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NURSING IN CRISIS
a study of contributing factors.

Merryl Hammond

A thesis submitted to the Faculty of Arts, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for a Master of Arts degree in Sociology.

October 1982.

ABSTRACT

NURSING IN CRISIS
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The purpose of this work was to study the so-called nursing crisis in some depth. A variety of research methods was used: record review of personnel files at "City Hospital", interviewing of nurses in positions of relative authority, questionnaires sent to a sample of nurses at provincial hospitals around the country, and use of official data provided by the South African Nursing Council and Association.

The conclusion is that the present nursing crisis (a problem of qualitative and quantitative aspects) should be viewed as an acute-on-chronic problem: the chronic aspect relates to the salaries and conditions of service in nursing, while the acute problems are caused by the recent economic upswing and the nursing education policies of the 1970s.

With specific regard to the problems of student and pupil nurses, the researcher suggests that these manpower problems are to a large extent caused by the nursing education policies, and that these in turn have evolved as a result of the lack of consensus and sense of community in nursing. Nursing's status as a semi-profession, rather than an occupation on one hand, or a profession on the other, is suggested to be fundamental to all these aspects.

DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted for the degree of Master of Arts in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

MERRYL HAMMOND
(Name of candidate)

NINETH day of OCTOBER, 1962.

CONTENTS

	Page
PREFACE	vii
LIST OF TABLES	viii
LIST OF FIGURES	xiii
PART ONE: INTRODUCTION	
CHAPTER	
1. INTRODUCTION	1
Objectivity and value commitment in research	1
Research objectives	7
Relevance of the study	9
Limitations of the study	10
Development of hypotheses	12
Study design	13
2. RESEARCH DESIGN AND METHODS	14
Introduction	14
The record review study	16
The experience survey	24
The postal survey	30
Additional information	39
3. FORMULATION AND TESTING OF RESEARCH HYPOTHESES	40
Introduction	40
The occupation-profession model	44
Hypothesis 1: There are manpower problems in nursing	52
Hypothesis 2: There is a lack of tight formal organisation in nursing education	59
Hypothesis 3: There is no community of nurses	65
PART TWO: STUDY RESULTS	
4. THERE ARE MANPOWER PROBLEMS IN NURSING	72
Introduction	72
Data from official sources	75
- There are shortages in several categories of staff at City Hospital	75

- Recruitment of student and pupil nurses is dropping severely at City Hospital 77
- Wastage of students is a severe problem at City Hospital 81
Data from questionnaires 89
- Many provincial hospitals around the country are experiencing manpower problems of a quantitative, qualitative or combined nature 89
- The shortages in the provincial hospitals are most severe in the student and pupil nurse categories 95
Data from interviews 99
- Interview respondents from different divisions within nursing express their opinions about manpower problems 99
Summary 101

5. *THERE IS A LACK OF TIGHT FORMAL ORGANIZATION IN NURSING EDUCATION* 103
Introduction 103
Data from official sources 104
- There are many official routes of entry into nursing 104
- The basic requirements for admission to nursing courses reflect the lack of tight, formal organization in nursing education 117
There have been many changes in the nursing curricula 124
Data from files 128
- The upgrading of the curriculum is having a disrupting effect on student nurses 128
The lack of relevant and appropriate minimum entrance requirements is evidence of the lack of tight formal organization in nursing education 136
Data from interviews 144
Summary 147

6. THERE IS NO COMMUNITY OF NURSES: THE DIVISIONS WITHIN *NURSING ARE DEEP AND FUNDAMENTAL* 150
Introduction 150
Data from files 150
- Evidence of the existence of bureaucrats 150

- Evidence of the existence of professionalisers 153
- Evidence of the existence of vocational professionalisers 156
Data from questionnaires 160
- Evidence of the existence of vocational bureaucrats 160
Data from interviews 163
Summary 168

PART THREE: CONCLUSION

7. CONCLUSION 169
Discussion of results 169
Placing the data in a broader economic context 175
Locating the data in the South African socio-economic-political structure 178
Nursing - in a perpetual process of professionalisation? 180
Some suggestions for future research 181

REFERENCES 184

APPENDICES

1. Initial letter of introduction to questionnaire respondents 196
2. Covering letter to questionnaire respondents and questionnaire 198
3. Letter of reminder to late questionnaire respondents 203
4. Kardex sheets in current use at City Hospital for student and pupil nurses 205
5. Clinical assessment form in current use for student and pupil nurses at City Hospital 208
6. College assessment form in current use for student and pupil nurses at City Hospital 210
7. Some relevant newspaper headlines 214

PREFACE

The current study was done partially in response to the staffing crisis in nursing manifest in 1980 and the years thereafter, and partially because nursing remains a relatively under-researched area in South Africa. My dual background in nursing and sociology qualified me well to undertake the study. It is hoped that the data presented here will be of interest to nurses at all levels (many of us never stop to analyse or question situations in which we are actively involved), and to sociologists concerned with the study of occupations and professions.

One very significant event has just occurred which is bound to influence the nursing situation in the future. In September 1982, it was announced that substantial changes were being made in order to "rationalise" nursing, and that salary increases of considerable proportions would be paid. It will be very interesting to observe the influence of these changes on nursing in the years to come.

I would like to thank a number of people who have been extremely helpful during the course of the study. To Peter Zarnitz, my supervisor; to the matrons and their long-suffering staff at City Hospital; to the anonymous respondents in the postal survey; to everyone who gave time to be interviewed; to Les Irwig and friends who taught me all I know about epidemiology; to Gill van der Meulen for the excellent and prompt typing; and to the moral corps of husbands, fathers, bosses, friends and family who have showed interest and concern throughout; to all these people I am sincerely grateful.

Merryl Hammond
October 1982

LIST OF TABLES

1. Representation of the various provinces in the postal survey sample ---------- 31

2. Representation of various sizes of hospitals in the postal survey sample ---------- 33

3. Representation of hospitals catering for different racial groups in the postal survey sample ---------- 33

4. Representation of hospitals by size and racial group in the postal survey sample ---------- 34

5. Total nursing staff position at City Hospital in January 1980 and January 1981 ---------- 76

6. Total student and pupil nurses at City Hospital in various months, compared with the staff establishment for these groups ---------- 78

7. Student recruits appointed in January and February only, 1979-1981 at City Hospital ---------- 79

8. Student nurse appointments and resignations at City Hospital, 1979 ---------- 82

9. Student nurse appointments and resignations at City Hospital, 1980 ---------- 83

10. Timing of resignations of January recruits in 1979 and 1980 at City Hospital ---------- 84

11. Reasons for student nurse resignations and the timing thereof at City Hospital - ---------- 85

12. Reasons for and timing of student nurse resignations at City Hospital - condensed ---------- 86

13. Reasons for terminations in each year of study for student nurses at City Hospital, March 1979 to May 1980 inclusive ---------- 86

14. Number of student nurses in the whole of South Africa who completed their studies in 1974, 1975 and 1976 compared with the number who commenced training in 1972, 1973 and 1974, expressed as a percentage ---------- 88

15. Total staff establishment, number and percentage of posts filled in various months at 31 provincial hospitals, 1979-1981 ---------- 89

16. The number of staff employed in various categories at the 31 hospitals in January 1981 as a percentage of the January 1979 figures ---------- 90

17. The staff establishments for various categories at the 31 hospitals in January 1981 as a percentage of the January 1979 figures ---------- 91

18. Analysis of the staff situations at 31 hospitals in January 1981 ---------- 92

19. Provincial distribution of adequately- and short-staffed hospitals, January 1981 ---------- 93

20. Size of hospital and adequacy of staff situation, January 1981 ---------- 93

21. Adequacy of staff situations in hospitals catering for different race groups, January 1981 ---------- 94

22. The total staff situation in white/"mixed" and black hospitals in January 1981 ---------- 94

23. Staff establishment, number and percentage of student and pupil nurse posts filled in white/"mixed" and black hospitals in various months at 15 training hospitals ---------- 96

24. Recruitment of new student nurses at black and white/"mixed" hospitals in January and February of the years 1979-1981 ---------- 97

25. Number of applications received and actual appointments made to student nurse posts at one black hospital in the Transvaal, for selected months ---------- 98

26. Total student general nurses on the registers at 31 December 1971-1979 ---------- 105

27. Number of students registered for integrated courses at nursing colleges, 1971-1979 ---------- 107

28. Number of student nurses who commenced training by year and race ---------- 119

29. Number of enrolled nurses entering diploma courses, 1971-1979 ---------- 120

30. Total number of pupil nurses on the rolls at 31 December, by race ---------- 122

31. Total number of pupil nursing assistants on the rolls at 31 December, by race ---------- 124

32. Minimum number of periods prescribed for various subjects for the diploma course in general nursing, 1970-1980 ---------- 125

33. Examination results of students registered at City Hospital, September 1980 ---------- 128

34. National anatomy and physiology failure rates, 1970-1979 ---------- 129

35. Average marks obtained in college tests by students who terminated training and who completed training at City Hospital ---------- 130

36. Reasons for resignation offered by students at City Hospital who were appointed between January 1979 and August 1980 ---------- 131

37. Educational factors in various groups of students at City Hospital ---------- 132

38. Average marks obtained in college tests by various groups of students at City Hospital ---------- 133

39. Practical assessments for students who completed and terminated courses at City Hospital ---------- 134

40. Type of matric and aggregate marks obtained by degree students at City Hospital, August 1980 ---------- 137

41. Type of matric and aggregate marks obtained by diploma students at City Hospital, July 1980 ---------- 138

42. Matric subjects of degree and diploma students at City Hospital ---------- 139

43. Matric results obtained by degree and diploma students at City Hospital ---------- 140

44. Type of matric studied by students who completed and terminated the diploma course at City Hospital ---------- 141

45. Matric results of students who completed and terminated diploma studies at City Hospital ---------- 142

46. Educational qualifications of pupil enrolled nurses who completed the course and who terminated studies at City Hospital ---------- 143

47. Changes in contents of files and origins of forms at City Hospital, 1950 - 1979. ---------- 152

48. Changes in recorded educational data in nursing files, 1941-1978 ---------- 155

49. Student nurse qualities assessed by ward sisters at City Hospital, 1950-1979 ---------- 158

50. Questionnaire respondents' opinions regarding subjects in the curriculum for general nursing students ---------- 160

51. Perceptions of questionnaire respondents working in training schools contrasted with those in non-training schools ---------- 161

46. Educational qualifications of pupil enrolled nurses who completed the course and who terminated studies at City Hospital ---------- 143

47. Changes in contents of files and origins of forms at City Hospital, 1950 - 1979. ---------- 152

48. Changes in recorded educational data in nursing files, 1941-1978 ---------- 155

49. Student nurse qualities assessed by ward sisters at City Hospital, 1950-1979 ---------- 158

50. Questionnaire respondents' *opinions* regarding subjects in the curriculum for general nursing students ---------- 160

51. Perceptions of questionnaire respondents working in training schools contrasted with those in non-training schools ---------- 161

LIST OF FIGURES

1. Steps in a descriptive study and related methodological issues ---------- 14

2. Example of tally sheet for factor analysis ---------- 21

3. The social derivation of a research project ---------- 42

4. Major steps in the study of South African nursing ------ 42

5. Pavalko's (1971) occupation-profession model with my own idea of nursing's position on each dimension ------- 48

6. Staff establishment and actual staff in the student and pupil nurse categories at City Hospital, 1974-1981 ---------- 80

7. Extract from matron's records of student nurse resignations at City Hospital, 1979 ---------- 81

8. The broad divisions in nursing and the major lines of conflict between them ---------- 173

9. Factors affecting manpower shortages in "white" hospitals: a model ---------- 177

10. Nursing's relation to the health sector, other sectors and the larger society ---------- 179

CHAPTER 1: INTRODUCTION

1. OBJECTIVITY AND VALUE-COMMITMENT IN RESEARCH

The traditional split within sociology between positivists favouring "the scientific method" and the group deriving its principles from the German Idealist philosophers and broadly classified as "interpretative sociologists" has tended to result in another split: value-free versus *value-laden research*. Positivists have insisted on the need for "objective evidence" (Nagel, *1963: 265)* and "*value-freedom*" (Lundberg, 1963: 66) in their attempts to explain social phenomena, while humanists or *phenomenologists* have tended to be less insistent.

The father of interpretative sociology, Max Weber, proposed the notion that an empirical discipline should maintain "value-neutrality" (Weber, 1949: 18-20), by which he meant that as a scientist, he studied facts "objectively", while as a citizen he got involved in matters of social policy. Weber has been criticized by contemporary academics (Gouldner, 1962; Becker, 1967; Douglas, 1970) for advocating such sociological "schizophrenia", although it is understood that Weber was under severe academic pressure at the time because of his unconventional proposals.

Modern-day phenomenologists are therefore proposing varying degrees of "value-commitment". Gouldner (1970: 76), Smith (1975) and Kaplan (1964), for example, all propose the need for <u>ethical values</u> in sociology. Becker (1967: 99) goes further: "Since it is impossible to do research *uncontaminated by* personal and political sympathies, the question is not <u>whether</u> we should take sides, *but rather <u>whose</u> side are we on?*" In other words, Becker sees the intrusion of <u>personal values</u> as inevitable, and suggests that we all at least state these values at the outset. And finally, Douglas (1970) and Gouldner (1962) propose that

sociologists should clarify their policy values as well. Douglas sees the major aim of sociology being resolution of serious social problems (*Douglas, 1970: vii*), and Gouldner states that social science must "pay its way" in society by contributing social change (Gouldner, 1962: 73).

A superficial examination of these suggestions tends to result in the impression being formed that all hope of objectivity in social research is lost. I believe that the opposite in fact applies. In the absence of values, objectivity[1] becomes impossible to attain. A researcher must hold ethical values in order to plan, implement and analyse honest and thorough work. Likewise, I believe that a researcher does necessarily begin work with particular personal values in mind. People who claim not to have "taken sides" on controversial issues are most commonly tacit supporters of the status quo - that is, they have chosen a side after all. Therefore Douglas' suggestion that we at least make our sympathies clear at the outset is a sound one. The chances of achieving objectivity in our research are greatly increased if we externalize the possible sources of bias. The issue of involving policy values in research work is perhaps the most complex, but I believe that until social research can prove its worth in the practical world, much effort will be wasted on gaining "knowledge for knowledge's sake". The natural sciences have always tested their theories by asking simply: "Does it work?" Not only will society benefit if social scientists adopt a similar outlook, but the quality of social research would surely improve as well if a researcher knew that his/her

(1) I use the term "objectivity" to denote "absence of bias" (Kaplan, 1964: 375) or "lack of sentimentality" (Becker, 1967: 110) - implying that a person ensures that a belief to which he/she is particularly sympathetic could be proved untrue in a research effort.

results were going to influence social policy. Would people not do everything in their power to ensure objectivity if this were the case?

It will be clear from the brief discussion that I not only strongly support the ideal of objectivity in social research, but also that I believe that this goal becomes attainable not despite, but rather because of value-commitment in sociology.

Given this background, I would like to try to locate the present research effort within the values that I as a researcher brought to bear on it.

The very first decision a researcher makes is what to study, and this decision for me was highly influenced by personal values. As Kaplan (1964: 381) points out: "Whatever problems a scientist selects, he selects for a reason, and these reasons can be expected to relate to his values or to the values of those who in one way or another influence his choice." In my case, it was both my own personal interest in nursing and the convictions of my research supervisor that influenced the decision about what to study.

In 1974 I began my nursing training at Addington Hospital and the University of Natal, and qualified as a registered nurse and midwife early in 1978. The social science degree which I obtained at the same time had awakened my interest in sociology and especially medical sociology. After an overseas holiday and a short spell working at Groote Schuur Hospital, therefore, I returned to the University of Natal to do an honours degree in sociology.

At the end of 1979 I moved to Johannesburg, having decided to commence reading for a masters degree at the University of the Witwatersrand, but feeling the need for a short break from studying. Two months working at the new "City Hospital" provided that break - and insight into the conditions under which the staff there had to work. The hospital had just been moved to new premises, and all the usual problems of adjustment were amplified by the staff shortages.

A brief look at some of the newspaper headlines during late 1979 and early 1980 is informative. In November 1979 the media began anticipating the "crisis" with attention being given to nurses' salaries. "The shocking pay that nurses get" appeared in the Rand Daily Mail on the 8th November, 1979 on page ten, and "The case and the crusade for nurses' salaries" in The Star on the 9th November, 1979 also on page ten.

Less than a month later, on the 5th December, the Rand Daily Mail gave front page coverage to "Birth of the new hospital", and best wishes for its success were expressed by various authorities.

From there, however, the picture became steadily bleaker with headlines such as the following appearing with monotonous regularity:

"Political row brews over hospital crisis" (The Star, 15th January, 1980, page one).

"Hospital crisis blamed on pay and bungling - Patients at risk, doctor warns" (The Star, 17th January, 1980, page one).

"Chaos reigns at Johannesburg Hospital" (Rand Daily Mail, 30th January, 1980, page seven).

"Huge staff drain hits hospitals" (Rand Daily Mail, 14th February, 1980, page one).

"Doctors report on 'crisis' at new hospital" (Rand Daily Mail, 20th February 1980, page three).

"Nursing crisis at Jo'burg Hospital worsens" (The Star, 18th March, 1980, page two).

It was during January and February 1980 that I was working at the hospital which was in the centre of all the media's reports. We were in the dreadful position of having to try and cope on the wards all day long, and then reading about the "crisis" or "worsening situation" when we came off duty. By the time the end of February came, I left the hospital with real relief (and considerable guilt) to commence my masters degree.

Even then, however, I failed to view the nursing situation as a fruitful research topic. I was hoping to expand on the research which I had done for my honours project, and it was only when my supervisor discussed the nursing problems with me that I began to realise the potential there.

It did seem sensible to focus on the nursing situation. After all, as my supervisor pointed out, nursing in general was an under-researched area in South Africa; the current problems were very topical; and my background and experience as a nurse put me in a unique position to conduct sociological research in the area.

Initially, however, I thought I had all the answers. For the previous two months every tea and lunch break had been spent discussing the causes of and solutions to the "*nursing crisis*". Had I not lived through it all? Did I not instinctively know all the answers? Why spend months and months researching a problem for which the solutions were so obvious?

As I began to read around the topic, however, I realised my mistake. The very superficial analysis I had made from common-sense experience was totally inadequate. There was clearly more to the problems in nursing than simple economics. After reading many sociological analyses of professionalisation, bureaucratisation, socialisation of novices, and formal organisations I began to see the current "crisis" in its true perspective, and was able to start the research from there.

Thus we see how firmly grounded that initial decision was in personal values. *If we agree with Becker's (1967: 99) point* that there is no question about whether researchers take sides, but should rather ask <u>whose</u> side are we on, then let there be no *doubt in the reader's mind:* my personal sympathies lie with the working nurses. It is their problems which prompted this work.

Having clarified my personal values, let us look briefly at the issue of policy values. As we have seen, some authors like Douglas (1970) and Gouldner (1962) have suggested that it is artificial to separate "sociological study" from "social study", and that the best sociologists can do is to clearly state the policy base from which they are working. I agree with this suggestion in principle, but actually find it difficult to do in a concise way. As I see them, the problems in nursing in South Africa are so intimately involved with issues at so many levels that solutions cannot be proposed without consideration of all these levels. To mention but a few of the most obvious factors, I believe we have to consider nursing-specific problems like educational uncertainty, lack of leadership and failure to attract recruits; then problems within the health sector as a whole, like the status of nursing relative to medicine, the problem of private versus state medicine and the trends towards professionalization; and finally, problems in the larger society like political ideologies, the perception of non-productive, service sectors in a capitalist economy, and attitudes towards predominantly female occupations in a male-dominated society.

I shall return to some of these points in the concluding chapter, but perhaps the above very brief exposition is sufficient to orientate the reader to my general approach. It should be emphasized at the outset that although the research has necessarily been limited to a study of nursing-specific issues, I am not proposing that this is the only source of problems or indeed the only area to implement changes.

Finally, it should hardly be necessary to mention that in addition to approaching this work with specific personal and policy values, I also considered certain ethical values. Although there were no major ethical issues involved, and most of the people who were approached for permission seemed only too happy to try to help in what they all perceived as a vital area of research, that did not decrease the need for a basic commitment to research ethics. Thus, confidentiality of subjects was assured, and all reasonable efforts were made to exclude sources

of bias. Perhaps most fundamental of all, I should quote from Andreski (1972: 2..): "When asked what he regarded as the most important method in his field, Georges Sorel replied: honesty."

I trust that I have clarified the issue of value-commitment as it applies to the present research. The last point to consider in this section concerns *how all these values affect* the objectivity of the work. I believe that the ethical values involved could only have increased the chances of objectivity. On the issues of personal and policy values, I can only echo what I mentioned earlier; that if one's results are likely to be considered in making policy decisions which will affect the lives of the people to whom one feels responsible (personal values), then one *is surely motivated to take the utmost care* in ensuring objectivity. This is certainly the approach I have used in this work.

2. RESEARCH OBJECTIVES

It will become clear when the research methods are discussed in detail that this study began in many respects as an exploratory study. Many of the hypotheses were only generated after data collection had begun. It would therefore have been *impossible* for me to express the objectives of the research as systematically as I can with hindsight. As I present the work now, however, I am able to clarify both the terminal and intermediate objectives of the work[1].

2.1 Terminal Research Objective

On completion of this study, the researcher should be able to name and explain some of the major nursing-specific problems *contributing to the manpower "crisis" in nursing.*

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(1) Intermediate objectives are objectives which must be attained before the overall or terminal objective can be. I am applying standard educational theory to a research area. See, for example, Guinée (1966: 107-111) and Quinn (1980: 80-81).

Two points require clarification in this statement. First, I have had to limit the objective to naming and explaining some of the major problems. This restriction has had to be imposed because of the methodological limitations of the study. These will be detailed shortly, but in brief it must be mentioned that in choosing particular methods to study social reality, one immediately limits the range of social reality which can logically be included in the field for consideration. As Denzin (1970: 297) states: "Research methods are not neutral "atheoretical tools" .... They in fact represent different ways of acting on the environment, so the results obtained will be different when using different methods."

Smith (1975: 275) is equally convinced: "Thus, research methods are never atheoretical or neutral in representing the world 'out there'. They act as filters through which the environment is selectively experienced."

What I am suggesting, therefore, is that the limitations necessarily imposed on the study by virtue of the methods I used, may have so narrowed the view of social reality I obtained that there may be entirely separate, equally major issues which are not even mentioned in this work. Hence the cautious use of the word "some" in the statement of the terminal research objective.

The second point needing clarification in the terminal objective concerns "nursing-specific" problems. As I have previously mentioned, it was beyond the scope of the present work to examine broader health sector issues or the over-riding socio-economic and political factors. It is study of those levels particularly that I am excluding in the terminal objective, although some theoretical analysis will be undertaken in the final chapter.

2.2 Intermediate Research Objectives

These can be simply stated:

1. to describe the size, nature and distribution of manpower problems in nursing;

2. to describe the basic nursing educational system and apply these findings to the manpower issue;

3. to examine the nature and composition of the "nursing community" and apply these findings to the manpower issue.

Each of these intermediate objectives is examined in the three substantive chapters (Chapters 4, 5 and 6) of this work.

3. RELEVANCE OF THE STUDY

The assumption about the relevance of this research when it was originally planned was that it might contribute in some way to solving the very severe staff shortages at City Hospital. In other words, it was hoped that the study, in using sociological methods, analyses and insights, would be of some immediate empirical relevance to nursing.

The second assumption was that the study might be of some sociological relevance by focussing on one of the important areas in medical sociology - nursing, and on one aspect of the sociology of occupations - a semi-profession.

As it happened; the problems at City Hospital proved to be reflections of deeper conflicts within nursing, and so the chances of immediate empirical relevance are greatly reduced. Nevertheless, I do believe that the insights gained have been extremely valuable, and trust that they may be useful to the many nurses who are so concerned about the situation in which they find themselves. If this work contributes towards stimulating debate and thought and constructive criticism among nurses

ar all levels, then I will be satisfied about the empirical relevance of the study.

On the issue of sociological relevance, I can only hope that the insights gained during the course of this study will prove of interest. Nursing in general and South African nursing in particular has been a relatively neglected area of sociological inquiry. It is hoped that this small contribution will be of some value. There are, of course, very definite and specific limitations which must be borne in mind when viewing this work as a sociological analysis of nursing in South Africa. Let us examine these limitations before discussing the development of hypotheses.

LIMITATIONS OF THE STUDY

As I see it, the limitations of the study can be traced to three major levels: theoretical, methodological and practical. Let us examine each in turn.

Theoretical limitations

For the particular purposes of this study, it was necessary for me to adopt a positivistic theoretical approach, despite my personal preferences for a phenomenological approach in sociology. Given the clear need for some very basic descriptive data of a quantitative nature in order to achieve the stated objectives of the study, I was forced to view the nursing "crisis" as some objective reality "out there" which I could study in abstraction and gain absolute knowledge about. This adoption of positivist premises was a purely pragmatic decision: I see the need for basic quantitative data at the outset. Thereafter, once the problem has been clearly defined and described quantitatively, I believe it will be necessary to adopt a phenomenological approach and to study the same problem from that totally different standpoint.

Given this particular theoretical approach, and the methods which logically were used, the data presented here are

necessarily "hard" and impersonal. It is for future researchers to complement this work with the essential "rich",(1) qualitative data which a different theoretical approach would allow.

4.2 Methodological limitations

There are two basic factors operating to cause methodological limitations in any study, and I have mentioned both of them briefly already. The first is that a researcher's theoretical approach tends to dictate which research methods he should use. It is quite clear, for example, that a positivist interested in a macro-scale study would have little use for methods like participant observation, depth interviews or case histories. A phenomenologist, on the other hand, trying to gain an understanding of his subjects' motives and meanings, would not need to use self-administered questionnaires or record reviews. Thus we see that the major methods used in *this study* were largely determined by the initial theoretical approach I adopted.

The *second point is that methods* themselves tend to "act as filters" (Smith, 1975: 275), allowing only certain aspects of *the total reality* to enter the arena for consideration. In a study using record reviews, for example, data which is not recorded on the records virtually "do not exist" for the researcher. Or issues not included in an interview schedule are effectively screened out of existence for the interviewer and the respondent.

