-sheets. This allowed sheeting to be placed over a waterproof strip under the patient's buttocks with the intention of avoiding the full sheet becoming wet or soiled and reducing the amount of washing patient's families had to undertake without the aid of a washing machine. Patients who were

ambulatory attended the nurse at the dispensary / health centre for dressings, injections and other treatments, e.g. blood pressure checks, usually between 10.30 and 12 noon each day. The doctor seeing his patients on the premises at these times also referred patients to the nurse to have treatments carried out.

Organising the Work

Public health nurses paid great attention to planning their work. This was essential to ensuring, as far as possible, that their domiciliary nursing duties were completed before they commenced their child welfare home visiting and clinic service in the afternoons. The school health service had to be accommodated during school hours. How this was facilitated varied between health authorities. Some health authorities assigned public health nurses to undertake the school health service and child health clinic duties on a regional basis. These nurses, who did not carry a caseload of district duties, were known as headquarters nurses. In other health boards, all public health nurses were assigned to a geographic area where their responsibilities included the school health service. This service was targeted at primary school level and required the nurse to screen vision and hearing and to assess posture and cleanliness. The public health nurse then assisted a medical officer of health in providing a medical examination for the children. Irrespective of family income, this service was provided free of charge and all follow up treatments, including referral to consultants, were also free. The child welfare service was provided by the public health nurse through a combination of home visiting and child welfare clinics held in health centres. This service aimed to provide the systematic supervision of children's health and development and to give advice to parents on diet, hygiene and accident prevention. Parents were encouraged to bring their children under six years of age to child welfare clinics between visits by the public health nurse. These clinics were staffed by a medical officer and public health nurse and were a preventative service where support and advice were given and when necessary children were referred to specialists for further assessment. When infants were about nine months of age, they were given a full medical and developmental examination by a medical officer and public health nurse. This was carried out at a health centre and was the only service for which an appointment was required. Immunisation clinics were also held at health centres where immunisation against tuberculosis, diptheria, whooping cough, tetanus and polio were given.

Changes in the Administration of Health Services

Major changes took place in the administration of the health services as a result of the Health Act 1970 which set up health boards to administer services at regional level. These boards replaced the local authority administration of health services from March 1971. In 1972 the dispensary system of providing general practitioner services for public patients was replaced by a general medical service which allowed all patients a choice of doctor and chemist. Doctors and chemists participating in the scheme were paid a fee per item of service provided. Families were means tested by the health boards to establish their entitlement to a free service. Those so entitled were given a Medical Card which ensured that they received the services of their general practitioner free of charge; they also received from the chemist prescribed medicines and if they were referred to a hospital for treatment, this was also free. Patients were entitled to attend their doctor in his rooms, as distinct from the dispensary, the objective being to eliminate the distinction between private and public patients. Increasingly fewer doctors had rooms in health centres/dispensaries, and all patients were visiting them in their private rooms. Since public health nurses continued to be based in health centres the general practitioner and the nurse became less closely linked. This was most apparent in urban areas where a public health nurse with an assigned geographic area of work could have up to thirty general practitioners visiting families in her area. This has become increasingly complex since the 1980s because some families have three different doctors attending. The mother of the family often retains the doctor she attended before starting her family, but she may have chosen a local general practitioner for the children. The father, on the other hand, may attend the doctor employed by his place of work. This does not happen to the same extent in rural areas because the work of the general practitioners and the public health nurses are often co-terminus.

Linking Hospital and Community Nursing Services

As a result of the Fitzgerald Report,[3] major investment in improving and developing services in the larger hospitals and the rationalisation of the smaller ones with the intention of their eventual closure became government policy. With significant improvements in technology and staffing levels in hospitals, early discharge of patients, allowing for a rapid turnover of services, was being

advocated. 'Reduced length of stay' became the buzz-word in the hospital world. This had implications for the community services and in particular for the public health nursing service. When patients still heavily dependent on nursing care were being discharged from hospitals greater demands fell on the public health nurse. Of great concern to the nurses was the fact that, while the patient was considered suitable to be discharged from hospital, little consideration was given to facilities in the home or family dynamics. With the patients and their families as the centre of their concern, the superintendent public health nurses held meetings with the matrons of hospitals to discuss discharge planning for patients. The outcome of these meetings was the development of better liaison between nursing staff in hospital and community services.

In each community care area in which a major hospital was situated, the superintendent public health nurse appointed one of her staff as a liaison public health nurse. The intention was that the public health nurse would bring a fuller picture regarding a patient's home circumstances to the attention of hospital staff to enable them to plan the patient's discharge in an informal way. The liaison nurse also took information from hospital staff on patients who had been discharged or were being discharged and passed it on to the relevant public health nurse. This two-way flow of information was seen as the only means by which continuity of nursing care could be achieved for the patient. It was obvious from the beginning that achieving this objective was going to be a long haul. This was understandable since hospital nursing staff in the early 1970s had little input into deciding when a patient went home. Hospital consultants or their registrars made these decisions and nursing staff concentrated on the needs of the incoming patients, with very little time allocated to considering the needs of patients who were going home. Medical social work departments in hospitals and the development of very good working relationships between social workers, hospital nursing staff and the liaison public health nurse contributed to the development of this service which continued to improve throughout the 1980s and 1990s.

While these changes were taking place in the health services, the majority of public health nurses were being assigned to what was known as "combined duties". This meant that their caseloads included the domiciliary nursing of patients, child welfare services and the care of the elderly, which included visiting the elderly in their homes to help them promote their own health and social well-being. Medication compliance, promotion of urinary continence

and reducing the risk of falls are examples of matters given particular attention by public health nurses. From the period mid-1970s to the mid-1980s it became increasingly obvious that both occupational therapists and physiotherapists were needed in the community if the early discharge of patients from hospital was to be a successful policy initiative. Occupational therapists were introduced to the service in the late 1970s and the appointment of physiotherapists followed in the mid-1980s. Though both these grades of staff were very thin on the ground, they contributed enormously to the provision of better patient care and safer practice by public health nurses. This was achieved by their assessing and recommending home adaptations, e.g. ramps and grab-rails, by increasing the mobility of patients, and by teaching patients, carers and nurses safe methods of transferring patients from bed to chair and how to encourage their mobilisation and rehabilitation.

Influence of Social Factors

A change of focus in the public health nursing service was occurring very quietly and, because it was without fanfare, some said it was unstructured. No one, however, could deny that these changes were brought about in the best interests of the patients and clients of the health boards. Factors which were driving these changes included:

- Social changes, including marital break-down.
- An increase in one-parent families and teenage pregnancies.
- Greater recognition and reporting of child abuse and violence within families.
- Demographic changes, a falling birth rate and increasing life expectancy.
- A diminishing nuclear family support system, partly owing to the development of large housing estates away from the centre of cities.
- The changing pattern of disease: tuberculosis and childhood infectious diseases were decreasing, while some cancers and certain chronic conditions caused by substance abuse and HIV/AIDS were on the increase.

In addition to the above, a new grade of senior public health nurse was introduced into the service. The seniors, as operational managers, were in a position to support and affirm public health nurses while helping them to identify the health needs of their target population. A more holistic approach

to the provision of services was adopted and the first tentative steps were taken away from the medical model of care. This was most noticeable in the preventative services of child health and surveillance of the well elderly.

Working with Children

The emphasis in child health home visiting was changed from one of supervision of children's health and development to one of working with parents to affirm and develop their own parenting skills and educating them to promote the health of their young. Visiting mothers and new-born infants are a high priority with all public health nurses. Most health boards recommend that a public health nurse should visit mother and infant within twenty-four hours of their discharge from the maternity hospital; translated into real terms, this means within twenty-four hours of the public health nurse receiving notification of the mother's discharge from hospital and the correct address for visiting. This situation has improved considerably since the late 1980s when it became policy in the maternity hospitals to discharge mothers and infants forty-eight hours after the baby's delivery. Since then, hospitals have been obliged to notify public health nurses by telephone or fax of the mother's discharge and to request the public health nurse to take blood from the infant for metabolic screening. This early discharge policy helps mothers successfully to breastfeed their infants. For this reason public health nurses in many areas have established breastfeeding support groups where breastfeeding mothers come together to support and learn from each other, with professional expertise being supplied by the public health nurse. Pre-natal / parentcraft classes, organised by public health nurses for expectant mothers are an opportunity for a systematic approach to promoting breastfeeding. Wherever the venue of the public health nurse's work in child health, their main focus is always on primary prevention. Giving mothers information on immunisation programmes to prevent infectious diseases, encouraging research- proven methods of feeding infants and toddlers with a high standard of nutrition, and advising on accident prevention techniques are some of the methods public health nurses use in primary prevention. Recognising risk factors in relation to safety and child protection issues are also part of a public health nurse's duty of care to the families with whom she works. The public health nurse works as part of a multidisciplinary team in the best interests of the children and families.

With well-established child health pre-school services and good GP services, some areas have streamlined their school health service. Public health nurses continue to carry out vision and hearing screening and will take referrals from

teachers or parents of any child whose health is of concern to them. Any deviation from the norm is referred to an area medical officer for further assessment and referral to a consultant when necessary. Area medical officers see these children at a school clinic; a public health nurse is not be required to be present. This is considered to be an effective system for the child, the school, the medical officer and the public health nurse. Apart from hearing or vision difficulties, another problem identified by public health nurses during the school health service is the problem of enuresis - bed-wetting or unintentional wetting during the daytime; it can be both. The stress this causes to the child and the parents is considerable. To meet this health and social need, most health boards have provided additional training for public health nurses, in the whole question of continence promotion, for all age groups. These public health nurses conduct enuresis clinics for children and find it a most rewarding part of their work. There is no joy like that of a child who has learned to control his bladder and/or bowel.

Working with the Elderly

To promote the health of the elderly, public health nurses work, in as far as their caseloads allow, with other statutory and voluntary organisations to monitor and promote the health and social well-being of the elderly. When public health nurses are notified, or become aware, of elderly persons, particularly those living alone, they will undertake home visits. The aim of these visits is to help the elderly to remain independent with dignity and to encourage families and neighbours to give support when necessary. The majority of public health nurses see this area of work as vital to a good health service and very much part of their role in primary and secondary prevention. However, working within existing resources and the expanding demands of their clinical nursing caseloads, this part of their work can rarely be allocated sufficient and consistent time to develop a quality service.

Clinical Nursing by Public Health Nurses

The caseloads of clinical nursing carried by public health nurses has changed in both volume and complexity. The volume is attributable to the reduced length of stay of patients in hospitals. The complexity can be explained by changing disease and social patterns and the development of hi-tech medical

procedures. Up to the mid- 1980s, the clinical nursing caseloads of most public health nurses were comprised of attending to the personal hygiene needs of patients, the management of chronic wounds, diabetic care, and other iron and vitamin injections; since that time, one can add aftercare of post-operative patients. This may be a simple surgical dressing procedure, but it can also include ostomy care; tube feeding and the care of central venous lines through which chemotherapy is given; care of the terminally ill in partnership with hospice services; and care of patients with maximum dependency levels owing to chronic illnesses such as Parkinson's disease and multiple sclerosis. The societal changes include diminished and sometimes lack of family support or help in caring for the patient. This can be due to any number of reasons, one of which is families who have made their homes a considerable distance from their ageing parents. The numbers of women now working outside the home and their expectation that all the care needs of their elderly parents will be met by the services of the health board. During this present national shortage of nursing staff of every grade, it can be frustrating for public health nurses to hear patients comment on how busy hospital nurses are and how they seem to be always running. The implication seems to be that the public health nurse is not busy as she drives to their gate and walks in! This concept contributes to their expectations of the public health nursing service. The demands on the public health nursing service are very onerous, however equally onerous are the demands made on many families who are caring for relatives with a long-term illness. It often happens that one room in their home resembles a small hospital ward, with a hospital bed, a hoist for lifting the patient, a suction machine and a drip stand to hold feeds being given by tube. Added to this is the loss of a room in their home. In addition, frequent though necessary visits by members of the multidisciplinary care team intrudes on the family's privacy.

Multiple Skills required by Public Health Nurses

A multiplicity of skills, personal and professional, are required of a public health nurse if she is to work effectively within the primary healthcare team to promote the well-being of individuals, families and communities. These skills include: -

- Continuous development of her professional knowledge and skills.
- The ability to evaluate her own work on the basis of best practice and current research.

- An ability to relate well with patients and to provide care in diverse situations, respecting the complicity of people's lives.
- A commitment to the team approach to care.
- The ability to empower clients to take an active part in determining their own future, while undertaking a major advocacy role where appropriate.
- A willingness to take risks in the interest of her patients/clients provided this is based on very good knowledge and a sound analysis of each situation.
- An understanding of her own strengths and weaknesses and a willingness to use her strengths and to draw on others to supplement her weakness for the benefit of those she works for and with.

The Challenges of the Future

This review of the development of the public health nursing service highlights how it has responded to changing health care needs and policy development. Flexibility and responsiveness will be essential as we continue to meet the needs of a progressive health service. The Commission on Nursing 1998 has identified the importance of the continuing development of the public health nursing service in delivering and coordinating a comprehensive, effective community nursing service.

Developments within An Bord Altranais, including pre- and post-registration nurse education, the development of specialist nursing posts, and a review of the scope of professional practice, are welcomed by public health nurses as promoting professional development. The move towards new primary health care models is seen as a new challenge for the twenty-first century. Greater integration between general practitioners and all community-based nursing services will undoubtedly advance the achievement of the mission statement of the public health nursing service, which is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work.

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Chapter Eight

Psychiatric Nursing

Anne J. Sheridan

Introduction

Understanding the practice of psychiatric nursing requires an appreciation of the context within which it occurs. Unlike our European neighbours who had proceeded towards community care for the mentally ill from the 1950s, in Ireland, until 1984, the care of the mentally ill continued to be delivered in large hospitals, which had, in the main, been built in the nineteenth century (Prior, 1993). As a result, the primary location of psychiatric nursing practice continued to be the in-patient setting. The physical structures of these "asylums" and their archaic administrative legacies influenced to a significant extent the nature of the care delivered within the hospital system. These hospitals had been built for the custody and containment of the mentally ill, and the systems that operated within their walls resulted in the depersonalisation of patients.

By 1950 the views of Irish society relating to mental illness and the mentally ill had changed very little from those held at the turn of the nineteenth century (Reynolds, 1992). The person with a mental illness was usually viewed as unpredictable and potentially violent. The fear and stigma associated with mental illness, owing principally to a lack of knowledge and understanding, was

largely responsible for the acceptance by Irish society of the continuation of outdated treatment and care facilities for the mentally ill.

Likewise, in addition to the lack of political and public interest in the plight of the mentally ill, the effects of continuing to provide care in deteriorating physical environments added further to the sense of alienation and lack of self-esteem experienced by the mentally ill, their families and the staff who cared for them.

Historical Overview

As a distinct discipline, psychiatric nursing has been recognised in Ireland since the introduction of the Nurses Registration (Ireland) Act 1919. Initially the title used was that of "Mental Nurse", but this was subsequently changed to "Psychiatric Nurse" by the Mental Treatment Act 1945. However, the origins of psychiatric nursing in Ireland predate the introduction of the 1919 Act and in fact began to emerge in the first institutions charged with the provision of care to the insane poor. In Ireland at the beginning of the eighteenth century, special provision for the insane was confined to a small number of charitable and private institutions. Swift's hospital, later to become St. Patrick's, was opened in 1757 and was the first of its kind in Ireland. The first public asylum for the insane was opened in 1814 as the Richmond Lunatic Asylum. By the 1830s ten asylums had been built throughout the country. A second phase of asylum development was initiated in the 1850s and during this period a further twelve asylums were built. The final phase of development occurred at the beginning of the twentieth century with the building of extensions to a number of district asylums.

Thus, by the first decade of the twentieth century, the asylum system as a means of providing care and treatment for the mentally ill had become firmly established. Within a century Ireland had arrived at a situation where virtually no public provision for the mentally ill existed to one where there were approximately 17,000 patients in asylums (Finnane, 1981). It was within these institutions of the nineteenth century that the first group of men and women referred to as keepers and attendants sowed the seeds of the discipline that today is known as psychiatric nursing.

In order to understand the factors that determined the culture and issues associated with the emergence of the discipline of psychiatric nursing within Ireland, it is necessary to appreciate the significant influence of its close

association with psychiatry, and developments in social policy, economic policy and international law (Nolan, 1993; Finnane, 1981). While developments in the care of the mentally ill were occurring throughout Europe and the United States in the early part of the twentieth century, the political situation in Ireland effectively prevented similar changes taking place (Shorter, 1997). The struggle for home rule, the eventual securing of independence and establishing of a Republic occupied the political leaders of the time; their concerns were singularly focused on establishing an Irish culture and identity. Improving the general standard of living, education, employment and public health demanded the scarce resources of the government of the infant Republic (Kee, 1982). The mentally ill, in practice a voiceless and vote-less minority, did not demand or receive the resources required to change their situation.

The first legislation dealing with the mentally ill introduced by the Irish government was the Mental Treatment Act 1945. This act superseded all previous legislation and was based on a framework similar to that in the United Kingdom. This act made provision for admission to psychiatric hospital on both a voluntary and a non-voluntary basis. This was the first time that psychiatric patients in Ireland had the option to enter and discharge themselves from hospital voluntarily. The 1945 Act also enshrined in law the rights of patients in psychiatric hospitals and dealt specifically with funding for these institutions (Cowman et al., 1997). Although amendments were made in the 1960s and 1970s, the 1945 Act remains the legislative framework upon which the care to the mentally ill is currently provided in Ireland.

Changes in the Care of the Mentally Ill

Within the past fifty years, the care of the mentally ill has undergone significant change. Unlike other branches of health care, however, the dramatic and decisive breakthroughs in understanding the nature and aetiology of disease are absent in mental illness (Porter, 1994). There have been no startling discoveries, no "cures" for schizophrenia or depression. In the majority of psychiatric illnesses, the possible causes are still being sought. The most significant factors that have contributed to changes in the care and treatment of the mentally ill in Ireland have been neither scientific nor medical, but rather social and economic. In particular, changes in social attitudes towards mental illness, as well as changes in social and economic policy, now, as in the past, continue to dominate how care is provided.

Defining the Role of the Psychiatric Nurse

Again, the past fifty years have seen the concern of psychiatric nursing being focused on attempting to define the role of the psychiatric nurse. Originally, nursing in general was defined by its close association with medicine and by the tasks its members undertook. Nursing was not considered to be an autonomous profession but rather was viewed as an adjunct to medicine. In the thinking of the majority of people, nursing tends to be associated with the care of the physically ill and with the physical care and comfort of the physically sick and dependent. While psychiatric nursing does not attempt to deny the physical needs of its patients, the majority of people who suffer from mental illness do not require physical care in the same way as those who are physically sick. Additionally, a significant proportion of psychiatric nurses were male, which again did not concur with the popular image of nursing (Sheridan, 1995).

Thus attempting to define psychiatric nursing and the role of the psychiatric nurse by using the same conceptual framework as general nursing presented serious difficulties for the profession. Psychiatric nursing was challenged to identify its particular contribution to the care of the patient and to articulate this as a distinct way of proceeding, which was different from other branches of nursing. So the 1950s can be identified as the beginning period of the transition of nursing away from an occupational group who primarily carried out the physicians' instructions towards a group who began to develop its own theoretical basis.

New Light through Old Windows

The accounts of the history of psychiatry and care of the mentally ill, in Ireland and elsewhere, focus on the negative aspects of the asylum system and the poor treatment meted out to its inmates. Few, if any, accounts attempt to identify the positive aspects of nursing care provided to the majority of patients. Since nursing has consistently been the prime deliverer of care and support to the mentally ill, this suggests that psychiatric nursing has some core truths, which it should recognise and use as central tenets in its continued professional progress. One such tenet is that of the relationship between nurse and patient and the recognition of the value of such relationship as therapeutic.