I have been acutely aware of both these issues in the present research, and have tried to overcome them in the manner suggested by both Denzin (1970: 297) and Smith (1975: 272-274):

(1. The term "rich data" is generally used to refer to data expressing a subject's personal point of view, his perceptions, his beliefs, *his feelings*. In other words, it is data from his consciousness, not mediated or moulded by a researcher's questions, interviewing techniques or coding. See Denzin (1970: 220) and Williamson, Karp and Dalphin (1977: 218-219).

methodological *triangulation*. As Denzin (1970: 300) explains: "Triangulation, or the use of multiple methods, is a plan of action that will raise sociologists above the paternalistic biases that stem from single methodologies." Triangulation of research methods will be discussed in detail in the following chapter.

4.3 Practical limitations

The major practical decision which I had to make was which hospital to focus on for the manpower study. The choice of City Hospital has imposed particular limitations on the study. First, given the South African situation where medical care is strictly divided along racial lines, the focus on City Hospital has caused a major bias in favour of white nurses working in a "white hospital". Second, the fact that City Hospital is situated in Johannesburg, the commercial centre of the country - where job opportunities in other spheres abound during economic upswings - may have tended to exaggerate the view of manpower problems which I developed. In addition, City Hospital is a provincial, as opposed to a private institution.

This second shortcoming has been adequately dealt with by including a questionnaire survey of other provincial hospitals around the country. The racial bias, however, needs to be clearly recognized and kept in mind. In fact I see this as the major limitation of the study. The few "black hospitals" included in the survey sample in no way compensate for the effects of this shortcoming.

5. DEVELOPMENT OF HYPOTHESES

The whole of Chapter 3 deals in detail with the generation and testing of hypotheses, so I shall not discuss this in any detail here. I only mention this step in this introductory chapter because the nature of the hypotheses does, of course, influence the choice of study design and of research methods. For the purposes of this research report however, I have chosen to discuss

the study design and choice of methods in general terms in the next chapter, and thereafter in Chapter 3 to outline each hypothesis and discuss how it was tested in detail.

6. STUDY DESIGN

As I have mentioned, it was the lack of basic quantitative data about the so-called "nursing crisis" which prompted this research and which dictated the basic theoretical approach. A descriptive study[1] was therefore designed to answer such questions as:

- what is the extent of the nursing staff shortages at City Hospital?
- in which categories are the shortages most severe?
- are there any patterns which can be distinguished to begin explaining some of the problems?

As I began collecting data, the superficiality of the initial assumption that manpower problems constituted the "crisis" became clear, and an exploratory phase[2] was included to generate and begin testing new hypotheses. It is hoped that some of the ideas explored here will be studied in more depth in future.

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(1) A descriptive study is one designed to answer the questions about size, characteristics and/or distribution of a particular research problem. See Selltiz, Jahoda, Deutsch and Cook (1965: 65-78) and Forcese and Richer (1973: 79-88).

(2) Selltiz, Jahoda, Deutsch and Cook (1965: 51-65) use the term "exploratory study" to refer to studies which serve to develop new hypotheses and generate further research. See also Forcese and Richer (1973: 79).

CHAPTER 2: RESEARCH DESIGN AND METHODS

1. INTRODUCTION

1.1 *Steps in a descriptive study*

I have stated that the research design for this study was basically descriptive with some exploratory phases as well. The basic steps in a descriptive study are depicted in Fig. 1 below, and the related methodological issues pertinent at each stage are also indicated.

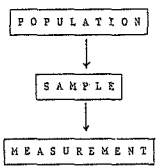

Figure 1: Steps in a descriptive study and related methodological issues[1]

I propose to use this framework to present the basic methodological information of this study. As we have seen, the technique of triangulation or use of multiple methods has been used, and so what I really have is three separate descriptive

(1) With thanks to L M Irwig of the Institute for Biostatistics (Transvaal Branch) of the South African Medical Research Council.

studies, each using different research methods and data sources. We shall examine each of these in turn. Before doing that, however, let us look briefly at the research process itself.

1.2 The Research Process

The research process can be divided into three phases, the first and most crucial of which is the data production phase. Most researchers use the terms "data collection" or "data gathering" to refer to this phase, but this seems to imply that facts or data are ready-made and simply need to be "picked up" by some passing observer. Data are not external "things" that can be collected or ignored at our will: they are specially produced or manufactured by us in the process of doing research. They are particular constructions of or abstractions from reality - partial and abstracted representations of a totality too complex to capture entirely.

I found that I constantly had to remind myself of the very limited nature of my data; to bear in mind that the view I was forming of the nursing situation was not only influenced by and dependant on the research methods I was using, but was in fact determined by those methods. For this reason, I prefer to think in terms of "data production", rather than data collection as the initial phase of the research process.

Once sufficient data have been produced to answer specific research questions, those data have to be ordered or processed or analysed. In other words, the second stage of research consists of "making sense" out of all the figures, observations and comments which were generated or produced in the first stage.

The third and final stage of the research process then takes place, bearing the two previous stages in mind. Data interpretation consists of determining how the data (which were specially produced and purposefully processed) actually relate back to the reality under study.

2. THE RECORD REVIEW STUDY

2.1 Definition of population

The population for this part of the study was all present and recent-past student and pupil nurses at City Hospital[1]. The "recent-past" category had to be included in order to ensure that trainees who had either graduated or resigned recently could also be studied. Data production for this study took place in the second half of 1980, and the "recent-past" period extended back for a maximum of eighteen months.

2.2 Generalizability to other populations

When practical limitations of the study were discussed in the previous chapter, I pointed out the problems caused by basing the record review at City Hospital. All those limitations basically affect *generalizability*. Therefore I would caution that the results are in no way generalizable to "black hospitals", and that they are probably also not generalizable to hospitals in small towns where the economic opportunities differ markedly from those in Johannesburg. Finally, generalizations could only be made to other provincial institutions where salary scales and conditions of service are similar to each other but different from those in private institutions.

2.3 Sample selection

This sample is a non-probability sample[2], of the accidental sample sub-type. In other words, I simply included the cases that were conveniently at hand until the sample was deemed adequate. As Selkiz et al point out, with accidental samples

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(1) Qualified nurses (i.e. registered and enrolled nurses and enrolled nursing assistants) were specifically excluded from this part of the study because of the problem of incomplete personnel records. For example, educational background data are often not available for these staff.

(2) In non-probability sampling we have no way of estimating the probability that each element has of being included, and no way of ensuring that each has some chance of being included. See Selltiz et al (1965: 514-515).

there is no way of evaluating the biases introduced in such samples. (Selltiz et al, 1965: 516). However, I was interested in studying the current situation and so deliberately chose to limit the sample to students and pupils affected at the time.

For this reason the accidental sample included all current student and pupil nurses, a group of students who had graduated from the diploma course in general nursing within the previous six months, and a group of students who had resigned before graduating and who had been appointed as students within the previous eighteen months.

2.4 Sample size

In the case of current student nurses registered for the diploma courses, the total number varied from month to month, with a range from 489 in July 1980 to 482 in September the same year.

The sub-sample of current pupil nurses was much smaller with a total of 38 in September 1980, and current degree students numbered 47 in September 1980.

The sub-sample of recent graduates included 88 people, and of resignations, 160.

2.5 Response rate

I am using this epidemiological term to refer here to the number of individual elements on whom I got complete information divided by the total number of elements in the sample, expressed as a percentage. Ideally, the response rate should be 80% or greater.

Because of the problem I encountered with incomplete files (several had one essential item blank, or one form missing), the response rates vary slightly depending on which particular aspect was being studied. I shall mention the precise figures when the results are discussed, but in general it can be

stated that the response rates for the three groups of current students and pupils and degree students were well above 90 per cent.

A somewhat lower response rate was obtained for recent graduates (74 per cent), probably because their files were busy being re-organized depending on whether the graduate was leaving the hospital, continuing to work there, or beginning a post-basic course there and so on.

A more encouraging response rate of 87 per cent was obtained for the students who had resigned in the previous eighteen months.

2.6 Data sources

The source of the data I produced for this part of the study was the personnel files kept by the authorities at City Hospital. In other words *I relied entirely on* "available data" (Selltiz et al, 1965: 315-330) or "secondary data" which can be defined as "pre-existing or prerecorded data which were not collected for the specific ends of a given social researcher" (Forcese and Richer, 1973: 179).

Before examining the advantages and disadvantages of using secondary data as source material, let us first answer the question: What is the nature and purpose of these personnel files? And how could they be of use to me as a researcher?(1)

In common-sense terms, the files are collections of very basic information about members of the organization (i.e. hospital)

(1) This is important for, as Selltiz et al (1965: 318) state: "By definition, the purpose for which available records have been *collected is different* from the purpose for which the social scientist wishes to use them."

concerning:

a) biographical details (age, sex, marital status, educational record, etc.)

b) salary advice

c) records of annual and sick leave

d) records of practical work performed (i.e." nursing service" or "training")

e) records of theoretical work done (i.e. "nursing education")

This information is kept by the hospital authorities for two reasons: first, because the administrators are employers of staff (hence a, b, c, and d "service"); and second, because they are officially responsible for the training of students who hope to qualify for admission to a professional register at the end of their courses (hence d "training" and e).

For the purposes of this research, the personnel files have often been viewed as mere compilations of information, and a method of simple factor analysis has been used in the data production stage. But the files could also be viewed as indicators or symbols of the self-image of nursing, and a method of content analysis could be used to analyse the files as professional and/or bureaucratic symbols.

The advantages of using the personnel files as source material can be listed:

- the files contained data about several assumed problems
- they were easily available
- they were systematically organized
- trends over time and between groups could be studied
- they could be used repeatedly without "influencing" them[1]

(1) Human research subjects, on the other hand, are very easily influenced. See Phillips (1971: 28-37) and Andreski (1972: 34-40), for example.

- the data had been compiled independently of my hypotheses
- the data were very reliable so results would be easy to replicate.

The disadvantages, on the other hand, included:

- the researcher has no control whatsoever over the type of information recorded[1] (Forcese & Richer, 1973: 182)
- the files, being important bureaucratic tools at the time the research was being done, were sometimes not available
- occasional clerical or typing errors were detected, although these were rare and could usually be corrected using other confirmatory evidence in the files (for example, testimonials, copies of certificates, correspondence, etc.)

2.7 Research methods

The basic research method used in this part of the study was record review, and as I have mentioned two different techniques of analysing the records were used: factor analysis and content analysis. Both these techniques represent good unobtrusive measures (Denzin, 1970: 260-292), or measures which specifically exclude the observer from the events under study in the knowledge that his presence as an observer is foreign and in some sense reactive.

(1) As Webb et al (1966: 111) state: "We should recognise that using archival records frequently means substituting someone else's selective filter for your own." They nevertheless maintain: "In any event, the Chinese proverb still holds: The palest ink is clearer than the best memory." Selltiz et al (1965: 318) also comment: "The guiding principle, then, for the use of available statistics consists in keeping oneself flexible with respect to the form in which research questions are asked. If a research idea or hypothesis can be formulated in such a manner that the available recorded material bears on the question, the use of such material becomes possible."

Factor analysis is the simplest method of quantifying secondary data, and consists of coding and counting items of interest. For example, I was interested in comparing the matriculation results of students who had successfully completed their courses with those of students who resigned before completion. Once I had the files of the relevant groups available, all I had to do was to look for the item or factor "matriculation results", and mark off each person's results in the appropriate place on the tally sheet (see Fig. 2 below).

Matriculation aggregate mark	Successfully completed	Resigned before completion
A	|	
B	卌 |	|
C	卌 卌 卌 ||	卌 ||
D	卌 卌 卌 卌 卌 |||	卌 卌 卌 |||
E	卌 卌 卌 卌 卌	卌 卌 卌 卌
F	卌 卌 |	卌 卌 卌 卌 ||
Not recorded	||	|

Figure 2: Example of tally sheet for factor analysis

Content analysis is also a method of quantifying secondary data, but in this case one is interested not in the factors or items filled in on the records, but rather in analysing the actual content of the record. (Forcese and Richer, 1973: 185). Content analysis is often done with a view to isolating and quantifying an attitude or a priority. For example, researchers may do content analysis of newspaper editorials over time in order to isolate changing political views; or they may count the number of times key words are used in speeches by politicians and so on. In my case, I was interested in studying the amount of space allocated to different aspects (e.g. educational data) on the nursing forms, and in comparing the content of official forms over time.

As Forcese and Richer (1973: 186) point out, there are three major steps in content analysis. First, one has to define the phenomena of interest. For example, I had to be clear that I was trying to measure "the process of professionalization", and I had to be sure that the concept was conceptually clear. Second, the units of investigation have to be clearly defined. Thus I had to clarify that I would study the official Kardex charts between the years 1941 and 1980. Third, operational indicators have to be specified. So I had to clarify that I would measure the number of square centimetres allocated to school and nursing educational information on the official Kardex charts.

2.8 Repeatability of measurements

Repeatability or reliability refers to the extent to which two different observers would get the same results, or one observer doing the measurements at two different times. A measurement is said to be repeatable if it fulfils the above criteria.

I believe that the measurements used in this part of the study are very repeatable, because the criteria for measurement were clearly spelled out in advance. As Forcese and Richer (1973: 186-187) point out: "... precisely designated indicators are the key to content analysis reliability... Less precision is attained the more the analysis depends upon judgement as opposed to recognition of units as indicators." (their emphases). And the same points can be made about the indicators for factor analysis.

Given that the source material is recorded and systematically filed, and given the clearly defined indicators used in this study, I believe the results can be viewed as extremely reliable.

2.9 Validity of measurements

Validity refers to the extent to which a measurement actually measures what it is intended to measure (i.e. "truth"). On this point I believe it is necessary to separate out the

measurements obtained by factor analysis and those obtained by content analysis.

I believe the factor analyses are very valid measurements of the real situation. In other words, I believe that if the personnel file stated that a particular individual had got a C aggregate mark, that is an accurate reflection of the mark actually obtained. I say this firstly because there is no reason for the hospital administrators to record false data; secondly because very strict control over the personnel files has to be exercised if the students are to be registered with the South African Nursing Council; and thirdly because there was so much confirmatory data in the files themselves (for example, a copy of the matriculation certificate which validated the factor recorded on the Kardex sheet). My only reservation in this regard is the possibility that occasional clerical or typing errors occurred which I did not discover. The incidence of errors for data that I could date, however, was very low, so I do not view this as a serious problem.

The validity of measurements obtained by content analysis, however, is subject to considerable debate. This is because there are no objective measures of "professionalization" or "bureaucracy": all the phenomena of interest have to be operationalized, and to do so one requires a certain amount of interpretation. Thus, regardless of how clearly the indicators are defined and the units of investigation are clarified, there remains an element of subjectivity which affects validity if not reliability. This is something the reader must bear in mind when the results are presented.

2.10 Processing and interpretation of data

Analysing or processing of data produced from the files was relatively simple because the data were numerical rather than verbal. Data were tabulated, and percentages, means and medians were calculated, and various statistical tests were applied when appropriate. The descriptive measure applied most commonly was the phi-coefficient, used to establish whether there

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were associations or correlations between variables. Variability or dispersion was measured by calculating percentages, *standard deviations*, and occasionally, coefficients of variation. In order to test whether correlations between variables were in fact significant or not, the chi-square *test and the t-test* were used.

After the phase of data processing, the final stage of data interpretation took place. This will be discussed in detail when the data are presented.

3. THE EXPERIENCE SURVEY(1)

3.1 Definition of population

The population for this section of the research was a very vaguely defined category: "nurse leaders", which was taken to include nursing educators and administrators working both in hospitals and at the Nursing Council and Nursing Association headquarters in Pretoria.

3.2 *Generalizability to other populations*

I believe that similar populations of "nurse leaders" in other parts of the country would have yielded similar results, although the definite limitations of the sample used here must be borne in mind.

3.3 Sample selection

Again I made use of non-probability sampling, but in this case *I used a purposive sample*. Selltiz et al (1965: 520-521) explain: "The basic assumption behind purposive sampling is that with good judgement and an appropriate strategy one can hand-pick the cases to be included in the sample and thus

(1) Selltiz, Jahoda, Deutsch and Cook (1965: 55-59) use the term "experience survey" to describe research designed to gather and synthesize the great experience of people working in positions of authority. As they point out, so much experience is never written down, and we should use interviewing in order to gain access to it. A specific feature of the sample used is that it is specialiy selected, as opposed to a randomly selected one: people are chosen if we think they are likely to contribute valuable insights.

develop samples that are satisfactory in relation to one's needs."

This very selective method of choosing respondents is justifiable for an experience survey, whose specific aim is to tap the experience of particular individuals who have been working in positions of importance and who are likely to be able to make interesting contributions.

3.4 Sample size

As Selltiz et al (1965: 56) point out: "Apart from interviewing enough people to ensure adequate representation of different types of experience, there is no simple rule for determining the number of informants who should be included in an experience survey. At a certain point, the investigator will find that additional interviews do not provide new insights, that the answers fall into a pattern with which he is already familiar. At this point, further interviewing becomes less and less rewarding."

I approached a total of 16 people, and their positions were as follows:

- 2 worked at Provincial Administration headquarters in Pretoria,
- 4 were matrons or administrative personnel at City Hospital,
- 5 were nurse educators or people working at the South African Nursing Association headquarters in Pretoria, and
- 5 were members of the South African Nursing Council or professors of nursing or university lecturers of nursing(1).

3.5 Response rate

I approached 16 people and did not get any refusals, so the response rate for this section was 100 per cent.

(1) The reason for this categorization will become clear when the data are presented: I have grouped people who expressed similar views on key issues together.

3.6 *Data sources*

In this case the data sources were people who agreed to be interviewed. The use of human *subjects immediately* raises all the issues of "reactive" responses (Denzin, 1970: 260-292; Phillips, 1971: 28-37), but the *major assumption* in doing the experience survey was that I would be able to gain access to *personal opinions* on controversial issues in nursing. It was the need for qualitative data which prompted this part of the research, although the complete absence of "working nurses" from the sample must be noted. As I have previously emphasized, the present work needs following up with a study of the experiences of the nurses who find themselves caught up in the "crisis situation".

3.7 Research methods

The research technique used in the experience survey was unstructured (or informal) but focussed interviewing. I did not have an interview schedule, but before each interview I drew up a rough guide of "topics to cover" with the particular respondent. Recording of responses was done by jotting down points with certain key phrases (for example, "We just need more hands" and "We'll do anything to get a pair of hands") written down word for word in quotation marks. After the interview, and always on the same day, I wrote up a "transcript" of the interview in neat.

The advantages of doing the experience survey can be listed:

- it was a *fairly quick and easy way of getting* information;
- *it was possible* to establish good rapport in the face-to-face situation, and to get information on *sensitive* issues;
- it was possible to approach relatively "inaccessible" people[1]

(1) As Williamson et al (1977: 187) point out: "It is possible to reach certain groups who are inaccessible to participant observation or survey (by interviewing them)."

- respondents could express themselves freely and I could probe when necessary in order to get more complete information.
- before, during and after interviews I was able to observe surroundings, witness interruptions and hear casual remarks which gave away certain "backstage" or unofficial information[1].
- I was constantly on my guard about the dangers of communicating my hypotheses[2] or my expectations of respondents[3].

The major problems and limitations of the data produced in the interview situation hinge on three points:

- The group interviewed was small and no attempt was made to select members randomly: the opinions of these people can therefore only be viewed as limited indicators of certain individual's views. They are in no way representative. Nevertheless, the insights gained from the experience survey were invaluable.
- All interview situations involve social interaction, and this implies impression management at best, outright deceit at worst.
- Unfortunately I have no way of distinguishing which comments or replies were offered freely and which were direct responses to questions or probes. If I had thought about this problem beforehand, I would definitely have used a tape recorder in the interviews.

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(1) Berreman (1973: 284), using Goffmanesque terms states: "Certain regions are 'backstage', not for viewing by the audience." He then goes on to stress that a social scientist judges success by the amount of backstage information he gathers, while subjects judge it by the amount they can withhold.

(2) Phillips (1971: 34-36) refers to "expectancy effects" in interviewing when the interviewer inadvertently communicates his feelings or beliefs and the respondent merely echoes these in his responses.

(3) Moser (1958: 252-3) isolates several different "interview expectations" which could result in bias, including role-expectations and probability expectations.

3.8 Repeatability of measurements

Because of the problems of obtrusive, reactive measures like interviews, it is impossible to guarantee measurement repeatability. So many factors, like the respondents personal reaction to me as a researcher, his or her subjective feelings about the nursing situation at that particular time, and the amount of stress he or she was experiencing, could have influenced their responses. This uncertainty about measurement repeatability, however, is not to devalue the information gained. As we have seen, the experience survey was specifically designed to gain insight into people's perceptions of a sensitive subject at a particular moment, and in any such qualitative research one has to sacrifice a certain amount of methodological rigour.

3.9 Validity of measurements

Once again, the problems of qualitative work enter here, and it is impossible to state that the measurements were definitely valid (i.e. that the responses I got corresponded with the "true" attitudes, beliefs or perceptions of the respondent). I have mentioned the precautions I took not to influence respondents and the problems of which I was aware during data production, and two points make me feel reasonably confident that respondents were expressing their own opinions[1].

First, when all the transcripts were examined for internal consistency, I found no cases of contradictions or discrepancies. Bearing in mind that many of the interviews took two hours or more, I believe that this can be viewed as a very reassuring observation. Second, the fact that respondents expressed strong views so discrepant from those of other respondents makes me

(1) Several authors have commented on respondents' desires for social approval and desirability in interview situations: a concern with imparting the "truth" is often secondary. See Phillips (1971: 32-33), Moser (1958: 247) and Hyman (1954: 48).

feel that I could not have been influencing them unduly in the interview situation. For these reasons, then, I believe that the experience survey data can be studied with reasonable confidence about their validity.

3.10 Processing and interpretation of data

The major problems in research which uses unstructured interviews or even structured ones with many open-ended questions arise during data processing[1]. The issue I was most concerned with was that I should not impose my own views or biases onto the data while I was coding and categorizing them. For this reason, I decided that the safest way to order them was to read the entire transcript through, and then to focus on several areas I considered important and any others which the respondent seemed to emphasize. I coded responses in the context in which they were made, in this way trying to avoid imposition of my conceptions onto the responses.

As I have mentioned, if I were to do this research again now, I would definitely have tape recorded the interviews, and could then have got independent assistants[2] to listen to the recordings and to code the data. When I present the results in subsequent chapters, I will refrain from paraphrasing responses, and will present the responses as full quotations wherever possible so that the reader can judge for him- or herself to some extent.

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(1) The very purpose of using these techniques is to allow research subjects to respond spontaneously instead of forcing them to respond in a "Yes/No" or "True/False", situation only to the options which the researcher saw fit to include. The challenge during data processing, then, is to preserve as much of that spontaneity as possible.

(2) This seems to me to be a very worthwhile method of analysing qualitative data. The independent assessors would not know the research hypotheses or the identity of the respondents, and would be able to analyse the responses and the nature of the questions and probes used by the interviewer without any preconceptions.

4. THE POSTAL SURVEY

4.1 Definition of population

The population for this section of the study was all provincial hospitals in South Africa in operation in 1980. All private and state-aided institutions were specifically excluded from consideration because of the different salary scales and conditions of service which may apply there and which may affect the nursing situation.

4.2 Generalizability to other populations

For the reasons mentioned above, I do not believe that results can be generalized to other, non-provincial hospitals, and because of the unique political factors which bear on South African hospital policies, I doubt that results would apply in other countries.

4.3 Sample selection

In this case I used a probability sample (one which allows one to specify the chances that the sample findings do not differ by more than a certain amount from the true population values: Selltiz et al, 1965: 521) of the stratified random sample type. This meant that I first divided the population into strata, then drew a simple random sample from each stratum, before finally joining these sub-samples to form the total stratified sample.

I used two strata: number of beds or size of hospital, where I classified institutions with 200 or fewer beds as "small", those with 201-500 as "medium" and 501 or more as "large"; and race of patients catered for, where hospitals admitting only white patients were called "white", only black patients were called "black" and those admitting both groups called "mixed"[1]. The former sampling criterion was used in order to ensure that large metropolitan institutions like City Hospital would not be over-represented, as some observers insist that the manpower shortage only occurs in urban areas where there are plenty of

(1) I used the 1980 Hospital and Nursing Yearbook of Southern Africa in order to get a complete list of all the relevant institutions.

other job opportunities available. The second sampling criterion (race of patients) was used on the assumption that I could guage the race of the majority of the nursing staff who are employed there, as some observers have claimed that the manpower crisis is specific to "white" hospitals.

The breakdown of hospitals in the universe according to each of these sampling criteria was as follows:

a)	Size:	Small	133	b) Population served:	White only 41
		Medium	41		Black only 25
		Large	32		"Mixed" 140
		TOTAL	206		TOTAL 206

Combining these two indices, there were nine possible groupings ranging from "small, white" to "large, black". Each hospital in a particular grouping was assigned a number, and scraps of paper with the corresponding numbers were then drawn from a hat until the pre-determined sample size had been achieved.

In retrospect, one other criterion for which I should have stratified is the province in which the hospital is situated, as some people claim that the nursing shortages are unique to the Transvaal. As it happened, the Transvaal was in fact slightly under-represented in the sample, as was the Cape Province as Table 1 shows.

TABLE 1. Representation of the various provinces in the postal survey sample.

	Total	No. in "ideal" 20% sample	No. in actual sample
Cape provincial hospitals	88	18	16
Natal provincial hospitals	22	4	6
OFS provincial hospitals	27	5	8
Transvaal provincial hospitals	69	14	11
TOTAL PROVINCIAL HOSPITALS	206	41	41

4.4 Sample size

The rule-of-thumb estimate for a sample size which would be likely to be representative of the population is usually fixed at ten per cent (Forcese and Richer, 1973: 125), and in general, the bigger the sample, the more representative it will be. Because the population in this case was relatively small (only 206 institutions), I was able to decide on a twenty per cent sample as a manageable one. As we have seen in Table 1, the total sample therefore consisted of forty-one hospitals stratified for the two sampling criteria already discussed.