It would be wrong, however, to convey the message that psychiatric nurses were not acting as therapeutic agents before this period. The role of the nurse

as a therapeutic agent had been formally recognised as far back as the 1880s, but no coherent theory had been articulated (Woods, 1888). In interviews with retired psychiatric nurses, who were working in the 1940s and 1950s it is obvious that some of these were using interpersonal relationship skills with patients and recognised the potential of the relationship as a therapeutic process (Sheridan, 2000).

While the psychiatric nurses of this period were using interpersonal skills with patients, their role remained a custodial one. The day-to-day running of the hospital appeared to take precedence over therapeutic work with patients. The emphasis placed on the occupation of patients, which was evident in the early years of the asylum system, was to a large extent maintained. Patients and nurses were primarily engaged in activities that contributed to the smooth running of the hospital. Such activities included domestic work, gardening, laundry duties, kitchen duties and a range of additional activities under the broad heading of "workshops". Likewise, social activities such as sporting events and concerts were organised regularly within the institutions. And so those nurses who had musical and sporting skills as well as those who had a trade such as carpentry, were considered valuable assets within the institutions.

Constraints on Psychiatric Nurses

Despite this, several confounding factors jeopardised the formalising and development of the caring role. One such factor was the imposed segregation of nurses and patients based on sex, which resulted in an artificial community and curtailed normal interpersonal relations. Nurses were also actively discouraged from social recognition of the patients as individuals with personal dignity. Further, the structures that were in place within the institutions imposed limitation on nurses' contact with their peers (Henry, 1989, Malcolm, 1989, Reynolds, 1992). Conditions of employment and the rules of the institutions, which required nurses to operate within complex systems to gain permission to leave the hospital during their time off duty, were obstacles to being fully integrated in normal activities outside the system. The mental hospital of this era was to a large extent a self-sufficient community existing as an independent entity outside the local surroundings.

Likewise, nurses were aware of the social order within the asylum. The power of the resident medical superintendent (RMS) within the institution was absolute; nurses who did not abide by the rules were at risk of being discharged

from their posts. A strict hierarchy was in operation, with the RMS at the top. Nurses, who operated somewhere in the middle, were constantly reminded by their superiors that they should not go either above or below their appointed position in this hierarchy. What is also obvious is that the management of the institutions discouraged the forming of interpersonal relationships between nurses and patients. Those in authority treated the nurses as well as the patients in a paternalistic way, denying both the freedom to manage their lives within the institutions. As one retired nurse put it:

> …the hospital was run like a battle ship by the RMS; everything had to be done at the appointed time, meals, baths, taking patients out in the grounds; what really counted was how cheaply the asylum could be run, that was what mattered ... (Sheridan 2000, unpublished)

The development of theories of nursing, while innovative in form, were in a sense the exposition of practices which were to an extent already in operation within the institutions. The truth is that psychiatric nurses, in spite of the constraints placed upon them by the complex and archaic institutional system, managed to have caring, productive and therapeutically beneficial relationships with their patients. The new light of nursing theory shining through the old windows of the asylums was really illuminating and assisting the development of the caring and compassionate relationships already in existence, and empowering psychiatric nurses to begin their transition away from the domination of the organisational system towards their becoming an autonomous group of practitioners.

A Brave New World

Throughout the western world the 1960s signified a period of rapid change. Many of the values and beliefs which had guided the world were suddenly seen as outdated; a new age of popular liberalism began to emerge. These changes were particularly evident in the United States of America. The practice of psychiatry and the provision of services for the mentally ill did not escape the challenges of this new critical approach, which emphasised the rights of the individual in preference to the collective. What emerged from this debate was an "anti-psychiatry" movement, which attempted to deconstruct and dismantle the old system of psychiatric practice. Institutions were viewed as bad places that dehumanised inmates and the continuance of these systems could no longer be justified. Public opinion forced policy-makers and practitioners

within psychiatry to abandon outdated and inhumane practices. For some of these "enlightened thinkers", the very existence of mental illness itself was in question. Mental illness, like the emperor's new clothes, was considered to be a myth, a social construct used to confine free and radical thinkers who did not abide by the rules of the state (Szasz, 1960). The asylum system itself was likened to leper colonies, in which the incarcerated were removed from society until they were fit to return as fully productive members (Foucault, 1971).

Redirection of Psychiatric Care

Psychiatric nursing, too, was the subject of international study and reflection. The World Health Organisation (WHO) established an expert committee on psychiatric nursing in 1955; it explored the possible future role of the psychiatric nurse and attempted to identify the particular skills required to fulfil this role. The changes within psychiatric practice generally, and nursing in particular, which were occurring in the United States and parts of Europe throughout the 1950s and early 1960s happened at a much slower pace in Ireland. However, some changes were taking place. The report of the WHO expert committee provided specific guidance relating to the education and training of psychiatric nurses and even went as far as to suggest some generic content for inclusion in the syllabus. Again the importance of the interpersonal aspects of the psychiatric nurse's role was highlighted, as was the need to focus on mental health and measures aimed at the prevention of illness.

The WHO expert committee recommended redirection of services towards rehabilitation and social integration of the patient back into society, and that senior nurses be included in the planning and management of nursing services and education. This report influenced two subsequent reports published by the Irish Department of Health: the first was concerned with the provision of care and services available to the mentally ill, while the second focussed specifically on psychiatric nursing. The WHO report had also provided the basis of the revision of the psychiatric nursing syllabus in Ireland and was implemented in 1960. This revised syllabus of training attempted to include the recommendations of the WHO report, particularly with regard to the inclusion of subjects such as psychology and aspects of the nurse's role. However, changing the nursing syllabus was not enough to facilitate a redirection of existing psychiatric services. Such a redirection required a fundamental shift in attitude by policy-makers and health service managers in relation to the

structure of the psychiatric service, its management and funding. These changes were to prove difficult to initiate and implement.

Towards a Community Approach

In 1961 the Minister for Health, Sean MacEntee, established a Commission of Inquiry to examine and report on services available for the mentally ill. The commission produced its report in 1966 and recommended a reorientation of the psychiatric services away from the traditional custodial institutional base towards a rehabilitative community-oriented approach to service provision. The report of the commission also examined issues pertaining to the prevention of mental illness, research and the educational preparation of health professionals, including nurses. The recommendations of this inquiry, which reported in 1966, were never fully implemented. Almost another two decades were to elapse before psychiatric services were subjected to the radical overhaul that was deemed to be required in 1966.

Following from the report of the inquiry a subsequent working party was established in 1970 to report on the psychiatric nursing services in the health boards. The report of this working party, published in November 1972, represented the first review of psychiatric nursing in Ireland. This report, commonly referred to as the Condon Report, focused specifically on developing the therapeutic role of the psychiatric nurse and recommended changes required in the system to achieve the transition from the predominantly custodial approach still operating within institutions to a more therapeutic one, which could occur both within and outside the hospital setting.

The key matters identified requiring change included recruitment and selection, education and training, organisational structures, promotion, support personnel, research, revision of duty hours, integration of sexes, both patients and staff, and effective communication structures within organisations. Thus the structures, which had hitherto constrained psychiatric nurses in the institutional settings, were in effect being dismantled.

Concept of Therapeutic Community

The changing attitudes of society during the 1960s and developments in knowledge and understanding had a significant impact upon how the treatment

and care of the mentally ill was conceptualised. The populist liberal culture, emanating principally from the United States, promoted notions of personal freedom and choice. The individual was deemed to be supreme and his rights paramount. Conversely, other structures were also beginning to emerge during this time. The notion of collective living in communes away from the general population began to develop almost as the antithesis of the individualist philosophy. These communes were influenced by the concept of democracy and utilitarianism in that the greater good of the community was paramount.

This idealistic concept of "community" was reflected in the approach to rehabilitation and resocialisation adopted by Maxwell Jones (1968). Jones created therapeutic communities based on a social model of psychiatry within the mental hospital. The intention of these communities was to provide a means through which patients could exert control over the environment in which they lived, namely the hospital. The therapeutic community was based on the concept of democratisation whereby the patient group determined all activities within the ward or unit. Within this framework, nurses acted as facilitators of the patient group and this required them to develop specialist skills. Specialisation allowed psychiatric nurses to become more involved in the treatment of patients. Rather than carrying out the instructions of the doctor the nurse had a set of therapeutic intervention techniques that allowed her more autonomy of practice.

However, therapeutic communities were to a large extent the exception rather than the rule within Irish psychiatric hospitals. In spite of the so-called social revolution in psychiatric care, the role of the psychiatric nurse remained relatively unchanged from previous decades. The emphasis of care continued to be orientated towards the physical needs of patients and the running of the hospital. In reviewing the psychiatric nurse's nursing records made during this period by far the greatest emphasis is on the physical care of the patient. Relatively little was documented about the patient's psychological or mental condition, and those records, which do comment on these aspects, tend to be a restatement of the doctors' record. It is also clear from these accounts that patients were required to conform the rules of the institutions and were not afforded an opportunity of determining their own rules (Sheridan, 2000).

Increasing Change in Ireland

In Ireland by the middle of the 1970s the pace of change was beginning to increase. These changes were influenced by a number of factors including

service developments in other European countries but particularly the United Kingdom, and the beginning of economic prosperity in Ireland. Additionally, Ireland's membership of the European Economic Community, had implications for the mutual recognition of professional qualifications and the freedom of movement of professionals throughout the Community.

Throughout the 1960s and 1970s the notion of specialisation within psychiatric nursing became well established, with a variety of courses available to provide education and training. The fields in which nurses began to specialise included addiction studies, behavioural psychotherapy, child and adolescent nursing and family therapy. While specialisation was beginning to be established, by far the vast majority of psychiatric nursing practice was still occurring within the confines of large mental hospitals. However, some community-based psychiatric services did exist. These were concerned mainly with the provision of outpatient clinics and domiciliary visiting.

A report by the Local Government Staff Negotiations Board in 1978 documented that there were 130 psychiatric nurses working in the community. However, the report also noted the absence of a standardised approach towards the organisation and operation of these services. A second study group on community psychiatric nursing in 1983 reported that in the preceding five years the number of psychiatric nurses working in the community had increased by only 33, to 163; the hospital remained the mainstay of provision for psychiatric services. The reports on community psychiatric nursing carried out in 1978 and 1983 respectively had recommended the provision of specialised educational preparation for the role of community psychiatric nurses, but these recommendations were never implemented. The reports had also recommended that all psychiatric nurses should be prepared to work in the community, a recommendation subsequently reiterated in the policy document *The Psychiatric Services – Planning for the Future* published in 1984.

During the 1960s and 1970s change was beginning to take place within the Irish psychiatric services. Unlike other countries in Europe, however, Ireland moved slowly. This sluggish pace of change has been a feature of Irish psychiatric services down through the decades and various theories have been postulated as to the cause.

However, 1984 became a watershed in the history of these services and resulted in fundamental changes in all aspects of the practice of psychiatry including nursing.

Old Light through New Windows- Planning for the Future

The publication by the Department of Health of the 1984 policy document *The Psychiatric Services - Planning for the Future,* was to establish a momentum of change, which was comparable in impact only to the establishment of the asylum system in the early part of the nineteenth century. The changes in the structure and organisation of the psychiatric services recommended by *Planning for the Future* were in the main an attempt to bring Ireland into line with the changes in psychiatric services that had occurred in other states across Europe. Psychiatric services were to be reorientated towards community care and away from their traditional base of the asylum. The large and by now dilapidated institutions were to be replaced by a range of community-based services including day hospitals and acute admission units in general hospitals. Rehabilitation was to be the main driving force in facilitating the return of long-stay patients to community living.

The funding of these changes was, according to the report, to be achieved to a significant extent by the redeployment of existing resources, both human and financial, away from the institutional base to the development of community facilities. As in previous reports on the psychiatric services, the role of the psychiatric nurse was viewed as central to the successful implementation of this new policy.

According to *Planning for the Future,* the role of the psychiatric nurse was,

> ... to restore the patient to health and to achieve the maximum improvement of his or her disability as a prelude to discharge from hospital. Where discharge from hospital is not feasible, nurses are responsible for improving the quality of life for long stay patients. (p74)

Psychiatric nurses were to finally relinquish their custodial role in favour of a therapeutic one, be skilled to work in all clinical settings within the traditional inpatient setting, and to move out of the hospital into the community when the new services were developed. The mechanisms recommended to achieve a nursing workforce who possessed such a wide variety of skills were a change in the pre-registration nursing curriculum and preparation courses for registered nurses. While the pre-registration curriculum was substantially revised in 1986, little if any education or training were provided to the existing population of registered nurses who, in effect, were to be the protagonists of change. Unlike the movement towards specialisation, which occurred in the 1960s and 1970s,

the drive during the two subsequent decades was towards the creation of a "generic" nursing workforce who could operate across all settings. Rather than providing specialist education and training to equip nurses to work with the community in the promotion of mental health and the early detection of mental illness in the primary health care setting, as well as in the care of those who were mentally ill, nurses were still viewed by policy- makers as the custodians of the system, which was to be created, albeit in the community.

Likewise, the focus of the nurses' role was primarily to be directed towards the long- stay patient population, with little or no mention of their existing or future role with those patients requiring acute care. This rather limited vision of the future role of the psychiatric nurse was perhaps a reflection of the composition of the study group, which included only one nurse among its membership; yet nurses continued to be the largest group of health care workers within the psychiatric services.

While the original vision of the proposed role of the psychiatric nurse in *Planning for the Future* may have been limited, in reality this fundamental shift in policy relating to the psychiatric services provided opportunities for the psychiatric nursing profession to develop its role vis-à-vis other members of the multidisciplinary team. The driving force behind the change was clearly identifiable and grounded in a coherent policy base, rather than being subject to the vagaries of the vested interest of any single professional group. Furthermore, the proposed change in services were not constrained by the over-reliance on a singular view of illness, treatments and care; rather, the policy facilitated the adoption of an eclectic approach to conceptualising health, illness, treatment, care and service provision. The needs of patients and service-users were beginning to emerge as the primary driving force behind service development.

For the practice of psychiatric nursing, what was initially envisioned by *Planning for the Future* and what eventually emerged demonstrates clearly the active participation of the profession in initiating and leading developments within the psychiatric services. Thus, the past two decades represent the period during which the most significant changes in psychiatric nursing practice have occurred.

Changing the Ways of Psychiatric Nursing

Prior to the implementation of the policy of planning for the future, it is safe to say that the majority of psychiatric nursing was practised within the confines

of large psychiatric hospitals. While the role and function of the nurse was less custodial than in previous decades, substantial emphasis was still placed on the confinement of people suffering from mental disorders. The publication and subsequent implementation of planning for the future provided the impetus for a re-conceptualisation of how people with mental illness could be treated and cared for; and while previous reports and commissions of inquiry had suggested community care as the way forward, the political will to implement such wide-reaching change had not been present.

The initial changes, implemented on foot of planning for the future, was the large-scale rehabilitation of the group of patients described as long-stay. The majority of these patients had been in hospital for five years or more, and some as long as twenty years. This programme of rehabilitation was to provide psychiatric nurses with the first of many challenging opportunities in developing their role and function. To engage in the rehabilitation of patients required psychiatric nurses to change their ways of practicing. Both nurses and patients had been used to a way of life that cast the nurse and other health professionals in positions of power vis-à-vis the patient. Thus psychiatric nurses had to begin to relinquish some of their previously "taken for granted" control and view the patient as an equal partner in the latter's care and treatment. Likewise, patients who had previously been subjected to the constraints of institutions were expected to take back their power and control and be self-directing individuals.

The required change in the attitude of nurses also had to be matched with a change in their nursing skills. Previously, nursing skills had been defined in relation to the needs of the patient, and many of these tended to reflect a general nursing profile. While psychiatric nurses themselves emphasised the importance of the therapeutic nurse-patient relationship, the majority were extremely proficient in physical nursing tasks. This emphasis of physical care was also reflected in the psychiatric nursing curriculum, which placed a high priority on physical sciences, medicine and intervention. Rehabilitation required psychiatric nurses to adapt existing skills and indeed to emphasise aspects of care previously delegated to the most junior of nursing students. The emphasis now was on teaching patients to care for themselves, not just in the physical sense, but, more importantly, in the social and psychological aspects of everyday living. Rehabilitation was, after all, about assisting the individual to reintegrate into a community he or she had become alienated from owing to many years of confinement in an institution. Psychiatric nursing practice, which

had previously relied on the routine of the institution and on the direction of the psychiatrist, began possibly for the first time in its history to chart its way in previously unchartered territories, at least in Ireland.

Significantly, nurses were now taking responsibility for conducting in-depth assessments of patients' needs. The focus, which had previously been placed on aspects of physical care, was replaced by patients' needs in social and everyday living skills. It soon became apparent that if nurses were to be proficient in conducting such assessments, they were also required to become expert in developing, implementing and evaluating programmes. Psychiatric nurses were by this time assisting patients to live in the community, and the previous resources of the institution such as catering, laundry and cleaning services had to be provided in a hostel setting. Thus it became important for patients to learn to shop, budget, cook, attend to their personal hygiene needs and perform a range of other everyday living skills not required by them within the institution. The role of the nurse transformed from one of providing services for the patient to that of teaching the patient the skills required to live independently within the community. While on the surface this appeared to be a relatively easy task, the reality soon highlighted the complexity of such an endeavour. Achieving success required psychiatric nurses to develop a completely different set of skills to those previously required. Their original training programme, which emphasised the physical sciences, was relatively ineffective in preparing them for their new roles. Instead, education and training in effective social and interpersonal skills analysis, educational techniques and crisis intervention were deemed to be more appropriate. To this end, An Bord Altranais initiated a review of the psychiatric nursing curriculum in 1986 which emphasised community practice and attempted to redress the existing imbalance of physical versus social sciences. The role of the psychiatric nurse as an educator was also highlighted, and specific preparation was to be provided to facilitate this new generation of psychiatric nurses to work as an equal member of the multidisciplinary team within the hospital and community. These changes were implemented in 1987 and, for the first time in the history of the psychiatric nursing profession, the nursing curriculum was designed and put into practice by nurses. Previous mandatory requirements to include medical lectures were dropped, although not precluded.

While the emphasis on planning had been on the rehabilitation of long-stay psychiatric patients, services to provide care and treatment to the acutely mentally ill within the community began to develop. It was recognised that not

all patients experiencing acute mental illness required hospitalisation and that a significant proportion could be effectively treated and cared for within the community setting. The emergence of the day hospital that provided a range of services to people with acute illness presented an additional set of opportunities for psychiatric nurses to develop their role. Unlike the rehabilitation of long-stay patients, people with acute psychiatric conditions required less assistance with social and everyday living skills. Instead, they required the development of strategies to enable them to continue coping with the pressures of living. Within the day hospital setting, nurses began to run groups such as anxiety management and assertiveness training and also adopted cognitive behavioural therapy, family therapy and other psychodynamic approaches. Apart from working with the individual suffering from an identified mental health problem, nurses began to include the support needs of the patient's family.

However, the changes demanded in the practice of psychiatric nursing were not achieved in a smooth and trouble-free way. What had been overlooked were the developmental needs of the profession itself. Psychiatric nurses, the majority of whom had never practiced outside large institutions, were faced with the same anxieties and difficulties as the patients. A major shortcoming of planning as a national policy and of the local policies developed by health boards was the failure to recognise the educational and training needs of existing psychiatric nurses. As in previous decades, the new policies were to be implemented in a cost neutral way and no provision was made to assist nurses, or indeed other health professionals, to develop the skills required to assist them to develop programmes of rehabilitation.

Shortcomings in Community Care

By the early 1990s a significant proportion of long-stay patients had been through rehabilitation programmes and were now living in the community, albeit in supervised accommodation. The development of high, medium and low support hostels, as well as group homes was initially viewed as a mechanism by which to re-integrate ex-psychiatric patients in the community. The original vision was that each patient would progress through the system and eventually achieve independent living, either with their family of origin or in their own home. However, it soon became apparent that the majority of long-stay patients required ongoing support to enable them to continue to remain outside the institution.

It was also recognised that the community, which had been viewed as a more humane place than the institution, was in reality an equally hostile environment where ex-psychiatric patients were frequently the subject of ridicule, hostility and on occasion violence. Many patients now living in the community existed in a form of twilight zone, working in sheltered workshops within the hospital setting during the day and returning to a hostel in the early evening dependent for their social integration on the activities arranged by nurses and bodies such as the mental health association.