4.5 Response rates

The overall response rate I was able to achieve after posting the questionnaire plus one reminder was 76 per cent. As I have mentioned, most researchers advise that an 80 per cent response rate should be aimed for (Forcese and Richer, 1973: 130), and in retrospect I feel sure that a second reminder would have pushed my response rate above 80 per cent. It is unfortunate that time pressures did not allow me to send a second reminder letter to non-responders.

Information about non-responders is limited, but tends to suggest that they had practical, rather than ideological reasons for not replying, and so the problem of systematic bias can probably be excluded.

Unfortunately, I made the mistake of addressing questionnaires to individual matrons rather than the impersonal "Matron in Charge". In two cases I am aware of (because the ladies concerned wrote to me explaining the situation), the matron was away from the hospital (in one case on study leave, and in another she had retired), and the questionnaire was eventually forwarded to the new address. Another letter I received from the Orange Free State apologised that co-operation would be impossible because "you will appreciate that with the present day acute shortage of nursing staff it is just not possible to set aside a single nurse to compile information and complete

schedules." That statement said almost as much as a completed questionnaire could have said! These three cases (7 per cent of the sample) were the only ones I received specific information about. Telephone conversations with various matrons before the questionnaires were posted revealed that it was matrons of small hospitals who felt particularly pressurized by the thought of extra work, because they had no assistants who could look up statistics for them. I believe that this probably accounts for the relatively low response rate from the small hospitals that I received.

Tables 2-4 show the number of hospitals in the sample and the response rates for each of the stratification criteria.

TABLE 2: Representation of various sizes of hospitals in the postal survey sample.

	Total	Sample	Replies received
Small	133	27	19 (75%)
Medium	41	8	7 (88%)
Large	32	6	5 (83%)
TOTAL	206	41	31 (76%)

TABLE 3: Representation of hospitals catering for different racial groups in the postal survey sample

	Total	Sample	Replies received
Black	25	5	4 (80%)
White	41	8	6 (75%)
"Mixed"	140	28	21 (75%)
TOTAL	206	41	31 (76%)

TABLE 4. Representation of hospitals by size and racial group in the postal survey sample

	Total	Sample	Replies received
Small black	9	2	1 (50%)
Small white	27	5	4 (80%)
Small mixed	98	20	14 (70%)
Medium black	4	1	1 (100%)
Medium white	9	2	1 (50%)
Medium mixed	27	5	5 (100%)
Large black	12	2	2 (100%)
Large white	5	1	1 (100%)
Large mixed	15	3	2 (67%)
TOTAL	206	41	31 (76%)

4.6 Data sources

In this case the data sources were again human subjects who agreed to complete a mailed questionnaire. (See Appendix 2 Because there was no face-to-face interaction between myself and respondents, some of the disadvantages of the interview method were overcome, but at the same time, new problems associated with the research method could have arisen. These will be discussed in the next subsection.

4.7 Research methods

The research technique used in the postal survey was a self-administered questionnaire including both open- and closed-ended questions and eliciting both qualitative and quantitative data.

The matrons of the hospitals were sent an initial introductory letter (see Appendix 1) in which I explained the purpose of the research and how they could help me. In order not to overburden them, I suggested that "a member of their staff" could complete the first part of the questionnaire and said that I would telephone them to get the name of the person concerned.

In fact, this proved unnecessary because most of the matrons completed the whole questionnaire themselves, and the telephoning proved to be an expensive, time-consuming and largely unsuccessful method of communication. Nevertheless, I believe that the response rate might have benefitted considerably from these initial contacts.

About ten days after the telephone calls, the questionnaire with a covering letter and stamped, addressed envelope, was posted. (See Appendix 2). After six weeks I had received 20 replies (49 per cent response rate). A reminder (see Appendix 3) with another questionnaire was sent to the remaining 21 matrons, and after a further six weeks, another 11 replies were received. That gave a total of 31 replies from a sample of 41 hospitals, or a 76 per cent response rate.

The data produced by the questionnaires can be divided into two sections. The first concerns data elicited in Section 1 of the questionnaire and deals with statistical data about student nurse recruitment in training hospitals and the percentage of posts filled in the various nursing categories over the last two years. These are fairly straight-forward quantitative data. The second group of data was elicited from Section 2 which required the respondents (who were, in all but two cases, matrons of some description[1]) to rank items, offer suggestions and express opinions - all highly subjective exercises. I would therefore stress that the data from the two appendices should be viewed differently, although there were problems with both. The major problems may be listed:

1. The statistical data requested in Section 1 could have been provided without much care, given the anonymous and impersonal questionnaire situation and the possible shortage

(1) The titles given by respondents varied from "principal matron" to "senior matron" to "chief matron". In the other two cases, the rank given was "registered nurse".

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(1) The titles given by respondents varied from "principal matron" to "senior matron" to "chief matron". In the other two cases, the rank given was "registered nurse".

of administration staff. I was, however, impressed by the obvious trouble many respondents took to complete the tables - for example, by giving separate figures for male and female nurses, or for black and white staff, or by providing footnotes which they thought might be of interest, and so on. My general impression was that respondents had gone out of their way to provide me with full information, and I would, therefore, place reasonable confidence in the results.

2. While studying the responses to questions in Section 2 of the questionnaire, I often wondered whether respondents were expressing their true beliefs, or whether they were merely trying to provide me with "socially acceptable" replies. Of course, this is always a problem in attitudinal studies, and I have no way of estimating the extent of the problem here. I do know that the matrons at City Hospital often expressed very individual and controversial opinions - ones which many nurses might have considered "unacceptable" - compared with the rather routinized clichés that some questionnaire respondents offered. The differences might be explained by the fact that the staff at City Hospital perceived themselves to be "in crisis" during the period they were interviewed, and that their opinions reflected the extreme pressure under which they were working at the time. On the other hand, the differences might be artifacts of the research technique: questionnaire respondents had not had the opportunity of "weighing up" my motives; there was no trust, no rapport established, so they might have just completed the questionnaire in an off-hand manner.

3. In 94 per cent of cases, matrons completed Section 2 of the questionnaire, and it is their personal, individual opinions which are expressed. These data must therefore be viewed as the isolated opinions of a number of individuals in senior administrative posts who happen to work at the

hospitals drawn for the sample. Had I asked senior sisters or other categories of staff to complete Section 2, the results would probably bear little resemblance to the ones received.

4. The final problem with the data collected was that several respondents had difficulty with the instructions for Q2 and Q6 of Section 2, which required people to rank items. Wherever there was evidence of confusion (e.g. some people just ticked items instead of using numerals, or "ranked" several items with one numeral, etc.) I omitted that questionnaire from the analysis and stated what total number was included.

Despite these limitations with the data, I see them as a very useful addition to the total study. It was a relatively quick and economical method of collecting comparative data from a fairly large number of randomly selected provincial hospitals around the country. I have therefore been able to examine the extent of the "nursing crisis" in manpower terms in more depth, and have been able to gain some insight into the perceptions of nursing held by administrators in other hospitals.

4.8 Repeatability of measurements

I believe that the quantitative data elicited in the first part of the questionnaire would stand up well to reliability tests. Respondents would have had no particular motivations for deliberately deceiving, and all the data requested were basic statistical data which are usually routinely collected.

The qualitative data, however, are subject to many of the same reservations already discussed with regard to the experience survey. For example, people would have been responding subjectively depending on whether they were feeling particularly pressured at the time and so on. I can therefore give no guarantees about the repeatability of those data.

4.9 Validity of measurements

Again, one has to separate the qualitative and quantitative parts of the questionnaire when considering validity. I believe that the quantitative data probably provided fairly valid measures of the actual staff situations; in other words, if a matron reported that only 68 per cent of posts were filled, then only about that number were in reality filled. I say this because the collection of routine data is systematically done by administrators in all hospitals, and the task tends to be done with considerable care[1].

The qualitative data, on the other hand, should be viewed with some suspicion concerning validity for the reasons spelled out in section 4.7.

4.10 Processing and interpretation of data

The data produced in Section 1 of the questionnaire were fairly easy to process, because they were quantitative and there was no ambiguity concerning categories or terms. Data were therefore tabulated, and percentages were calculated. Trends emerged, and these could be compared with the findings at City Hospital. In some analyses, the three hospitals catering only for black patients were excluded from the calculations, as it became evident on inspection that their staffing situations differed quite markedly from the average white or "mixed" hospitals. Similarly, the data for hospitals of different sizes and in different provinces were analysed separately to determine whether these factors had any bearing on the manpower situation. Where appropriate, tests of significance were done to determine whether correlations between variables were significant or not.

(1) In fact, many nurses - and others, no doubt - take the compiling of routine statistics so seriously that other, more important tasks, often get neglected. This paradox is even sadder when one considers that the vast majority of such "statistics" is never used for planning, policy-making or evaluation at all.

The data produced in Section 2 had to be processed rather differently, for they were of two different kinds. First, there were four questions which required respondents to rank items on the order or degree of importance. In the analysis of these questions, I developed simple scales to take account of the respondents' weightings. For example, in question 2 of Section 2 (see Appendix 2), I gave a score of three to a respondent's first choice, two to her second, and one to her third choice. The total scores given to each category by all respondents were summed to arrive at an overall score. It was then useful to represent these results on a continuum or a bar graph.

There were two open-ended questions in Section 2 of the questionnaire. I found it most useful to read through all the responses initially, just jotting down phrases which struck me as important. I saw several "themes" emerging, and gave these titles (e.g. "professional theme"), and then reread the statements to check that I had picked up all major themes. Responses were then coded according to the themes and the frequency with which major themes recurred could be easily assessed. As always occurs when qualitative data are analysed, much can be lost in coding and categorising, so I shall refer to actual statements made by respondents whenever necessary.

5. *ADDITIONAL INFORMATION*

I occasionally made use of additional sources to complement and test the findings obtained using the major research techniques. These minor data sources were the official statistics, circulars and publications of the South African Nursing Council (SANC) and South African Nursing Association (SANA). These sources were very useful because they provided an overall national picture over considerable periods of time.

The major advantages of using these sources were that it was a quick, easy and cheap way of getting information to supplement my own research findings, but the disadvantages were that figures were sometimes inaccurate or incomplete.

CHAPTER 3: FORMULATION AND TESTING OF RESEARCH HYPOTHESES

1. INTRODUCTION

If "theory and research are the two major constituents of science", as Wallace (1971: 19) states, then the issue must surely be: how do these two constituents relate to one another? It is generally accepted that theory is both the starting point for research, by suggesting hypotheses for investigation (Forcese and Richer, 1973: 47; Wallace, 1971: 18) and the result of cumulative research (Forcese and Richer, 1973: 47; Wallace, 1971: 18).

The two processes involved in this "dialogue" are referred to as deduction ("the derivation of relationships which are unobserved from previously established generalizations"; Forcese and Richer, 1973: 42) and induction (*the process of organising* isolated observations or facts into some set of ordered relationships or generalizations; Forcese and Richer, 1973: 41-42). As Wallace (1971: 19) explains, deduction from theory helps us to know what to observe in the research process, while inductive construction of theory helps us understand what has been observed.

Most authors agree that the deductive process is preferable to induction (Forcese and Richer, 1973: 42; Selltiz et al, 1965: 36-37), but Popper (1959: 27-59) insisted that induction is never justified because propositions constructed inductively are not "falsifiable". In other words, Popper insists that since we cannot observe in a vacuum, *that all empirical work needs to* be guided, then we must begin with a hypothesis deduced from theory and test it. If we do not do that formally, then each observation we make will be interpreted in the light of some implicit theory which we favour, and will be seen as more "evidence" to support that theory (Fletcher, 1974: 23). Forcese and Richer (1973: 49) spell this out: "Ideally, the researcher

will have deduced hypotheses from highly formalised conceptual systems. But whether the deduction has been explicit or not, the researcher invariably will have been influenced by models with which he is familiar."

While this whole debate about the values of induction and deduction is fundamental to positivists, who call for strict "scientific rigour" in all research, I believe that we should not lose sight of the fact that there are bound to be many instances in social scientific research where the theory will be *inadequately* formed for logical deduction to be possible. As Selltiz et al (1965: 52) state: "Theory is often too general or too specific to provide clear guidance for empirical research. In these circumstances, exploratory research is necessary to obtain the experience that will be helpful in formulating relevant hypotheses for more definitive investigation."

In addition to the problem of the relative youth of social scientific theory and its consequent inadequacies as a basis for logical deduction in many instances, we must also consider the difference between causal hypotheses (which clearly aim to establish that a particular characteristic is one of the factors which determine another characteristic or occurrence; Selltiz *et al, 1965: 36) and what may best* be described as "descriptive hypotheses" which merely assert that something has a particular characteristic, or distribution, or frequency. (Selltiz et al, 1965: 35-36). Clearly, causal hypotheses need to be stated before data production begins, and so the process of logical deduction from theory would be an *ideal way of generating causal* hypotheses. "Descriptive hypotheses", on the other hand, could conceivably become apparent after the process of data production had begun - almost as incidental benefits of exploratory research.

I would like to apply what has been discussed in this theoretical introduction to the research project I undertook. This could possibly best be done by *depicting the* relations between theory and research diagrammatically. Figure 3 below is taken from Forcese and Richer (1973: 41).

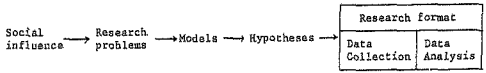

Figure 3. The Social Derivation of a Research Project (Forcese and Richer, 1973: 41)

While this representation may simplify some of the processes involved, I find it *useful because it emphasizes* that the research process is initiated by social influences, and that "models" or *conceptual frameworks* or even theories are ideally used to generate hypotheses.

In the case of my own work, the representation is somewhat more complex. Figure 4 attempts to isolate the essential features, and the discussion which follows should help to clarify the issues.

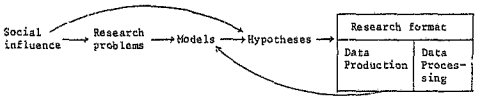

Figure 4. Major steps in the study of South African nursing.

The social influences which affected the present study have been discussed already, and included the media campaigns, my personal background and interest in nursing, and my supervisor's conviction that the "nursing crisis" should be researched. As Figure 4 shows, these influences led both to the selection of the research problem and to the formulation of the first hypothesis: There are manpower problems in nursing. So immediately we see that one of the three major "descriptive" hypotheses was not deduced from sociological theory, but was generated from the strong social influences at the time. A second *hypothesis: There is a lack*

of tight formal organization in nursing education, was deduced from the model of occupation and professions, which will be discussed in subsequent sections of this chapter. Finally, in the process of producing data to test hypotheses 1 and 2, certain other insights occurred and I saw the need to refer back to other aspects of the model already used in order to deduce a further hypothesis: There is no community of nurses. This hypothesis was then tested as well.

From this brief explanation, the reader will see my difficulty with regard to some of the theoretical issues raised at the beginning of this section. First, I have no way of classifying my first hypothesis which was generated directly from social influences, rather than mediated by sociological models. One might say it was "deduced from common-sense" rather than deduced from theory. Second, I have the problem of the third hypothesis which was stimulated during the research process yet which referred back to the model which had already been used for hypothesis generation. I have been unable to find any reference to this type of process in any of the methodological literature. Perhaps this is indicative of the vast gap between the theory of research, which states all possibilities clearly and logically, and the practice of research, which is almost always an unpredictable but exciting process.

One way in which the present research did proceed in an expected manner concerned the operationalising of hypotheses. This meant that the concepts used in the hypotheses needed to be clarified or defined, and then working definitions (Selltiz et al, 1965 : 42-44) needed to be outlined. In other words the abstract or complex concepts contained in the hypotheses had to be translated into observable or measurable events for the purposes of the research. In sections 3-5 of this chapter we shall examine the hypotheses, their component concepts, and the precise methods used to test them. Before doing that, however, I would like to give a brief overview of the sociological model referred to above as the major source of hypothesis generation for this study. Once that has been done, the specific concepts used in the hypotheses can be viewed in the context of a comprehensive model.

2. THE OCCUPATION - PROFESSION MODEL

2.1 Theoretical background

After reading the many different views of authors concerned with the sociology of occupations and professions, several things became clear. First, a lot of people have *invested* a lot of time in trying to isolate the essential differences between an occupation *and a profession*. Second, there is a notable lack of consensus about the issues. And third, there *are two major approaches* to the problem of defining a profession: an historical and an ahistorical approach.

The historical approach concentrates on isolating particular stages through which an occupation must progress before achieving professional status. Wilensky (1964: 137-138) used this approach and isolated the following five essential stages in the process:

1. People begin doing a particular job full-time.
2. A link with a training institution is established.
3. Members form an association.
4. They obtain legal sanction.
5. A code of ethics is developed.

As Denton (1978: 181) points out, a major critique of this historical approach *is* that *several occupations* have in fact passed through all these steps, and yet are not viewed as *professions by society*. "... (S)omething in the essence of the concept (of profession) is missing," he claims.

The second major approach in defining professions can be called ahistorical in that it seeks to isolate distinguishing features or characteristics of professions without regard to the stages they have gone through. This approach has been used ever since Flexner published his work "Is Social Work a Profession?" in 1915. He isolated six important criteria:

1. Professional activity is basically intellectual with great personal responsibility.

2. It is based on great knowledge, not routine.
3. It is practical, rather than academic or theoretical.
4. Its technique could be taught, this being the basis of professional education.
5. It is strongly organised internally.
6. It is motivated by altruism, with members working for some aspect of the good of society. (Becker, 1970: 88).

Since Flexner's analysis there have been many revisions, some emphasising one particular aspect, others focussing on another. Carr-Saunders and Wilson (1933), for example, stressed that a profession was typified by a long and specialised training period; Tyler (1952) focussed on a clear code of ethics and practice based on general principles rather than routine skills. Similar revisions were made by Goode (1957), Geer (1968) and Denton (1978). A new idea was emphasised by Merton (1960: 663) when he insisted that it is the autonomy which society grants to a profession which distinguished it from an occupation. Freidson (1970: 34) agreed, stating that it is the autonomy which allows professionals to claim dominance in a division of labour and to be self-directing in their work which distinguishes them from occupational workers.

The major critique of the ahistorical approach is the lack of consensus about the number and nature of features which supposedly characterize professions. As we have seen, some analysts isolate only one feature, while others mention half a dozen or more.

The influence of each of these different ways of approaching the problem of defining a profession (historical and ahistorical) has resulted in several analysts viewing occupations and professions on a continuum, rather than as absolute categories. Goode (1957) used the term "aspiring profession", and Etzioni (1969) introduced the term "semi-profession" to describe occupations in the grey area between the two poles of the continuum.

Synonymous terms include "marginal professions" (Wilensky, 1964) and "professions in process" (Pavalko, 1971). I found this concept of a striving profession to be most useful in an analysis of nursing, for it allowed one to "place" the occupation's achievements on independent criteria, as we shall see in the next section.

Before moving on, however, I must clarify the base from which I shall be working with regard to the concept "semi-profession". Several of the authors I have already mentioned made reference to entirely intangible features of professions when they perceived gaps in their analyses and explanations. Flexner, for example, ended his very mechanical analysis with the following caution: "What matters most is the professional spirit... The unselfish devotion of those who have chosen to give themselves to making the world a fitter place to live in can fill social work with the professional spirit and thus to some extent lift it above all the distinctions which I have been at such pains to make." (Becker, 1970: 88).

Becker (1970: 90) points out that a lot of the confusion surrounding the definition of a profession arises from the use of the word profession as both a scientific concept (to objectively classify a phenomenon) and a moral concept (to subjectively describe something desirable). He refers to the "symbol" of profession - an ideal image of what an occupation ought to be. Denton (1978: 182) bases his whole analysis of professions on a division of attributes into two groups: those which are most closely associated with the "image of a profession" in the public's mind, and those which are secondary.

The dual use of the word profession results in one of the paradoxes I have always been amused by: people working in the lowliest occupations with no claim to professional status often behave more "professionally" than members of established professions. Thus a distinction must be made between "professional" used as an adjective with distinct moral undertones, and "profession" as a non-judgmental noun.

2.2 The case of nursing as a semi-profession

Pavalko (1971: 16-26) proposes that we should think in terms of a continuum linking occupations and professions. He mentions eight different dimensions or criteria that should be considered, and stresses that a group may have progressed a long way along one dimension, and not at all along another.

The dimensions outlined by Pavalko (1971) are:

1. Theory or intellectual technique: a profession has a recognised "body of knowledge" based on scientific principles; an occupation does not.

2. Relevance to social values: a profession deals with matters of vital human interest such as health, justice and so on; an occupation does not.

3. The training period: a profession has a long, specialised and symbolic training period in which the professional subculture is important; these factors don't apply to occupations.

4. Motivations: the manifest motivations of professionals are service-oriented, while occupations are characterised by self-interest.

5. Autonomy: professions enjoy both collective and individual autonomy; occupations do not.

6. Commitment: professionals feel a long-term commitment to their jobs; occupational workers experience short-term commitment.

7. Sense of community: this is high in professions, where members feel a sense of common interests, values and goals; and low in occupational groups.

8. Code of ethics: this is highly developed in professions; not in occupations.

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I found Pavalko's formulation to be useful in that it emphasises the process of professionalization which occupational groups go through, and it allows for the recognition of groups which are mid-way between the occupational and professional poles of the continuum: the semi-professions.

In Figure 5 I represent the position I believe nursing to have attained on each of the dimensions isolated by Pavalko (1971), and there follows a brief discussion in support of the diagram.

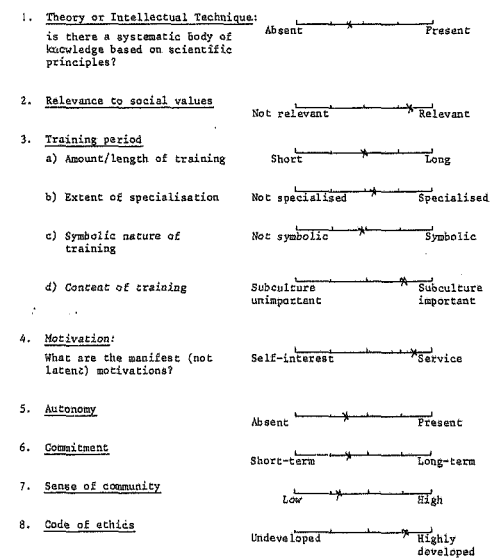

Figure 5. Pavalko's (1971) occupation-profession model with my own idea of nursing's position on each dimension

Discussion of Figure 5

1. Theory

Most of the theoretical content of nursing courses is adapted medical theory: anatomy, physiology, pharmacology, medical physics and chemistry, microbiology, parasitology and so on. As I shall argue when the nursing curriculum is discussed in detail, much of the theory taught to nurses is in fact irrelevant in practice, but adds great prestige to a striving profession.

2. Relevance to social values

Nursing, dealing as it does with health and illness, life and death, has long had high relevance on this dimension.

3. Training period

a) Length. The length of training required to qualify as a "professional" nurse is still only three years - a short time when compared with the five, six or seven years of basic training for lawyers, engineers, architects and doctors.

b) Specialisation. There is moderate specialisation during the basic training course for nursing.

c) Symbolic nature. Too much emphasis is still laid on tasks, routines and procedures in nurse training, and students tend to learn by rote rather than by principles and problem-solving methods.

d) Subcultural content. The nursing subculture is important during socialisation of nurses. Much is learnt by role-acting and imitation of other nurses - in fact, this forms one of the most important parts of nursing education as it is presently organised in South Africa.

4. Motivations

The motives of the vast majority of nurses are clearly service-oriented and caring. Perhaps the most sacred element in nursing ideology remains one's responsibility to the individual patient.

5. Autonomy

This really has two separate aspects, individual and collective autonomy. At the individual level, autonomy is negligable. Nurses function as paramedics (Cockerham, 1978: 145; Freidson, 1970: 136; Katz, 1969: 69; Sloanhan, 1972: 441-442) for the vast majority of their time. They do not have the independence to be self-directing in their work.

At the level of collective autonomy, most nurses cite the existence of the South African Nursing Council as a very important achievement for nurses. (Radliff, 1970: 32; Williamson, 1977). Yet, when a careful study is made of the Nursing Act No. 50 of 1978, we find that the Nursing Council may be anything but a council of nurses. As the Act stands, a *statutory* council could legally consist of:

	17 registered nurses	(57%)
	9 medical doctors	(30%)
	1 pharmacist	(3%)
and	3 "laymen"	(10%)
	30	100%

Furthermore, in section 9 of the Act, we read that only twelve members are needed to constitute a quorum. This means that a Nursing Council meeting could theoretically be held in the absence of a single nurse representative.

Compare this situation with that of the South African Medical and Dental Council. In section 5 of the Medical, Dental, and Supplementary Health Service Professions Act (No. 56 of 1974), we find the composition of the Council is as follows:

16	medical doctors	(64%)
4	dentists	(16%)
1	pharmacist	(4%)
1	nurse	(4%)
and 3	laymen	(12%)
25		100%

Note that nurses may constitute only 4 per cent of the Medical and Dental Council, while doctors may constitute up to 30 per cent of the Nursing Council. Nurses may account for as little as 57 per cent of their Council, while doctors and dentists never account for less than 80 per cent of theirs. And finally, note the requirements for a quorum at a Medical Council meeting: a quorum shall consist of nine members "of whom not less than four shall be medical practitioners, at least one shall be a dentist ..." (Act No. 56 of 1974, Section 9).

On the basis of these figures, I seriously question the notion of collective autonomy in nursing.

6. Commitment

Several authors have noted that nursing is characterised by a lack of commitment (Cockerham, 1978: 155-157; Denton, 1978: 194; Krause, 1971: 122). Of course, one needs to bear in mind the problems in any predominantly female occupation, where members may break service for marriage and childbearing. But it has been found that nurses experience notably shorter-term commitment to nursing than other females do to other occupations.

7. Sense of community

The notion of a community of nurses [illegible] fact form a major concept, and will be discussed [illegible]ely. Suffice it to say here that I see so many [illegible]s within nursing that I cannot view nursing as a cohesive community at all.

8. Code of ethics

As illustrated in Figure 5, I see the code of ethics in nursing as being highly developed.