These shortcomings in community care for people with mental health problems are not, however, limited to Ireland. The impact of mental illness on the individual often results in his or her withdrawal from social interaction; simultaneously, the lack of understanding in the community at large of the needs of people with mental illness frequently results in them being considered unpredictable, dangerous and thus undesirable. In spite of the deficits of community care, it is widely accepted that the quality of life for people with mental illness and the quality of care they receive has improved, compared with what was possible to provide within the constraints of the large institutions.

Towards the New Millennium

For the profession of psychiatric nursing, the 1990s signified a period of consolidation on the one hand and constant change on the other. The changes within the practice base of psychiatric nursing which occurred in the latter half of the 1980s and early years of the 1990s continued, albeit at a slower and more considered pace. Nurses continued to consolidate their knowledge and skills base and expand the scope of their practice. Matters not previously seen as important in psychiatric nursing, such as clinical nursing research, began to emerge. Nurses accepted that it was no longer appropriate to base practice on assumptions; these had to be tested and if found inappropriate changed.

A study by Cowman et al (1997) on the role and function of the psychiatric nurse identified nine main categories relating to the activities of psychiatric nursing. These included assessing patients' needs and evaluating care, planning care, nurse-patient interactions, pharmaceutical interventions, education, documenting information, co-ordinating the services of nurses and other professionals for patients, communicating with other professionals and grades of staff and the administration/organisation of clinical work. Unlike their colleagues of previous generations, psychiatric nurses perform independent

functions and collaborate with other professional groups. Interestingly, this study identified that psychiatric nurses still consider the central tenet of psychiatric nursing to be that of the caring relationship between patient and nurse. The caring relationship is the vehicle through which all therapeutic interventions are planned, delivered and evaluated.

While changes in social and economic policy continued to be a major influencing factor in determining nursing practice, other determinants began to emerge. Health care in the 1990s began to be viewed as a commodity, and patients were reconceptualised as consumers. Coupled with the demands of the patients to be involved and consulted about their care was the greater demand for accountability for the use of public funding.

A further change in the practice of psychiatric nursing that emerged in the 1990s was the introduction of a new programme of education. The profession viewed the linkage of nursing education with the third-level system as a desirable change. This desire was given added weight by Ireland's membership of the European Union in that such integration of nursing had occurred in other member states. In Ireland the transition from the traditional apprentice-based model of nursing education began with the setting up of a diploma in nursing at University College Hospital Galway and the National University of Ireland Galway in 1994. This programme had been extended to all schools of nursing by 1998. The transition to a diploma programme had implications for the delivery of services in that students no longer formed a major part of the work force within hospitals, but had supernumary status.

Attracting Nursing Students

During the 1990s psychiatric nursing again faced the age-old challenge of attracting candidates into its educational programmes. While other nursing programmes did not witness a major decline in applications, psychiatric nursing experienced a significant decline in applications for nurse training in 1998. While various factors have been postulated for this decline, including recruitment and selection criteria, grant funding of students, as opposed to receiving a salary, the profession was forced to recognise that, as a discipline, psychiatric nursing did not have the same attraction as other more high profile disciplines within nursing. Tackling this issue required that the profile of psychiatric nursing should be promoted as a challenging and rewarding career choice. The Department of Health and Children provided funding to assist

with the planned publicity campaign undertaken throughout the country by all grades of psychiatric nurses.

The 1990s can also be considered as the decade of unrest within the ranks of the nursing profession. Industrial relations issues concerning pay and conditions of service, as well as issues relating to continued career development for nurses were constantly to the fore and culminated in the appointment of a government commission in March 1997. Its final report in September 1998, *Report of the Commission on Nursing,* is dealt with elsewhere in this publication.

Following the commission's report the profession expected a resolution to all the outstanding issues that had been on the industrial relations agenda since the early 1990s. While some of the recommendations were implemented, a significant proportion was overlooked. The expectations of the profession that the report of the commission would serve as the vehicle for major change were not realised, and the result was the first national nurses' strike, in October 1999. It lasted nine days. At the time of writing a number of issues remain to be resolved.

The New Millennium and Beyond

In concluding this chapter, it is necessary to attempt to identify the challenges facing psychiatric nursing practice for the new millennium. In a sense the challenges, if not exactly the same as the last millennium, are remarkably similar. Psychiatric nursing is required now, more than ever before, to articulate its distinctive nature as a health care discipline in the care of the mentally ill. As a group of health professionals who are inextricably linked and interdependent with other professions, psychiatric nurses must seek to identify their unique contribution to the health status of the Irish population of the twenty-first century. The reliance on pre-existing artificial boundaries between mental and physical health relied upon by previous generations of nurses are no longer appropriate in this age of trans-disciplinary working. As part of its continued development, psychiatric nursing is required to become more prominent in identifying areas of need not previously considered. For instance mental health promotion and the early detection of mental illness within the primary health care setting are two aspects that remain to be developed by psychiatric nurses, in conjunction with other primary health care professionals.

Likewise, expanding the research and knowledge base of psychiatric nursing remains a challenge for the twenty-first century. While it is recognised that the core tenet of psychiatric nursing is the caring relationship between patient and nurse, there is a need to continue investigating the nature of this relationship and to respond to the changing needs of the users of our services. The need to provide evidence of the effectiveness or otherwise of nursing interventions is a challenge to which the profession must respond.

The demands of these challenges require psychiatric nursing to attract into the profession and retain sufficient candidates of a high calibre. Nursing, like other service professions is faced with the realities of a shrinking pool of possible recruits. Thus a significant challenge for the nursing profession is to attract and retain sufficient recruits to ensure the continued development of the profession. This challenge is particularly urgent in the case of psychiatric nursing.

This chapter has presented a brief account of the last fifty years of psychiatric nursing practice. It does not claim to be comprehensive, but rather has attempted to identify some of the key issues that have faced the discipline of psychiatric nursing over the past five decades. The author recognises that there are many more. The most significant factor influencing changes in the practice of psychiatric nursing in Ireland in this period has been the reorientation of psychiatric services from the institution of the hospital to a community-based service. This change has affected all aspects of psychiatric nursing practice from pre-registration education through to advanced practice. While hospital-based provision of care remains, the vast majority of practice in psychiatric nursing now takes place within the community, and the role and function of the psychiatric nurse has changed significantly in response to the new demands placed upon it. As in the past, social and economic changes will continue to dominate and indeed dictate changes in practice, rather than discoveries in medical science. However, the core tenet of psychiatric nursing practice in the future, as in the past, will remain the caring relationship between the nurse and the patient.

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Chapter Nine

Mental Handicap Nursing

Fintan Sheerin

Introduction

While it is accepted that informal nursing is an ancient art, having its origins in early human development, it could be said that nursing, as a profession, traces its history back only about 150 years to the endeavours of Florence Nightingale and her peers. From basic beginnings, it has diversified greatly, leading to specialisation in many fields of client care. Despite this, the register of nurses maintained by An Bord Altranais contains relatively few sections, these representing the principal divisions of Irish professional nursing. One of these stands apart from the others in relation, not only to its perspective of nursing, but also to the fact that it is still in its infancy. Mental handicap nursing has been a reality for just thirty-eight years, and, like any young member in a family, it is only coming to terms with its unique identity within the nursing profession. This chapter seeks to trace the development of mental handicap nursing to date, and to evaluate its contribution to mental handicap care in current Irish services.

The introduction of the mental handicap nurse to services, in the 1960s was not characterised by revolutionary change. Sure enough, it may have had a positive effect on physical care and on the organisation of that care.

Conceptually, however, it served to continue the custodial approach to caring for people with mental handicap that had its roots in the scientific, positivistic approaches of the nineteenth century. It was not until many years later that the real effects of the mental handicap nurse would be seen.

The first specialised mental handicap service in Ireland was set up in 1869 at the Spa Hotel in Lucan, under the name of the Stewart Institution for Idiotic and Imbecile Children. It transferred eight years later to Palmerstown, where it continues to serve people with mental handicap. At the time of its initiation, it existed alongside, and in tandem with, the State workhouses and lunatic asylums, both of which had become foci for the movement of those who constituted the ever-growing underclass of society. This included those with any form of mental handicap. Gradually, throughout the first half of the twentieth century, under the leadership of religious congregations and voluntary bodies, these institutions were to be transformed into an organised and structured approach to meeting the total needs of people with such handicaps.

Care in Irish Mental Handicap Services in the 1950s

Nineteen fifty marked the enactment of the new Nurses' Act, thus amending the structure of the profession and creating a new regulatory body, An Bord Altranais, but, whereas this was to have implications for nursing within the general and mental illness fields, as well as for midwifery, it made no mention of mental handicap nursing. This is because no formal inroads had been made by the nursing profession into the field of mental handicap. It is true, of course, that there were nurses working in this field; these pioneers came largely from general and psychiatric nursing, and, true to those disciplines' philosophies, they attempted to employ illness-oriented approaches to the care of people who were not ill, per se. It would be unfair, however, to be overly critical of these nurses, for they trained and worked at a time when people with mental handicaps were still considered to be 'abnormal' and 'deficient', requiring others to perform all basic living activities for them. And so, in keeping with the prevalent medical model, mental handicap centres maintained, and indeed solidified, their status as hospitals, with all the institutional trappings of such establishments.[1]

It is important to understand the context within which such services were developing. Public and professional attitudes had not altered significantly from

those that had seen people with mental handicaps committed to lunatic asylums under the Lunatics Act of 1867. The nineteenth century had been marked by developments in scientific knowledge, which compounded the problems of those with mental handicaps. These specifically related to advances in the understanding of genetics and evolution, and to their impact upon societal thought which challenged the long-held social beliefs that had been supplied by philosophers and theologians.[2, 3] As these theories became more widely accepted, assumptions began to be made regarding those who were seen to be unfit or deviant in society. The proponents of these theories - eugenicists - held that the children of mentally handicapped parents would always be themselves disabled, owing to the belief that "feeblemindedness… behaves as a Mendelian recessive."[4] Allied to this was the negative eugenic stance that the 'unfit' should be prevented from reproducing, for it was considered that allowing persons with mental handicap (the unfit) to procreate would lead to a preponderance of such persons in society, and ultimately threaten social security.

This all served to uphold and indeed further the stigmatism and prejudice that had hitherto existed towards people with mental handicaps, but, whereas previous confinement movements had removed them to institutions, on the basis of custodialism, this new institutionalisation was to provide the grounding for the growth of a medical paradigm of care, centering on these people as *disabled, abnormal* and *unfit.* That this sense of stigma was still evident in Ireland, in the 1950s, is confirmed by Robins's treatise on the history of the Daughters of Charity service to persons with a mental handicap.[5]

The Introduction of Mental Handicap Nursing

The latter years of the 1950s had seen a sense of social awareness develop regarding the needs of people with mental handicaps. This, in part, stemmed from the experience of staff who had been working in mental handicap centres, and who had come to realise that, while the mental handicap was not amenable to medical treatment, the person had the potential to develop further. The increased focus on social deprivation and human rights that had been developing, following on from World War II, as well as from the 1948 United Nations Declaration on Human Rights, had also resulted in heightening an awareness of the needs of people with mental handicaps. With the reducing stigma and increasing public concern, came a new drive to address these needs. This drive was to find expression in the development of new services, such as

those formed under the aegis of parents and friends' groups. Nursing too was to respond to the growing movement. Robins notes that pressure from parent groups had led the Department of Health to approach An Bord Altranais regarding the possibility of providing specialised training for nurses working in the field of mental handicap.[5] It is likely that another factor in this regard was the concurrent exploration of such training in Britain. This was to lead to the acceptance of a new syllabus for registration as a mental subnormality nurse (RNMS) there in 1957.

An Bord Altranais acceded to the Department's request, and commenced its new course in 1959, at two newly opened schools: St. Louise's School of Nursing, Clonsilla, County Dublin, and St. Mary's School of Nursing, Drumcar, County Louth. It would be expected that the introduction of specialised nurses into the field of mental handicap care would have led to vast changes in the manner in which basic needs were met. This was not the case, initially, for there were simply not enough nurses to effect such change. To a large degree, the custodial approach to care was maintained, being provided principally by the non-qualified staff who had been hitherto at the centre of such care. It was only as the number of nurses increased that they started to become influential in relation to the actual manner in which care was provided. While some of the peripheral emphases did change, with an increasing regard being paid to meeting the total needs of the person, the manner in which care was provided was strongly modelled on the then-fashionable approach – task allocation. This simply meant that staff were assigned tasks for which they were responsible; for example, bathing, toileting, feeding and the like. Furthermore, these were performed within the context of a traditional nursing environment. Thus classical 'Nightingale wards' were frequently to be found in mental handicap hospitals at that time,[6] with their typical dormitory arrangement of beds around a central nursing station. This writer recalls working in such 'wards' during their transformation into more homely living units.

Nineteen sixty-five was an important year in relation to the development of mental handicap services in Ireland, for that year witnessed the culmination of four years' work on the part of the Commission of Inquiry on Mental Handicap.[7] This far-reaching report was to set in train developments that would guide the maturation of mental handicap services for many years ahead. The section on nursing provides an insight into the role of mental handicap nursing during in the first decade of its existence. The focus of such nursing was seen to be concerned with:

(a) treatment and care of the severely handicapped of all ages
(b) treatment, care and training of the lower ranges of moderately handicapped children and
(c) treatment, care and training of moderately and mildly handicapped adults with further involvement in the care of other mentally handicapped persons where illness or emotional crisis present.[7]

The 1965 report made some specific suggestions on the subject of nurse training. It proposed that more emphasis be placed on social and emotional issues, something that was to develop, albeit inadequately, in later syllabi. It also suggested that there might be a move towards common basic training for nurses, before their specialisation in general, psychiatric or mental handicap. This is an issue that arose again during deliberations prior to the 1998 *Report of the Commission on Nursing*,[8] when it received less than enthusiastic support from mental handicap nurses. That it was originally suggested by an interdisciplinary commission, bereft of nursing representation, may reveal some understanding as to the framework within which mental handicap nursing care was viewed and provided a medical, illness-oriented model. When this issue was revisited in recent times, it was considered that the 'common basic training' aspect, whether forming an initial component of all nurse training, or an entire generic nursing course, would, on account of the fact that the commonality would largely comprise biomedical sciences, lead to the development of mental handicap nurses who would have a biomedical view of their roles. As we shall see anon, such an approach would be in direct opposition to the paradigm that is developing in modern mental handicap nursing.

Continuing Growth of Mental Handicap Nursing

The beginning of the 1970s heralded further development in mental handicap nursing, with new schools of nursing being opened in Dublin and Limerick. These were to contribute greatly to nursing numbers throughout the next thirty years.

The addition of the schools came at a time when new ideas from abroad were provoking unrest within Irish mental handicap services. Principal amongst these was the concept of normalisation, elucidated by Wolfensberger in 1972,[9] from a notion developed by Bank-Mikkleson. In its expanded form it suggested that people with mental handicaps should make "available to all mentally retarded people…patterns of life and conditions of everyday living which are as close as

possible to the regular circumstances and ways of society."[10] This concept, which was to become a major force in the planning of services in the late 1970s and throughout the 1980s, was probably a manifestation of a wider, unorganised movement that was steadily affecting mental handicap services throughout the world. As such, it may have been a continuation and refinement of the social consciousness that had sparked off the growth of services in the 1950s. Whatever its origin, it came at a time when Irish services were already focussing more strongly on the need for providing alternative living choices for people in their care. This was to place a demand on mental handicap nursing that it would find difficult to meet. It is clear now that there were signs of the future direction of services well before the concept of normalisation affected them.

The National Association for the Mentally Handicapped of Ireland (NAMHI) had foreseen some of the future needs in 1962, in its report on day training centres.[11] In it they had identified the need for the orientation of staff to be "towards teaching and training rather than nursing"(p.9). This would be echoed, nearly thirty years later, in the 1990 Review Group Report,[12] which would identify training of residential personnel "in home-making, home-sharing, housekeeping and home-management, counselling and personal support" (p.50) as being prerequisite. For mental handicap nursing, such a change of focus would be problematic in the extreme, for it would move the discipline far away from the centre of nursing, thus potentiating the perception of alienation which mental handicap nurses were beginning to feel. This had its basis in the growing sense of awareness that mental handicap nursing was coming to regarding its own identify and its difference from the mainstream of the profession. This was to come to a head in the following decade, but for now, the signs of change were all around, and, with the publication of the government report, *Training and Employing the Handicapped* in 1974,[13] it appeared certain that the character of mental handicap services was to change phenomenally.

Mental handicap nursing's response to the challenge came through An Bord Altranais, and the issuance of a revised syllabus of training in 1979,[14] which looked critically at skills and knowledge requirement of the nurse in what was beginning to be seen as a field of nursing that was unlike any other. The headings used in the syllabus are a testament to this (Fig.1).

- Nursing
- Mental handicap
- Social sciences
- The needs and special requirements or mentally handicapped persons
- Special therapeutic methods
- Medicine and allied sciences

Fig. 1. Sections of the Mental Handicap Nursing Syllabus of Training 1979[14]

Whereas it must be acknowledged that the revised breakdown was, to a degree, revolutionary and went some way towards meeting the needs of people with mental handicap, it remained closely tied to mainstream nursing through its maintenance of a strong emphasis on procedural nursing, pathology and biomedical sciences. This served to maintain a strong biomedical focus within the discipline and so limited the potential for developing nursing concepts along the normalisation pathway.

A Time of Change

The 1980s were characterised by continued change within mental handicap services. There appeared to be an even more heightened social awareness of these marginalised people, evidenced by the publication of several government reports, namely the *Report of the Working Party on Services for the Mentally Handicapped* (1980),[15] *Towards a Full Life* (1983)[16] and *The Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland* (1983)[17]. What was particularly interesting about these reports was that their focus was changing in response to the idea that people with mental handicaps had the potential for development within many different parts of their lives. Thus, education, training and employment were coming to be seen as possibilities, and indeed rights, of even the most handicapped persons.

Education had played an important role in the development of services in Ireland. It had, however, been generally provided, in a formal way, only to those who were seen to have greater potential; that is, those with what were termed 'mild' and 'moderate' mental handicaps. Teachers had made an immense contribution to the quality of these people's lives. Those people with more marked needs, however, received basic care and training from mental

handicap nurses, within their living areas, or within developing nurse-led day services. This educative and training aspect had been seen to be a growing competency within mental handicap nursing, and had been identified as such within the revised syllabus. The 1983 report on education was to severely challenge that concept, noting that 'even allowing for modifications in the new syllabus, nurses of the mentally handicapped are primarily nurses, not teachers' (para 6.10c).[17] It further consigned the role of the registered mental handicap nurse to one of solely providing care, within residential living units.

This role, though, was also being re-evaluated, for residential services were being increasingly relocated away from traditional institutions, under the community-based residences model. This was spurred on by the 1980 Working Party Report.[15] These new residences were to change the lives of many people with disabilities, and open the door to a myriad of new possibilities. They were also to lead to a questioning of the role of the mental handicap nurse in such environments, and to contribute eventually to the development of a new generic care-worker role.