To summarise my views of nursing as a semi-profession, I see it approaching the professional end of the continuum on several dimensions, but remaining near the occupational end on other dimensions. It will be my thesis that it is precisely the semi-professional status of nursing - the position of marginality and the desire to achieve full professional status - that is at the root of the major problems in nursing.

But this analysis depends on an ahistorical approach to defining professions. What of the historical approach outlined by Wilensky (1964)? As I see it, nursing is a typical example of an occupation which has in fact passed through all the stages which supposedly lead to professionalisation, but is not viewed as a profession by society. (Denton, 1978: 81). So whichever analysis we use, the conclusion remains the same: nursing in South Africa is a semi-profession.

This then, was the theoretical base from which I worked. I found the occupation-profession model to be a very useful guide or "reality filter", and it helped me to focus on particular aspects of importance. As Forcese and Richer (1973: 41) state: "The model will serve to narrow down the research interest into a form amenable to investigation." This was certainly the case in my experience.

3. HYPOTHESIS 1: THERE ARE MANPOWER PROBLEMS IN NURSING

3.1 Generation of the hypothesis

This was the initial hypothesis of the study, and the one which was generated entirely by "social influences" as we saw in Figure 4 of section 1 of this chapter. It just seemed logical to investigate the aspect of nursing which was causing the most debate and publicity at the time.

As we can see from the phrasing of this hypothesis, there was no attempt to determine causes of the manpower problems. Rather the intention was to describe the nature and extent of the manpower problems in South African nursing. I would therefore classify this as a "descriptive" rather than a causal hypothesis.

3.2 The concept of manpower in nursing

Perhaps the first point that should be made about manpower in nursing concerns the distribution of available manpower within the various medical services. The vast majority of nurses in South Africa work in hospitals - hence the hospital-based research I conducted. Unfortunately, detailed breakdowns of the employment of various categories of nursing staff are not available, but the limited data for 1976 show that 50 035 people were employed in hospitals, and 2 9[illegible] in the various community services (including regional o[illegible]e Department of Health, local authority posts and community psychiatric posts). (SANA Report on Nursing Service 1978: 9-21).

This hospital-oriented distribution of nurses has important implications when manpower issues are considered. First of all, the highly bureaucratic organisation of most hospitals obviously affects nursing, especially in organisational matters like job descriptions, career structures and working conditions (Hockey, 1976: 40; Knopf, 1975: 63-65). Second, interpersonal issues of doctor-nurse and nurse-patient relationships are best understood within the formalised context of hospital administration (Benne and Bennis, 1959: 198; Johnson and Martin, 1958: 373-377; Stein, 1968: 101-105).

Despite the obvious importance of these organisational aspects of manpower problems, the present study has focussed on the issues of manpower shortages. This was a necessary limitation of the study, given the choice of research techniques. These were the issues which were receiving great attention in the media at the time (see Appendix 7) and were the problems I originally believed to constitute the "crisis in nursing". As we shall see as the thesis develops, however, my initial impression

was subsequently rejected, and I came to see the manpower problems in nursing as mere reflections of much deeper conflicts within the occupation.

3.3 Isolation of observable elements

Before data production could commence, it was necessary to reduce the hypothesis into manageable tasks which could be completed in the present study (Selltiz et al, 1965: 47). Some choices were made because secondary data were easily available, others because my own insights suggested fruitful avenues. In any event, the elements I focussed on for the present study included:

- overall staffing statistics at City Hospital;
- recruitment of student and pupil nurses over time at City Hospital;
- wastage of students at City Hospital;
- the nature and extent of staff problems at provincial hospitals around the country; and
- opinions of interview repondents regarding manpower problems.

Each of these elements will be considered in turn in the following section.

3.4 Testing the hypothesis

HYPOTHESIS 1: THERE ARE MANPOWER PROBLEMS IN NURSING

3.4.1 Data from official sources

a) There are shortages in several categories of staff at at City Hospital

Data production: Because "shortages" are always relative to some ideal figure, I could not be satisfied with a study of the official City Hospital monthly statistics in which the actual number of posts filled and the "staff establishment" (number of available posts in each category as determined by Provincial authorities) are contrasted. I therefore tried to discover how the ideal

staff establishment is in fact determined. Clearly, if the establishment is a gross over-estimation of the need, then "shortages" will not disrupt the functioning of the hospital, and vice versa. In order to gain insight into the determination of staff establishments, I interviewed some of the nurses involved in this work in Pretoria. Thereafter, interpretation of the official hospital data was made much more meaningful.

Data processing: The official figures over two years were studied to discover trends in manpower situations. Percentages were calculated and tests of significance done.

Data interpretation: As I have mentioned, this was made more meaningful with an understanding of the methods used to calculate staff establishment. Factors to be borne in mind include the possibility of the hospital's needs having changed since the move to new premises in 1980, and what real effects "shortages" have on the functioning of the hospital. My experiences as a sister in the hospital and the many media reports provided useful insights in these regards.

b) *The recruitment of student and pupil nurses is dropping severely at City Hospital*

Data production: One of the matrons kept monthly statistics of all recruitments of new students and pupils, so I was able to study the gross trends over two years.

Data processing: Data were tabulated, percentages calculated and tests of significance done.

Data interpretation: Although I had no control over the data provided to me, and occasional mistakes may have occurred in the recording of recruitments, I do not believe that there was any chance of conscious or

sub-conscious "window-dressing". My contact with the administrative staff at City Hospital over a whole year has convinced me that they are long past the stage of pretending that things are going well. They are seeking genuine solutions to very severe problems.

c) "Wastage" of student nurses is a severe problem at City Hospital

Data production: One of the matrons at City Hospital keeps a book in which the names of all new recruits are recorded together with the date on which they were appointed to the staff. Should a student subsequently resign, that date is also entered. She then keeps a tally of all these resignations at the back of the book, and this proved most helpful. Another record kept by the matron since March 1979 also proved useful: she kept a note for every resignation whether the student concerned was in her first, second or third year of study. In this way, I could analyse when the problem periods were. The third useful record kept by the matron was the stated reason for resignation of each student. The reason was given verbally in an interview and written on the resignation form. The matron made a brief note of the reason in her "resignation book."

Data processing: Data were tabulated and the percentage of wastage was calculated for students in 1979 and 1980. The mean length of time between appointment and resignation was calculated as was the standard deviation from the mean. Finally, reasons for resignation were studied by categorising and calculating percentages.

Data interpretation: This was done bearing in mind the controversies over how wastage should be computed. National wastage figures (supplied by official SANA publications) were used to compare the City Hostpial findings.

3.4.2 Data from questionnaires

a) Many provincial hospitals around the country are experiencing manpower problems of a quantitative, qualitative or combined type

Data production: Respondents were asked to provide data about the total staff situation at their hospitals (see Question 2 of the first part of Appendix 2). Using the data provided, I was able to trace changes in trends over the years (1979 - 1981) and between categories of staff. Not only were the actual number of posts filled analysed, but changes in staff establishments were also studied.

Data processing: Data were tabulated initially by summing the figures for the whole sample to isolate gross trends over the years. Thereafter, the staff situations at the individual hospitals were studied and they were classified as either "adequately staffed" or "short-staffed" using a 10 per cent deficit as the cut-off point. Analyses were then done to see whether there were significant differences between hospitals in different provinces, of different sizes, or catering for different race groups.

Data interpretation: This was done with all the problems of data production (possible inaccuracies and misunderstandings) and processing in mind. Despite these problems, the questionnaire data have provided a very valuable guide to the manpower situation in provincial hospitals around the country. For the real question is what is really happening in all the other provincial hospitals? We are told that the crisis in manpower is only a problem at City Hospital, or only in the Transvaal hospitals, or only in the very large hospitals, or whatever. We are also told that it would not be "moral" to recruit black nurses in white hospitals because "they are just as short of nurses as we are". I hoped to answer some of the queries surrounding the term "crisis" by sending out

the questionnaires and I believe I have been able to do that. Also, the term "manpower crisis" took on qualitative connotations for the first time (for example, matrons are having to use nursing assistants to fill senior posts), and that was a very important discovery.

b) The category which seems to be experiencing the most severe shortages in provincial hospitals is the student/pupil nurse one

Data production: The data provided by respondents at hospitals which serve as training schools for students and/or pupils was analysed in depth once I saw on inspection that these groups were relatively much shorter of recruits than other nursing categories.

Data processing: Data were tabulated, percentages calculated, and tests of significance were done when the black hospitals were compared with white and "mixed" ones.

Data interpretation: Again, despite obvious limitations in the data, the findings showed definite trends which can be used to make sense of the situation in many provincial hospitals.

3.4.3 Data from Interviews

a) Interview respondents express their opinions about manpower problems

Data production: It was a fairly simple process to stimulate respondents into discussing their views about manpower issues, their perceptions of the seriousness of the problems, and their ideas for solving them. As I have explained, the manpower issues were receiving considerable publicity in the media at the time, and they were often emotive issues for people to discuss.

Data processing and interpretation: These data were fairly easy to process or order because respondents tended to fall

into only a few easily distinguishable "camps" by virtue of their responses to key questions. I found their responses to be of interest not only at the level of manpower issues per se, but they also helped me to understand the broad philosophical approach which different individuals were using to analyse the nursing situation.

4. HYPOTHESIS 2: THERE IS A LACK OF TIGHT FORMAL ORGANISATION IN NURSING EDUCATION

4.1 Generation of the hypothesis

This hypothesis was generated from the sociological literature on professions and occupations as was discussed in section 2 of this chapter. Because of the emphasis on education as an observable issue in the struggle of a semi-profession for status, it seemed likely that nursing education would be a fruitful area to research.

4.2 The concepts of formal organisation and nur[illegible]ucation

Turner and Hodge (1970: 31) suggest that there are two general approaches to the organisation of professions and professionalising occupations, a community approach and a formal organisation approach. I shall analyse nursing from both points of view, because it is not always the case that an occupation with tight formal organisation also has a strong sense of community and vice versa.

In the formal organisation approach to occupational or professional organisation, the emphasis is on matters of control over the education and socialisation of novices, registration of acceptable graduates, and formal control over members of the profession. Control is exercised in different ways at each of these levels. For example, education is strictly controlled by setting specific entrance requirements, inspecting training schools, and prescribing a detailed curriculum; while control of registration is exercised by special professional bodies created to examine all applicants and to check that they have fulfilled

all the training requirements. (Millerson, 1964: 28-29).

In general, occupations tend to have a loose, if not non-existant, formal organisation. There is no standardisation of training, no specific entrance requirements, no external examining body, and no formal registration. Professions, on the other hand, usually show evidence of a tight formal organisation.

The issue of "nursing education" has a long history, going back to the latter years of the last century. The basic dilemma within nursing is often viewed as the conflict between "nursing service" and "nursing education". Just as the initial advocates of formalized nursing education had to fight a hard battle to get their ideas accepted by the more vocationally oriented nurses of the time,[1] so the conflict continues even today, although at a different level. Today, the issues are: is university education for nurses a good or a bad thing (Denton, 1978: 195-204; Saunders, 1954: 445); how many different courses should there be (Saunders, 1954: 445); and how much theoretical background do nurses really need (Becker, 1970: 92-94; Katz, 1969: 63-64; Miller, 1975: 222; Spalding and Notter, 1970: 65).

As we shall see, some groups within nursing are advocating more university courses, longer educational periods, and more theory, while others suggest less of all these things. As several authors have pointed out, nursing education is the issue around which much of the drive for professional status has centred. (Becker, 1970: 92; Denton, 1978: 195; Katz, 1969: 63-64).

4.3 *Isolation of observable elements*

The same process already described caused me to focus on the educational and training aspects of formal organisation in particular. Within that broad area of interest, though, there were several particular issues which appeared suitable for study.

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1) See discussions in Glaser (1966: 4-30) and Searle (1965: 140-167), for example.

These included:

- examination of the official routes of entry into nursing;
- study of the basic entrance requirements for admission to a nursing course;
- curriculum changes over a decade;
- effects of curriculum changes on students' success; and
- opinions of interview respondents regarding educational policies.

4.4 Testing the hypothesis

HYPOTHESIS 2: THERE IS A LACK OF TIGHT FORMAL ORGANISATION AT THE NURSING EDUCATION LEVEL

4.4.1 Data from official sources

a) There are many official routes of entry into nursing

Data production: The various directives for training courses supplied by the Nursing Council and the regulations published as government notices pertaining to the various courses were studied. In this way I was able to (a) learn about all the basic training courses available; (b) distinguish the differences between these courses.

Data interpretation: Viewing the developments of training courses historically, and with the background knowledge of the divisions within nursing, I was able to make certain conclusions about the reasons for the lack of uniformity in nursing education portals or routes of entry.

b) The basic requirements for admission to nursing courses reflect the lack of tight formal organisation in nursing

Data production: The official regulations and the amendments published in the Government Gazette have been studied and changes over a decade have been noted.

Data interpretation: When some of the unexpected amendments to regulations were compared with national staff figures at the time, the conflict between different groups in

nursing became apparent.

c) There have been many changes in the nursing curricula

Data production: Detailed factor analyses of the SANC official circulars detailing curriculum changes were made, noting the number of teaching hours devoted to each subject and the total theoretical time over the whole prescribed course. In this way, shifts in emphasis could be traced over a 10 year period.

Data processing: The figures generated by factor analysis were compared for various years to trace trends in educational emphasis.

Data interpretation: Once the official minimum requirements had been identified and changes over the years noted, it was possible to draw certain conclusions about nursing education and the role it plays in the drive for professionalisation.

4.4.2 Data from files

a) The upgrading of the curriculum is having a marked effect on student nurses

Data production: I started by doing factor analyses of the Kardex sheets of all the current student nurses at City Hospital in order to see whether their examination results reflected any trends. There is sufficient space on the sheets for authorities to record the results of re-writes and third entries, so it was easy to guage which particular subjects were causing most trouble.

Since there appeared to be high failure rates even among current students, I decided to compare the examination and test results obtained by a sample of recently qualified students and a sample of students who terminated their training for any reason. Finally, I studied the actual

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Since there appeared to be high failure rates even among current students, I decided to compare the examination and test results obtained by a sample of recently qualified students and a sample of students who terminated their training for any reason. Finally, I studied the actual

reasons given on resignation by those who terminated, to see how prevalent "problems with theory" or "academic difficulties" were.

Data processing: Results of the initial factor analysis were tabulated showing the correlations between subjects and results. Percentages were calculated to highlight differences. Where groups were being compared, data were tabulated and tests of significance were done.

Data interpretation: The fairly convincing results from this source were confirmed by my own experiences and the comments of several of the questionnaire and interview respondents. The conclusions I draw are therefore made with a considerable degree of confidence.

b) The lack of relevant and appropriate minimum entrance requirements is evidence of the lack of tight formal organisation in nursing education.

Data production: My point here is that given the emphasis on theoretical teaching in nursing curricula today, people need a certain amount of background knowledge and academic ability to succeed. Such knowledge and ability is by no means guaranteed by the setting of very general minimum entrance requirements, such as those which currently apply in nursing.

In the case of student nurses (both diploma and degree students) I correlated the Matriculation subjects studied and the aggregate mark obtained by all students at City Hospital in July 1980. The type of matric was classified as either "academic" (six or seven subjects, none of them commercial) or "commercial" (one or more of the subjects studied was typing, bookkeeping, shorthand, etc.). The aggregate mark was recorded as a symbol (e.g. C or D).

In the case of pupil nurses, the minimum entrance requirement is Standard 8, although many do have Standard 9 or Matric.

For this group then, I focussed only on the standard of education achieved, and all current pupils were included in the sample. Using the same method (factor analysis of educational data in the files) I got comparative data for samples of students and pupils who had successfully completed their courses, and who had prematurely terminated their training, in order to see whether there were differences in their educational backgrounds.

Data processing: Once the initial factor analyses had been completed and the data tabulated, trends could be studied. Descriptive measures were used to describe the situation among current students and pupils, while tests of significance were done to evaluate the differences between students who had completed and those who had terminated training.

Data interpretation: This was done bearing the comments made by some interview respondents and by several authors in mind. The analytic data was especially useful in highlighting the need for more specific entrance requirements or a less detailed theoretical component in nursing courses.

4.4.3 Data from interviews

a) People involved in the implementation of nursing education express reservations about it

Data production: In this section I am concerned with the opinions of the people who are actively involved in educating and training student nurses. The matrons and their staff and the tutors concerned with City Hospital often raised the issues voluntarily, and spoke with great conviction about the need for radical revisions in the sphere of nursing education.

Data processing: A method of qualitative analysis was used, so that broad and recurrent "themes" could be isolated from interview transcripts.

Data interpretation. In view of the rapport I was able to establish with the respondents, I feel confident that the remarks made to me (with the assurance of anonymity) reflect the true feelings of the people concerned.

5. HYPOTHESIS 3: THERE IS NO COMMUNITY OF NURSES

5.1 Generation of hypothesis

It was this hypothesis which *suggested itself to me as a direct* result of the data production process for the two previous *hypotheses, and which happened to reinforce the sociological model* I had already used for stimulating Hypothesis 2. In other words, *this hypothesis could have been logically deduced from the occu*pation-profession model, but I had focussed on another aspect (nursing education), and it was only inputs I received during the research process which prompted me to go back to the model and formulate a third hypothesis, which in turn was tested using other methods.

The reader will appreciate the problem I have in classifying this process: there are elements of induction (in that it was isolated observations which seemed to require ordering) and of deduction (in that I realised that the original model could be used as a framework).

5.2 The concept of professional community

In the community approach to professional organisation, the emphasis moves away from formal issues to qualitative aspects of the relationships between members of a professional group and between the group and society. Goode (1957: 194-200) started from a functionalist premise and saw professions being held together by consensus and shared identities between members. As Strauss and Bucher (1971: 9) explain: "Functionalism sees a profession largely as a relatively homogeneous community whose members share identity, values, and definitions of role and interests."

Goode (1957) in fact isolated eight points which indicate the presence of a "community":

1. *Members of the community are bound by a sense of identity.*
2. Members share values in common.
3. *Membership of the community has a terminal status in most cases.*
4. Role-*definitions are agreed upon for both members and non-members.*
5. Members share a *common language only partially understood* by outsiders.
6. The limits of the community *are reasonably clear in social terms.*
7. It produces the next generation by *selecting trainees and* controlloing their socialisation.
8. The community has power over its members.

The way Goode (1957: 194) begins his analysis is as follows: "A characteristic of established professions and a goal of aspiring professions, is the 'community of profession'." In other words, he is in fact using this criterion to define occupations as professions or semi-professions. I was therefore interested in assessing the sense of community within nursing.

5.3 Isolation of observable elements

For the present study, I was unable to gather data about all eight points *mentioned by Goode, so* I concentrated on the notion that a community is bound by a sense of identity and shared values. *My research hypothesis is that nurses as a* group do not constitute a "community" in this sense; on the contrary, there are definite and opposed *sub-groups within* nursing which are working in conflict with one another.

This hypothesis was originally generated during the experience survey, and thereafter, data from different sources were used to test it. In the following section, I shall discuss each source and method in detail, starting with the sources over which I had little or no control, and ending with sources over which I had greater control.

5.4 Testing the hypothesis

HYPOTHESIS 3: THERE IS NO "COMMUNITY" OF NURSES; THE DIVISIONS WITHIN NURSING ARE DEEP AND FUNDAMENTAL

5.4.1 Data from files

a) *Evidence of the existence of bureaucrats*

Data production: Content analysis of the personnel files used up to forty years ago[1] at City Hospital was done. Aspects examined included the actual layout and organisation of the files, the type of forms used, whether these were uniform throughout the province or specific to the particular hospital and so on. Files were traced by getting the names of prize-winners off the rolls of honour kept at the local College of Nursing. I was able to get names of student nurses as far back as the last century, but none of these very early records were available in archives. By studying the files of students who began their training in different years over the last four decades, I was able to trace any evidences of increasing bureaucratization of the files. The assumption here was that signs of bureaucratization of the files would give some indication of the amount of bureaucratization in real life - in nursing practice. Those responsible for the process, then, would constitute one of the groupings within nursing: the "bureaucrats".

The only real problems I encountered during data production were *lost files (this was not serious however, as the files did not change radically from one year to the next, so trends could still be traced) and the fact* that the older files had all been "culled". This means that "unnecessary" documentation gets removed in order to *save filing space. I spoke to the* people responsible for culling and was reassured that the process would not have influenced *my findings significantly.*

(1) Formal records have only been kept in the Archives section of City Hospital for this period of time.

Data processing: Most of the data were descriptive and qualitative, so processing consisted of comparing gross qualitative changes over the years.

Data interpretation: This has to be very tentative, given the tenuous assumption made in the production phase. Nevertheless the results showed definite trends which confirmed much of the evidence about bureaucratization in the literature[1] and my own experiences of nursing.

b) Evidence of the existence of professionalisers

Data production: Personnel files over the last forty years were also subjected to content and factor analyses of various items relating to educational data. The amount of space allocated to educational issues on the summary Kardex sheet was measured, and the presence or absence of detail and additional forms in the files was noted.

The assumption here was that an increase in educational data would be evidence of increasing influence of "professionalisers" who focus on educational issues as part of their drive for professional status for nursing.

Data processing: The data were tabulated using both qualitative and quantitative measures, so trends over time could be easily assessed.

Data interpretation: Again, there is a very tenuous link between patterns in personnel files and developments in the real world, so interpretation must be done with caution. Nevertheless, I do believe that the original idea of viewing the files as symbols was valid, and so certain conclusions can be drawn from evidence, i.e. the files.

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(1) See, for example, Kramer (1966); Mauksch (1966); and Bullough (1974).

c) Evidence of the existence of vocational-professionalisers

Data production: Given the major emphasis placed on education of novices in *semi-professions*, I had always assumed that the tutors would form part of the "*professionalisers*". During the interviews, it became clear that this was not necessarily the case, and I was able to use the files to confirm this.

I did content analyses of student assessment forms (forms used by superiors to evaluate a student's progress) used over the last thirty years[1]. The items assessed (e.g. punctuality, neatness, etc.) were noted for each different form used over the years, and the trends could be compared with the one form initiated in 1978 which was specifically designed by tutors for use in the college.

Data manipulation: Data were tabulated after dividing the qualities assessed into *two broad categories:* "*vocational*" and "professional". In this way it was possible to see:

a) how often the forms were changed;
b) what changes were made each time;
c) how the tutors' form compared with those designed by matrons or Provincial officials.

Data interpretation: If we view the content of a form as a *reflection* of the priorities and sympathies of its designer, then certain conclusions can be drawn about the orientation of tutors as a group. It was on the strength of these findings that I felt the need to classify some members of the nursing community as a marginal group: "vocational professionalisers".

5.4.2 Data from questionnaires

a) Evidence of the existence of vocational-bureaucrats

Data production: Two questions were included in the questionnaire (*see* Q4 and 5 of Appendix 2) which required

(1) The first file which contained a standardised assessment form was dated 1950.

respondents to express their views on the general nurse training programme. The first required them to state whether they thought the formal teaching time for each of seven subjects should be increased, decreased or left unchanged.

The second question was left entirely open-ended, and respondents were invited to make any general comments on the formal, theoretical aspects of nurse training.

The major problem I encountered was that some respondents had not had contact with a training school for general nurses for many years, and were clearly out of touch with the requirements of the curriculum. Three people did not complete question 4 and seventeen omitted question 5. Fortunately I was able to account for these differences in the analysis stage because the first part of the questionnaire gave an indication of whether the matron was working in a training school for students or not.

Data processing: The data from question 4 were tabulated initially, and percentages were calculated. Thereafter, the group was divided into respondents working at training schools and those working in non-training schools, and tests of significance were done to see whether the differences in their responses were significant or not.

Qualitative analysis was done for the data from question 5, with responses being categorised according to major "themes" which emerged.

Data interpretation: Given the problems of a questionnaire which is not entirely anonymous (the hospital and rank of the respondent were asked for), but where the respondents had never met me to evaluate my sincerity and motives, the data must be viewed with a certain amount of suspicion. In view of the fact that confirmatory data are available from other

sources, however, I feel that these can be used fruitfully.

5.4.3 Data from interviews

a) Evidence of divisions within the nursing community

Data production: As I have mentioned, it was during the experience survey that I first became aware of the perceptions of some nurse leaders who saw themselves belonging in different "camps" from other leaders. Initially, I had asked no specific questions on the issue, but as I became aware of the problem I occasionally asked whether the respondent agreed with the curriculum changes made by the Nursing Council, or if she approved of the public statements made by the Association and so on. In this way I could judge where their sympathies and interests lay, and could see several "us versus them" situations emerging.

Data processing and interpretation: This has been discussed in the previous section of this chapter. Even when the considerable problems of interviewing as a method and qualitative analysis are borne in mind, I believe that the findings have great relevance to the present study.

This discussion brings an end to the introductory section of the research report. In the next three chapters, each of the hypotheses will be examined in depth. Chapter 4 deals with the results pertaining to manpower problems; Chapter 5 with nursing education; and Chpater 6 with the issue of a professional community.

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CHAPTER 4: THERE ARE MANPOWER PROBLEMS IN NURSING

1. INTRODUCTION

In this chapter I propose to use a basic economic framework to analyse the aspect of the "nursing crisis" which has in fact received the most publicity and attention recently - the (wo)manpower shortages. (See Appendix 7 for newspaper clippings on the subject). *Many people never look further than the staff shortages in nursing; they see the shortages as equivalent to the "crisis", rather than one symptom thereof.* The solutions most often proposed, therefore, tend to be limited to the economic level: Improve the salaries and the working conditions of nurses and the problem will be solved.

While I would be the last person to disapprove of such measures - I believe the exploitation[1] of nurses has continued for far too long - I hope I shall show in future chapters that the problems in nursing occur at levels other than simple economic ones, and that the solutions will consequently need to be more profound.