It has been noted above that, in the 1970s an awareness was developing that mental handicap nursing was decidedly different from other branches of nursing. This perception was to be fuelled, in the 1980s, by a developing folklore of anecdotes based upon individual nurses' experiences of applying for post-registration courses in paediatric and, especially, general nursing. Many of these told of negative comments being made about the academic ability of mental handicap nurses and of the belief that mental handicap nursing was 'not real nursing'. This writer recounts asking on why his two letters of application for such post-registration training had gone unanswered by a director of nursing in a general hospital. The director advised him to pursue psychiatric nursing first and then reapply, since it was found that 'mentally handicapped nurses [sic] do not do as well in general [nursing] as psychiatric nurses do"! While such stories may be considered to be unimportant, they did contribute to a developing air of negativity towards mainstream nursing. Conversely, it is conceivable that they actually helped mental handicap nursing to become more aware of its unique identity. It is also possible that this negativity may have led mental handicap nurses to reject many of the developments that were affecting other branches of nursing, owing to the perception that they were relevant only to those other branches. Thus, nursing process, nursing care plans and conceptual models of nursing did not find favour with many mental handicap nurses. This further contributed to poor documentation of care, so resulting in

an absence of the recorded knowledge that would have formed the basis for describing and defining what mental handicap nursing was, and that would have provided a pool of expert practice for novice nurses. Developments did take place, however, in the organisation and provision of nursing care. It has been noted above that a 'task-allocation' approach had previously been employed in this regard. New approaches became evident in the 1980s, with client allocation and key worker approaches being developed. The former referred to the allocation of a nurse and his/her assisting care staff, to the total care of a group of people with mental handicaps, over a specified period of time. The latter, which was to become the norm in the 1990s, took on some of the characteristics of primary nursing approaches, with the nurse having total responsibility for the care of a small group of clients over a long period of time. This formed the basis for developing the advocacy role of the mental handicap nurse.

Despite these developments, mental handicap nursing in the 1980s had failed to take control of its own future, but rather developed in a reactive manner. It became increasingly receptive to participating in the performance of tasks prescribed by other professionals. Thus, in the absence of a clear sense of professional identity, the discipline started to see itself as being the coalface of mental handicap services, acting on the directions of others and employing interventions that were more properly ascribed to professions other than nursing. Herein arose the much-bemoaned perception that mental handicap nurses were the 'dogs bodies' for everyone else on the multidisciplinary team. But, whereas nurses frequently placed the blame for this situation with the other healthcare professions, it is clear in hindsight that mental handicap nursing was seriously culpable for its inability or unwillingness to come to terms with itself as a professional entity.

As the 1980s came to a close, the finishing touches were being made to a new report on mental handicap services that was to maintain the momentum in moving those services farther away from the nursing concept of caring, into a social and educational paradigm, grounded in the concept of enablement rather than disablement.

New Structures and New Systems – the 1990s

The last decade of the twentieth century was an important one for mental handicap nursing, for it was during this period that the discipline found its voice

and began to speak out against what was perceived to be its unequal treatment within the wider nursing profession. This was set, however, against the background of even further changes in the focus and structure of mental handicap services, which were recommended by the 1990 report *Needs and Abilities*.[12] While this report represented an important milestone in the development of mental handicap services in Ireland, it may have been viewed cautiously by nursing, for it moved these services more deeply into the socio-educative paradigm. In describing the development of services that had grown out of narrowly focussed custodialism, to blossom in a diversity of individually determined approaches to meeting needs and developing potentials, it appeared that nursing was becoming part of the history rather than of the future. It did, though, provide some focus for nursing's future, as it described the improving quality of life that was coming to be expected for people with mental handicaps, such that an increasing number of them were achieving senior citizenship.[18] Herein lay possibilities for future development in mental handicap nursing, since nurses could play a role in elderly care, and also in meeting the illness-related needs of the older person.

In 1992 An Bord Altranais produced another revised syllabus of nurse education and training, aimed at reflecting the trends in modern services. Unfortunately, this appeared to represent merely a reorganisation of what had gone before, with much emphasis remaining on the biological sciences. The opportunity to produce something new and revolutionary had been missed. With the developments in services progressing steadily, nursing was left poorly prepared to meet the challenges of the new millennium. Nurses, however, were extending their role. Thus, they led developments within computer-assisted learning, multi-sensorial and alternative therapies, and recreational endeavours. A quiet revolution, fuelled by a new-found confidence, was taking place amongst ordinary nurses. This confidence was further manifested in nurses' successful protest, outside the An Bord Altranais office, against the suggested downgrading of mental handicap training to a post-registration status. Their voice was again to be heard as part of the all-profession industrial action in the mid- to late 1990s.

In 1997 the Working Group on the Role of the Mental Handicap Nurse[20] issued its report, which described the RMHN as being "an essential and integral element of the multi-disciplinary team required to deliver the services which persons with a mental handicap require"(p.11). This was a resounding endorsement of the mental handicap nurse. Curiously, though, the report was

never officially published. It also contained some disturbing details regarding the demographics of mental handicap nursing: it was revealed that, of the 2,020 registered mental handicap nurses on the register, 1,561 (77.3%) were working in some form of residential care, whereas, according to the annual report of the National Intellectual Disability Database of 1996, only 28% of the people with a mental handicap were in full-time residential services. This meant that approximately two-thirds of the complement of registered mental handicap nurses were involved in providing services for a minority of the mental handicap population, and particularly for those who had the greatest need. Relatively few nurses were involved in the provision of day or community care. This was to have implications for service provision in the immediate future, for with a chronic shortage of nurses developing across all nursing disciplines, it was to become increasingly difficult to employ nurses within services other than residential care. This was allied to the fact that many service managers were considering the nurse to be poorly trained and ill-prepared to meet the needs of day and community services.[6] The consequence of this was that, by the turn of the century, new generic posts were being devised, such as could be filled by individuals whose professional ethos and skills was more closely matched to those required in normative service areas. And so, the posts, variously entitled 'house-parents' or 'team leaders', were opened to applications from social workers, psychologists, child-care workers, educationalists, as well as nurses.

The uncertainty that mental handicap nurses felt about their future was to some degree reduced by the 1998 *Report of the Commission on Nursing*,[8] which affirmed the "need to promote the distinct identity and unique working environment of mental handicap nursing" (p.172). It was unfortunate, though that registered mental handicap nurses represented themselves so poorly at the Commission's consultative meetings, thereby causing that body to solicit submissions at special meetings in two mental handicap centres. Despite the confidence that had been expressed during the early part of the decade, it became obvious that many of the concerns and fears that had manifested themselves during the 1970s and 1980s were still evident in the late 1990s. Accompanying these, however, was a recognition that mental handicap nursing needed to change in order to respond to the complexities of services and clientele.

Changes were afoot, though, within the realm of nurse education. Following on from the developments that had been occurring within the fields of general and psychiatric nursing, mental handicap nurse education moved forward onto

an academic level, through the new collaborative approach that had seen relationships forged between nursing schools and third-level institutions. Such courses would lead to nurses in mental handicap graduating with university diplomas, and with the possibility of completing a bachelor degree in nursing studies thereafter. As mental handicap nursing moved tentatively into the new millennium, it did so with a mix of both confidence and uncertainty.

The Future of Mental Handicap Nursing in Ireland

The first fifty years of mental handicap nursing in Ireland have seen the growth of a new nursing discipline which has, since its inception, been constantly challenged to change, at a pace and to a degree not required of other disciplines. As a discipline, it has tried to respond to this challenge in a positive way, but has been stifled by its uncertain relationship to and identity within the wider nursing profession. However, while mental handicap *nursing* has trailed behind, and reacted to, developments within the wider mental handicap field, mental handicap *nurses* individually have been innovative and proactive, The third millennium will place further demands on the discipline to which it will have to respond. It is this writer's opinion that mental handicap nursing stands at a crossroads now which will determine its future development or demise. There are extrinsic factors which will influence this. Ireland has allied itself firmly within the European Union and to the process of standardisation therein. The effect of this has already been seen within nursing, in EU Directives that have standardised the general nursing programme throughout the European Union. It is conceivable that, in the absence of mental handicap nursing amongst the vast majority of EU countries, it could be considered to be an inappropriate approach to addressing the needs of people with mental handicaps. This could be compounded by the paradigmatic movement away from the biomedical model and towards a social-educational-developmental approach.

More importantly, there are intrinsic factors that will influence the future of mental handicap nursing. These relate specifically to the ability of the discipline to respond appropriately to the demands of the changing services, in such a way that mental handicap nursing would have to expand its concept of self to the limit of and beyond what is conventionally defined as 'nursing'. It is within the grasp of the discipline to achieve this and to identify its unique identity and place within the profession. The future of mental handicap nursing is in the hands of mental handicap nurses.

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Chapter Ten

Sick Children's Nursing

Antoinette Kelleher and Eileen J. Musgrave

'No brightness shines like the light of hope in the wide, clear eyes of a child'.

What is so special about children that when they are ill, they require a specially trained nurse to care for them? Not until the early nineteenth century was childhood recognised as a distinct stage of development. Children were beginning to be valued as a country's future, and the realisation that children require specialist care and services make it therefore worthy of investment. Although some general hospitals had wards designated for the care of sick children, a number of children's hospitals were established throughout Europe. They were founded, like all hospitals of that time, as charitable institutions to care for the poor, funded by donations and endowments. The nursing attendants in these early children's hospitals were often drawn from orphanages, workhouses and working-class homes. They were untrained, were expected to carry out the orders of the doctor and were not allowed to make decisions of their own. Even to cut a child's hair required the doctor's permission.

An early advocate of specialist training for sick children's nurses was Catherine Wood, appointed in 1878 Lady Superintendent to the Hospital for Sick Children, Great Ormond Street London.[1] Although Wood had no formal nurse training, she appears to have great insight into the needs of sick children.

Writing in the *Nursing Record,* she describes adult patients as "being able to be treated as responsible persons, trusted by themselves and their co-operation in their treatment secured, so that they are not forever in the minds of their nurse, like a child." She continues to state that ,on the other hand, the child "is entirely dependent upon its attendant – it can give no reliable help in detailing its symptoms, or in giving an account of its daily functions; it very probably refuses all food and all medicine when first offered … moreover, it must never be left alone; its attendant must always be on watch for any change in its physical condition."[2]

To fulfil the aspirations of Wood and others, schools of nursing were founded, nurse training was formalised and sick children's nursing was finally regulated in Britain and Ireland, in its own specialist discipline under the Nurses Act 1919.[3] Subsequently in Ireland, sick children's nursing became subject to the provisions of the Nurses Acts 1950[4] and 1985[5]. Supporting the decision for the education and training of sick children's nurses is the Court Report which states that sick children should be nursed by nurses who have been trained to do so.[6]

Early Views on Removing Children to Hospital

Prior to the mid 1800s hospital services for sick children did not exist as we know them today. Dispensary services had been instituted in some European cities. Charitable institutions existed to care for the abandoned, orphaned or crippled, but truly sick children were not admitted to hospital for fear of infection and because children were generally not valued very highly within society. It was also thought that children should not be separated from their mothers. A distinguished physician, George Armstrong (1777), states: "if you take a sick child away from its parent or nurse you will break its heart immediately."[7] At that time and for many years to come the infant/child mortality rate was astronomically high compared with today,[8] childhood infectious diseases, with no effective preventive measures were killers, and much of the population lived in abject poverty. Even for the rich, standards of hygiene left very much to be desired. Yet it was recognised that a sick infant/child should remain with his/her mother. However, in the latter half of the nineteenth century, there was a shift of opinion, with a growing awareness of disease processes. It was now considered more beneficial to remove sick children from their 'unhealthy' environment to a 'healthier, safer' place until they recovered.

The Establishment of Irish Children's Hospitals

In Ireland three such hospitals were founded. In 1821, The National Children's Hospital was founded; first established in Pitt Street (now Balfe Street) as the Pitt Street Institution[9]. It was then transferred in 1884 to Harcourt Street and in 1998 was incorporated into the Tallaght complex. This was the first hospital in Britain and Ireland to be established specifically for the treatment of sick children. It was also one of the first hospitals in Ireland to have a school of nursing. Charles West, a famous doctor who worked in Harcourt Street, Dublin, founded The Hospital for Sick Children, in Great Ormond Street, London in 1852.[10]

In 1872 a second hospital was founded by a group of charitable people concerned at the high incidence of death and disease among the children of the poor in Dublin. The Children's Hospital, Temple Street began its existence as St. Joseph's Infirmary for Children. It was first sited in Buckingham Street with a complement of twelve beds. In 1879, with the lease due to expire, coupled with increasing demand for beds, a site in Temple Street was purchased. Prior to this, the Governors, realising that running the hospital had become full time work, had asked the Irish Sisters of Charity to take responsibility for the administration of the hospital, which they agreed to do and took up residence on the 22 April 1879. In June of that year the new premises were formally opened, with a complement of twenty-one beds. This new institution was known as The Children's Hospital, Temple Street still under the patronage of St. Joseph, which it remains to the present day. Over the intervening years, as adjacent buildings became vacant, they were purchased to facilitate expansion of hospital services. A training school for sick children's nurses was opened in 1893.[11]

Not until the 1930s, did it become apparent that a third hospital was necessary. This was to provide paediatric hospital services for inner city families who had moved to the newly developed areas in Dublin, Crumlin and Ballyfermot. In January 1938 Dr. Edward Byrne, the then Archbishop of Dublin, purchased a 15-acre site for this purpose. With the advent of World War ll, the building programme was delayed until 1950. Then, under the auspices of Dr. John Charles McQuaid, the Archbishop of Dublin, Our Lady's Hospital for Sick Children was finally opened in 1956. The Daughters of Charity were requested to administer the nursing and other services of the hospital.[12]

These three hospitals, originally established for the treatment and care of sick children of the poor in their respective localities, now accept children according to their special needs from all over Ireland and in some instances from abroad, irrespective of their social strata.

It would be all of 150 years before the wisdom of Armstrong's statement gained new recognition, by which time many of the diseases for which children were originally admitted to hospital would be controlled. Nevertheless, children are still being admitted to hospital, albeit for very different reasons and their parents' presence in hospital is acknowledged to be a significant factor in ensuring the psychological as well as the physical well-being of the infant/child.

Changes in the Nature of the Patient Population Between 1950 – 2000

In the 1950s it was common for children to be admitted to hospital for what today would be considered minor conditions. Over the intervening years there has been a shift in emphasis. It is now recognised that children should only be admitted to hospital when the care they require cannot be given at home. Infection, in its many guises, was responsible for many hospital admissions. Then, even a sore throat carried the potential threat of developing rheumatic fever and its consequent sequel of heart disease in the adult. The advent of effective antibiotic therapy has almost eradicated the incidence of rheumatic fever. Repeated episodes of sore throat, inadequately treated, could also lead to enlargement of the tonsils and the consequent necessity to remove the tonsils and adenoids; they could also lead to the more serious threat of mastoiditis, also necessitating admission to hospital. Respiratory infections, particularly in the infant and young child, required admission to hospital.

Skin disorders and infections, notably eczema, psoriasis, boils and impetigo figured highly on hospital admission lists. Inadequate nutrition often led to a high incidence of iron deficiency anaemia, requiring hospitalisation for treatment. Many admissions to the medical wards were for social reasons. Children with cancer and some congenital heart conditions had a poor prognosis. There was a high incidence of spina bifida with its consequent complications, necessitating repeated admissions to hospital. In 1956 there was a poliomyelitis epidemic. The children who suffered deformities as a complication of this disorder required hospitalisation for correction and increased the demands on orthopaedic skills. Even the advent of *Batman* in the

1960s led to many children being admitted to hospital following their misguided aspirations of being able to fly! Children, being children, inquisitive and adventurous, regardless of era, will always fall off their bicycles and tumble out of trees, sustaining injuries as a result of these activities, which may necessitate a stay in hospital.

In 1950 children were segregated in hospital into medical/surgical, infants/children's wards. Today, while that concept still holds true, the treatment of some conditions has become more specialised, i.e. in 1950 children with cancer would have been admitted to a medical/surgical ward, depending on the type of cancer; now they are admitted to a purpose-built unit, staffed by specialists in oncology. Over the years increasing specialisation in both medicine and surgery has led to improved methods of detection of disease and more effective treatment, resulting in an increased survival rate in conditions once considered hopeless.

The Nature of Sick Children's Nursing in the 1950s

In the 1950s children with serious illness often languished in hospital for long periods of time with minimal involvement, if any, of the family. Today, children's hospitals have become centres for acute care. Improvements in treatment, greater family participation in care and liaison between hospital and community, have shortened the child's stay in hospital.

When one remembers that in 1934 doctors were considering whether nurses should be allowed take blood pressure and compare that seemingly simple task with those being undertaken by sick children's nurses today, the change seems almost breathtaking. These changes have opened up many new career opportunities for nurses. Before the *Commission on Nursing Report* (1998), promotion for senior, expert clinical nurses was away from the bedside.[13] The development of clinical career pathways, recommended in the Report, will ensure that clinical nurse specialists will remain in contact with the client group.

Subsequent Developments in Sick Children's Nursing 1950 -2000

A host of influences, almost too many to mention in an account such as this, affected sick children's nursing. These included decreased neonatal mortality rates, survival of infants/children with conditions which had yet to be

diagnosed correctly, let alone treated, i.e. cystic fibrosis, and others once thought hopeless. Improvements/innovations in medicine, surgery, anaesthesia and diagnostic procedures all spurred on changes in nursing techniques and procedures. One such procedure which children greatly feared was to receive an injection, aptly referred to by them as 'needles'. Traditionally, medicines were given orally or by injection; the intravenous route being used primarily for the infusion of fluids.

The Intravenous Nursing Team

Hitherto, the intravenous (IV) route was used only for the infusion of fluids, administration of medicines in emergency situations and the taking of blood specimens. Today, for a number of reasons, the IV route has become a common method for the administration of many varieties of medicinal preparations, thus alleviating the distress caused when injections have to be made intramuscularly. Because gaining access can be a painful and particularly frightening experience for children, it therefore became evident that a specialist team was required for this procedure. Nurses replaced the old regime of doctors inserting the cannula. In 1978, the first IV team was introduced. The concept derived from the need to administer an individual's nutrition (total parenteral nutrition - TPN) via the intravenous route. Owing to the success of this innovation, the IV team has continued to expand its expertise to all facets of peripheral cannulation. The philosophy of the team was to create a relaxed and calm atmosphere in which to perform the procedure. Children requiring repeated admissions for intravenous therapy derived considerable comfort from the knowledge that a member of the IV team would insert their cannula.

Visiting and Facilities for Parents

Traditionally, visiting children in hospital was a contentious issue. For some, the presence of parents in the ward was seen as a threat; it was also considered that it upset the child.[14] However, studies undertaken by Bowlby[15], Robertson[16] and Hawthorne[17] as well as the Platt Report [18], indicate the benefits of parental presence during hospitalisation. These revolutionised the concept of parents visiting and staying with their infant/child in hospital and restrictions were relaxed when 'open' visiting became the norm in the late 1960s. Although there was limited accommodation for parents of the very ill, it was not until the

1970s that definitive accommodation was provided. Despite the availability of parent accommodation, some parents, wishing to be in closer proximity to their children, chose to sleep in their child's cubicle on an armchair or on a 'fold-up' bed and mattress. The campaign for parental participation was vigorously pursued by the Association for the Welfare of Children in Hospital (AWCH), set up in the United Kingdom in 1961. It was established in Ireland in 1970 and then became known as Children in Hospital, Ireland in 1998.[19]

Play

Play, as an essential element in the transformation of anotherwise formidable setting, was similarly part of this group's campaign. While play must be everybody's concern in a children's hospital, it is the sick children's nurse who is pivotal in ensuring its provision in conjunction with the play specialist.

Family-Centred Care

The importance of including the family in helping a child to recover from illness or injury cannot be overlooked. A natural progression from having parents visiting/staying with their child in hospital is the concept of family-centred care, which attempts to meet the emotional, social and developmental needs of children and families in all health care settings. In family-centred care, the family is considered to be a partner in the child's care, learning about the child's condition and participating in decisions regarding the provision of care.[20] In this way, families gain greater confidence and competence in caring for their child, particularly so necessary today, with early discharge from hospital and in some instances children requiring complex procedures at home.

Day Care

Florence Nightingale in *Notes on Hospitals* states that in all hospitals, and in a children's hospital more than others, the patient must not stay a day longer than is absolutely necessary.[21] While the concept of day care was initially introduced in the 1970s in order to reduce waiting lists for admission to hospital, its advantages for all concerned soon became apparent. It also coincided with the concept of parents becoming more involved in the care of their children. Maintaining the modern philosophy of keeping children safely

with their families, day care is an excellent means of providing certain elements of care, including minor surgery and some medical and diagnostic procedures. However, it is important to recognise that adequate preparation is essential, pre- and post- admission, to reduce anxiety in the child and family.