With the proviso, then, that the manpower shortages are reflections of a more fundamental crisis in nursing, that they tend to

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(1) Apart from the frank financial exploitation of nurses which tends to be rationalised by their sex and "dedication", *I see an emotional exploitation occurring as well.* Nurses are caught in a Catch-22 situation: "professional" standards demand that they act with dignity and calm even in a crisis situation, so speaking to the press is frowned upon, noisy outbursts at Nursing Association meetings are noted with displeasure, and strikes are positively taboo. And yet, when it comes right down to the issues which concern them *every day - their salaries, their hours of work,* their lack of overtime pay, their status and so on - they receive the same treatment as any ordinary occupational group. Professional behaviour is demanded of them at all times, yet the most basic benefits of professionalism are denied them.

originate at other levels entirely, let us proceed with an analysis of the staff situations at City Hospital and a sample of other provincial hospitals around the country. In the final section of this chapter, I shall summarise the results and discuss the factors I see operating to cause the current manpower crisis in nursing.

As I mentioned in Chapter 3, the concept "staff shortage" *is* a very relative one: a hospital is short-staffed relative to some ideal number of staff. *Clearly, if that ideal is a gross* overestimation of the staffing needs of the institution, then "shortages" up *to a certain point will not be serious.* If, on the other hand, the original ideal estimate was accurate or even *an underestimate,* then even small deficits will have serious implications for the running of the institution.

The only effective way I could evaluate the nature of the ideal figure, or official "staff establishment" of the hospitals, was to hear from the people actually responsible for computing these figures for the various hospitals. I therefore spent a morning in the offices of the "Organization and Management" section of the Transvaal Provincial Administration in Pretoria, where some of the nurses involved in this work explained and demonstrated their system of estimation of staff needs.

At the outset, I was very interested to note that the same authority (the Provincial Administration) is responsible for both estimating the staff needs and for allocating the budgets for all the provincial hospitals. I therefore assumed that economic considerations must play some part in the work of the Organization and Management staff.

I was informed that once every five years, the staff at this office perform an "estimate" of the staff needs of each provincial hospital under their jurisdiction, and every fifteen years or so, a full "assessment" is done. It apparently takes a full year to complete an assessment on a single hospital with only 200 beds, and about three months to complete the assessment of the staff needs of a single ward.

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What happens during such an assessment is that one of the nurses employed in Organization and Management spends about a week teaching the sister in charge of a ward how to classify the patients in the ward as either:

- requiring intensive nursing care
- category A (critical care, needing hourly observations)
- category B (needs 2-hourly observations)
- category C (needs 4-hourly observations)
- category D (needs routine care only)

The lady I was interviewing at the time mentioned that this was a "*sensitive area*", but when I asked whether this meant that the ward sisters tended to overestimate the amount of care their patients required, compared with the estimation of the Organization staff, the reply was a hesitant: "Well ... not always ... No, ... not necessarily," and no further clarification was offered. Given the economic interests of the Provincial Authorities, however, I assumed that this would most often be the case.

Other important points which need to be considered during an assessment are the age and sex of the patients, the nursing discipline involved (surgical, medical and gynaecological wards apparently have different needs), and finally, the number of *patients on the ward*. The assessments used to consider the maximum number of patients a ward could accommodate, but now the staff needs are calculated according to the mean number of patients per ward. Again, the evidence of the Provincial Administration's economic concerns is apparent here.

The next step is to calculate a "norm structure" for the ward. This means that every nursing task which needs to be done is identified and allocated to a particular nursing category. Basic tasks are allocated to nursing assistants, for example, and complex tasks to registered nurses. Then, time-and-motion studies are done to discover how long it takes for each nurse *to complete* the various tasks. The distribution of work throughout the day is studied, and alternatives are considered if these could result in a more economical and effective use of staff time.

Once all this information has been gathered for a particular ward, it is all fed into a computer which calculates exactly how many nurses in each category that ward requires on the morning, afternoon and night shifts. The figures for the whole hospital are then summed and adjustments are made to take account of off-duty periods, the time students have to spend in college, and annual, sick and study leave allowances.

When I commented to my respondents in Pretoria that this system of determining the staff establishments for hospitals sounded very organised and systematic, they agreed but added that certain other factors were also considered, and that "adjustments" were often made. For example, if a particular hospital is known to be very popular and can always get enough student nurses, then those posts would be increased at the expense of some other staff category. If, on the other hand, it was known that the general level of education in the area was low and most people would only apply for nursing assistant posts, then these might be increased rather than the more senior posts. Just how common and arbitrary these "adjustments" are I do not know, and what effect they have on all the complicated computations that preceded them is also unknown.

2. DATA FROM OFFICIAL SOURCES

2.1 There are shortages in several categories of staff at City Hospital

City Hospital last had a full assessment done in 1972, and since then the hospital has moved to vast new premises. All the administrators I interviewed at City Hospital agreed that the study group from Organization and Management now working on new estimates will surely recommend considerable increases in all nursing categories in order to adequately staff the new premises. This is despite the fact that a considerable number of wards have had to be closed due to staff shortages. The expected increase in staff establishment is important to bear in mind when studying the figures presented below. The percentage deficits of staff will be even greater if the size of the denominator (official staff establishment) is increased.

Table 5 shows the official staff establishment (as determined by the staff of Organization and Management) for each category of nursing staff and the actual number of staff employed on two days in the years 1980 and 1981[1].

TABLE 5. Total nursing staff position at City Hospital in January 1980 and January 1981[2]

Nursing category	Staff establishment	No. of posts filled in January 1980	No. of posts filled in January 1981
Matrons	33	26 (79%)	24 (73%)
Senior sisters	193	163 (84%)	190 (98%)
Full-time sisters	461	295 (64%)	310 (67%)
Part-time sisters[3]	0	159	111
Enrolled nurses	21	14 (67%)	13 (62%)
Student & pupil nurses (excluding degree students)	942	636 (68%)	548 (58%)
Degree student nurses	140	39 (28%)	38 (27%)
Nursing assistants	499	127 (25%)	77 (15%)
TOTAL NURSING STAFF	2 289	1 459 (64%)	1 311 (57%)

From this table it is evident that in 1980, the categories which were reasonably well-staffed were senior sisters (84% of available posts filled) and matrons (79% of posts were occupied). The part-time sisters were plentiful, b . because there are no official posts for them it is impossible to say whether this number was adequate or not. In 1980, the lowest proportion of staff were employed in the nursing assistant (only 25% of posts were occupied) and degree student nurse categories (28% of posts were filled).

(1) The nursing administrators keep monthly statistics of the employees at the hospital on one day each month, and these are summarised for official records called "City Hospital - Staff Establishment for January 1980" and so on.

(2) Sources: City Hospital Staff Establishment figures for 7-1-1980 and 7-1-1981. Note: figures in brackets indicate the number of posts filled as a percentage of the staff establishment.

(3) Note: These sisters are employed in nursing assistant posts.

The situation did not change much in the following year, except that in all but two categories (senior sisters and full-time sisters), the number of posts filled decreased. The categories which were hardest hit by these decreases were the student and pupil nurse and nursing assistant ones, both of which suffered a ten per cent decrease over one year. When the *total staff* position is studied, it is evident that in 1980, City Hospital was functioning *with only 64 per cent of its posts filled*, and in 1981, this percentage dropped to 57 per cent. This is a *significant difference* ($\chi^2 = 25$; d.f. = 1; $p < 0,01$).

We can therefore conclude that the overall staff situation at City Hospital is far from adequate, and that the position has worsened considerably over a year.

2.2 The recruitment of student and pupil nurses is dropping severely at City Hospital

It is usually the case in large training hospitals that nurses-in-training form the major part of the work-force. City Hospital is no exception; as Table 5 above has shown, there are 675 posts for registered and enrolled (i.e."qualified") nurses, and 1 082 for student and pupil nurses. Any shortages in these trainee categories, therefore, can have a great effect on the functioning of the hospital as a whole.

Table 6 shows the percentage of authorised posts filled in the student and pupil nurse category *in four different months. Note* that the figures for January are the highest because of two *important points: students who wrote* their final examinations in November often stay on while waiting to hear their results, *and as we shall see*, large intakes of new students begin in January each year. By February, most of the former group are upgraded to sisters, several second year students who have failed their first year examinations resign, and many of the new recruits terminate their training prematurely.

TABLE 6. Total student and pupil nurses[1] at City Hospital in various months, compared with the staff establishment for these groups[2]

	Staff establish-ment	No. of posts filled	Percentage of posts filled
January 1980	942	636	68%
July 1980	942	486	52%
January 1981	942	548	58%
February 1981	942	491	52%

One of the important points to note about Table 6 is that there is a considerable loss of students and pupils during the year (from 68% to 52% in seven months). A few students transfer to other hospitals, and some graduate, but as we shall see the loss can largely be attributed to resignations of students who have no desire to complete their studies. Given the fact that only 58 per cent of posts were filled in January 1981, the predictions for mid-year are very grim indeed.

This highlights the other notable point about Table 6: there has been an absolute decline in recruitment in 1981. In fact 14 per cent fewer students and pupils were registered at City Hospital in January 1981 than in the same month 1980.

As Table 7 shows, the recruitment figures for the year of 1981 are considerably lower than the two previous years.

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(1) Note that degree students are excluded: only about 27 per cent of these posts are filled as we saw in Table 5.

(2) Sources: Totals for January 1980 and 1981 are extracted from Table 5 as are "*authorised posts*". In July 1980 I counted the Kardex sheets filed for each student and pupil who was presently studying at City Hospital, and the February 1981 figures are from City Hospital Staff Establishment for February 1981.

TABLE 7. Student recruits appointed in January and February only, 1979-1981 at City Hospital[1]

Year	STAFF SITUATION	
	No. of recruits	% deficit relative to previous year
1979	225	
1980	166	-26%
1981	127	-23%

This table shows that the 1981 January and February recruitment figures for student nurses were only 56 per cent of those for two years previously.

What makes this recent decrease in recruitment even more serious is the fact that the 1979 figures were by no means adequate in themselves. The total figure for all months in 1979 was only 178 new recruits[2], while for 1978 it was 401.[3]

One of the professors at City Hospital who was concerned about the nursing situation there, studied the staffing figures over a number of years. Deducing trends from his report[4], some interesting facts emerge. First, the staff establishment for pupils has risen dramatically since 1974 - from 684 to 942 - as the hospital expanded to meet the growing demands of the city. The total number of nurses available each year, however, has remained remarkably stable with the result that the percentage of posts filled has dropped steadily over the years. Figure 6 shows these trends.

(1) Sources: one of the matrons keeps recruitment figures for the hospital's monthly statistics.

(2) Same source as (1) above.

(3) According to an anonymous report by a professor at City Hospital in January 1979. He studied nursing figures over five years and presented an internal report: "Conditions of Service of Members of the Nursing Profession, Allied Medical Disciplines and Administrative Staff". A copy of this report was given to me by one of the matrons at City Hospital.

(4) See reference in (3) above.

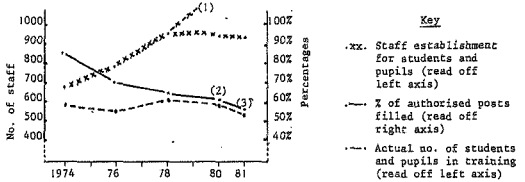

FIGURE 6. Staff establishment and actual staff in the student and pupil categories at City Hospital, 1974-1981 (4)

The broken line on Figure 6 shows that the supply of nurses has remained remarkably stable over eight years: between five and six hundred nurses-in-training are available at City Hospital each year. As the *demand* for these nurses has increased (see the line with crosses), so the percentage of posts filled (solid line) has decreased.

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(1) The staff establishment has not been revised since June 1978, and if the trend between 1974 and 1978 were continued, the establishment for 1981 could be as high as 1 200.

(2) Using the figures for *January* and *July* 1980 *as shown* in Table 6, I calculated a mean for those two months only. Note that if the staff establishment had increased to more than 1 000, these plots would have been lower down due to the increased denominator.

(3) These plots are based on the January and February figures only, as shown in Table 6.

(4) The students referred to here exclude midwifery and other post-graduate students, as well as the degree students. Sources: 1974-1978 - from the report mentioned in footnote (3) on previous page. 1980-1981 from the *City Hospital Staff Establishment* figures for 1980 and 1981.

In summary, we have seen that the demand for students and pupils at City Hospital has increased markedly in recent years, but the supply has remained very stable. This has resulted in there being increasing numbers of unfilled posts in these categories. In other words, there have been shortages relative to the staff establishment requirements for some years. But in addition, there has been an absolute decrease in the number of recruitments over the last two or three years, as we saw in Table 7. It would appear, then, that severe shortages do exist, and that the situation is worsening.(1)

2.3 Wastage of student nurses is a severe problem at City Hospital

"Wastage is the term used to refer to the process of student and pupil nurses resigning from their posts before successful completion of their training course. During the period that I worked at City Hospital, I became very aware of the problem of "drop-outs" or "early resignations". It was a common tea-time topic of conversation, and I actually spoke to several young students who had handed in their resignations and were waiting for the end of the month before leaving.

I was fortunate to be allowed access to the records of one of the matrons at the hospital. She had kept a rough table of all student nurse resignations as they occurred by marking off each in the appropriate space. Figure 7 below is an extract from the table.

Number of appointments each month		MONTH OF RESIGNATION				
		January	Feb.	March	April	May
January	179	卌 卌 //		////	///	卌 ////
February	46	–	/	/	//	
March	14	–	–	///		/

Figure 7. Extract from matron's records of student nurse resignations at City Hospital, 1979.

(1) Administrators had been hoping that the mini-budget announcements on 16-2-1981 would offer real incentives to prospective nurses in order to break the downward spiral of recruitment. The meagre salary increases offered, however, have made them even more despondent about prospects for 1982 recruitment.

From the extract, one can see that twelve of the 179 students who were appointed in January 1979 resigned within their first month, and that by the end of May, 28 of them had terminated their training. Let us study the figures obtained from this source[1] during the years 1979 and 1980 in order to try to assess just how important the problem of wastage is at City Hospital.

TABLE 8. Student nurse appointments and resignations at City Hospital, 1979[2]

No. of appointments 1979	Number of resignations each month 1979												Total loss
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Jan 179	12	0	4	3	9	6	10	4	4	3	4	1	60
Feb 46	–	1	1	2	0	2	0	1	3	1	2	0	13
Mar 14	–	–	3	0	1	1	0	0	1	0	0	1	7
Apr 11	–	–	–	1	0	0	1	0	0	1	0	0	3
May 5	–	–	–	–	0	0	1	0	0	0	0	0	1
Jun 5	–	–	–	–	–	0	0	0	0	0	0	1	1
Jul 7	–	–	–	–	–	–	0	2	0	0	1	0	3
Aug 7	–	–	–	–	–	–	–	1	0	0	0	1	2
Sept 1	–	–	–	–	–	–	–	–	0	0	0	0	0
Oct 2	–	–	–	–	–	–	–	–	–	0	0	2	2
Nov 1	–	–	–	–	–	–	–	–	–	–	0	0	0
Dec 0	–	–	–	–	–	–	–	–	–	–	–	0	0
Annual gain 278	12	1	8	6	10	9	12	8	8	5	7	6	92

(1) The figures presented in Table 8 do not correspond directly with those in the matron's records, as I occasionally found evidence of appointments or resignations which had not been recorded in her records while I was studying the Kardex sheets of current students.

(2) Note: the resignations only reflect those which occurred during the calendar year in which a student was appointed. Source: Matron's monthly statistics (corrected).

TABLE 9. Student nurse appointments and resignations at City Hospital, 1980[1]

No. of appointments 1980	Number of resignations each month 1980												Total loss
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Jan 106	3	6	4	3	3	3	6	2	3	0	1	2	36
Feb 60	–	7	2	4	1	2	3	1	0	3	1	2	26
Mar 12	–	–	0	1	2	1	0	2	1	0	0	0	7
Apr 14	–	–	–	0	1	0	2	1	0	0	0	0	4
May 7	–	–	–	–	2	0	0	0	0	0	0	0	2
Jun 2	–	–	–	–	–	0	0	0	0	0	1	0	1
Jul 4	–	–	–	–	–	–	0	0	0	0	2	0	2
Aug 7	–	–	–	–	–	–	–	0	0	0	1	1	2
Sept 4	–	–	–	–	–	–	–	–	0	0	0	1	1
Oct 0	–	–	–	–	–	–	–	–	–	0	0	0	0
Nov 1	–	–	–	–	–	–	–	–	–	–	0	0	0
Dec 2	–	–	–	–	–	–	–	–	–	–	–	0	0
Annual gain 219	3	13	6	8	9	6	11	6	4	3	6	6	81

From these tables it is evident that a considerable percentage of students terminate their training within twelve months or less. Taking the January intakes only, for we have figures for the whole year, we see that 34 per cent in 1979 and the same percentage in 1980[2] terminated within twelve months. The equivalent percentages for the whole groups were 33 per cent and 37 per cent for 1979 and 1980 respectively.[3]

(1) See footnote (1) for Table 8.

(2) For 1979: 60/179 = 34% wastage, and for 1980: 36/106 = 34% wastage.

(3) For 1979: 92/278 = 33% wastage, and for 1980: 81/219 = 31% wastage.

Table 10, based on the figures given in Tables 8 and 9 shows the distribution of resignations over the twelve month period for the January recruits only.[1]

TABLE 10. Timing of resignations of January recruits in 1979 and 1980 at City Hospital

Month of resignation	Year of recruitment		Total
	1979	1980	
January, February	12 (20%)	9 (25%)	21 (22%)
March, April, May	16 (27%)	10 (28%)	26 (27%)
June, July, August	20 (33%)	11 (31%)	31 (32%)
Sept, Oct, Nov, Dec	12 (20%)	6 (17%)	18 (19%)
Total	60 (100%)	36 (101%)	96 (100%)

This shows that the vast majority of the resignations which occurred during the first year in fact took place *within* eight months of appointment.[2] The biggest single problem area is the resignations which occur during the first or second month - these are especially worrying in view of the fact that January and February are spent full-time in nursing college. In other words, 22 per cent of those who left in the first twelve months did so without ever having worked as a nurse on the wards.

Let us examine the reasons given for the resignations which occur during the early part of nurse training.

(1) I have limited the study to January recruits because the distribution over twelve months is available.

(2) When I did factor analyses from the files of 1979 recruits who had resigned within 12 months (of the 106 names I had from the matron's records, 94 (89%) files were traced in the archives and 76 had left within twelve months) I found that the mean period spent in training was only 4,5 months ($\bar{x} = 3,2$)

TABLE 11. Reasons for student nurse resignations and the timing thereof at City Hospital[1]

Length of time in training	Reason given			Total
	Disillusioned[2]	Personal[3]	Other[4]	
0-1 month	21 (75%)	5 (18%)	2 (7%)	28 (100%)
2-3 months	21 (78%)	6 (22%)	0 (0%)	27 (100%)
4-6 months	29 (74%)	9 (23%)	1 (3%)	39 (100%)
7-12 months[5]	15 (56%)	10 (37%)	2 (7%)	27 (100%)
13-18 months	4 (22%)	7 (39%)	7 (39%)	18 (100%)
Total	90 (65%)	37 (27%)	12 (9%)	139 (101%)

From this it is clear that disillusionment with nursing is responsible for the bulk of resignations among recently recruited student nurses. It is also evident that disillusionment is most likely to occur during the first six months of the course. In order to make calculations easier, I have condensed Table 11 to form a 2 x 3 table.

(1) *Source:* Reasons for resignation are expressed verbally to a matron in a personal interview and are filled into her book as well as onto the resignation form. I studied the matron's book.

(2) Reasons given included "I am not suited to nursing", "I made the wrong career choice", "I cannot cope with nursing", "I am unhappy nursing", etc.

(3) Includes "homesickness", "getting married", "I am ill", "my mother is sick", etc.

(4) Includes "I failed exams", "I can't cope with the theory", and "language problems".

(5) The totals for this and the following row are not complete, because students who were only appointed a few months prior to the research in September 1980 had not yet had a chance to resign during these periods.

TABLE 12. Reasons for and timing of student nurse resignations at City Hospital - condensed

Length of time in training	Reason given		Total
	Disillusioned	All other	
0-6 months	71 (76%)	23 (24%)	94 (100%)
7-12 months	15 (56%)	12 (44%)	27 (100%)
13-18 months	4 (22%)	14 (78%)	18 (100%)
Total	90 (65%)	49 (35%)	139 (100%)

From this we see that there is a moderate association between the variables ($\phi = 0,38$) in the direction that 76 per cent of students who resign within six months give disillusionment as the reason, against 56 per cent and 22 per cent who resign between seven and twelve and thirteen and eighteen months respectively ($\chi^2 = 20,3$; d.f. = 2; $p < 0,01$ so this pattern is significant).

So far we have only considered resignations during the early part of the course. I found another record kept by one of the matrons to be very useful. For each month since March 1979 the matron had noted whether a student who was resigning was in the first, second or third year of study. Table 13 shows the results of this analysis over a period of fifteen months.

TABLE 13. Reasons for termination in each year of study for student nurses at City Hospital, March 1979 to May 1980 inclusive

Year of study	Reason given			Total
	Disillusioned	Personal	Other	
First	78 (57%)	41 (30%)	18 (13%)	137 (67%)
Second	17 (33%)	21 (40%)	14 (27%)	52 (25%)
Third	3 (19%)	6 (38%)	7 (44%)	16 (8%)
Total	98 (48%)	68 (33%)	39 (19%)	205 (100%)

Note that disillusionment becomes far less important in the second and third years of study. (Combining the second and third columns of the table in order to make a 2 x 3 table, we have $\phi = 0,26$ - a small to moderate association in the direction that students are more likely to resign due to disillusionment in the first year of study (57%) than in the second (33%) or third (19%). $\chi^2 = 16$; d.f. = 2; $p < 0,01$ so these differences are significant). In other words, students soon discover whether they are suited to nursing or not. As we saw in Table 12, the first six months after appointment is the most crucial period in this regard.

Table 13 above also shows that we can expect about two-thirds of all resignations to occur among students who are in their first year of study, about a quarter among second years, and less than one tenth among third years. Using these rough indicators, we can predict that by the time the students who commenced in January 1979 graduate, there will only be about 89 (50%) of the original 179 left.(1) And of the 106 who started in January 1980, only about 52 (49%) can be expected to complete their training.(2)

These figures of about 50 per cent wastage rates sound dramatic, but they are fairly typical among white South African students. The latest available figures for the country as a whole are shown in Table 14.

(1) Extrapolating from Table 8 , if the 60 students who resigned within twelve months of appointment in January 1979 represent about 67% of the total wastage, then a further 30 can be expected to leave in second and third year. That gives a total loss of 90 out of the original 179 over three years.

(2) Likewise, if 36 terminations represents 67%, then a further 18 can be expected to leave before graduation, giving a total loss of 54 from the original 106 students recruited in January 1980.

TABLE 14. Number of student nurses in the whole of South Africa who completed their studies in 1974, 1975 and 1976 compared with the number who commenced training in 1972, 1973 and 1974, expressed as a percentage[1]

Race	% of completions		
	1974	1975	1976
White	49%	44%	54%
"Coloured"	44%	34%	59%
Indian		33%	49%
Black[2]	53%	58%	70%

This shows that wastage is a severe problem in nursing not only at City Hospital but in the whole country. Also, the problem seems to have been present to the same extent some years ago[3] so we cannot conclude that the situation is worsening. However, as we saw at the end of the section on recruitment, fewer students are presenting themselves at City Hospital each year, so the pool of students is in fact diminishing.

(1) Source: SANA Report on Nursing Education (1978: 6). Note, however, that there is a controversy about how wastage should be computed. A less pessimistic picture can be obtained by dividing the number of wastages in a year by the total student body that year. This, however, causes the denominator to be greatly increased with relatively low-risk second and third year students.

(2) Black nurses are more likely to successfully complete their studies. This could be due to strict selection of these students (many people apply for posts, so the matrons can be selective), increased work commitment, and the high prestige that nursing enjoys in the black community.

(3) Searle (1965: 259) found a wastage rate of 52% among students during the years 1952-1960.

3. DATA FROM QUESTIONNAIRES

3.1 Many provincial hospitals around the country are experiencing manpower problems of a quantitative, qualitative or combined nature

Bearing in mind the way in which staff establishments are calculated, as we discussed in the previous section, let us now look at the overall staff situations which questionnaire respondents in a stratified sample of provinical hospitals around the country reported, in order to assess whether the situation at City Hospital is at all typical or not.

Table 15 shows the total number of available posts (staff establishment) and the number of posts filled in the various nursing categories at the thirty-one hospitals in the sample for the months of January 1979, January 1980 and January 1981.

TABLE 15. Total staff establishment, number and percentage of posts filled in various months at thirty-one provincial hospitals, 1979-1981

[illegible]	January 1979			January 1980			January 1981		
	Staff est.	Number filled	% filled	Staff est.	Number filled	% filled	Staff est.	Number filled	% filled
Sen. sister	315	276	88%	327	321	98%	331	336	102%
Sister (full-time)	1819	1630	90%	1841	1662	90%	1859	1681	89%
Part-time sister	4	83	2075%	4	84	2100%	3	92	3067%
Enrolled nurse	1052	883	84%	1075	909	85%	1145	960	84%
Student & pupil nurse	2814	2165	77%	2725	2074	76%	2742	2005	73%
Nursing assistant	1362	1184	87%	1426	1286	90%	1450	1303	90%
Total	7366	6221	84%	7398	6336	86%	7561	6377	84%

There are several important points to note about Table 15. First, as is evident in the case of part-time registered

nurses in all three years and senior sisters in 1981, matrons can appoint one category of staff against posts which remain unfilled in other categories. (For example, a *nursing assistant* can be appointed against an enrolled nurse's post, and so on). As we shall see shortly, many of the hospitals had to make use of such "juggling" of posts in order to get enough staff.

The second point to note is the enormous shortage of posts which exist for part-time sisters. Nurses have been asking for more of these posts for years, so that the many registered nurses with young children can be utilized in provincial hospitals.

Third, we see that the total percentage of posts *filled* in all the hospitals has remained fairly stable over the three years, and that the average shortfall is about 15 per cent.

Fourth, it is evident that the absolute numbers of staff in *every category except* student and pupil nurses increased over the three years. This point will be discussed in detail in the next sub-section. The percentage *increase* in each of the categories in 1981 over 1979 is as follows:

TABLE 16. The number of staff employed in various categories at the thirty-one hospitals in January 1981 as a percentage of the January 1979 figure

Senior *sisters*	122%
Sisters (full-time)	103%
Part-time sisters	111%
Enrolled nurses	109%
Nursing Assistants	110%
Student and pupil nurses	93%

Finally, Table 15 shows that the problem of recruiting enough student and pupil nurses must have come to the

attention of the provincial authorities, for they have increased the staff establishments for every category except this one - in which fewer posts are now offered than in 1979, as Table 17 shows.