Intensive Care Nursing

Originally, patients requiring constant care and supervision were 'specialed'. With the vast strides in surgical/medical techniques, nurses caring for very ill patients required a greater expertise.[22] Out of this movement the concept of intensive care nursing was born. Initially, this expertise was acquired by experience; senior nursing staff being role models. In time, the need for a specialised course in intensive care nursing became evident. In 1971, Our Lady's Hospital for Sick Children, Crumlin, converted part of a boy's surgical ward into an intensive care unit while awaiting sanction to construct a purpose-built unit. The Children's Hospital, Temple Street and the National Children's Hospital, Harcourt Street (1973) followed suit. Some paediatric units in general hospitals around the country may have had one/two beds dedicated for intensive nursing care.

Radiography

Initially, a State Enrolled Nurse was employed in radiography to assist the consultant radiologist in such procedures as the setting out of trolleys and preparing contrast medium for gastric or intestinal screening studies. As procedures became more complex, requiring more nursing involvement, a full time general nurse was employed. With technological advancement, i.e. ultrasound, cardiac catheterisation, magnetic resonance imaging, the work became more varied and the number of nurses increased. The presence of a nurse in this department helped to allay children's anxieties when faced with yet another strange environment.

Metabolic Disorders

In the 1930s some children who suffered from mental handicap were discovered to have an abnormal constituent in the urine which had a peculiar odour. It was subsequently discovered that high levels of the amino acid

phenylalanine in the blood were responsible for the handicap and led to the eventual diagnosis of phenylketonuria. Subsequently, it was discovered that early detection of this disorder, followed by dietary management, prevented brain damage occurring in these infants, leading to a more normal lifestyle. This in turn reduced the incidence of children with this disease being hospitalised. In 1960 a national screening laboratory was set up in The Children's Hospital, Temple Street to detect phenylketonuria and other metabolic disorders by means of the Guthrie Test (Metabolic Screening Test).[11] Today, children with this condition attend the metabolic unit in the hospital for follow up and monitoring.

Oncology

With the development of oncology as a speciality in the late 1960s/early 1970s, came the need for nurses to become skilled in caring for children with cancer. While oncological nursing courses for sick children's nurses exist in other countries, there no such course is available in Ireland. However, those nurses undertaking the Higher Diploma in Oncological Nursing in UCD have the option of selecting the paediatric module available in this course. In hindsight, this provides better opportunity because these nurses may then work in either discipline.

Liaison Nursing Service

The liaison nursing service in Our Lady of Lourdes Hospital had its beginnings in 1969 in an outreach programme, designed to assess the level of asymptomatic bacteriuria in school-going children. A urinary tract infection clinic - still in existence today - was set up and a mobile unit visited schools to conduct urinary surveillance. This unit soon became known as 'The Wanderly Wagon' after the famous children's television programme of that name! A nurse appointed to the clinic travelled with the mobile unit to conduct this surveillance. This nurse was also responsible for seeing, with the physician, children with significant bacteriuria who were referred to the clinic educating parents in the treatment and prevention of urinary tract infection, and monitoring progress. An anecdote associated with this service deserves mention: in one school, two girls sent to fill specimen jars with urine soon returned with them full. However, such is the beguiling innocence of children,

one of them said to the nurse, 'Mary couldn't fill hers, so I filled it for her'!

In 1985, a nurse was appointed to the endocrine unit, whose specific function was to provide a comprehensive diabetic nursing service. The Oncology Liaison Nursing service commenced in 1988. Initially one nurse was appointed who covered the entire twenty-six counties! Today there are three oncology liaison nurses. Liaison work has developed to include local hospitals, providing shared care and, where palliative care is required, involving the local cancer nurses, working in hospice groups. Today, those children with cancer who die more often do so in their own homes, rather than in hospital. The Cystic Fibrosis Liaison Nurse was appointed in 1990, followed in 1993 by the Cardiac Liaison and the HIV Liaison Nurses. Since then, many other liaison posts have been created. There are now in excess of forty posts filled in the three children's hospitals.

Nursing Practice Development Co-ordinator

In recognition of the value of nursing development units in other hospitals, the position of the Nursing Practice Development Co-ordinator (NPDC) was created in Our Lady's Hospital in November 1998. The role of the NPDC involves the development, implementation and evaluation of evidence-based practice guidelines, protocols and policies, through research and audit, in collaboration with all nursing colleagues throughout the hospital. The NPDC also chairs the Nurse Practice Committee, which has representatives from all clinical areas. Prior to this, a Nursing Practice/Procedure Committee was in existence, which was responsible for developing and updating nursing procedures as required.

Paediatric Resuscitation Training

Over the past decade the need for paediatric resuscitation training has become more evident. As a result, since 1998 resuscitation training officers have been appointed in the children's hospitals. The responsibility of these officers is to ensure that adequate resuscitation training is provided for all staff at these hospitals, who are ultimately responsible for the provision of such an essential service to the patients. Parents of children at risk of life-threatening episodes are also trained in resuscitation techniques. The resuscitation training officers also formulate, review and update guidelines in relation to resuscitation.

Paediatric Liaison Nurse to the Department of Health and Children

A Chief Nursing Officer was appointed to the Department of Health and Children in 1998 to strengthen the nursing policy and planning function of the Department. The Report of the Commission on Nursing [13] recommends that additional nurses be recruited to the Department from the health services in order to support the Chief Nursing Officer's role and to allow the Department access to professional nursing expertise. This led to the appointment of, among others, a nurse advisor for sick children's nursing in April 1999.

Nursing Hierarchy

In the 1950s a strict hierarchy existed in nursing, with very well defined boundaries between the various grades. Matron reigned supreme, in starched cap and apron; her pronouncements were accepted as law. When she – usually female at that time – came on 'rounds', a little rustle would travel ahead of her and caps would be straightened, errant hair stuffed underneath out of sight, aprons tweaked into place and stockings checked for ladders. Even the most unruly child would be brought to attention and beds tidied.

Ward sisters' humour would be noted when matron came on duty to see whether it was going to be a 'good' or a 'bad' day. One ward sister will always be remembered for her reply when a student nurse occasionally dared to question her orders: "Nurse, while you are in the pink [students in that hospital wore pink] and I am in the blue, I'll rule the roost." Needless to say, she had the expected sobriquet of 'the cock'! But often underneath these stern exteriors there lurked a kind heart, especially noted, by student nurses spending their first Christmas in the hospital. Over the years the demarcation lines between the various grades have become a little blurred, particularly during the 1990s. While discipline, of necessity, is still enforced it is done in a less autocratic manner. Titles and uniforms too have changed.

Nurse Education and Training
Schools of Nursing

Although in 1950 many of the general hospitals had children's wards, only two establishments provided preparation for entry to the sick children's division of the Register. Schools of nursing was founded in The National Children's Hospital Harcourt Street in 1884[9] and in the Children's Hospital, Temple Street in 1893.[11] An Bord Altranais gave its approval for Our Lady of Lourdes Hospital to open a school of nursing in 1957.[12] These three schools remained the sole centres for the education and training of sick children's nurses until the mid-1990s. In 1996, sick children's nursing finally came of age when approval for third-level status was granted. Links were formed with third-level institutions. University College Dublin formed a partnership with Our Lady's Hospital for Sick Children, Crumlin and The Children's Hospital, Temple Street, while Trinity College Dublin linked with The National Children's Hospital, Harcourt Street and so it remains at the present day.

Courses Providing Entry to the Sick Children's Division of the Register - Three Year Course

In 1950 the Children's Hospital, Temple Street and the National Children's Hospital, Harcourt Street were offering a three-year basic course in Sick Children's Nursing: Our Lady's Hospital for Sick Children followed suit in 1957. The minimum age of candidates at entry was sixteen years and the educational requirement was Intermediate Certificate,[23] with female applicants predominating. As at present, there were two intakes of students to the course each year.

At that time a three-months preliminary training school was included at the beginning of the course. This was the only concentrated period of study during the three-year programme. For their remaining time as student nurses, nurses attended lectures during off duty time or if convenient while on ward/department duty.

The syllabus, which provided a sound foundation for the practise of nursing, was subdivided into Part I and Part II. Part I concentrated on Anatomy and Physiology; Hygiene; First Aid; Bacteriology; Ethics and Psychology in relation to Nursing and the Theory and Practice of Nursing.[24] A module on Invalid Cookery was also included! This was one of the first 'casualties' when hours

were required for other topics. The elements of Part II were an expansion of those contained in Part I and in addition included such topics as The Normal Child; Principles of Medicine and Medical Nursing; Principles of Surgery and Surgical Nursing; Dietetics and Pharmacology. This syllabus remained almost unchanged until 1985 except for some changes generated by the increasing demands of professional and technological advances.[25] In the mid-1960s, a study block system was introduced to replace the original, haphazard system of lectures. This provided for a systematic approach to the academic aspect of the course. A certain number of weeks were allocated each year to allow students to be released from clinical areas to come into the School of Nursing for study blocks.

To assess the student's knowledge and skills, both written and oral examinations were taken. Over the years, to concur with developments in nursing and nurse education, the titles and formats of these examinations were changed and in some instances discontinued. To comply with a Bord Altranais ruling for all disciplines in 1984, the age of entry was increased to seventeen years and the educational requirement now became the Leaving Certificate. This three-year direct entry course to sick children's nursing was sadly discontinued in the latter half of the 1990s with the last entry of 25 students undertaking the course from 1995 to 1998. The two main reasons for discontinuation were the limited number of places available to undertake general nurse training and the perceived unemployability of Registered Sick Childrens' Nurse outside children's hospitals. This discontinuation is to be lamented. Students undertaking this course were noted for their particular dedication to sick children and their parents. Many returned to sick children's nursing having completed general nurse training. During general nurse training, their observational skills and holistic approach to nursing were noted.

The Four-Year Integrated Course

Over the years, registered sick children's nurses experienced difficulty and delay in securing places for general training - without which they were regarded as 'unemployable', except to work in paediatric hospitals. To obviate this difficulty, and the delay in obtaining places for general nurse training and to avoid repetition of experience and tuition, the four-year RSCN/RGN course was introduced in 1970. It was first run in conjunction with a number of general hospitals. Because of the demands of this course, a greater degree of

maturity was required of candidates on entry. The preferred educational requirement, although not mandatory, was a minimum of three honours in the Leaving Certificate or the equivalent. The students on the first four-year course, which commenced in Our Lady of Lourdes Hospital, were supernumerary posing a financial burden for the hospitals concerned. This course became known as the traditional four-year course to distinguish it from the Integrated Course, where a reciprocal arrangement was made between Our Lady's Hospital and two general hospitals: James Connolly Memorial Hospital, Blanchardstown in 1979 and The North Charitable Infirmary, Cork in 1982.

The course was divided into five phases. For candidates beginning sick children's nursing, phases one, three and five were undertaken in the paediatric hospitals and two and four in the general hospitals. For candidates commencing in general nursing, the opposite arrangement prevailed. The content of the course followed the syllabus content of both the sick children's and the general courses, the aim being to equip students with the knowledge and skills to function in either discipline. The examination system differed from that of sick children's or general nursing, in that it incorporated elements from both disciplines. The intermediate examination was taken approximately midway through the course and consisted of one written paper which was subdivided into two, one dealing with sick children's nursing and the other with general nursing. There was also an oral examination. The questions for this examination were set by the relevant schools of nursing and were submitted to An Bord Altranais for approval. At the completion of the course, a final examination was undertaken: three written papers and four orals originally. Subsequently this was changed to two papers and four orals. Eventually, as in all the other disciplines, the oral examinations were discontinued.

After this 'marathon', the student emerged eligible to register as an Registered Sick Childrens Nurse/Registered General Nurse. Records indicate that students, on completing the course, were very mature, adaptable, confident and independent, displaying an intelligent approach to nursing care and taking responsibility for their study. Their exposure to the culture of other hospitals and its attendant demands for adaptation, responsibility, ingenuity and initiative seemed to have evoked a maturation which was very noticeable on their return to Our Lady's Hospital. In the authors' opinion, the Integrated Four-Year Course should have been adopted as the way forward in sick children's nursing. The dual qualification thus awarded, as well as the difficulties named above, also afforded the dedicated sick children's nurse an

opportunity to travel abroad to gain valuable experience in those countries where only one register exists, i.e. Australia and the United States of America. The Children's Hospital, Temple Street developed a somewhat similar course as the traditional four-year course mentioned above, linking with St. Vincent's Hospital, Dublin.

Post-Registration Course

To facilitate nurses who were interested in pursuing a course in sick children's nursing, and who were already on another division of the register, a shortened course was developed and introduced. The content of this course provided experience and tuition in the nursing of sick children. Over the years, the duration of this course varied from thirteen months to two years. Students undertaking it, because they had already completed Part I of a three year course in another discipline joined an existing group or remained a separate group and followed Part II of the sick children's syllabus. On completion of the course, they sat the same final examination as students on the three-year course. Many candidates, who undertook this course did so for the purpose of not only working in sick children's hospitals, but to increase their employment opportunities in paediatric units of general hospitals. It also increased their eligibility to pursue a career in public health nursing. In 1987 the National Children's Hospital, Harcourt Street discontinued the three-year basic course but continued with post-registration.

In the mid-1990s, following discontinuation of the three-year basic course, the existing post-registration course became the only means by which nurses could obtain a certificate in sick children's nursing. It also was linked to universities, and its duration, title and status became fixed. The duration was 18 months and the status and title became 'The Higher Diploma in Nursing Studies (Sick Children's Nursing)'.

Courses for Sick Children's Nurses
Paediatric Intensive Care Nursing Course

The paediatric intensive care nursing course was first began in 1990. Currently there are two such courses, of six-month duration, being held each year. The course has An Bord Altranais Category II status. In the future, it is envisaged that this course will be at Higher Diploma level.

Concurrent Issues Pertaining to Sick Children's Nursing Maintaining Standards

The responsibility for maintaining standards pertaining to nurse education and training rests with An Bord Altranais, via its rules and regulations, in conjunction with five-yearly (or more frequently) inspections of schools of nursing by education officers of An Bord Members.[26] These inspections involve visiting the schools of nursing in the three sick children's hospitals to view the relevant records and to assess the suitability of the clinical areas to which student nurses are allocated. In addition, each nurse, whether student or otherwise, has an individual responsibility to maintain standards within the limits of their experience and in accordance with the *Code of Professional Conduct for each Nurse and Midwife*.[27]

The Systematic Approach to Nursing Care

The documentation of nursing care has always been a matter of discussion. It has passed through many fashions, ranging from labourously writing voluminous, repetitive reports, to the development of modern care plans. In the 1980s the concept of the systematic approach to nursing care, known to some nurses as the nursing process and to others as the process of nursing, was gradually being introduced into Ireland. It is based on a systematic problem-solving approach, through assessment of the child, planning of nursing intervention, implementation of care and the evaluation of care given. The documentation was developed by using a model of nursing the *Activities of Living* as identified by Roper, Logan and Tierney.[28] During An Bord Altranais's routine five-yearly inspections of the sick children's hospitals, An Bord's Nursing Process was recommended and it was subsequently introduced in varying forms.

Uniform

The nurse's 'cap', derived from the mobcap, was a necessary item of female apparel in the days of long hair. With the advent of shorter hair, it no longer became necessary, but yet it remained, more as decoration to complete the outfit rather than for its usefulness. It finally met its demise in the 1990s. Other items of uniform, once thought necessary for dignity and professionalism, have

met a similar fate. For health and safety reasons, tunics and trousers have replaced the white/coloured dress, starched apron, collar and cuffs.

Male Nurses

While men have formed a significant part of the student/registered population in other disciplines, it is only in recent years that they have applied to be students in sick children's nursing. For a true representation of gender in society, it is important that males come forward in greater numbers to add their own perspective to this discipline.

Challenges for the Future

On the threshold of a new century, what challenges lie in store for sick children's nursing? Children and their parents in Western society today are better educated, more aware of their rights and have greater expectations of those who provide health care. Increasing complexity in medical science will demand that new skills are developed. Early discharge from hospital and day care will require education and support for families. Further development of the principle of 'shared care' will benefit children who require home-based care. Increased survival rates of children with conditions where life expectancy was once limited will result in them becoming adolescents with special needs. Societal changes resulting in single parents, teenage pregnancy culminating in parents who are themselves little more than children, children who are victims of family instability, a greater ethnic mix, will also pose their own challenges. Further legislation may impose new and greater demands on health care providers.

Despite the improvements that have taken place, today's children are beset with as many if not more paradoxes than in previous times. In a world that recognises the United Nations Charter for Children,[29] many children still live in abject poverty, are exploited by some adults for their own purposes, and child maltreatment is still a major problem. These are just a few of the many challenges facing sick children's nursing. No doubt there will be many more. The greatest challenge is the danger of becoming so engaged with technology or academia (necessary and laudable though these are) that the individual needs of the child and his/her family may be overlooked. This could put at risk that human, caring approach, for which Irish nurses, regardless of discipline, have been so justly famous.

Conclusion

Sick children's nursing has come a long way since the first hospitals for sick children were founded. Starting off with care being provided by the uneducated, supervised by the untrained, it has progressed in parallel with advances in medical science. First regulated early in the twentieth century, with direct entry to training and having its own separate register, it was granted official recognition in the latter half of that century. Along the way there have been gains and losses; one great loss was that of direct entry to both the four- and the three-year courses. However, the developments and trends far outnumber the losses. Innovative techniques in medicine and surgery have opened up new career opportunities. Hitherto, once basic nurse education and training was completed, the ladder of opportunity removed nurses from the bedside. Now, with the development of clinical career pathways, those dedicated to direct patient care have the opportunity to continue in that direction.

The education and training of sick children's nurses has also moved with the times, eliminating outmoded practices and introducing innovation. Whether it reverts to direct entry, continues as it is at post-registration or a combination of both remains to be seen. Whatever choice is made, it is important that nurses, male or female, are attracted in sufficient numbers for specialist training in sick children's nursing. Children are the nation's future. Investment in the best possible health resources to secure that future is vital, so that the light of hope will shine brightly in the wide, clear eyes of the nation's children.

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Chapter Eleven

Nursing Education

Judith Chavasse

Hospitals needed women to nurse patients in their wards, and in the nineteenth century it had been found[1] that a better quality of woman was attracted if training was provided. Preparation of nurses has thus been intimately related to hospitals and their needs; hospitals provided training to ensure that nurses could care for patients safely and behave in a seemly fashion. Noone recognised nursing knowledge, only skills and customs; both hospitals and their training schools concentrated on 'getting the work done'. In Ireland, this continued into the 1980s, with minor modifications. Demand for theoretical teaching was met by including biological sciences and medical information, as itemised in the syllabi of An Bord Altranais from 1953 to 1980. But society was changing; applicants to nursing were increasingly well educated and nurses were becoming more assertive. They wanted validation of their latent, experiential knowledge and professional recognition. At the same time some were becoming aware that there is more to nursing than assisting physicians, that nurse theorists in the USA were identifying 'new nursing', with its emphasis on holism, caring, communication, partnership and a "process" approach to care.[2] It would be the end of the century before this was embodied in Irish nursing syllabi.

Beginnings

When the Board took over from the General Nursing Council of Saorstat Eireann in 1950, its nursing education function was concerned with training nurses for nine divisions of the register: general nurses (RGN), midwives (RM), male (RGN(M)) (of male nurses qualified as general nurses), mental nurses (RMN), sick children's nurses (RSCN), infectious diseases nurses (RIDN), sanatorium nurses (RSN), and two supplementary (post-registration) divisions for tuberculosis and orthopaedic nurses. The RGN(M), RIDN and RSN divisions and the supplementary one for tuberculosis nurses were discontinued as they became obsolete and new divisions were opened when they were approved.

Over the years the Board issued rules to regulate nursing education; these were brought up to date at intervals. The length of training was three years, except for midwives and RIDNs. Most of the voluntary hospitals required their students to stay for a fourth year in order to staff the hospital at minimum cost. Although few nurses thought of leaving after three years, the sanction for doing so was refusal of the hospital's badge. Regulations for the approval of training hospitals concerned the availability of clinical experience, educational facilities, the standard of nursing practice and of student nurses' (residential) accommodation. The Board also had rules allowing for shortened training for nurses in one division of the register to join another.