TABLE 17. The staff establishments for various categories at the thirty-one hospitals in January 1981 as a percentage of the 1979 figures

Senior sisters	105%
Full-time sisters	104%
Enrolled nurses	109%
Nursing assistants	106%
Student and pupil nurses	97%

While compiling the data for Table 15, I noticed that in many hospitals the matrons were employing nursing assistants (people with only six months of training) in enrolled and registered nurse posts. I started to wonder whether this was significant and whether these hospitals were not in fact suffering a "qualitative crisis", even if the quantitative crisis experienced at City Hospital was foreign to them. The data in Table 18 are the result of detailed analyses of the staff situations at the individual hospitals whose matrons responded to the questionnaire. I have arbitrarily called any institution which lacked more than ten per cent of its staff establishment "short staffed". I feel that this figure is an acceptable cut-off point in view of the fact that the people responsible for setting the establishment work for the province which has to pay the staff and so the establishment is likely to be "realistic" rather than generous.

The hospitals can be divided into two basic groups on the basis of this 10 per cent cut-off: "adequately staffed" and "short-staffed". As Table 18 shows, however, there were several subdivisions within these.

TABLE 18. Analysis of the staff situations at thirty-one hospitals, January 1981.

"Adequately staffed":

a)	adequate in all categories ..... (16%) 5	15
b)	adequate total after "juggling"(1) ..... (16%) 5	
c)	adequate total due to increasing nursing assistants(2) ..... (16%) 5	

"Short staffed":

a)	inadequate total despite "juggling"(1) ..... (6%) 2	16
b)	inadequate total despite increasing nursing assistants(2) ..... (39%) 12	
c)	inadequate in all categories ..... (6%) 2	

From this table it is clear that only five of the thirty-one hospitals (16%) were adequately staffed in all categories. Six per cent were short staffed in all categories, 22 per cent had to "juggle" their staff in some way, and fully 55 per cent were using nursing assistants in more senior posts. I see these figures as very significant in terms of the "qualitative" crisis, although the fact that 52 per cent of the hospitals were "short staffed" according to my criteria is alarming enough in quantitative terms.

Table 19 shows the provincial distributions of the short staffed hospitals, and although the differences are not statistically significant, it would appear that the Cape and the Transvaal are worse off in terms of manpower than the other two provinces.

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(1) "Juggling" refers to the use of one staff category to fill posts in another category, except the use of nursing assistants in more senior posts - a practice I've considered separately because of its prevalence.

(2) This group consists of cases where nursing assistants are being used in student or pupil, enrolled nurse or sisters posts. It is a form of "juggling", but an especially important one (see (1)).

TABLE 19 Provincial distribution of adequately - and short-staffed hospitals, January 1981.

	Province				Total
	Cape	Natal	O.F.S.	Transvaal	
Short-staffed	7 (58%)	1 (25%)	2 (33%)	6 (67%)	16
Adequately staffed	5 (42%)	3 (75%)	4 (67%)	3 (33%)	15
Total	12 (100%)	4 (100%)	6 (100%)	9 (100%)	31

In order to keep things in perspective, however, I might point out that of the five hospitals which had adequate staff in all categories, there was one in each of the four provinces and a second in the Orange Free State.

Table 20 shows the distribution of the short-staffed hospitals according to the size of the hospitals.

TABLE 20. Size of hospital and adequacy of staff situation in January 1981

	Size of hospital			Total
	Small	Medium	Large	
Short staffed	8 (42%)	5 (71%)	3 (60%)	16
Adequately staffed	11 (58%)	2 (19%)	2 (40%)	15
Total	19	7	5	31

Again, although the differences are not significant, it appears that the small institutions in small towns (where there are fewer employment opportunities for disenchanted nurses?) are relatively better off as far as manpower is concerned.

Finally in this section, Table 21 shows the distribution between white, black and "mixed" institutions.

TABLE 21. Adequacy of staff situation in hospitals catering for different race groups in January, 1981

	Race of patients			Total
	White	"Mixed"	Black	
Short staffed	4 (67%)	11 (52%)	1 (25%)	16
Adequately staffed	2 (33%)	10 (48%)	3 (75%)	15
Total	6	21	4	31

The differences are not significant when the situation is studied in this way, but as we shall see, they are when the actual numbers of vacant posts are examined.

In order to accurately address the question concerning the extent of the manpower shortage in various racial groups,(1) I have asked the question: do the white and "mixed" hospitals in the sample have a significantly greater proportion of unfilled posts in all categories than black hospitals?

TABLE 22. The total staff situation in white/"mixed" and black hospitals in January 1981

	Staff situation		Total posts
	Posts filled	Posts vacant	
Black hospitals	2 443 (94%)	155 (6%)	2 598 (100%)
White/"mixed"	3 933 (79%)	1 030 (21%)	4 963 (100%)
Total	6 376 (84%)	1 135 (16%)	7 561 (100%)

From this table it is evident that the answer to the question posed above is a definite yes. The differences are highly significant ($\chi^2 = 282$; d.f. = 1; $p < 0,001$). These findings would tend to give lie to the claims of authorities that the manpower shortages are as acute among black nurses as white ones.

(1) Government spokesmen commonly state that the nursing shortage extends to all racial groups, and so it would be "immoral" to attract black nurses for white hospitals for this would "deprive their own people and communities" of their services.

We can therefore conclude that the staff shortages at many white and "mixed" provincial hospitals around the country do exist, and that in some cases the problems are more qualitative (i.e. using lesser qualified personnel in senior posts) than quantitative. The data I received for black hospitals contradict official statements that these hospitals are as desperate for staff as white institutions, but it must be remembered that there were only four black hospitals in the sample, and that generalization is therefore impossible.

3.2 The shortages in the provincial hospitals are most severe in the ar[illegible]upil nurse categories

A total [illegible] of the thirty-one provincial hospitals studied were [illegible]ing schools for student and/or pupil nurses. As we saw in Table 15, the absolute numbers of staff in every category except student and pupil nurses increased over three years, while this category suffered a deficit of seven per cent (Table 16). In addition, the staff establishments for every category except this one increased over the years, while those for students and pupils decreased by three per cent (Table 17).

I see this decrease in the staff establishment for students and pupils as a direct response on the part of the provincial authorities to the absolute shortage of applicants. As I have explained, the people I interviewed in Pretoria mentioned that factors such as the local supply of applicants and the availability of "suitable" recruits influence the determination of the overall staff establishment for a particular hospital. For example, in some areas matrons get plenty of applications for enrolled nurse posts, and very few for nursing assistant ones. In such cases, the official staff establishment would be changed to accommodate these conditions. The result of such alterations on a national level appears to be that posts for other categories are being increased at the expense of those for students and pupils, because there are more applicants for

other posts. This has the important effect of masking, to some degree, the extent of the shortages of staff in the student and pupil categories.(1)

Table 23 shows the details of the staff positions at the fifteen training schools for students and pupils.

TABLE 23. Staff establishment, number and percentage of student and pupil nurse posts filled in black and white/"mixed" hospitals in various months of fifteen training hospitals

Hospital	January 1979			January 1980			January 1982			
	Staff est.	Number filled	% filled	Staff est.	Number filled	% filled	Staff est.	Number filled	% filled	
Black	647	547	85%	647	540	84%	647	561	87%	N=3
White/ "mixed"	2167	1618	75%	2078	1534	74%	2095	1444	69%	N=12
Total	2814	2165	77%	2725	2074	76%	2742	2005	73%	N=15

The first thing to note from this table is the steady decline in the percentage of posts filled over the three years - as we saw in the earlier discussion of Table 15. On closer examination, however, we see that the percentage of posts filled in white/"mixed" hospitals has declined markedly over the three years - from 75 per cent in 1979 to 69 per cent in 1981.(2) Over the same period, the percentage of

(1) For example, Table 15 shows that only 73% of the available student and pupil posts were occupied in January 1981. Had the total number of posts available not been decreased since 1979, however, this percentage would have been 71%. (Divide the 2005 occupied posts in 1981 by the 2814 available posts in 1979). Even this is a conservative estimate, however, for as we saw in Table 17, the staff establishment should have actually increased over the years, not merely have remained stable.

(2) Compare these findings with those for Git Hospital, where 68% of posts were filled in January 1980, and only 52% in January 1981. Although the "crisis" is extreme there, the trend appears to be general in white/"mixed" hospitals throughout the country.

posts filled in the black hospitals actually increased from 85 per cent to 87 per cent. When I examined the 1981 figures in more depth, I found that these differences were highly significant ($\chi^2 = 80$; d.f. = 1; $p < 0{,}001$).

The final point to be made about student nurses concerns the figures I obtained for the recruitment of new student (not pupil) nurses. Only eleven of the thirty-one hospitals acted as training schools for students, and Table 24 shows the recruitment figures at black and white/"mixed" institutions over three years.

TABLE 24. Recruitment of new student nurses at black and white/"mixed" hospitals in January and February of the years 1979-1981 (N = 11)

	Months and Years			Total	
	Jan + Feb 1979	Jan + Feb 1980	Jan + Feb 1981		
Black hospitals	64	65	66	195	N=3
White/"mixed"	497	395	370	1262	N=8
Total	561	460	436	1457	N=11

Although the differences here are not statistically significant, the trend is quite apparent: at black hospitals, the 1981 figure was 103% of the 1979 one, while for white and "mixed" hospitals, the equivalent figure was only 74 per cent.

The starkness of the contrast between the black hospitals and the white or "mixed" ones was made very clear when one of the matrons at a black hospital supplied me with figures in addition to those I had requested in the questionnaire. When she was completing the question 1 of the first part of the questionnaire (see Appendix 2), she filled in the total number of applications that she had received for student posts and the number eventually recruited after a selection and a personal interview. The figures she supplied are shown below.

TABLE 25. Number of applications received and actual appointments made to student nurse posts at one black hospital in the Transvaal, for selected months

	Month and Year						Total
	Jan 1979	Feb 1979	Jan 1980	Feb 1980	Jan 1981	Feb 1981	
No. of applications	270	349	512	454	592	414	2591
No. of appointments	11	14	13	13	11	24	86
% of applicants who were appointed	4%	4%	2,5%	2,9%	1,9%	6%	3,3%

Although none of the other matrons volunteered similar information, I have heard from several sources that similar selective screening occurs at most urban black hospitals. Compare this state of affairs with the situation I found at City Hospital, where "unless there is something really wrong with a girl, we have to accept her and hope for the best," as one interview respondent there phrased it. There is thus little doubt in my mind that the current national shortage of students is an entirely artificial one - an artifact of the South African political system which dictates that nurses of one race group shall not be employed in an institution reserved for patients of another race group.

The data from these provincial hospitals tend, therefore, to confirm the original research hypothesis that the manpower crisis at City Hospital was not a unique national occurrence. Although the extent of the shortages is considerably more severe at City Hospital, other institutions are also struggling to staff their wards adequately (i.e. with sufficient and appropriately qualified nurses). In view of the fact that only 16% of the sample were found to have 90% or more of their available posts filled with appropriately qualified staff, I think we can safely conclude that the manpower crisis exists on a national level.

4. DATA FROM INTERVIEWS

4.1 Interview respondents from different divisions within nursing express their opinions about manpower problems

The interviews conducted with people working at City Hospital centred largely around manpower shortages, because this was seen as "the crisis". The hospital had been receiving a lot of publicity in the media, and the staff there felt almost desperate about the situation.

One of the matrons in fact commented on the publicity: "The newspapers have killed us! Did you see we hit the headlines again this morning? During their campaign earlier this year, so many applicants phoned us to cancel their applications for nursing posts. They got put right off, reading so much about 'critical shortages' and 'crisis situations'."

When asked what the major problems in the Allocations Office[1] were, the reply came with absolutely no hesitation: "Trying to staff a hospital with too few nurses!"

One of the matrons made the following statement when asked whether she thought that wastage of students could be decreased with stricter selection criteria. "I must be honest with you - we accept anybody here. What can you do .... when you're desperate for staff ..."

Another matron related to me what a visitor to the hospital had recently said: "Boy, I believe that you've got problems here. I've been here all day and the thing that's been most talked about is the fact that you've recruited one new nurse! I've never heard anything like it!"

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(1) A number of administrative staff are employed full-time to ensure that the wards are "adequately staffed", and that students are allocated to a variety of clinical wards to get all-round experience.

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One of the medical administrators I interviewed was telling me about the doctors' resentments: "For once we have no shortage of accommodation for patients, but now there's this terrible nursing shortage. You just can't win. Also, the doctors are frustrated because the patients aren't getting the nursing care that they could and should get. Mind you, the care here is still better than in a lot of rural hospitals, for example, but this is a training school, and it's not ideal."

Several respondents referred to the need to use "other staff" to perform some of the basic nursing tasks which were simply not being done because of the nursing shortages at City Hospital. Two typical comments were: "The domestic workers have no formal training and theoretically they should only be ward maids. But some of them are marvellous.." The other respondent stated: "Some of our ward domestics have been taught how to do very simple tasks like rubbing backs and giving out meals and so on, but it's a very dicey situation because of Government policy ... Some of them are real gems, though."

This mention of Government policy brings us to the last point about manpower which must be mentioned. Several of the interview respondents mentioned the need for us to start considering using black nurses to alleviate the shortages. Some of these comments included: "I believe that we in South Africa should use all available manpower - at all levels, not only in nursing. On the whole, I think the patients here would accept black nurses. After all, when you're sick all you really care about is that there's someone to care for you."

Another similar comment came from one of the college staff: "As I see it, this 'nursing crisis' is all a political problem. I mean, there is no shortage of bodies to do nursing is there? If we could use all the manpower that's

available, there would be very little problem..."

One of the matrons agreed: I have no doubt that we'll be training black nurses here soon. We have to use the whole nation's resources.

Other respondents, however, expressed very different views. One matron said: "We've just got to pull together and provide some kind of a service. If we're not careful, the blacks will take over altogether."

Another respondent who was personally in favour of employing black nurses, pointed out that many nurses feared that black nurses would accept lower pay and therefore set back the struggle to improve salaries, and also that the Government would pay less attention to the demands of nurses if the manpower crisis were overcome by using black nurses.

Perhaps the most insidious justifications for restricting nursing along racial lines came from some respondents in Pretoria: "If we used black nurses then we would be depriving the other racial groups and they would then suffer a shortage. We would be preventing the black nurses from serving their own people ... And they would get spoilt too - they wouldn't want to go back to the black hospitals. I suppose they'd get better pay in private hospitals, and then there'd be problems. No - we can't allow that ... No."

5. SUMMARY

In summary, we have seen that the staffing position at City Hospital has been getting progressively worse over a few years, and that by 1981 only 57 per cent of all available nursing posts were filled. The situation was particularly bad in the case of pupil and student nurses (where only 52 per cent of available posts were occupied in February 1981) and nursing assistants (where only 15 per cent of posts were occupied in January 1981).

Wastage figures for student and pupil nurses revealed that about one-third of all new recruits at City Hospital resign within the first year of their courses - many of them within the first month or two before they ever work on the wards at all. Wastage decreases but does not cease in the second and third years of study. When national figures were studied, we found that the trends in wastage are by no means unique to City Hospital, and that this has been a problem for many years.

When the questionnaire data were examined, it became evident that many hospitals were experiencing a qualitative rather than a quantitative crisis. Only five (16 per cent) of the 31 hospitals in the countrywide sample were adequately staffed (where fewer than 10 per cent of their posts were unfilled) in all categories. Another ten (32 per cent) were able to increase their staff only by "juggling" staff or by using extra nursing assistants to fill higher level posts. Fully sixteen (52 per cent) of the hospitals remained "short staffed" despite all efforts.

Although the sample of "black" hospitals was very small and conclusions can only be very tentative, the differences between the staff situations at these institutions and at white/mixed hospitals were striking. This racial division needs further study at several levels.

Throughout this chapter on manpower problems, one particular problem has been evident. That is, the relatively greater shortages in the student and pupil nurse categories. These nurses can be seen to suffer the same hospital-level problems as their more senior, qualified colleagues, but in addition to these they also have to cope with the nursing education system. It therefore seemed logical to examine the education system in some detail, to see whether the shortages in these student categories could be explained by factors operating in that system.

CHAPTER 5: THERE IS A LACK OF TIGHT FORMAL ORGANIZATION IN NURSING EDUCATION

1. INTRODUCTION

As I explained in detail in Capter 3, this hypothesis was generated from the sociological literature on occupations and professions. In medical sociology in particular, the emphasis on "upgrading nursing education" has been noted around the world wherever nurses have been trying to improve their professional status. (Becker, 1970: 92; Denton, 1978: 195; Katz, 1969: 63-64). Thus changes in the educational system are often closely linked to the drive for professionalisation. I naturally wondered whether the same applies in South Africa.

My past experiences as a student nurse had caused me to become aware of certain problems in nursing education, but these were experienced at an emotional level. Once the trends wi in the manpower issue (discussed in Chapter 4) became clear, .. seemed essential to study the educational system in more depth. As we shall see, the more data I got from personnel files and official sources, the more certain I became that this is indeed a fruitful area of stud'. The interview data confirmed many of my previous impressions.

Following the format of presenting data obtained from sources over which I had minimal control and progressing to data from sources over which I had greater control, this chapter will examine the major problems in nursing education as they emerged in the study.

2. DATA FROM OFFICIAL SOURCES

2.1 There are many official routes of entry into nursing

As a student nurse myself I was always aware of the fact that there were several different "*factions*" in nursing: those of us doing the degree course were very different from our diploma contemporaries in terms of aspirations and interests, and they in turn *differed from* the enrolled nursing pupils and so on. While being aware of the existence of different nursing programmes,[1] I never stopped to wonder why so many were *offered* when doctors and other professionals could only do one training course.

When I thought about *this during the* early part of this research project, I assumed that the proliferation of routes of entry must have something to do with the drive for professionalisation, *and so the* research hypothesis was that new programmes would be introduced if they could add something to the professional stature of nursing. For example, I *assumed that the* degree courses would have been hailed as a triumph because of the prestige associated with university contact. Let us examine the various programmes and their *origins to see whether* this hypothesis can be accepted or not.

a) The Diploma Course in General Nursing

Over a hundred training colleges are responsible for the bulk of nursing education in South Africa, and the *majority of nurses* in South Africa are trained in diploma courses leading to registration as a general nurse. In 1979, for example, the total student body (*including degree* students, people doing integrated courses, student midwives and student psychiatric nurses) was 20 570[2], and of these 13 704 (67%) were registered *for a diploma* in general nursing.

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(1) South Africa is not unique in offering so many programmes. Most *countries now* offer at least a degree, a diploma and a certificate in nursing. America recently introduced an "associate degree" as well (Williamson, 1977: 67).

(2) Source: SANC 1979 Statistical Returns C3/MSO(c)

The racial distribution of these students over the last ten years shows a fairly steady growth especially in the non-white groups, as *Table 26 shows*. This growth is rather remarkable when it is realised that in order to qualify for the diploma course, a student must have Standard 10 certificate[1] or be an enrolled nurse.

TABLE 26. Total Student General Nurses on the Registers at 31 December each year 1971-79, by race[2]

RACE	YEAR				
	1971	1973	1975	1978	1979
White	2 729	3 388	3 382	3 539	4 855
"Coloured"	839	534	838	1 348	2 171
Indian[3]		154	222	371	568
Black	3 190	3 241	3 911	4 680	6 110
TOTAL	6 758	7 317	8 353	9 938	13 704[4]

Despite the increases, especially in the "Coloured" and black groups, however, the ratios of registered nurses to population groups show how much more progress has yet to be made. In 1976, these ratios for white, "Coloured" Indian and black nurses were 1:163, 1:725, 1::188 and 1:965 respectively[5].

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(1) The Sached Trust Annual Report for 1978:36 shows that there has been a rapid increase in the number of black students achieving Standard 10 at school: in 1971, only 2 399, and in 1976, 7 996.

(2) Sources: 1971 - SANA Report on Nursing Education (1972:10)
1973 - " " " " " (1975:9)
1975 - " " " " " (1978:4)
1978/9 - 1979 SANC Statistical Returns C3/M80(a)

(3) A separate register for Indians was only opened in 1973 - these nurses were previously classified as "Coloured" by the Nursing Council.

(4) The 1979 figures seem very questionable - the increases are so sudden.

(5) Sources: SANA Report on Nursing Service (1978: 1-3).

The course itself, which leads to the basic nursing qualification - registered nurse or "sister" - lasts *three years. A minimum* of 3 000 hours have to be worked in the practical situation, including a minimum of one month or maximum of three months each year spent doing night duty[1]. The directives also provide for a minimum of 960 periods of formal education in the subjects prescribed by the *Nursing Council*[2]

Much has been written about the inadequacies of diploma educati... and most authors deplore the very authoritarian atmosphere in college[3] and the strict limits imposed on education in the broad sense[4]. Several of my nursing friends who changed from the degree to the diploma course used to complain about the way topics were handled and criticism was discouraged in the latter course. They noticed a vast difference between the liberal and broad education based on general principles in the degree course and the very rigid and structured *teaching emphasizing procedures* in the diploma course. Their observations seem to be confirmed by the writings of several authors. (Cohen, 1980: 169; Corwin & Taves, 1963: 199; Group & Roberts 1974: 372; Raabe, 1980: 174; Searle, 1975: 47; Stein, 1968: 104).

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(1) Government Notice R879 of 2/5/1975 as amended by R2316 of 5/12/1975 and R1570 of 12/8/1977 and R1666 of 3/8/1979.

(2) See SANC Directive for Diploma for Registration as a General Nurse, 25/2/1980. As Williamson (1977: 56) points out, lectures may be organised on a *lecture release, study day* or block system.

(3) Stein (1968: 104), for example, refers to the "military flavour" of student-instructor relations. Similar points about the strict discipline in nursing education are made by Cohen (*1980: 159-169*) and Raabe (1980: 175-176).

(4) *Raabe* (1980: 177) found that students were taught to read uncritically, to avoid probing questions and originality of thought. She actually heard one tutor saying to the students: "Don't bother thinking for yourselves."

b) The "Integrated" Diploma Courses

Another route of entry to the professional registers was created recently when the authorities started discussing the possibility of integrated courses in general nursing and midwifery. This would mean that specially selected students would have the opportunity of qualifiying in two capacities in a shorter period than was usually required. Instead of a three year diploma in general nursing followed by a one year post-basic course in midwifery, students could complete both courses in three-and-a-half years.

This course was first offered in the Transvaal in 1970, and then in Natal in 1971. Since then there has been a very rapid growth of these integrated courses, as Table 27 shows.

TABLE 27. Number of Students Registered for Integrated Courses at Nursing Colleges, 1971-79(1)

REGISTRATION	YEAR				
	1971	1973	1975	1978	1979
General + Midwifery	660	478	916	2 376	2 482
General + Psychiatric	-	-	-	60	86
Gen + Midwifery + Psych.	-	-	53	10	10
TOTAL	660	478	969	2 446	2 578

Although these are diploma courses and most of the comments mentioned above would apply here, it is important to note the reasons for the introduction of these courses. Many nurse leaders were feeling dissatisfied with the fragmental nature of nursing education, where [illegible] was taught in isolation

(1) Sources: 1971 - SANA Report on Nursing Education (1972: 10)
1973 - " " " " " (1975: 9)
1975 - " " " " " (1978: 4)
1978/79 1979 SANC Statistical Returns CS/M80(a)

and nurses were trained almost exclusively for hospital practice. They thought that the nurse should be equipped to practise in a comprehensive health service, and that she should be able to give "first-level care" (Searle, 1975: 53) in general and psychiatric nursing as well as midwifery and public health nursing. The old view of the nurse as provider of bedside care was no longer adequate: a new vision of the nurse was held by some of the influential members of the profession, and so an appropriate training course was devised.

c) The Degree in Nursing

The merits and demerits of degree courses in nursing are still loudly debated. Nurses who believed that a university degree would best equip students for the challenges and demands of nursing practice, administration, education, research and planning waged a determined campaign to have degree courses instituted in South Africa(1). The first undergraduate course began at the University of Pretoria in 1956, and since then there has been a steady but slow growth. By the mid-1970s, ten universities offered such degrees, but still only about six or seven hundred students are registered for these degrees in any year(2).

At present, basic degree courses in nursing are almost exclusively for white students only. Although the University of the North and University of South Africa offer post-basic degrees in nursing, there must be thousands of suitable black matriculants

(1) Proposals were made in the last century, but opposition from both nurses and universities was too great. In the 1930s, registered nurses were admitted to do post-basic courses in teaching. But still, people wanted to see undergraduate degree courses in nursing.

(2) In 1969, Williamson (1977: 76) found that only 1% of nurses in SA had graduated from degree programmes against 72% from diploma and 27% from enrolled courses. That percentage has remained static over a whole decade. See 1979 SANC Statistical Returns C15/M80, C3/M80(a), C2/M80(d).

who would make the most of an undergraduate degree course. Financial problems would not pose a great problem given the current practice of providing degree students with the same "study allowances" (i.e. *salaries*) *as* diploma *students* throughout the period of study. A black student nurse could therefore pay her own way through *university without* relying on parents or others for financial support. According to Nursing Council officials, the new medical university near Pretoria, MEDUNSA, is planning to offer South Africa's first basic degree *course* for black students soon. The predominantly Indian university at Durban-Westville is also planning such a course. In the *meanwhile, small progress* has been made at the University of the Witwatersrand in 1980: th. students were accepted for the B.Sc. course in nursing, and special arrangements have been made for them to get their practical experience in black hospitals and clinics[1].

In South Africa, theoretical and practical components of the course are integrated throughout the four or five years, with the initial years containing a majority of theory and the senior years having more practical experience[2]. The theory is taught mainly on university campuses, and most subjects are given together with other students[3]. The students also have to fulfil a minimum number of hours of practical work in order to satisfy the Nursing Council's requirements for registration.

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(1) This is in accordance with the present government's policy that black nurses may not treat white patients.