As described earlier the Board's active involvement in nursing education began in 1955 when Roseanne Cunningham was appointed to the newly created post of Education Officer. She became a huge influence on nursing education in throughout her professional career; not only did she undertake a remarkable range of responsibilities, from inspecting training hospitals to teaching on the nurse tutor diploma course, she promoted any developments in nursing education up to her retirement in 1975.

Training for the General Division of the Register

Although all divisions of the Register have equal status in law and the Board asserts that they are equal in esteem, general nursing is widely seen as being the norm. It is the largest division, with most training hospitals and students; regulations for 'General Training' were made first and then applied to the other divisions. EU Directives continue this, and Directives for general nurses are

issued before any others. This programme will be discussed first.

As indicated above, there was negligible awareness in 1950 that nursing might have its own body of knowledge. The emphasis in the 1954 syllabus was on 'matters likely to be of everyday practical use to nurses while tending the sick' and guidance to lecturers suggested that a nurse should be able to 'recognise those signs and symptoms which indicate the onset of trouble (rather than be) conversant with the pathology of the disease.' The syllabus was divided into two phases, with forty-four hours of lectures (twelve on the Theory and Practice of Nursing and four lecture-demonstrations on Invalid Cookery) to be given in the first year. Teaching that year was devoted to elements of basic medical sciences, ensuring that the students could carry out routine tasks safely on the wards. The 58 lectures in years two and three have medical titles, except for the twelve hours on the Theory and Practice of Nursing.

The lecturers were mostly medical consultants; lectures were given at any time that suited them. This could be in the students' on-duty or off-duty time, including early evening or morning, before or after night duty. Many hospitals had no sister tutor; teaching was undertaken by the nurse whom the matron considered to be most suitable. There were two examinations: Preliminary ('Prelim.') and Final, one at the end of first year, the other on completion of the course. The candidates had to take a record of nursing tasks completed to each of these examinations.

Voluntary hospitals charged a fee for training; these ranged form £50 to £200, a significant outlay for parents. Hospitals relied on the 'students' to nurse the patients in the wards; some were paid a small salary, but not all. In 1953 'probationers' in the Adelaide hospital[3] were paid £40 in the first year of training, rising to £50 in the third year; this was the average.

The most accurate title for the learners was that used in the health authority hospitals: trainees. They were neither students nor apprentices, since they usually learnt to practise by doing the best they could, guided by other trainees with perhaps six months' more experience. Some ward sisters, lay as well as religious, did teach but it was only one of many duties. A nurse who qualified in 1952 recalls: 'We had excellent teaching in the wards; I remember Sister Claude used to take the most junior when washing and setting up the sickest patient. It was done superbly - and we really learnt the best ways and concern for the patient's comfort in every respect.[4] Most hospitals insisted that ward sisters should complete ward [progress] reports on each student but these were not part of the official assessment structure. Education always took second

place to service. Up to the early 1960s, there could be only two registered nurses allocated to a ward of forty-two patients; some ward sisters refused to let students go to lectures and, if the ward was busy, it was difficult to blame them.

The Board's 1957 Rules stated that a preliminary training school was essential for all students within the following three years and the block system of protected study time was introduced in 1966.[5] By 1969[6] students in most hospitals were being relieved of ward duties for 'block', although in some they still came from wards or had to attend lectures when they were off duty. From an educational point of view, there is much to be said for intermittent lectures, if they are integrated with clinical experience; the difficulty was in protecting study time. Unfortunately the block system resulted in separation of theory from practice, overloaded timetables and a tendency to cram without reflection.

European Union Influence

The next milestone in nursing education initiated an important, and continuing, influence on nursing education; this was a Directive[7] from the Council of the European Union (many of official bodies have been given new titles since 1950; the title current in 2000 is used in this chapter). It stipulated criteria for 'mutual recognition' of general nursing qualifications amongst the states of the European Union and that nurse training should comprise theoretical and technical instruction, as well as clinical instruction, extending the scope of both theory and clinical experience required. The 1977 syllabus was in response to this. Implemented in 1979, it introduced a wider range of practical placements and subjects and extended the protected study time to 26 weeks or 1,040 hours in the three-year training period. A proficiency assessment form for assessing practical learning was introduced; this formalises the assessment of students' learning in the clinical area, increasing ward- based nurses' responsibility for nursing education. In 1983, 'Prelim' was abolished, thus enabling a more integrated curriculum to be developed in the schools of nursing.

Further EU influence was to follow, with a Directive in 1989[8] which specified that theoretical instruction should be 'balanced and co-ordinated with clinical instruction' and that the 'length of the theoretical instruction (be at least) one third and the clinical instruction (at least) one half' of the minimum training period. Ireland effected this by increasing block study time to forty weeks for each student.

Towards University Education

At the same time there was increasing recognition that nursing could neither meet the needs of health care developments, nor be recognised as a profession, without an educational system which freed students from the need to staff their hospitals. A move to higher education was seen by many to be the best answer, but there were questions of policy and funding to be asked. In 1973 the National University of Ireland, Galway (NUIG) proposed a four-year degree course for student nurses; this was supported by An Bord Altranais but nothing came of it.[9] By 1987 An Bord Altranais had taken a policy decision that basic nursing education should be 'moved to third level institutions.[10] There were various similar proposals; for example, from 1981 to 1994, University College Dublin (UCD) was seeking to introduce a direct entry degree. This proposal was rejected, officially because it was thought inopportune to introduce a new curriculum before publication of the report of the Board's review.[11]

An Bord Altranais undertook a consultative review of nurse education from 1991 to 1994.[12] This recommended changes at both basic and post-registration levels, with the introduction of supernumerary status for students, a common introduction to nursing for all divisions of the register (followed by different programmes for each) and academic accreditation for all courses.

In April 1994, the Western Health Board approached An Bord Altranais with a view to promoting a nursing programme, planned jointly with NUIG, as a pilot course following completion of the review. This was approved and a three-year Registration / Diploma course was inaugurated at University College Hospital, Galway (UCHG) and NUIG in 1994. It was funded primarily by the Western Health Board. The curriculum was the result of several years of negotiations between the hospital and NUIG; its structure was a compromise dictated by various influences. The chief features were strict conformity with the An Bord Altranais syllabus and assessment regulations, a formal link between NUIG and the UCHG School of Nursing, biological and social sciences being taught by university lecturers and completed during the first academic year, nursing studies being taught by nurse tutors in study blocks over the three years, and students having undergraduate and supernumerary status, with a non-means tested grant. The exception to the latter was for fourteen weeks rostered and paid service in the third year. The course was evaluated[13] and various weaknesses and some strengths were identified; it is likely to be replaced by a degree programme in 2002.

By 1997, all student nurses, preparing for all divisions of the register, were following the outline of the Galway curriculum. Evaluation of this in its original venues took place simultaneously with the deliberations of the Commission on Nursing;[14] the latter recommended that, from the start of the 2002 academic year, basic nursing education should be a four-year degree programme. It also recommended that students should have a 'continuous clinical placement as a paid employee of the health service', lasting for 12 months, and that a forum of representatives of third-level education, schools of nursing, health service providers and the Board be set up for two years to plan the changes.

Psychiatric Nursing Education

In the early 1950s most psychiatric nurse training took place in the local health authority hospitals, where untrained staff were recruited as attendants.[15] Staff were rostered through all units, including the refractory, geriatric, acute and ancillary units and the infirmaries (where the full range of medical and most surgical procedures and care were provided for patients). While the female staff wore a white uniform, the men wore a heavy navy suit and a peaked cap; both sexes had frieze coats for outdoor work, which included walking patients in the grounds and, for men (patients and staff) work on the farm, in the piggery and the hospital workshops. Female patients worked in the laundry, kitchen and sewing room and the staff worked alongside and / or supervised them. The hospital was rigidly divided into male and female sides and was self-sufficient in almost every respect. Discipline was strict. Before going on duty, especially night duty, staff had to line up for inspection of their smartness and sobriety. The slightest misdemeanour or untoward event had to be recorded in triplicate after the staff member had finished the shift. From 1955 on, discipline was relaxed and uniforms more appropriate to nursing were introduced.

Attendants who showed promise or were interested were entered on the nurse training programme. They took 'Prelim.' after 18 months and received a bonus of £5 if they passed their finals within the three-year period. Their 'Prelim' was the same as for general nursing, so it was important to be rostered to the infirmary during the first year; despite this, the practicals could involve identifying instruments and laying up for procedures which were strange to these candidates. It was the matron's responsibility to ensure that nursing was taught; this was normally delegated to a female deputy matron who took classes during duty hours. Most 'doctors lectures' were given at about 8 pm, to

facilitate attendants after they came off duty or before they went on night duty.

Certain private hospitals, notably St. Patrick's Hospital, Dublin, have a long history of nurse training. Some of the others were single sex hospitals, run by religious orders who trained their own members as nurses. The system was similar, except that patients did not work and everything was on a smaller scale.[16] In April 1956, one young Brother's current duties were in the kitchen, when his Superior told him that he and his colleagues were to take 'Prelim' the following month, and the State Finals that September. At that stage, no formal teaching had been provided, although these Brothers had picked up information from other Brothers and the psychiatrist. Their textbook was a handbook for psychiatric nurses (from which the pages dealing with human reproduction had been carefully excised). The young Brothers requested teaching by nurse tutors from the local psychiatric and general hospitals and this was provided; all passed the examination. Aspects of nurse training could be equally lax in public hospitals; in 1955 some of the 'nurses' in one were not registered with An Bord Altranais, although they were supposed to be supervising 'students.[17]

When the Board took office, psychiatric nursing was beginning to develop a therapeutic role, in contrast to a custodial one. The Board's first revision of the psychiatric syllabus was in 1968, when regulations for the training programme were also clarified and became mandatory. Two further revisions were completed in 1982 and 1986. One significant aspect of the 1982 revision was that all examiners were to be nurses, not psychiatrists, thus achieving a nursing orientation, in contrast to a medical one.

A programme which prepared students to register for both the psychiatric and the general divisions was approved by An Bord Altranais and run jointly by the St. John of God Psychiatric Hospital, Stillorgan and the neighbouring St. Michael's Hospital in the early 1980s.

The trend was to recognise nurses as practitioners with specific psychiatric skills, able to participate fully in multidisciplinary therapy, in the community as well as in hospitals. The 1984-86 revision was in response to the report *Planning for the Future*[18]. It enabled schools to plan their own curricula and encouraged them to incorporate models of nursing, before the introduction of such innovations for the other divisions. But it also coincided with a remarkable reduction in both student numbers (down by 25% between 1983 and 1993), and an embargo on recruiting students into psychiatric nursing in 1987, although two schools were allowed to enrol students and start a course six

months later.

Education in psychiatric nursing began to gain in status in 1991, when the EU Commission started discussions on a Directive for 'specialist training' which was to include psychiatric and sick children's nursing. In Ireland, a single cohort of twelve student psychiatric students took the Galway programme between 1995 and 1998. In 1998 preparation for the RPN division of the Register became the Registration /Diploma programme, with fifteen students that year and twenty in 1999.

Paediatric Nursing Education

Paediatric nursing education has followed the patterns of general nursing closely, probably because medical diagnoses are similar for both children and adults. The first Bord Altranais RSCN syllabus was produced in about 1956; it was revised in 1985, when the nursing process and a problem-solving approach to nursing was introduced.

All three paediatric hospitals in the State are in Dublin and, because employers wanted to be able to deploy nurses to any ward in a hospital, employment has been difficult for nurses registered only in the RSCN division. This makes registration in another division almost essential. However children's nurses found it difficult to get places in the shortened general programmes, especially after the EU Directives for general nursing required more specific clinical placements and longer periods in "Block". It was therefore decided to that the three-year programme would no longer be approved and the last three-year programme was completed in October 1998. A four-year integrated (general and paediatric) curriculum had been devised by Our Lady's Hospital for Sick Children, Crumlin with some of the general hospitals, commencing in 1970; it continued for twenty-two years. It was generally acknowledged to be very successful but was rather expensive. Both these developments have made way for the Registration / Higher Diploma in Nursing Studies (Sick Children's Nursing) (NUI) and the Post-Registration Diploma in Sick Children's Nursing.

RNMH Nursing Education

Nursing of the Mentally Handicapped or, as it is likely to become, Intellectual Disability Nursing, is the newest of the divisions of the Register.

The first students to complete the new RNMH training course were registered in September 1960. It is a relatively small field and has not been the object of EU Directives. The nurse educators have always been united and proactive in developing their syllabi, working closely with the Board. Syllabi have been revised three times since the first, in about 1956, demonstrating progressive development from the lists of discrete topics which formed the first syllabus. Then came a period when syllabi themselves were still topic based, but explanatory guidelines encouraged integration, until the 1993 syllabus. This was well integrated, identifying not only learning objectives, but emphasising the educational processes recommended. As well as educational development, the content reflects the changes in care of and respect for those with learning disabilities (see Chapter Nine).

In 1997, nursing of the mentally handicapped was the last to link with higher education. Now the eight schools of nursing are linked with Dublin City University, Trinity College Dublin, University College Cork, University of Limerick, St. Angela's College, Sligo, and Dundalk Regional Technical College. This makes Ireland the only country in Europe with basic nursing education in this field taking place at third level.

In 1990 /91, following the collapse of the Central Application Bureau, the Federation of Voluntary Bodies in the Care of the Mentally Handicapped set up its own Nursing Applications Centre, to process applications for RNMH education. This became part of the Central Applications Office in 1999.

Schools of Nursing

From 1890 to 1969, the Dublin Metropolitan School for Nurses, located at the Royal College of Surgeons in Ireland provided theoretical instruction for trainees from some of the Dublin hospitals. Early schools of nursing in hospitals consisted of a classroom, usually in the nurses' home. Gradually, separate practical rooms and a tutor's office were provided, but facilities were always sparse; it was a constant struggle to create and maintain a library or study space.

Most nurse tutors had no special preparation but many of them were highly intelligent and creative women. Religious Sisters were most likely to have a teaching qualification, because their congregations used to send them abroad to study for one. After 1962, when the first diplomates from the UCD tutor course reached the schools, numbers rose steadily. There were also clinical teachers on the staff of the school but they were teaching mainly in the wards

and departments.

Although hospitals were reluctant to relinquish their 'own' training schools, from the mid-1980s the number of schools was falling. Several general hospitals were closed during this period and health boards amalgamated schools of psychiatric nursing to form regional schools.

Students' Experiences in the Latter Half of the Twentieth Century

With the exception of psychiatric nursing, most student nurses have been young women; this is still true. Even in psychiatric nursing, the balance has been changing; by 1999 women were easily outnumbering male applicants.[19] Up until the 1970s there were few job opportunities for girls; nursing was one of the most popular, with many applicants for each place. The students were almost all school leavers, from a school system which encouraged conformity, especially from girls. Discipline in the hospitals was strict. A student from the 1950s recalls: 'we had to be in by 9.15 p.m., with a late pass until midnight just once a month --- we had to pay if we broke thermometers or delph.' Another says: 'we were discouraged from talking socially to the male patients and Res (the medical residence) was entirely out of bounds.' A student who was deemed to have misbehaved, or complained of lack of facilities, was likely to be told: 'If you don't like it here, there are plenty of others to take your place.'

In the late 1960s almost half the students were required to live in nurses' homes throughout their training and 85% had to live in for the first two years;[20] most of them would have preferred to live out, especially since they wanted more privacy or felt that 'we talk shop all the time'. Even in the early 1980s students felt that they were not expected to think for themselves: 'it was like the first day in primary school, even though they told us "OK, you are adults," but yet we are treated as if we have no minds of our own".[21]

This ethos tended to create a compliant work-force for the hospital; students would stay until they completed their course and then leave, when the sanction of dismissal without a qualification was no longer effective.[22] From an educational perspective, it limited their ability to provide holistic care and engendered dependency and and inability to take responsibility. Despite all this, many students recall that they were happy and fulfilled, with the satisfaction of being able to make a difference to a patient's well-being.

During 1987 there were severe financial restrictions nationwide. While these

affected many aspects of nurse education, including a reduction in student numbers, they had a particularly heavy effect on students. Their salaries were reduced, at a time when they were required to travel more and to undergo the extra placements required by the EU Directives. To alleviate this, meals on duty and some periods in residence were provided. It seemed as if hard-won improvements in students' conditions were in danger, but fortunately they were maintained.

Evaluation of the Galway curriculum[23] provides a picture of students' experiences in the late 1990s. They were overloaded with science in the first year and were over examined and overtired throughout the programme; however, they were also highly motivated and appreciative of tutors and the ward nurses' teaching. When, in some clinical areas, they did get individualised teaching, 'having each student allocated to a staff nurse made each learning opportunity with an Intensive Care Unit patient very effective', though 'some staff could have been more student friendly'. A wide range of learning activities were provided, especially in the school of nursing and wards, where supernumerary status enabled students to 'leave the ward for an hour or two. They stay with a patient if he's going for a test, come back and do the post-operative care afterwards.'

A new group of students appeared in numbers during the 1980s: the registered nurses who were upgrading their education. They did this with very little support from their employers and at considerable cost to themselves: fatigue, having to balance family commitments and the financial outlay. They gained in personal confidence and brought extra competence into the health services.

Continuing Education

The first university education specifically for nurses started in 1960 in UCD with the Nurse Tutor Diploma. This was in response to a long felt need, articulated most frequently by the Irish Matrons' Association, and negotiated by the Board with the UCD Faculty of Medicine. This two-year, full-time diploma course became the required preparation for all tutors; an option specifically for midwives was added in 1979. The programme was extended from 1984 to a course leading to a primary degree in nursing (BNS); the three-year, full-time version was for nurse tutors and included a large educational component. A part-time mode for practitioners commenced in 1991, the first

degree programme in nursing in Ireland.

An Bord Altranais commenced a six-month course to prepare clinical teachers in 1982; this was held at various intervals for several years, but then lapsed. UCD accepted clinical teachers to take shortened tutor courses between 1982 and 1988, to enable them to become tutors. For a time there was little demand for clinical teachers but by the late 1980s the need had reappeared. UCD modularised the BNS course, thus enabling nurses with only one year available or wanting to teach in the clinical area to do a Diploma in Nursing Studies. The Board validated this as a clinical teaching qualification.

Recognition that all professionals need continuing education is a phenomenon of the 1980s, but nurses have adopted it with enthusiasm, possibly because of the limited opportunities provided by their training. While training for a second registration had been undertaken by many to increase their employment options, continuing education only became a reality in 1974, with the inauguration of the Faculty of Nursing of the RCSI. Courses were run in various centres throughout the country and, while there was a lack of clarity about the final award, nurses signed up for evening 'diploma' courses in great numbers. There was clearly a hunger for continuing professional education. The Faculty has continued to provide a range of post basic courses, moving away from the excessively medical orientation of the early syllabi of the early days towards something approaching the 'new nursing' discussed by Salvage.[24] The highest award the RCSI can give is a Fellowship, which can be gained by examination or be awarded for service to nursing.

Another educational possibility is Distance Learning, enabling study anywhere and at the student's own pace. The first initiative in this for registered nurses was the Gateway Project, organised by the Board and funded jointly by the Kellogg Foundation and the Department of Health and Children in 1987. This was intended to introduce primary health care[25] and promote nursing's unique body of knowledge. In the mean-time, the National Distance Learning Centre had been set up. In 1989 the Centre and the Board started negotiations which led in 1997, to a primary degree in nursing for registered nurses. This was by self directed learning and allowed for accreditation of Prior Certificated Learning (APCL) for the first time in Ireland.

The educational opportunities discussed so far are chiefly for academic study in nursing. There have also been a variety of clinical courses with and without academic input. The most significant of the former are the Higher Diploma in Public Health Nursing (see chapter seven), the Higher Diploma in Oncological

Nursing (partly funded by the Irish Cancer Society) and the Diploma / Master's degree in Care of the Elderly in Trinity College Dublin. The latter is of particular importance, given the low status accorded to nursing older people and the increasing number of them in our society. Its origin epitomises the problem of funding nursing education.