(2) In certain overseas courses, students spend the first two years full-time on campus, and only then enter the clinical fields. See Williamson (1977: 99).

(3) The opportunities for contact and debate with non-nursing students is of enormous value when compared with the absolute isolation of diploma students in the nursing colleges.

This discussion brings to an end the consideration of the various routes of entry to the "professional registers" in nursing. But the opportunities to enter nursing do not end there. South Africa still has a "semi-professional" group of enrolled nurses and a "sub-professional" group of nursing *assistants*. Let us examine these courses in some detail now.

d) The Enrolled Nursing Courses

In Britain in the 1930s, discussions began about the desirability of giving professional recognition to the "assistant nurses" who had long been working with nurses in the hospitals. The advocates of *professionalisation reacted* violently, claiming that such a step would sound the death knell to high standards of practice and that nursing would never attract educated women if "inferior grades" of workers could undersell them (Abel-Smith, 1960: 159). Similar problems were encountered in South Africa, and the medical profession was particularly reactionary in this regard[1]. For many years early this century, "nurse aides" were performing invaluable services in the hospitals, yet were receiving no recognition from the "profession". Despite reassurances from people in favour of recognising a second grade of nurses, that standards of professional nursing would not be lowered and that these aides would only perform under the supervision of registered nurses, it took until 1957[2] before their category gained statutory recognition. As Searle (1965: 272) states: "As in England, it had taken some forty years to regularise the practice of, and give proper recognition to, an indispensible second class of nurse."

(1) Leading doctors declared: "If we once establish the contention that the community ... requires a supplementary grade of nurses, we equally establish the fact that they require a supplementary grade of medical practioner." See Searle (1965: 271).

(2) The Nursing Act No. 69 of 1957 was passed in that year.

The enrolled nursing course has been most popular in non-white groups where many people do not have the minimum of a Standard 10 education, and therefore do not qualify for admission to a diploma course.

The old designation "nurse aide" has been changed to "enrolled nurse" in South Africa. Pupil enrolled nurses complete a two year course which has a smaller theoretical content than the diploma course but which never-the-less requires a certain amount of time to be spent in a college setting.

These nurses are trained primarily to be practically competent workers who can assist the registered nurse by performing the more routine and basic bedside tasks[1]. It is, however, widely acknowledged that enrolled nurses are often left to perform the functions of registered nurses - and that they often do so perfectly competently. This then adds fuel to the fire of those who complain that the diploma course is becoming "too theoretical" or "too stiff": if an enrolled nurse can manage to run a ward without all the detailed and formal education prescribed for diploma students, then why keep up-grading the diploma course?

e) The Nursing Assistant Courses

We have seen how much opposition greeted the suggestions that a second grade of nurse should be recognised, so it is not surprising that it took even longer for a third grade to be accepted. A "sub-professional"[2] group has been an essential part of the nursing force for many years especially in

(1) As Williamson (1977: 142) states: "The objectives of the programme are to build a sound working force in this valuable semi-professional group, which will release the registered nurse for more complex activities."

(2) This is a term used by Williamson (1977: 150) to distinguish this group from the "semi-professional" enrolled nurses.

black hospitals, but only very recently were controls introduced. In the early 1970s it was made compulsory for "orderlies" to train as nursing assistants or else to work only as porters. Nursing assistants had to enrol with the Nursing Council and become junior members of the Nursing Association. (Government Notices R1206 of 7-7-1972 and R1833 of 20-10-1972). At the same time, a special curriculum was drawn up to ensure that pupil nursing assistants would receive some systematic training - previously "in-service" training was often disjointed and arbitrary.

The course consists of one hundred days which must be completed within two years (Government Notice R1834 of 20-10-1972). The Council prescribes a total minimum number of fifty periods of instruction in several subjects[1] and as much as possible is taught in the practical situation rather than in formal lectures. The expressed purpose of the course is "to provide the pupil with elementary knowledge about basic nursing." The idea is that nursing assistants should always function under the supervision of enrolled or registered nurses[2].

f) Yet another Category of Nurse?

Given the shortages of assistants in recent years, the very limited training this category receives,

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(2) This does not always happen, as a recent report noted: "A diabetic lay in a coma the whole night ... when an assistant failed to treat him "because he seemed so fast asleep." (Sunday Tribune 11-1-1981: 1).

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and the very simple nature of many basic "nursing" tasks[1], people have been tempted to make use of the ward domestics instead of assistants. When I was working as a registered nurse at City Hospital, some of the "maids" were receiving unofficial in-service training to equip them to do certain basic nursing tasks like feeding and back-rubs in addition to their normal housekeeping duties of cleaning, dusting and so on. This is a very delicate situation both for political and professional reasons.

As one matron commented: "It's very dicey because of government policy regarding black nurses working with white patients. But some of our maids are real gems!" Another administrator said, "Theoretically, these women should only be ward maids. But some of them are marvellous ..."

The official view of the Nursing Council is, however, quite clear: "Untrained people may not work as nurses or assistants. If you have a very sick patient who needs feeding, for example, these women may not do that. That is nursing and it must be done by a nurse." So said one of the officials at the Council.

But under the present circumstances, it is quite understandable that the rules are being bent by the people who simply have no alternatives in the practical situation. It would appear, then, that in addition to the five official categories of nurses we have discussed, yet another category of "nurse"- a product of circumstance - may play an important role in the nursing team of the future....

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(1) For example, spoon-feeding a very ill patient, bottle-feeding children, helping people to the bathroom, and so on. As Abel-Smith (1960: 237) notes: "Nursing duties in hospital must include many tasks of a simple nature which, if the patient were at home, would be performed by relatives."

g) Discussion

Now, to return to the question I posed at the beginning of this sub-section: *why are* there so many different routes of entry into nursing? Originally, at the turn of the century, there was only one official portal or route of entry - a diploma course with very little formal education and a great deal of repetitive practical work. The constant shortages of staff and the widespread use of untrained junior personnel in most hospitals caused some people to advocate the introduction of a second grade of nurse. As we have seen, this suggestion initially caused an uproar: the professionalisers felt sure that such a step would only serve to lower nursing standards and to make nursing's claim for professional status less credible(1).

Gradually, however, peop[illegible] that nursing was changing dramatically fro[illegible]ased practice to a hospital-based one, and that many bureaucratic tasks like supervision of junior staff, management of stocks and supplies, co-ordination of health workers and so on now needed to be done. The professionalisers began to see the merit in registered nurses assuming these new roles, and became quite amenable to the idea of "passing down" certain basic bedside tasks to a second grade of nurse. Others decried this move of the registered nurse away from the bedside: "real nursing"(2) for them involved

(1) As Abel-Smith (1960: 159) observes: "The reaction of Mrs Bedford-Fenwick and her *supporters was every* bit as violent as might be expected... This would be the death knell of high standards in nursing." Some nurses in England dramatically complained that the "lamp is flickering out" (Abel-Smith 1960: 236) when there were moves to recognise a second grade.

(2) As Benne and Bennis (1959: 380) state: "Bedside care is still - to *many nurses* - 'real' nursing." They continue, referring to certain educators and administrators in nursing: "Their separation from the bedside care of patients seemed to account for this sense of unreality in their work" (Benne and Bennis, *1959:* 381).

direct patient care and they hated to see the diploma course moving towards more formal education and less service.

In response to a long-cherished desire, the professionalisers finally succeeded in introducing a basic degree course in nursing in 1956. They wanted to see nurses being fully equipped to meet the demands of any job - from highly technical nursing to administration, education or even research. They abandoned the image of the nurse as mere comforter and drudge[1], and wanted to see nursing moving foward boldly to make a real impression on health care. The status associated with a university link was considerable, and people dreamed of social recognition and increased prestige for the vocation as a whole. In South Africa, however, the degree courses did not grow nearly as rapidly as expected. The diploma course was still the driving force in nursing. So people began looking at that course with a view to improving it. They sought to transplant some of the ideals of degree education into diploma programmes. Hence the new integrated courses which reflected the profession's growing concern with comprehensive health care.

Once again, however, not everyone was impressed by the change: administrators who had to staff hospitals resented "their" students spending so much time in college and in preventive and promotive health spheres. For through all these changes in programmes, one common problem remained: a shortage of staff to meet the most basic requirements of hospital patients. The old issue of good bedside care was still a problem, and yet another dilution of the nurse's functions occurred in the early 1970s when nursing assistants were formally recognised.

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(1) Schulman (1979: 279) states: "Many of these (basic nursing) functions seem to be 'dirty work' and beyond the pale of professionals. As a nurse said: 'One doesn't go through four years of college to do scut work. There are others who can do that.'"

It is my contention that because so many conflicting images of nursing exist within the profession, because nursing has never defined its roles clearly or created a specific niche for itself[1], the question inevitably arises: what educational preparation does a nurse require? If everyone agreed that nurses should only provide comfort and basic care, then it would be relatively easy to decide on a suitable training course. Or if it were agreed that nurses should be able to provide high-level technical care as well as skilled emotional support, then most would agree that a university education would be necessary. But given the lack of consensus concerning the proper role of the nurse and the conflicting ideas held by members of the various "factions" within nursing, the debate about the merits of practical training or service versus formal education is one of the most heated in nursing today.

As Searle (1975: 44) states: "Some employers of nurses and some authorities providing nursing education facilities, and many nurses too, are by no means sure of the road which nursing education should follow, or what the existing and potential role of the professional nurse should be." King (1962: 240) makes a similar point: "....nurses are uneasy, aware of the new demands being made on the role and searching for definition of a revised role and ways of educating students for it."

The different solutions offered by people with different visions of nursing have resulted in a compromise situation: there has been a proliferation of routes of entry into nursing. Gone are the days of one nursing course for all; these days there is a course to suit everyone, from the highly specialised and formalised degree to the

(1) As Saunders (1954: 445) states: "There is uncertainty everywhere. Is the widening gap between nurse and patient acceptable? What is the role of the nurse? Is university education a good thing? These are all evidence that no-one is very certain anymore what a nurse is or what a nurse properly should do." See also Denton (1978: 191).

very practical training of the nursing assistant course... And every faction within nursing, from the most devoted professionaliser to the most conservative, traditional administrator, has something to please them in the bevy of official programmes.

On the basis of these conclusions, I had to reject the research hypothesis that only professionalising changes would be made to official routes of entry, and conclude that the existence of so many routes of entry reflects the basic confusion and lack of consensus in nursing as a whole.

2.2 *The basic requirements for admission to nursing courses reflect the lack of tight, formal organization in nursing education*

In this section I hope to highlight one aspect of the professional-vocational conflict in nursing by examining the development of minimum entrance requirements for the various nursing courses. Having noted the existence of so many different routes of entry into nursing, the original research hypothesis was that the powerful professionalisers would ensure that the minimum entrance requirements would be steadily increased. As we shall see, however, this hypothesis could only be accepted with certain reservations, because the ideals of professionalisers have often clashed with the demands of service institutions for sufficient manpower.

a) The diploma course entrance requirements[1]

In 1915 the Colonial Medical Council in the Cape first made it compulsory for all student applicants to have at least a Std 6 certificate (Searle, 1965: 295).

(1) Note that the degree courses in nursing have always required candidates to have a Std 10 certificate with a university entrance so I shall not discuss these courses here.

Although individual hospitals often set higher standards, it took many years before the minimum entrance requirement could officially be set at matriculation level where professionalisers wanted it; in fact that happened just a decade ago. From November 1970 on, it has been compulsory for all students to have Std 10 or be an enrolled nurse[1]. This proviso for enrolled nurses angered some people who wanted to close "the profession" to all without a Std 10 certificate (Searle, 1964: 14-15).

Whether it was pressure from certain "professionalisers" in nursing or a genuine problem of wastage[2] that prompted an amendment is unclear, but in 1975 pupil nurses who wanted to go on to become student nurses were given two years and six months (i.e. until November 1977) to finish the enrolled course (Government Notice R879 of 2-5-1975). Anyone who became enrolled after that date would have to study for her Matric before she could enter a diploma course.

In August 1977, just before the time limit was due, another amendment was passed and the enrolled nurses were granted an extension until November 1980 (Government Notice R1570 of 12-8-77). That date has now passed and so far there has been no talk of another extension.

One might have expected that an occupation truly intent on gaining professional status would have proceeded with far less caution that the above summary suggests. But nursing is first of all committed to providing a service,

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(1) See Government Notice R3792 of 28-11-1969 for the details.

(2) The reason given for the amendment to prevent enrolled nurses from continuing into diploma courses was: "Experience has shown that candidates who are admitted by virtue of enrolment (without a Std 10 certificate) very often cannot make the grade and have to terminate training. In most cases they are lost to nursing. The regulation has consequently been amended ..." (SANC Sixth Council Report, 1976: 71-72).

and the policy-makers are perfectly aware of the fact that student nurses provide essential services in many of the country's hospitals[1]. This awareness places enormous constraints on the policy-makers - they have always to consider the effects their decisions will have on the *supply of available nursing staff.*

Soon after the introduction of the Standard 10 regulation in 1970, it became obvious that fewer applicants for diploma courses were coming forward. This was especially so in the case of non-white nurses, as very few girls actually completed twelve years of schooling[2]. The following table shows this trend.

TABLE 28. Number of student nurses who commenced training by year and race[3].

	YEAR	RACE			TOTAL
		WHITE	"COLOURED"[4]	BLACK	
(No minimum Std 10)	1969	1 720	658	1 435	3 813
(Std 10 from November on)	1970	1 624	501	1 286	3 411
(First full year of Std 10)	1971	1 466	141	735	2 342
(Second full year)	1972	2 012	307	1 299	3 618

(1) When asked in an interview whether student nurses made up the majority of the labour force in the City Hospital, one of the administrators replied with no hesitation: "Oh yes - definitely."

(2) The Sached Trust Annual Report (1978: 36) shows the increase in the number of black students passing Matric since the early 1970s: 1971 - 2 399; 1972 - 2 911; 1973 - 3 176; 1974 - 3 393; 1975 - 5 347; 1976 - 7 996.

(3) Source: SANC Report of the Sixth Council, 1976: 37

(4) This term includes Asians and people of mixed racial origin; a separate register for Asians was introduced in 1973.

The sudden drop caused by the Std 10 regulation introduced in 1970 was anticipated by the authorities, and they were grateful for the enrolled nurses who helped to swell the numbers in the early days. By 1975, the number of applicants had increased to levels comparable with "pre-Std 10 days", and the authorities thought that they could safely close the door on the enrolled nurses in the near future - hence the regulation giving pupil nurses two-and-a-half years to qualify. The realisation that they might be prevented from doing the diploma course caused a flood of enrolled nurse applicants in 1975/6, as the table below shows.

TABLE 29. Number of enrolled nurses entering diploma courses, 1971-9 (1)

YEAR	NO. ENROLLED NURSES	TOTAL STUDENTS	ENROLLED AS % OF TOTAL
1971	222	2 342	9,5%
1973	223	2 914	7,7%
1974	557	3 925	14,2%
1976	1 061	4 585	23,1%
1978	970	5 109	19,0%
1979	1 449	7 652	18,9%

In 1977, when the amendment to exclude enrolled nurses without a Std 10 certificate was due to take effect, the authorities must have examined the figures and seen that over 20 per cent of general nurse applicants came from the ranks of the enrolled nurses in 1976, and of these only a small minority had a Std 10 certificate and would have qualified to do the diploma course in

(1) Sources: SANA Report on Nursing Education 1972: 12
" " " " " 1975: 13
" " " " " 1978: 6
1979 SANC Statistical Returns C5/M80

any event. This knowledge must have prompted the authorities to extend the deadline for another three years - until November 1980. As I have mentioned, this deadline has now passed and there has been no further talk of an extension. Although the table above shows that 19 per cent of diploma course applicants in 1979 came from the pool of enrolled nurses, the statistics show that a much larger percentage of the enrolled nurses now have a Std 10 certificate[2] - so they would in fact be eligible to do the diploma course even if the proviso for enrolled nurses were removed.

Thus we see that the constraints imposed by the service needs prevented the nursing authorities from increasing the minimum entrance requirements for the diploma courses as rapidly as they might have liked. I see the concessions and amendments made to regulations as clear evidence of professional-vocational conflict in nursing.

Let us now consider the enrolled nursing courses in their own right, and examine the minimum entrance requirements prescribed.

b) Enrolled nursing courses

Enrolled nurses form the so-called "semi-professional" group of nurses, and as one step in the process of professionalisation, the course was increased from 18 months to two years in 1970. At the same time, the

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(1) According to the figures given in the SANA Report of Nursing Education (1978: 13), in 1976 only 3,7% of pupil enrolled nurses had Std 10; 5% had Std 9 and 92% only Std 8.

(2) The statistics given in the 1979 SANC Statistical Returns (C17/MB0) show that in 1979, fully 21,8% of the pupil nurses had a Std 10 certificate; 4% had Std 9 and only 74% had a Std 8 certificate.

authorities decided to introduce a minimum entrance requirement - Std 8 (Government Notice R45 of 9-1-1970). Prior to 1970, no minimum standard of education had been prescribed. There have been no amendments to this regulation in ten years.

We might have expected similar problems as the diploma courses experienced after the introduction of a minimum standard. But the enrolled courses attracted all the girls who would have entered diploma programmes had Std 10 not been prescribed.

The table below shows the phenomenal increase in pupil nurses during the early 1970s when the Std 10 regulation had its effect, and a gradual tapering off more recently as diploma registration increased again.

TABLE 30. Total number of pupil nurses on the rolls at 31 December, by race[1]

	YEAR	RACE				TOTAL
		WHITE	COLOURED	ASIAN	BLACK	
(No minimum)	1969	225	106		1 181	1 512
(Std 8, but also Std 10 for diploma)	1971	950	729		2 999	4 678
	1974	1 309	1 030	198	3 777	6 314
	1976	1 290	1 131	172	3 245	5 838
	1978	1 336	747	95	3 073	5 251

Because of the pool of applicants created by the Std 10 regulation for diploma courses, the enrolled courses flourished in the 1970s despite the longer period of training and the minimum entrance requirement introduced. In this case, at least, the authorities did not have to amend regulations to accommodate the service needs of hospitals: there was sufficient labour to ensure enforcement of the professionalising reforms.

(1) Sources: SANA Report of Nursing Education 1972: 20
" " " " " 1978: 12
1979 SANC Statistical Returns C15/M80

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(1) *Sources:* SANA Report of Nursing Education 1972: 20
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(1) Sources: SANA Report of Nursing Education 1972: 20
" " " " " 1978: 12
1979 SANC Statistical Returns C15/M80

c) Nursing assistant courses

Nursing assistants, the "sub-professional" group, were only brought under the control of the Nursing Council in the early 1970s (Government Notice R1206 of 7-7-1972) and their training has only recently been systematised (Williamson, 1977: 151). Prior to these reforms, random on-the-job training was given, but there were no standards or minimum requirements.

At the same time that the Nursing Council took over responsibility for the nursing assistants, they tried to introduce a minimum standard of education for applicants - Std 6 (Government Notice R1834 of 20-10-1972). Within a short while, however, that regulation was deleted and no minimum qualification was required (Government Notice R1796 of 4-10-1974). In 1979 the matter was raised again, and the Std 6 minimum has been passed again (SANC circular No. 45 of 22-10-1979). The new regulation is due to appear in the Government Gazette in the immediate future.

A brief study of the staffing situation, however, makes me wonder whether the new minimum will every be introduced. The numbers of pupil nursing assistants have dropped so dramatically recently that I doubt whether this category could withstand the decrease that such a regulation is bound to bring. Table 31 overleaf, illustrates the point.

In conclusion, then, it seems to be evident from the data presented in this section that what may be called "professional-vocation conflict" exists in nursing. One group of nurses is trying to "upgrade" nursing education and increase minimum entrance requirements, but another group - directly concerned with meeting service needs of institutions, pulls in the opposite direction. A resultant lack of formal organization in the nursing education system is evident. Nursing as a

vocation will necessarily prevent nursing as a striving profession from making changes as rapidly as the professionalisers would desire.

TABLE 31. Total number of pupil nursing assistants on the rolls at 31 December each year, by race[1]

YEAR	RACE				TOTAL
	WHITE	"COLOURED"	ASIAN	BLACK	
1973	1 361	570	26	1 842	3 799
1976	1 462	615	39	2 171	4 287
1978	1 396	287	30	1 575	3 288
1979	587	278	34	1 417	2 416

2.3 There have been many changes in the nursing curricula

In the previous two sections we have seen the notable lack of formal organization in nursing education regarding routes of entry and minimum entrance requirements. In this section, we shall examine the changes made to the curriculum for general nursing students over a decade. This seems to be one area where nurses in favour of "professionalising" changes have been very successful.

Table 32 shows the changes made to the curriculum for the diploma course in general nursing over the last decade.

(1) Sources: SANA Report on Nursing Education 1975: 18
" " " " " 1978: 14
1979 SANC Statistical Returns C20/MBO.

TABLE 32. Minimum number of periods prescribed for various subjects for the diploma course in general nursing, 1970-1980[1]

YEAR	NUMBER OF PERIODS PRESCRIBED FOR:				TOTAL
	Natural and Biological Sciences[2]	Medical Sciences[3]	Social Sciences	Nursing	
1970	180 (25%)	131 (18%)	40 (6%)	369 (51%)	720 (100%)
1971	180 (26%)	126 (18%)	40 (6%)	354 (50%)	700 (100%)
1975	270 (28%)	150 (16%)	120 (13%)	420 (44%)	960 (101%)

From this table, the considerable increase in the total amount of time devoted to theoretical instruction, the large absolute but gradual relative increase in biological and natural science time, and the sudden increase in social science time are evident.

The increases in natural and biological subjects are, in my opinion, excessive. I believe that if nurses are taught the scientific principles relevant to the practice of nursing, that is sufficient. Detailed lectures in physics or anatomy are not necessary - I know from my own experience that almost the entire chemistry course we did was wasted on me as a nurse. A basic knowledge of these sciences would have sufficed[4]. However, given the fact that nursing is striving for professional status, the curriculum emphasis on "scientific" subjects is fully understandable in the light of the prestige these subjects enjoy in society.

(1) Source: Official SANC circulars, numbers 1 of 1970; 12 of 1971; 31 of 1975.

(2) Natural sciences include chemistry and physics, and biological sciences include anatomy, physiology, microbiology and parasitology.

(3) I classified pharmacology, pathology and first aid as "medical sciences"

(4) I agree with Spalding and Notter (1970: 65): "Emphasis needs to be placed on fundamental understanding in the areas of anatomy physiology, microbiology, chemistry and physics as a basis for learning the scientific principles underlying nursing." (my emphasis)

The recent increase in social science teaching time can, I think, be explained by the same desire for professional status[1]. Nurses have traditionally taken on the responsibilities for caring, kindness and understanding[2] - they have been the humanisers of medical care. It is therefore understandable that many nurses have eagerly adopted the formalised, "scientific" knowledge from the social sciences to bring new status to their traditional roles. I do not mean to imply that the social sciences can serve no other purpose for nursing - on the contrary. But I am not sure that the emphasis in social science instruction is not largely misguided at present. First, the actual content of the courses as outlined in the official directives seems to be rather rigid and unstimulating. I would like to see broader and more topical social scientific and even philosophical concepts being introduced, rather than the basic text-book detail about culture, roles, personality, groups and so on[3]. Second, the traditionally authoritarian atmosphere and didactic methods in nursing colleges are totally inappropriate for the kind of teaching required in social science.

I began reading an article by Searle (1975: 67-68), one of South Africa's best known and most influential nurses, in which she advocated some radical changes to the curriculum, and I agreed whole-heartedly. "Great moral issues confront medicine and nursing in the present

(1) It is interesting to note that despite the recent increase in social science content of the curriculum, South Africa is still giving less of the total percentage to these subjects in 1981 than the Americans gave in 1946! See Gelinas (1946: 44) for the comparable figures.

(2) Johnson and Martin (1958) refer to the "expressive functions" of the nurse which complement the "instrumental" ones of the doctor. They conclude that the nurses role as "expressive specialist" is more important than as a "technical expert".

(3) See the official SANC Directive for the diploma course (25 February 1980) for details of the course outline. I would like to see questions about health care organisation, doctor-nurse relationships, terminal care, genetic engineering, alternative medicine and so on raised.

age... (and nurses need) knowledge to exercise judgment in such matters ... (There are many issues) which need careful examination, reflective thinking, debate ..." As an example the author cites the problem of euthanasia and decries the fact that nursing tutors never raise it as a moral issue. In the very next paragraph, however, the author proceeds to spell out exactly how every self-respecting nurse should feel about the matter. "A nurse cannot compromise on such issues," we are told. (Searle 1975: 68). One is left wondering why the lack of "reflective thought and debate" is bemoaned if all the "great moral issues" can be so easily settled! Perhaps the "ghosts of the Crimea"(1) will always haunt even the most enlightened nurses, and perhaps I am being naïve to hope that real change will come. In the meantime, I view the dramatic increase in the social science component of the curriculum as yet another genuflection towards professionalisation.

The total increase in the theoretical component of the nursing course (from 720 periods in 1970 to 960 in 1975)(2) is, of course, perfectly consistent with the process of professionalisation. Whether more "education" as opposed to practical "training" is necessary or even desirable is questionable - as the various respondents made only too clear in the interviews. In 1970, the minimum prescribed theory made up only 19 per cent of the specified nursing course(3); by 1975 the figure was 24 per cent. But these are the minimum requirements laid down by the Nursing Council, and Williamson found the average amount actually implemented in South Africa to be 28 per cent of the total course (Williamson 1977: 118).

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(1) A phrase used by Group and Roberts (1974) to refer to the authoritarian nature of nursing and nursing education in the last century.

(2) The minimum requirements for the enrolled nursing course increased as well, from 183 periods in 1970, to 281 in 1975 and 286 in 1976. (Source: SANC official circulars Nos. 8 of 1970, 24 of 1975 and 37 of 1976).

(3) 720 of the 3 720 specified hours were devoted to theory (i.e. 19%). The remainder of the total 5 700 hours could be allocated "at the discretion of the person in charge of the school." (See Williamson 1977: 118).

The merits and demerits of the curriculum changes notwithstanding, I saw the changes as definite evidence that nursing is in the process of professionalisation, and that the influence of professionalisers on nursing is considerable.