Yet another field of study is management. This has been offered for nurses in both multidisciplinary and single professional form by the Institute of Public Administration since 1963/64, by Limerick University in conjunction with the Professional Development Unit of the Irish Nurses Organisation (INO) since 1995, and by the Office for Health Management with Leeds University and the Royal College of Nursing since 1997.

Many courses were started to meet a need in the hospital for specific skills, such as neonatal nursing or nursing in the operating theatre. They were run on an apprenticeship system without much academic input. Funding arrangements varied, but the participants were normally hospital staff or else were given a small fee, which could contribute to paying for some tutorial / organising time. Most of these courses are now being developed as university-validated diplomas with greater theoretical content, while maintaining their strong practical element.

The issue of in-service education is closely linked with practice and is an expanding field which is being improved, both as regards availability and relevance. Study days and workshops are also provided by professional bodies, such as the INO.

It will be apparent that there is a diversity of topics and levels in continuing education for nurses. Both because of its statutory remit for nursing education and because employers look to An Bord Altranais to ascertain whether or not courses are relevant to nurses, the Board saw a need to categorise courses. In 1989 approved courses were classified in three categories:1 - in-service courses and others with no learning assessment; 2 - specialist clinical courses in which learning is assessed and an award made; and 3 - courses validated by a university or other higher education body. It is likely that responsibility for continuing education will have been transferred to the new National Council for the Professional Development of Nursing and Midwifery by the end of 2000.

Funding Nursing Education

Traditionally the cost of nurse training was hidden in a hospital's budget, whether this came from voluntary contributions, hospital charges, health boards or directly from the Department of Health and Children (DOHC). This caused little disruption as long as student nurses provided cheap labour. It ceased from the 1970s when the EU Directives[26] concerning protected study time and planned clinical placements required the DOHC to accede to long-standing, but unheeded, proposals for proper nursing education.

The 'Galway Curriculum' for the Registration / Diploma in NUIG was planned with an optional fourth year leading to a primary degree; there was no prior agreement about funding for this. In 1997, university fees for undergraduates were abolished, but nursing students at NUIG were not eligible and had to pay fees. To register a protest, the students, by then registered nurses, picketed the Dáil in February 2000.

Funding for continuing education was inadequate and unevenly available. Courses for which funding could be found were started and then were recognised by the Board; for example, the Diploma in Gerontological Nursing, at St. James's Hospital. This is significant because there was a clear and urgent need to upgrade the nursing of the elderly, a low status aspect of nursing where nursing input can contribute dramatically to increasing length and quality of life. It seems that this should be a priority if there were policies for nursing education. Instead, it was left to two hospitals, where nursing management was flexible and creative enough to organise the nursing budget in such a way as to release staff and resources. In one case, existing links with TCD were extended and the course commenced in 1990, to be developed later as a Master's programme.

Funding for continuing education was addressed by the Commission on Nursing 1998 which recommended that the nursing and midwifery planning units proposed for the health boards should support students' fees. There was no recommendation about funding the running of courses.

Another influential development occurred with the inauguration of a Nursing Policy Division in the DOHC in 1998, this is referred to in Geraldine McCarthy's paper. As a result of this, the influence of the DOHC on nursing education has become more constructive and more collaborative.

The fourth influence is both the most important and the most subtle: it is the effect of J. Salvage's 'new nursing'. This has been the rise of nursing as an

academic discipline for professional practice. The chief features of this are an emphasis on caring, communication, partnership with patients and clients and a process approach to individualised care in pursuit of enhanced health.[27] Much of this is still being explored, both in debate and through research, but it is integral to the reciprocal relationship between nursing practice and nursing education.

The Future

The year 2000 is an appropriate one from which to record the past, as nursing education is about to undergo the greatest change to date. From October 2002, as recommended by the Commission on Nursing,[32] pre-registration education in general, psychiatric and mental handicap nursing will be a four-year degree programme, approved by the Board. The Forum mentioned above is the body charged with planning this change. Much has been learnt from the experiment originating in Galway, and the concepts of 'new nursing' are now understood and being accepted. There will also be changes in post-registration education as this becomes the responsibility of a new National Council for the Professional Development of Nursing and Midwifery in 2000.

At the time of writing, prospects for nursing education look good, but there are dangers. The greatest of these is that the move to third-level education will widen the gap between nursing knowledge and practice; plans for senior posts in clinical nursing and for education in research have the potential to bridge this gap. How nursing education should be funded is still unresolved, but this will cause recurrent problems if clear policy decisions are not made. There are great opportunities for partnership between universities and schools of nursing but, to date, this has not been widespread and will need much attention.

The years 1950 -2000 have seen preparation for a nursing career change from a practical training, barely recognised even by registered nurses, to third-level education which is beginning to provide professional nurses with a genuine understanding of their patients' and clients' needs and of their own practice.

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Chapter Twelve

Nursing in a Changing World

Geraldine McCarthy

In this chapter it is proposed to examine social, demographic, environmental, epidemiological and technological trends and health care responses, together with implications for nursing itself. The influences of major recent policy documents including the *Health Strategy - Shaping a Healthier Future*[1], *Future of Nurse Education and Training*[2] and the recommendations of the *Commission on Nursing - Blueprint for the Future*[3] will be discussed. Nursing will be situated within the changing world of education and professional practice, and there will be some reflections on the role of the nurse in the future.

Trends affecting the Health Services and Nursing

Social trends include globalisation, free trade and inequity. Disappearing borders between organisations, societies and nations have resulted in consequent changes in education, economics, business, information availability, health and social services. Some of the consequences are the formation of the European Union, the liberation of health trade with the introduction of competition for health service provision, especially in the private sector, and travel between countries for health treatment. For Irish nurses the establishment of the Eastern Regional Health Authority in 1999 and the implications of EU Directives on nursing are examples of initiatives that have had an important impact on their careers. Distribution of wealth and numbers

living on actual or borderline poverty is a concern in a growing economy, with inequity of access to health and social services. While attempts have been made to redress inequities highlighted in the Health Strategy,[4] the reality of unequal distribution of both wealth and health service provision is likely to continue well into the twenty-first century.

Demographic changes, especially population growth, internal migration to urban areas and the clustering of peoples in cities, together with migration into Ireland and the creation of a multi-ethnic culture, have significant consequences for the health service and for nursing. Growth in the number of elderly and in single-parent families also pose new challenges. Disease patterns in Ireland have changed significantly in the last fifty years from infectious diseases to those related to cardio-vascular diseases, cancer and accident-related conditions. These are expected to continue as major health concerns. The effects of unhealthy lifestyle practices, especially smoking, inadequate diet, sedentary habits and stress will most likely continue to challenge public health endeavours. At the beginning of the twenty-first century, changes in the environment are also of growing threat to the quality of health.

Evolving Health Care Structures and Systems

During the past fifty years and in response to the trends identified above, health services have undergone considerable change, some quite dramatic at the end of the 1990s. It is forecast that change will continue and possibly escalate. In reflection on the past, it is obvious how demand for health care grew beyond its genesis in private charity and increasingly became the concern of the State. Hensey[5] says: "The years immediately after the war brought a flood of plans and schemes for development and change of the health services". From 1950 to 1970 local authorities operated hospitals side by side with voluntary hospitals; nursing, while having its roots in community services, developed predominantly within these institutional structures. In the 1960s and 1970s major health reforms were introduced in response to changing patterns of disease. Medicine advanced and the numbers of doctors and nurses employed in institutional and community health care settings increased. The Health Act 1970[6] established regional health boards, with the resultant development of general and specialist regional hospitals, community services and services for special groups (such as psychiatric and mental handicap, the elderly). Regional hospitals (renamed university hospitals in the 1990s) were affiliated to

universities and, together with the voluntary hospitals, developed during the 1970s and 1980s as major teaching hospitals for nurses and other health care professionals. Hospitals, where the majority of nurses still work, have evolved into very complex organisations with general and specialist services provided, day care services becoming the norm and resultant changes in the role, function and requisite education of the nurse.

The late 1980s and early 1990s saw the publication of a number of reports on the future of the health services in Ireland[7]. Since 1994, the rate of change has been unprecedented and Ireland has developed as an economy faster than most other countries. Over the years new initiatives have been advanced to meet health care needs and to achieve health and social gain. The Health Strategy [8] emphasised health promotion, disease prevention, the pertinent use of expensive resources, evaluation and the promotion of better service links, particularly with community services. The strategy also stressed the importance of equity in relation to private and public health care and the provision of services for special and marginalized groups were also expressed concerns.

The Management Development Strategy for the Health and Personal Services[9] emphasised the necessity for clinical, professional and health service managers to operate effectively in a more open and accountable culture. This has meant major changes in the way health and social services are provided and used and have led to the introduction of organisational restructuring and new management models.

The Health Strategy[10] also recommended the reorganisation of the health boards into regional authorities - a process which has begun with the establishment of the Eastern Regional Health Authority in March 2000. These changes, together with increasing legal requirements (for example, those for children, nursing homes, and freedom of information) and the emergence of a more well informed, enlightened, demanding and litigious conscious public, have major implications for nursing education and clinical, practice and for nurse educators, managers and clinicians, some of which will be examined in the remainder of this chapter.

The work on nurses has changed dramatically as a result of trends outlined and health service responses. Nurses have been intimately involved in developments, but little has written of their contributions which often go unrecognised. It is to be hoped that this will change as nursing develops. Since 1998 innovations have also created an important leadership opportunity for nurses at the highest levels in education and service. These include the creation

of posts at professorial level in nursing, a chief nursing officer at the Department of Health and Children, and directors of planning and development at health board/authority level. These senior positions are of prime importance to the development of nursing and midwifery during the next fifty years. In particular, influences on strategy and policy have potential for long-term effects.

Nursing within an Evolving Health Service

Today, 26,695 wholetime equivalent nurses work in the health services (30,532 persons), approximately 17,971 work within hospitals, 1,489 as public health nurses and 7,244 in special facilities (1,058 in midwifery, 792 with sick children, 1,934 with mental handicap clients and 4,460 in psychiatry). If the health services are to be refocused in the community, as suggested in the Health Strategy Document, then this employment pattern is of concern. The number of registered nurses grew in Ireland to 48,945 registered on the 'live register' in 1994, with a reported 33,344 in active practice of some type[11]. However, the nursing profession is rapidly greying[12]. Over the years, nursing as a career in Ireland has, contrary to experiences elsewhere, continued to attract large numbers of highly motivated applicants, far in excess of the number of training places available[13]. Recent research shows that the majority of entrants to nurse education programmes were: female (89%), single, aged 18 to 19 years old. Nursing was their first choice of career (80%) and they had altruistic reasons for entering the profession[14]. However, with greater career opportunity in a booming economy, changes in social structures and in nurse education, nursing may have to compete for students with other occupational groups.

The emigration of Irish nurses continues as a pattern, with approximately a thousand nurses per year seeking validation of qualifications from an Bord Altranais. This may be attributed to a lack of educational opportunities in Ireland, poor promotional prospects and perceived inadequate remuneration. The trend, while continuing, must also be attributed to the desire for travel and to experience other cultures. It is costly to invest substantially in nurse education and then to allow this skilled resource to be exported.

The Changing World of Nursing

The working environment of nurses has changed considerably in the last fifty years and is set to change even more in the years ahead. The development and reorganisation in hospital institutions are of vital importance to nurse education and clinical practice. The training of nurses began within hospitals, and the education of nurses today in general nursing, mental handicap, midwifery and specialist fields remains hospital-based. Education of nurses in psychiatric and public health nursing is based on a primary health and community model.

Up to the mid-1970s most registered nurses were female and unmarried; the hours of work were long and the pay poor. Young women preparing for marriage were recruited to training schools and educated in an apprenticeship manner to supply service for a few years before marriage[15]. This led to the emergence of a hierarchical structure with few experienced nurses and many young apprentices. A revolving door situation occurred in the large hospitals where many young nurses each year emerged from training programmes to fill vacancies created through retirement or resignations from service. These nurses stayed for a short period in employment and many subsequently travelled to work in the United States and more recently in Australia for different periods. An exception to this was the psychiatric nursing service where until the 1980s men were traditionally recruited and employed until retirement.

In the 1950s and 1960s there were no independent schools of nursing and a poorly developed body of nursing knowledge. There were few nursing tutors and the matron or her assistant taught the trainees at the patient's bedside. The matron knew the character and ability of each probationer; she directed, disciplined and had no hesitation in advising nurse candidates to leave nursing if she thought they were unsuitable. The matron also determined whether employment was offered to the nurse after graduation. Control, autocratic leadership and management was the order of the time. Nursing was an emerging profession, administered by women, and together with teaching offered educational opportunities[16]. Many matrons who led Irish nursing up to the 1990s were educated on the Nightingale model where education was, according to Abel Smith, permeated by "the religious zeal of Kaiserwerth, the military discipline of Scutari and the cultural pattern of Ms. Nightingale's Victorian home"[17].

Supervision in nurse training up to the 1990s extended into all facets of the nurse’s life. Ms. Nightingale's ideas of vocation, discipline, diligence and

obedience lived on in Irish nursing and was perpetrated by an outdated method of education, which included personal training based in schools of nursing within the hospital culture. The effects have been profiled by Treacy[18], who describes general nursing students as being "in a pipeline"[13] where every facet of their lives were controlled, and more recently by Begley[19] who maintained that midwifery training produced nurses who were governed by rules and socialised into a hierarchical and controlled nursing system. The ideals which have continued to be imbued have affected professional growth and health care policy, where the nursing voice was rarely heard. Roles, education, autonomy, accountability and nurse management have also been prevented from developing to their full potential. The present problem of retention in nursing may also be a reaction to these restraining forces.

Sexual Division in Nursing

The sexual division of labour is important in nursing[20,21]. In the nineteenth century, women were excluded from the labour market by Factory Acts, legal prohibitions and trade practices. Married nurses were discouraged from working in Ireland until the lifting of the marriage bar in 1974. Nursing today still figures predominantly as a female occupation,[22] and married nurses in increasing numbers continue to work, particularly in part-time employment. Efforts are now being made to attract more males and mature individuals into nursing. While some success is reported in psychiatric and mental handicap nursing, general nursing still attracts predominantly female school- leavers[23]. It is conceivable that the "entry gate" to nursing will be widened in the future, allowing entry to people with diverse backgrounds. Trends in the USA suggest that individuals seeking a second or third career path may find nursing attractive, and that as education becomes more academic and specialist practice with autonomy and opportunity the norm, individuals with eclectic backgrounds and skills may be attracted and retained in nursing.

Despite pressure on An Bord Altranais in the 1970s a second grade of nurse primarily to offset shortage of nursing personnel was not introduced[24]. Instead, a study of nurse training was undertaken[25] which, together with the more recent Blueprint for the Future[26] did not recommend the introduction of a second nursing grade. Over the years, nurses - both student and registered have been the primary health care professionals giving personal care to patients. When the pre-registration educational changes were introduced in 1994, health care

assistants and ward clerks were introduced into the workforce. The number of these in employment has grown considerably over the past six years, leading to problems of skill mix, which had not been encountered previously in Irish nursing. This is of concern to registered nurses with respect to workload, quality of care and the availability of the registered nurse to supervise clinical education of student nurses on undergraduate and post-graduate courses. It is a problem that is likely to get worse. A word of warning has been issued from the USA where there has been a return of almost full professional nurse staffing in many major hospitals and health care agencies, in the interest of quality.

Political and Industrial Activity

Nurses have over the last twenty years have become more politically alert and have begun to acknowledge the role they must play in the politics of health and health care. Many organisations have been established to help nurses achieve objectives through negotiation with government. Amongst these are the Irish Nurses Organisation and the Irish Nurse Managers Association (formerly the Irish Matrons' Association). The former remains the largest organisation representing Irish nurses. It has grown throughout the years in membership and activity in professional and educational domains. Through this, nurses are represented on the International Council of Nurses. Irish nurses may not have to date exploited the opportunity that this provides in forging links with international nursing, the EU and WHO.

In 1998, as a result of the growing frustrations of nurses, four trade unions amalgamated to form an alliance comprising the Irish Nurses Organisation, SIPTU, IMPACT and Psychiatric Nurses Association. In the late 1990s this Alliance represented the views of nurses and was instrumental in achieving substantial salary increases and the establishment of a Commission on Nursing. The concerns of nurses were subsequently set out in the Commission on *Nursing Interim Report*[27] and many submissions were received. However, one year after the Commission recommended significant changes[28] in education, clinical practice and management, nurses took industrial action and staged a six-day national strike. The author contends that this was the result of pressures felt by nurses, rather than remuneration.

Today nurses operate in the aftermath of industrial unrest. There are significant problems to be resolved: in excess of one thousand nursing positions are vacant in the Dublin area, there are great difficulties in retaining nurses.

Already nursing has become a non-standard job, with more short-term, part-time and contract work demanded. The desire for flexibility, labour contracting, competitiveness, and the lack of interest in employment security, as traditionally known, means that more nurses will search vigorously for new opportunities and non-standard work practices. Workforce planning is perhaps the greatest challenge ahead for nurse managers, but the implications are significant for both education and clinical practice.

Legislation in Transition

The profession is regulated by nursing legislation. The 1950 Nurses Act[29] established An Bord Altranais, which has since regulated nurse education and practice. The Nurses Act 1985[30] subsequently gave nurses authority to regulate further nursing through a majority of Board members. The powers of the Board were extended in training, examination, registration and professional discipline. The year 1987 saw the establishment of a 'live' register which provides current information on the number of nurses in the country and their individual records. At present the Board manages the records of all registered nurses and oversees the education of approximately 4,000-6,000 student nurses at any one time. It advises on practice concerns and deals with fitness to practice issues. The Nurses Act 1985 is currently under review. The work of the Board has changed considerably in the last five years, exhibiting a more enabling rather than a controlling ethos. It now operates in a more open partnership with the Department of Health and Children, third-level institutions, the National Council and the employing authorities. The visibility of the Board is greater helped by the formulation in 1999 of the Guidelines and Standards of Education[31], Scope of Practice[32] and ongoing work on competencies. Other initiatives of importance to nursing has been the provision of research scholarships[33] in an effort to increase research competency.

Educational Provision

Education based on existing hospital systems of "apprentice-type" training continued to exist in Ireland until 1994. It produced nurses who were highly skilled at hospital work but were unquestioning and submissive[33,35]. The system neither challenged the other health care professions nor made demands. It could have existed only in a world where women were prepared to be

submissive, self-denying, hard-working and amenable to discipline. It appears that in Ireland up to 1994 women who entered nursing portrayed these characteristics.

Requirements for the provision of educational programmes changed extensively with the establishment of formal schools of nursing in 1966[36]. The matron or chief nursing officer (now director of nursing) of the hospital is still the administrative head of the school, even though the post of principal tutor created in 1969 carries varying degrees of authority and autonomy. In 1980 the Working Party on General Nursing[37] recommended the rationalisation of schools to a total of fifteen. Some rationalisation has occurred and since 1994 all education has moved to a partnership between health care organisations and twelve third-level institutions for the provision of both undergraduate and postgraduate education.

The number of hours devoted to theory, type of material presented and range of clinical experience offered has changed considerably owing to General Nursing Directives 77/452/EEC and Midwifery Directives 77/453/EEC,[38] which are concerned with mutual comparability and recognition of formal qualification throughout the Community. This has led to a situation where a nurse proficient in the language of another EU member state has the right to practice in that country. Recruitment companies have entered Ireland because of this enabling employment regulation to recruit nurses to work elsewhere. This trend is expected to continue and increase as students become accustomed to working in other health care systems through placement funded by the EU which are available in third-level institutions.

University Education

Despite criticisms[39,40] since the 1940s that the nurse was the only member of the health care team not receiving a university education, international trends and proposals for reform,[41,42] of the apprenticeship system of nurse education continued until 1994. The 1980 Working Party on General Nursing recommended a 'common basic training', where students of all disciplines of nursing would study similar material together. In 1984 Bord Altranais took a policy decision that nursing education should move into universities and institutes of higher education. In 1994, after four years of deliberation and consultations,[43] a review body recommended changes at basic and post basic levels, with the introduction of diplomas and degrees and academic

accreditation for all courses. These recommendations were endorsed by the Government in the Health Strategy, where it was stated that "it is necessary to align the regime for nurse education more closely with the demands of a modern day health service"[44].

Between 1994 and 1998 all nursing education programmes were linked for accreditation to a third-level college[45]. Some institutions offer specialist programmes in psychiatry nursing and mental handicap nursing. The number of nursing students studying in individual third-level institutions in 1999 varied from 80 to 556[46]. The change has meant supernumerary status for student nurses, with student involvement in clinical areas to gain experience rather than to give service; a grant rather than a salary, extension of the theoretical component and teaching of specialist subjects in the biological and social sciences by university departments and access by right to a one- year degree programmes. However, students still remain in schools of nursing for most of their education, have little opportunity to mix with other college students and work at least a 30-hour week, making them significantly different from other third-level students.

Commission on Nursing

The Commission on Nursing recommended that responsibility for the provision of an undergraduate degree in nursing be transferred to the third level sector by 2002. The Nursing Education Forum, established in 1999,[47] is preparing a document outlining the principles and partnerships arrangements for the transition to take place. It is possible that all students attending schools of nursing at the time of transfer will become the responsibility of the third-level institution since it will be impossible to maintain two different structures for education - the schools of nursing in hospitals (offering the diploma) and the third level departments/schools (offering the degree).

While the Commission deliberated on the merits of a "generic" nurse, it decided that, contrary to the practice in other countries, that nurses should not be educated in a generic manner. Rather, three distinct programmes will continue to be provided, in general, psychiatric and mental handicap nursing. Supplementary registers in psychiatric and mental handicap nursing have meant that nurses qualifying and registering in one branch of nursing and wishing to pursue study in another cannot presently do so at State expense. Another difficulty is that as there are no EU directives pertaining to the branches of

psychiatric and mental handicap nursing; nurses who qualify in these subjects cannot work elsewhere. In the future, provision may be made to help those who wish to gain another registration through direct funding. It is also conceivable that individuals with bachelor and masters degrees from other disciplines may wish to study nursing. Imaginative programmes which take cognisance of experience and previous academic awards will be required to allow these individuals to become registered nurses and to achieve an academic award in nursing.

Recruitment of Students

Up to 1995, each hospital school of nursing, using An Bord Altranais criteria as guidelines, set its own educational standards of entry, advertised, interviewed and recruited students. This created many difficulties for potential students, parents, teachers and administrators and resulted in a system which was both inefficient and expensive. In 1973 An Bord Altranais introduced minimum educational standards; these are updated regularly. In 1995 a centralised system of application and selection for nurse training was established which is now administered by An Bord Altranais. Currently a test is used (prior to Leaving Certificate examination) to assess applicants' aptitude for nursing. This has led to much criticism from both nurses themselves and the public. Candidates chosen by the test are interviewed and awarded a place in a nursing programme, which is confirmed on receipt of specific grades at the Leaving Certificate examination. In 2001 applications are to be processed by The Central Application Office (CA0).[48] Once the degree programmes commence it is uncertain whether the interview will remain in the recruitment process because of its expense and the recommendations of the Points Commission[49]. It can be predicted that recruitment procedures similar to all other students will apply.

Establishing Departments/Schools of Nursing in Third-Level Institutions

A major challenge ahead will be the establishment of Departments/Schools of Nursing, headed by a nurse with appropriate academic qualifications within third-level institutions where they already do not exist. Where facilities exist, it will involve extending the role and function of schools or departments. This means the establishment of nursing as an academic discipline with equal rights

and responsibilities. There is also the requirement to staff the departments with adequate numbers of nurse lecturers with specific academic qualifications and expertise in nursing subjects. During 2000 there were four Professors of Nursing in Ireland (University College Cork, University College Dublin, Faculty of Nursing, Royal College of Surgeons, and Dublin City University). It is predicted that the number will increase and that the role and function will change over time; some will involve themselves exclusively in research, others will hold both service and academic commitments. The possibility will exist in the future of professorial level joint appointments. Opportunities will then exist for professorships in the branches of medical nursing, surgical nursing, psychiatric, mental disability and cancer nursing and for a greater link between theory and practice.

Future Nurse Educators

The number of nurse teachers in the country has always been small and, although numbers have increased over the years, wastage has been considerable. It appears from an economic and role point of view that teaching was not an attractive career pathway for many well-qualified and motivated nurses[50,51]. Since 1966 most nurse tutors hold National University of Ireland Diplomas in Nurse Teaching and since 1988 all tutors hold Bachelor of Nursing degrees. A number of teachers have taken Masters' degrees in education and more recently in nursing itself. When the transfer of nursing education to third-level institutions takes place, two possible scenarios may develop. Inadequate interest may be found amongst the nurse teachers in positions within third-level institutions as work will increase significantly to implement the undergraduate degree. Conversely, criteria for lectureship with respect to not just teaching and clinical practice, but also for research and publications, may place inordinate pressure on nurse teachers, who may find it difficult to compete for lectureships. In other countries throughout the world (for example, Australia) when nursing was established in third- level institutions recruitment of lecturers took place from other countries with well- established, third-level nursing programmes. The pattern may prove similar in Ireland. There is a possibility that three types of lecturer/teachers of nursing will evolve. First, those based in academia, with the same terms and conditions, and fulfilling the same roles in teaching, researching and publication as all other lecturers. Secondly, nurse teachers employed by the health service or in third

level but with different work and terms of employment. Joint appointments between service and education, as recommended by the Commission on Nursing,52 may also be established. The author predicts that a mix of these three types of appointments will be implemented.

Professional Development

Over the years Irish nurses have continued to study after receiving a first qualification. Traditionally this meant studying for a second nursing registration, with the most popular choice being midwifery. However, this has changed and fewer nurses are applying for educational programmes leading to a second registration, and greater numbers are choosing degree programmes. Up to the 1960s there was very little post-basic nurse education provided by either employing authorities or An Bord Altranais. Nurses aspiring to university education or to studying specialist courses in nursing have had to travel to the British universities. This must be explained on the one hand by a lack of understanding or commitment to ongoing education in nursing and a lack of suitable nurse leaders to plan and co-ordinate education programmes. As a result, in the 1980s and 1990s some Irish nurses pursued full-time third-level degree courses, predominantly in education, psychology, sociology, law, social policy, child care and public administration. Some returned to nursing; others were lost to the profession.

Professional organisations united to campaign for both in-service and university education. A major step in the promotion of education was the establishment of the Nurse Tutor Diploma Course in University College Dublin in 1960, the Diploma in Public Health Nursing in 1986, and a Bachelor in Nursing degree in 1988. In 1990 University College Dublin established a degree for registered nurses. University College Cork followed in 1995 and Dublin City University in 1996, and today the number of graduate programmes is growing. Since the introduction of the reforms in student nurse education, a significant number of registered nurses study each year for nursing degrees. This has led to considerable difficulty for predominantly female nurses, who must combine family and work commitments with a student role. It appears that only some nurses will have the time, energy or desire to upgrade their qualifications. It is expected that difficulties will arise in the workplace, with some graduates and some non-graduates expected to work side by side. While nurses who graduated before the educational changes of 1994 are

assured that their educational qualifications are adequate and may not impede professional advancement, experience in other countries shows that those who progress along career paths have received at least a first degree.

Professional Practice

Growth in knowledge and trends discussed in the first part of this chapter, together with advances in medical science, investigation and diagnostic modalities, treatment options, including organ and tissue transplantation, have contributed to changes in the role of the nurse. Most nurses work in acute general services or in long-stay hospitals, and many work in a generalist mode. A professional problem is that these nurses have been unable to articulate their work or claim responsibility for many of the excellent health care outcomes that have been achieved. Many nurses who wish to be treated as professionals are still unprepared educationally and often unwilling to take on the full responsibilities which accompany clinical independence and autonomy. Most nurses who work in hospitals have been indoctrinated into collective responsibility and find it difficult to accept primary nursing with its individual client relationship and accountability. Rather, they prefer to work in a traditional task-orientated manner. For nurses who are willing to accept a more extensive and responsible role, there is frequent opposition from other health care professionals and from health service managers who want the nurse to remain subservient. This will become more of a problem as nursing evolves to operate on a professional model, become more skillful in expediting diagnostic and treatment protocols, and more active in planning of the discharge of the patients.

As scientific medical knowledge developed over the last fifty years and as specialisms in medicine evolved, some nurses became skilled in dealing with special groups on patients such as those with renal, oncological, critical care, palliative, orthopaedic, neurosurgery/neuromedicine conditions. Nurses began to perform many of the procedures formerly carried out by medical colleagues and thus became indispensable to the health services. Some nurses were provided with specific education and rewards, though the majority were not recognised in this manner. However, by the 1990s it was recognised that nurses working in specialist fields were not interchangeable; specific skills were required for dealing with specific client groups. The requirements for highly skilled nurses will persist and the role will expand further; yet today there is a

failure in many hospitals to fill positions in specialty areas, such as theatres and intensive care units, despite multiple advertisements. It is possible that nurses require greater rewards to compensate for the work done and psychological strain experienced in accident and emergency or intensive care. It is also possible that, as a shortage of nurses continues, specific care workers such as physician assistants or technicians may be introduced into the workforce.

As doctors handed over still more work, clinical nurse specialisation has evolved in circumscribed fields; for example, diabetic nurse specialist, stomatherapists, incontinence advisor, behaviour therapist and nurse in pain management. These nurses work extremely closely with medical practitioners in the management of patient caseloads. It appears that specialist nursing roles will develop and expand with an increase in nurse-led clinics and services. Some nurses will work as independent practitioners and will hold prescribing rights within limits. This has occurred already in a small way. However, the adhoc manner in which nurse specialists roles have evolved led the Commission on Nursing 1998 making specific recommendations in that connection.

Clinical Career Ladders

Clinical practice developments have led to a requirement for and transition to career planning and the creation of formal clinical career ladders, with supportive focused and relevant education. The Commission on Nursing recommended the recognition of a formal clinical career ladder and the creation of positions at clinical nurse specialist and advanced nurse practitioner levels throughout the health service. It also recommended that this be done in liaison with the National Council for the Professional Development of Nursing and Midwifery. This Council was established in January 2000[53] to monitor the development of nursing and midwifery specialities and to formulate guidelines for the assistance of health boards and other relevant bodies in the creation of specialist nursing and midwifery posts. Twenty members appointed by the Minister include representation from nursing and midwifery, An Bord Altranais, Office of Health Management, Health Service Employment Agency, Department of Health and Children and third-level institutions.

Into the Future

While acknowledging the transition in nursing during the past fifty years, it is important to consider some possible future changes. These include a transition from traditional and functional models of care to professional practice models, with responsibility and autonomy for focused nursing care of individual or groups of patients centred on the needs of patients and the role of registered nurses. It also means that nurses must respond to the advancement of scientific knowledge and technology by maximising available resources, while still taking on more of the procedures carried out by doctors.

As we advance into the twenty-first century, it is possible that hospitals and homes will become more high tech. Shopping, banking and the retrieval of health-related information will become more home-based and acceptable. Some people will carry their health information, including genetic fingerprinting on a microchip card a piece of jewellery or in skin implants. More patients will be cared for at home, with a range of complex care available, including some surgery. Hospitals will treat only the critically ill, and self care kits including those for diagnostic and monitoring functions, will become more common. The practices of medicine and nursing will continue to expand. The number of health care assistants and technicians employed in health care will increase dramatically. Care will be delivered based on partnerships and teamwork, with the maximum use of available knowledge and skills and with a resultant blurring of work-related and professional boundaries. Managed care and care pathways will be expected for each client. There will be a requirement for new competencies relating to community representation, collaboration, interpersonal skills, networking, strategic planning and risk-taking. It is also possible that, as work patterns change, team members will change much more frequently than heretofore.

Direct patient care will be provided by care assistants, supervised and directed by a nurse. In this way nurses will become co-ordinators rather than direct carers. Consultations with nurses will be through telecommunication or home tele-conferencing facilities, rather than face to face in clinic or on home visits. As the interest in alternative medicines continues to increase, a range of skills will be required to treat individuals in non-traditional ways. As the health service focuses more on value for money, low cost nurse administered community units with respite beds will be established. This will mean that nurses will have admission and discharge rights. Increasing domiciliary

midwifery service, nurse-led birthing centres, and pre- and post- natal community care provision will become the norm. The theatre nurse of the past will become the technician of the future. These changes will require a range of new skills and education to keep pace with services demanded by social and technological change and by the public.

Non-traditional ways of earning a living in nursing will continue and a growth in self- employment will evolve. Entrepreneurial nurses will formulate patient care plans and self-care packages for the Internet, will counsel patients via telephone or video links, and will work in the insurance industry as care auditors. Nurse consultants will establish themselves as experts in a range of fields and will sell services in contractual arrangements to lead community development projects, give expert testimony in legal situations, provide managerial and clinical practice consultations and possibly provide aid to pressure group activists. The setting of standards and measurement of outcomes of care including the use of audit as a means of ensuring continuous improvement, will become established norms in practice, and the teaching of students will be seen as both an expectation for practice and an opportunity.

As we enter the twenty-first century, it can be predicted with some certainty that nurses will continue to be seen as major contributors to health. Nursing will remain an attractive profession because it plays such a vital role in caring for the sick, the injured and in providing personal satisfaction, which goes well beyond the material. As one of the two great, comprehensive health disciplines, it will play a greater leadership role in health care policy development and implementation. Nurses will continue with zeal to improve the clinical care of the sick, but will challenge medical knowledge and dominance. The fact that nursing in itself is therapeutic will be claimed and will be recognised as a discrete health discipline, with much to offer in relation to care rather than cure. The real nature of nursing will be clearly defined, understood and accepted. More men may enter nursing, nurses will use the political, personal and professional power available to them and will develop in an educational environment which up to now have been available to other health care professionals, but not to nurses. Nurses will also become less acquiescent participants and more questioning health care professionals. In order to respond to future trends and challenges, nursing education will continue to develop. Multidisciplinary, graduate and post-graduate education will become more readily available.

Conclusion

In this chapter, trends in globalisation, business and trade, society, illness patterns, work settings and work itself have been profiled, and their effects on health care described. The chapter outlines present-day nursing and situates it within an evolving health care system. It shows how changes have affected the role of the nurse and progression to a self-governing and self-disciplining profession. It also highlights the challenges ahead and makes some predictions regarding possible future scenarios.

The past fifty years have seen many developments in nursing, and the profession moves into the next century with strengths in personnel and structures. In particular, nurses are better educated, specific research is being established, and there are opportunities at the highest levels for influencing policy and strategy. Increasingly, specialist nurses are taking on responsibilities for patient care previously performed by doctors, and are becoming more autonomous in practice. Collaborative practice and teamwork is becoming more commonplace, with quality and the progress of the patient more measurable. The value placed by the public on nursing is high and leaders more pertinent to the next century are emerging.

Looking into the future, while recognising the achievements of the past, the author suggests that nurses must establish themselves as truly independent, autonomous practitioners accountable directly to their peers and the persons whom they serve. Nursing has options to make progress in many directions. It needs to maintain a strong professional ethos committed to caring. It is important, as technology advances, that it is seen as an adjunct and not as a replacement for nurses. The challenge for the years ahead is to organise the approach of the profession to ensure that nurses have, through appropriate education, the knowledge, the skills necessary to empower individuals, groups and communities and flexibility to respond appropriately to the challenges provided. The future of Irish nursing is bright. Nurses have served the health service well during the last fifty years and will continue to do so in the years ahead.

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APPENDICES

Membership of An Bord Altranais 1997-2002

Sheila O'Malley, Administration, Public Health Nursing (Elected) – ***President***

John Byrne, Clinical Practice, Psychiatric Nursing (Elected) – ***Vice President***

Mary H. Gilmartin, Administration, General Nursing (Elected) – ***Chairperson, Fitness to Practise Committee***

Thomas Beegan, Health Board Representative (Appointed)

Bernard Carey, Department of Health & Children Representative (Appointed)

Prof. John Carroll, Third level Education Representative (Appointed), Resigned 2000

Dr. Brid Corkery, Registered Medical Practitioner, Psychiatric Nurse Teaching Hospital (Appointed)

Antoinette Doocey, Clinical Practice, Public Health Nursing (Elected)

Mary Durkin, Clinical Practice, General Nursing (Elected)

Maeve Dwyer, Administration, Midwifery (Elected)

Fiona Edwards, Clinical Practice, General Nursing (Elected)

Geraldine Feeney, General Public Interest Representative (Appointed)

Ann Fox, General Public Interest Representative (Appointed)

Dr. George Henry, Registered Medical Practitioner, Midwifery Teaching Hospital (Appointed)

Dr. Rosemary Hone, Registered Medical Practitioner, General Nurse Teaching Hospital (Appointed)

James Hough, Training, Psychiatric Nursing (Elected)

Seamus Hoye, Administration, Psychiatric Nursing (Elected)

Eileen Kelly, Training, General Nursing (Elected)

Mary Kelly, Non-Health Board Hospital Representative (Appointed)

Veronica Kow, Training, Paediatric Nursing (Elected)

Con McCarthy, Appointed Nurse (Appointed)

Catherine McTiernan, Administration, Psychiatric Nursing (Elected)

Ann Martin, Clinical Practice, Midwifery (Elected)

Jacinta Mulhere, Clinical Practice, Mental Handicap Nursing (Elected)

Kathy Murphy, Third level Education Representative (Appointed) October 2000

Norma O'Brien, Representative from Field of Education (Appointed)

Bridget O'Neill, Training, Mental Handicap Nursing (Elected)

Norah Mansell Quirke, Training, Midwifery (Elected)

Derek Smith, Administration, Mental Handicap Nursing (Elected)

Peta Taaffe, Department of Health & Children Representative (Appointed)

Staff of An Bord Altranais December 2000

Chief Executive Officer	Eugene Donoghue
Deputy Chief Executive Officer	Gerry Donnellan
Chief Education Officer	Yvonne O'Shea
Finance Officer	Jim O'Sullivan
Education Officers	Vincent Breheny
	Maria Neary
	Catherine Shine
Careers Officer	Christine Hughes
Staff Officers Admin	Desmond Bell
	Fionnuala Boyle
	Mary Boushell
	Annette Dunphy
	Hilary Flynn
	Sarah McCormack
	Catherine Rooney
	Margot Saunders
Grade IV Admin	Antoinette Beegan
	Gwen Byrne
	Mary Hinds
	Mary Rose Kiely
	Sheila McGuinness
	Ann O'Brien
	Mary Doyle
	Veronica O'Rourke
	Valerie Wade
Grade III Clerical	Mary Flynn
	Linda Lawlor
	Jean McGowan
	Paula Ryan
Receptionist	Mary Foster
Porter	Sean Preston

An Bord Altranais Register of Nurses at 1st January 2000

Registered Nurses

STATUS	FEMALE	MALE	TOTAL
Active	47354	3586	50940
Inactive	9758	631	10389
Total	**57112**	**4217**	**61329**

Registered Qualifications

DISCIPLINE	FEMALE	MALE	TOTAL	ACTIVE	INACTIVE	TOTAL
General	49327	1334	50661	41698	8963	50661
Mental Handicap	3339	406	3745	3339	406	3745
Midwives	15609	9	15618	12978	2640	15618
Other	593	27	620	397	223	620
Psychiatric	7257	3301	10558	9106	1452	10558
Public Health	2061	1	2062	1796	266	2062
Sick Children's	3966	27	3993	3333	660	3993
Tutor's	396	80	476	405	71	476
Total	**82548**	**5185**	**87733**	**73052**	**14681**	**87733**

Qualifications Registered 1999

DISCIPLINE	EU	IRELANDS	OTHER	TOTAL
General	1090	886	167	2143
Mental Handicap	–	104	60	164
Midwives	121	214	5	340
Psychiatric	–	89	146	235
Public Health	–	72	14	86
Sick Children's	–	120	62	182
Tutor's	–	19	12	31
Total	**1211**	**1504**	**466**	**3181**