3. DATA FROM FILES

3.1 The upgrading of the curriculum is having a disrupting effect on student nurses

We have just seen how the curriculum for student and pupil nurses has been upgraded due to the influence of professionalisers. The changes in the courses have not occurred in a vacuum - as I soon discovered doing factor analyses of the personnel files at City Hospital. Let us look at the effects of these changes on the careers of the student nurses themselves.

Using the method of factor analysis of the nursing examination results of students who were registered at City Hospital in September 1980, I was able to prove that many students have considerable difficulty with certain subjects. Table 33 shows the results of these analyses.

TABLE 33. Examination results of students registered at City Hospital September 1980(1)

Result	SUBJECT							
	Nursing I	Rewrite	Anatomy	Rewrite	Nursing II	Rewrite	Physiology	Rewrite
Hons.	52 (16%)	0	66 (20%)	0	12 (9%)	0	11 (8%)	0
Pass	267 (81%)	6 (100%)	186 (57%)	13 (42%)	112 (86%)	2 (100%)	95 (73%)	5 (33%)
Fail	10 (3%)	0	77 (23%)	18 (58%)	7 (5%)	0 (19%)	25 (19%)	10 (67%)
	N=329	N=6	N=329	N=31	N=131	N=2	N=131	N=15

(1) Source: Factor analyses of examination results recorded on Kardex sheets of all current student nurses. Note: of the 482 students who were registered in September 1980, only 17 had results of third year examinations recorded, so I have excluded these from consideration here. One hundred and thirty one had second year results recorded and 329 had first year results recorded. Those students who had been appointed during 1980 had not yet written any examinations, so they do not appear in the table. (See Appendix 4 for example of Kardex sheet).

So great was the difference between failure rates for "Nursing" and those of anatomy and physiology that I wondered whether this could be evidence of a national trend. I studied the official Nursing Council statistics over a decade and found that these two subjects have consistently caused problems, as Table 34 shows.

TABLE 34. National Anatomy and Physiology Failure Rates, 1970-1979[1]

YEAR	% FAILURE RATE IN:	
	Anatomy	Physiology
1970	12,3%	Not available
1971	23,8%	35,2%
1973	37,2%	47,7%
1976	30,1%	31,7%
1979	28,9%	18,7%

Factor analyses of marks obtained by students in college tests proved fairly conclusively that academic difficulties are experienced by many students and that these difficulties often cause the student to resign from nursing. In Table 35 we see that students who complete their studies successfully very rarely failed their college tests, while those who terminated training rather commonly did so.

(1) The results given here are for students doing the diploma in general nursing and midwifery.
Sources: SANA Report on Nursing Education 1972: 16
" " " " " 1975: 14
" " " " " 1978: 8
SANC 1979 Statistical Returns C6/M80.

TABLE 35. Average marks obtained in college tests by students who terminated training and who completed training at City Hospital[1]

	AVERAGE MARKS OBTAINED			
STUDENTS WHO:	70% or more	50-69%	less than 50%	Total
Terminated	15 (15%)	47 (48%)	36 (37%)	98[2] (100%)
Completed[3]	22 (34%)	38 (58%)	5 (8%)	65 (100%)
TOTAL	37	85	41	163

Here we have a moderate *association* ($\phi = 0,35$) between the variables in the direction that more students who terminate their courses (37%) fail college tests than those who complete (8%) ($\chi^2 = 19,6$; d.f. = 2; $p < 0,01$) and the difference is significant.

Given the high failure rates in examinations and college tests, it seemed reasonable to assume that "academic difficulties" would account for a significant number of student resignations. I was therefore very surprised to discover that of the 139 files I studied of students who had terminated during 1979 and 1980, only 9 students (6%) gave this reason. Table 36 shows these results.

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(1) Source: Factor analyses of the assessment forms completed by tutors after each period in college. At the end of each assessment, the results obtained in tests were recorded. I computed the average mark for each student. (See form in Appendix 6).

(2) Of the 160 names from the matron's book, 139 files were traced (87%), but 41 students had left before any assessments were completed, so N = 98.

(3) In order to get comparable data, I studied the assessments from their first year of study only, as the majority of the terminations had resigned within a year. Of the 88 students who completed between November 1979 and March 1980, 65 files (74%) were traced.

TABLE 36. Reasons for resignation offered by students at City Hospital who were appointed between January 1979 and August 1980[1]

REASON	NUMBER	PERCENTAGE
"Disillusioned with nursing"	90	65%
"Personal reasons"	37	27%
"Academic difficulties"	9	6%
Other[2]	3	2%
	139	100%

This seemed to be a very small percentage of wastages due to academic problems in the light of overseas data[3] and the high failure rates already discussed. I therefore wondered whether students were not giving more "socially acceptable" reasons for their terminations (for example, "my mother is ill" or "my husband has been transferred") rather than admitting that they could not cope with the academic requirements.

I studied the factor analyses regarding matric subjects and results which I had performed on the files of students who actually stated that they could not cope with the theory, and compared these with people who gave other reasons for resigning. As a control group, a sample of students who successfully completed the course is included in the next table.

(1) Source: "reason for resignation" is written on all resignation forms by the students, and these forms are filed in the personnel file.

(2) All three students here were Afrikaans-speaking and said that they could not manage the English lectures. (They all left during their first month when they were in college full-time).

(3) See, for example, Miller (1974: 39) who found that 31% of student wastages were related to theory. See also Bergman et al (1974: 101) and Singh and Smith (1975: 47).

TABLE 37. Educational factors in various groups of students at City Hospital[1]

Students who:	TYPE OF MATRIC		AGGREGATE MARK			TOTAL
	Academic	Commercial	A,B or C	D	E	
Terminated due to "academic problems"	3 (33%)	6 (67%)	0 (0%)	2(22%)	7(78%)	N=9[2]
Terminated due to personal reasons	12 (33%)	24 (67%)	4 (12%)	20(55%)	12(33%)	N=36[3]
Terminated due to "disillusionment"	45 (50%)	45 (50%)	15 (17%)	48(53%)	27(30%)	N=90[4]
Completed the course	40 (64%)	23 (36%)	12 (19%)	36(57%)	15(24%)	N=63[5]

From this we see that people who gave personal reasons had exactly the same distribution as the "academic difficulties" students regarding type of matric: very few had academic matrics,[6] and so many of them could have been expected to have problems with the nursing syllabus. Condensing the terminations due to theory and those who gave personal reasons, we find that $\phi = 0,22$ - a small to moderate association in the direction that students who gave either of these reasons for their resignations are less likely to have academic matrics (33%) than those who gave "disillusionment" as the reason (50%) or those who completed the course (64%). The differences are statistically significant ($\chi^2 = 9,6$; d.f. = 2; $p < .01$).

(1) Source: Factor analyses of educational data recorded on Kardex sheets and/or confirmed in educational certificates in the files of students.

(2) Of the 139 students appointed during 1979 and the first half of 1980 who resigned during the same period, 9 gave "academic difficulties" as the reason.

(3) Although 37 of these 139 terminations gave personal reasons, one was an enrolled nurse who did not have metric, hence N = 36.

(4) Of the 139 terminations, 90 gave "disillusionment" as the reason. Note that the 3 who gave "other" reasons are not included.

(5) I traced the files of 65 students who completed between November 1979 and March 1980, but 2 were enrolled nurses with no matric, so N = 63.

(6) I use this term to refer to a matric which included no commercial subjects like typing, accounting, etc.

The aggregate symbols obtained for matric do not show significant differences except in the group which gave "theory" as the reason for resignation. As Table 37 shows, fully 78 per cent of these students only received an E aggregate.

The similarity between those who gave "academic difficulties" and "personal reasons" as explanations for resignations again became evident when I compared the average marks obtained in college tests.

TABLE 38. Average marks obtained in college tests by various groups of students at City Hospital[1]

Students who:	AVERAGE MARKS OBTAINED			TOTAL[2]
	70% or more	50 - 69%	less than 50%	
Terminated due to "theory"	0 (0%)	3 (38%)	5 (63%)	N = 8
Terminated due to "personal"	2 (7%)	13 (45%)	14 (48%)	N = 29
Terminated due to "disillusionment"	13 (21%)	32 (52%)	16 (26%)	N = 61
Completed course[3]	22 (34%)	38 (58%)	5 (8%)	N = 65

Once again, by condensing the first two rows (those who gave "theory" and those who gave "personal" reasons) we have a moderate association ($\phi = 0,4$) between the variables in the direction that students giving either of these reasons are far more likely to have failed college tests on average (51%) than those who were disillusioned (26%) or who complete their training (8%). These differences are significant ($\chi^2 = 27,9$; d.f. = 4; $p < 0,01$).

(1) Source: factor analysis of marks recorded by tutors on college assessment forms. (See Appendix 6).

(2) The totals for students who terminated are smaller here because 41 of these students left before any tests were written.

(3) Note that for these students I studied the test marks obtained during the first year of study only, in order to standardise the data to some extent. (The vast majority of terminations studied had occurred within 12 months of a student's appointment).

These results led me to believe that many of the so-called "personal" reasons may in fact be invented in order to save face, and that academic difficulties are probably a much greater factor in wastage of students than the data would tend to suggest at first glance.

It is commonly believed that some of the best "practical nurses" can get by without in-depth theoretical backgrounds, and several of the matrons I interviewed complained that they were losing good "practical material" due to academic difficulties. In fact, I found that students who terminated - regardless of their stated reason - seemed to do relatively badly on the wards as well as in college. This became evident when I did factor analyses of the assessments completed by ward sisters[1]. Table 39 shows these results for students who completed their training and those who terminated.

TABLE 39. Practical assessments for students who completed and terminated at City Hospital[2]

Students who:	AVERAGE ASSESSMENTS[3]			TOTAL
	Excellent	Good or Average	Below Average	
Completed[4]	21 (36%)	37 (63%)	1 (2%)	59 (101%)
Terminated[5]	4 (6%)	60 (86%)	6 (9%)	70 (101%)
TOTAL	25	97	7	129

(1) Before a student leaves a ward during her rotation through the hospital, the sister-in-charge has to complete a practical assessment form. (See Appendix 5).

(2) Source: factor analyses of assessment forms. (See Appendix 5).

(3) Where there were several forms available, I calculated a mean for each student. Note: on the older forms, a percentage was given, and I classified 70% or more as "excellent"; 50-69% as "good or average", and less than 50% as "below average". On the recent forms, 1-2 was "below average", 3-5 was "good or average" and 6 or 7 was "excellent".

(4) I studied the assessments for the first year of study only. Of the 65 students, 59 (91%) had assessment forms filed.

(5) Of the 139 terminations, 70 (50%) had assessments filed - the rest left before such assessments were done.

There is a moderate association between the variables ($\phi = 0,39$) in the direction that students who complete their training are more likely to receive excellent assessments (16%) than those who terminate (6%) and the difference is significant ($\chi^2 = 19,77$; d.f. = 2; $p < 0,01$).

It would appear, then, that nursing may not be losing such good "practical nurses" due to academic standards after all. However, given the nature of practical work required of new students, I cannot believe that those who terminated found ward duties "too difficult". More likely, these girls were *already disillusioned* by their experiences in college, and were not applying themselves as well as students who had enjoyed their time in college and had been stimulated by their successes there. Had these same students initially registered for the more practically orientated enrolled course, they might have *excelled on the wards*. This would make an interesting area for further study.

Nevertheless, I think the data presented here prove that the recent curriculum changes are having a marked and disrupting effect on the careers of many student nurses, who simply cannot cope with the formal, theoretical aspects of their nursing courses. This either means that the prescribed course is "too difficult", or that the recruits are inadequately prepared - either intellectually or in terms of previous exposure to certain key subjects at school - to cope with these requirements. I shall examine the latter proposition *in the next* sub-section, but at this stage I think it is important to note that many students are having great difficulty with their theoretical work, and a considerable number are having to resign because of this. The depression, insecurity and high turnover of staff resulting from these problems *must obviously have a negative effect on all* concerned - the students themselves, their teachers, the hospital staff, and ultimately, the patients.

3.2 The lack of relevant and appropriate minimum entrance requirements is evidence of the lack of tight formal organisation in nursing education

Factor analyses of the nursing examination and test results made it quite clear that success as a student nurse these days is coming to depend more and more on academic achievements rather than practical competence alone. Before condemning the curriculum changes as unrealistic, I decided to investigate the academic backgrounds of the students and pupils who were being expected to cope with the curricula. We have already discussed the minimum entrance requirements laid down for recruits to the various courses, so the question I was really asking here was: are these minimum requirements appropriate, bearing in mind the nature of the nursing courses being offered today? And following on from there; if not, why not?

I began by doing factor analyses of the matric subjects studied and the aggregate mark obtained by students in various programmes at City Hospital. Note that the official entrance requirements had been met in all cases (i.e. the students all had a Std 10 certificate or were enrolled nurses). My point is that "Std 10" is a very broad category, including a certificate with six or seven academic subjects all in the first class, and one with a borderline pass in several commercial subjects which will be of no assistance to a nursing student.

Table 40 shows the results of the factor analyses for degree students, most of whom had "academic matrics" (i.e. one with no commercial subjects) rather than "commercial ones" (i.e. a matric with one or more commercial subjects like typing, bookkeeping or shorthand).

TABLE 40. Type of matric and aggregate marks obtained by degree students at City Hospital, August 1980[1]

Marks obtained	TYPE OF MATRIC			TOTAL
	"Pure"(2) Academic"	"Ordinary" Academic"(3)	One commercial subject	
A aggregate	1	0	0	1 (2%)
B aggregate	5	2	1	8 (17%)
C aggregate	11	2	2	15 (32%)
D aggregate	17	4	0	21 (45%)
E aggregate	0	0	0	0 (0%)
Not charted	2	0	0	2 (4%)
TOTAL	36 (77%)	8 (17%)	3 (6%)	47 (100%)

From this we see that fully 94% of the students had done "academic matrics", and that 77% had in fact done "pure academic" subjects. The marks obtained were generally very good - none had got E aggregates, and 51% had got a C average or higher. Also, only 2 people (4%) did not have their marks recorded; this is significant because so many of the diploma students had nothing charted. Let us compare these findings with those of the diploma students.

Of the 489 diploma students who were registered at City Hospital in mid-July 1980, 12 (3%) had no school information charted on their Kardex sheets at all, and fully 88 (18%) had matric subjects but no results charted. This can, I think, be taken as an indication that academic results are considered much more important in the selection of degree

(1) Source: Factor analyses of educational data recorded on the Kardex sheets of all current degree students at City Hospital in August, 1980 (N = 47). (See Appendix 4).

(2) I called an academic matric "pure" if seven subjects were studied or six excluding any "ordinary" subjects like music, bible studies, art, domestic science, etc.

(3) Here, students would have had one or more of the "ordinary" subjects mentioned in (2) above.

than diploma students[1]. Seventeen of the student nurses (3,5%) did not have matric at all, but had been accepted for the course because they had completed the enrolled nursing course. I shall exclude this small group from Table 41, which shows the matric subjects studied and results obtained by the diploma students at City Hospital.

TABLE 41. Type of matric and aggregate marks obtained by diploma students at City Hospital, July 1980[2]

Aggregate	TYPE OF MATRIC						Total	% excluding "not charted"
	"Pure" (3)	"Ordinary" (4)	One Comm.	Two Comm.	Three or more Comm.	Not charted		
A	1	0	0	0	0	0	1(0,2%)	0,3%
B	6	2	3	1	0	0	12(3%)	3%
C	19	15	14	5	4	0	57(12%)	15%
D	55	59	45	19	6	0	184(39%)	50%
E	21	37	35	17	8	0	118(25%)	32%
Not charted	28	21	20	12	7	12	100(21%)	-
TOTAL	130 (28%)	134 (28%)	117 (25%)	54 (11%)	25 (5%)	12 (3%)	472 (100%)	-
% excluding "not charted"	28%	29%	25%	12%	5%	-	-	100%

(1) In fact, the administrators at City Hospital were quite frank: one matron said: "I must be honest - we accept anyone who applies" and another administrator said: "Unless there is something really wrong, we don't prevent a student from starting.... there is no active selection here for th. diploma course."

(2) Source: factor analyses of educational data recorded on Kardex sheets of current student nurses who had completed Std 10 (i.e. excluding 17 who were enrolled nurses without matric) $N = 472$.

(3) & (4) See footnotes (2) and (3) for Table 40 for explanations of categorisations.

From this it is evident that only 28% of the students had done "pure" academic matrics, and a considerable proportion had done commercial subjects in matric (42%). Futhermore, the results obtained were notably lower than those of degree students. - 38% only got E aggregates, and only 18% got a C or higher.

Combining and condensing Tables 40 and 41 above, we have the following:

TABLE 42. Matric subjects of degree and diploma students at City Hospital[1]

Nursing course	MATRIC SUBJECTS STUDIED			Total
	"Pure academic"	"Ordinary academic"	"Commercial"	
Degree	36 (77%)	8 (17%)	3 (6%)	47 (100%)
Diploma	130 (28%)	134 (29%)	196 (43%)	460[2] (100%)
Total	166	142	199	507

This shows that degree students have many more "pure academic" matrics than diploma students. There is a moderate association in the direction that degree students are likely to have fewer commercial matrics (6%) than diploma students (43%) ($\phi = 0,3$) and the differences are significant ($\chi^2 = 46,93$ d.f. = 2, $p < 0,01$). Given the nature of nursing education these days, we can conclude that many of the diploma students who are accepted are in fact academically unsuited to nursing.[3]

(1) Source: extracted from Tables 40 and 41.

(2) N = 460 as I have excluded the 12 students who had nothing charted.

(3) I am in no way suggesting that a student who got very poor marks and did several commercial subjects for matric could not be an excellent practical nurse. I am saying that such a student is very unlikely to successfully complete the theoretical requirements of her nursing course.

Combining and condensing Tables 40 and 41 we have the following:

TABLE 43. Matric results obtained by degree and diploma students at City Hospital[1]

Nursing course	AGGREGATE MARK			Total[2]
	A,B,C	D	E	
Degree	24 (53%)	21 (47%)	0 (0%)	45 (100%)
Diploma	70 (19%)	184 (49%)	118 (32%)	372 (100%)
Total	94	205	118	417

Here, there is a moderate association ($\phi = 0,3$) between the variables in the direction that degree students are more likely to receive A,B or C aggregates (51%) than diploma students (18%), and the differences are significant ($\chi^2 = 36,6$; d.f. = 2; $p < 0,01$).

The reader might expect that students accepted for a university degree course would have better academic histories than those doing the diploma in nursing. In order to get some idea of just how important academic background is in the diploma course, I compared the histories of a sample of students who *successfully completed* the course with a sample of those who terminated before completion.

(1) Source: extracted from Tables 40 and 41.

(2) Note: I have excluded those who had incomplete data charted.

TABLE 44. Type of matric studied by students who completed the diploma and students who terminated their studies at City Hospital[1]

Students who	TYPE OF MATRIC			Total[2]
	"Pure academic"	"Ordina. v academic"	"Commercial"	
Completed	22 (35%)	18 (29%)	23 (37%)	63 (101%)
Terminated	27 (20%)	34 (25%)	77 (56%)	138 (101%)
Total	49	52	100	201

From this we find a small association (ϕ = 0,02) between the variables in the direction that students who complete their studies are less likely to have commercial matrics (37%) than those who terminate (56%) and the differences can be considered significant (χ^2 = 7,59; d.f. = 2; p < 0,05). These findings seem to suggest that students who enter a diploma course without a basic background knowledge of the natural and biological sciences are at a distinct disadvantage.[3] At City Hosital, although there is no formal selection of diploma students, there seems to be a kind of "natural selection" occurring in the classrooms and those who are academically unsuited eventually resign anyway.

A student's academic history with regard to the subjects studied in matric seems to be more important than the aggregate mark obtained.

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(1) Sources: factor analyses of educational data on Kardex sheets in the files of ex-students. (See Appendix 4).

(2) Of the 88 students who completed between November 1979 and March 1980, 65 (74%) files were traced, and two of these students were enrolled nurses who did not have matric, so N = 63. Of the 160 students appointed during 1979 and the first eight months of 1980 and who resigned during the same period, 139 files were traced, and one of these was an enrolled nurse with no matric so N = 138.

(3) As Searle (1975: 56) states: "Only a tutor can appreciate the burden of having large numbers of students...who have an inadequate background in the natural sciences."

TABLE 45. Matric results of students who completed the diploma course and those who terminated[1]

Students who:	MATRIC AGGREGATE			Total
	A,B or C	D	E	
Completed	12 (19%)	36 (57%)	15 (24%)	63 (99%)
Terminated	19 (14%)	73 (53%)	46 (33%)	138 (100%)
Total	31	109	61	201

Although there is a small association between the variables ($\phi = 0,1$) in the direction that students who complete the course are less likely to have E aggregates (24%) than students who terminate (33%), the differences are not significantly greater than they might be if chance were operating. ($\chi^2 = 1,98$; d.f. = 2; $p > 0,05$ so we cannot reject the Null Hypothesis).

So much for the degree and diploma courses. The enrolled nursing course which was designed to train practically competent nurses who could assist registered nurses with the more routine nursing tasks (Searle, 1965: 261-263; Williamson, 1977: 142-143) has not been exempted from considerable upgrading, as we have seen when the curriculum changes were discussed. The result seems to be that although a pupil enrolled nurse only needs to have a Std 8 certificate in order to qualify for admission to the course (Government Notice R45 of 9-1-1970) pupils with such limited school educations can often not cope with the demands of the training course. Table 46 shows that a pupil with matric is much more likely to successfully complete the enrolled course than one with Std. 8.

(1) Source: Same sources as for Table 37, except that I have included the three Afrikaans students who were excluded from Table 37, hence N = 148 for terminated students. Note that the data for these groups is more complete (i.e. no "not charted" category) because I was working from the files in which certificates are kept, even if data were left unrecorded on the Kardex sheets as with current students.

TABLE 46. Educational qualifications of pupil enrolled nurses who completed the course and who terminated at City Hospital[1]

Pupils who:	EDUCATIONAL STANDARD ACHIEVED			Total
	Std 8	Std 9	Std 10	
Completed	4 (19%)	6 (29%)	11 (52%)	21 (100%)
Terminated	18 (67%)	5 (19%)	4 (15%)	27 (101%)
Total	22	11	15	48

Here we have $\phi = 0,49$, so there is a moderate to large association in the direction that pupils who complete are far more likely to have Std 10 (52%) than those who terminate (15%) and these differences are significant ($\chi^2 = 11,53$ d.f. = 2; $p < 0,01$). Even in the so-called "practical" nursing course, then, academic background is of vital importance in determining success or failure as a pupil nurse.

At first glance it would appear that the solution to the dual problem of high failure rates and poor academic backgrounds in student and pupil nurses is quite obvious. There is, at present, a vast gap between the academic capabilities of many nurses and the academic achievements they are expected to attain. The rational thing to do would therefore be to reduce this gap either by increasing the minimum entrance requirements or by reducing the theoretical requirements of their courses.

Implementation of either of these obvious solutions, however, presupposes a certain degree of cohesion within nursing - a consensus which patently does not exist. Professionalisers, intent on upgrading nursing education in order to give

(1) Source: factor analyses of educational data recorded on Kardex sheets of ex-pupil nurses. Of the 25 pupils who successfully completed the course between September 1979 and September 1980, I traced 21 (84%) files in the archives. And of the 33 pupils who terminated during the same period, 27 (82%) files were traced.

credence to their claims of professional status, are highly unlikely to agree to a lowering of theoretical standards - although they would undoubtedly encourage the introduction of more appropriate entrance requirements. Service-providers, on the other hand, could never agree to the setting of more stringent entrance requirements because they simply have insufficient applicants from which to select - although they would be delighted at a decrease in the theoretical component so that more of the academically "unsuitable" recruits could survive the course.

The result of this conflict of interests is the almost chaotic situation which I found at City Hospital, where students and pupils are appointed with no formal selection process and even in cases where the matron recorded grave doubts about the applicant's chances of success[1].

4. DATA FROM INTERVIEWS

4.1 People involved in the implementation of nursing education express reservations about it

Interviews were held with several people directly involved in nursing education, either with the formal theoretical teaching at college, or with the clinical teaching which occurs on the wards. The following statements are representative of the views that different respondents expressed; they include the most positive and the most negative responses I received in connection with the diploma course curriculum.

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(1) One of the matrons interviews the applicants before officially appointing them, and she records her impressions on a special "Matron's Interview" form which is then filed. Because of the shortage of staff at City Hospital, the matrons are forced to appoint people about whom such comments as "I think this lass will battle with the theory" and "Her matric marks are poor - have warned her about college requirements" are made.

"These girls come here to nurse, but the syllabus seems to be pushing them up to degree levels. Since 1976 when the regulations changed, the results have shown the battle that the students are having. It's crazy - we are losing such good practical material that way."

"Well really, I think they are going overboard with the education side. A lot of the nurses get disillusioned - often they fail, but even if not, they are being taken further and further away from the patients. A lot of them think, 'We didn't come here to get some degree or something; we want to work with sick people.'"

"I'm all for giving the girls a good grounding in education, but I often wonder whether we aren't going to extremes. I mean, they spend a full year in college now - that leaves very little time for practical teaching on the wards."

"The curriculum is balanced, but it's too full. After a certain point they just switch off, so all that teaching is wasted on them."

"One of our major problems in trying to staff the wards properly is having so many failures in anatomy and physiology. The kids have to go back to college and that leaves us so short! Next month, forty students are rewriting! ... What I hate is all these failures. They spend so much time in college, away from the wards, then after all that they fail, so have to be taken off the wards again to rewrite."

These and similar comments reflected the extent of the disagreement with Nursing Council policies on nursing education. These opinions were by no means limited to people at City Hospital. As we shall see in Chapter 6 when questionnaire results are discussed in more detail, people around the country are seriously concerned with the "excess" of formal teaching and the "gap" between theory and practice in nursing education.

On the existence of so many routes of entry into nursing, most respondents accepted this without question. As I see it, it would not be a bad thing in itself provided that each category of staff was being specifically trained to fulfil particular functions. The amount of overlap between their functions in reality, however, has always amazed me. When I asked interview respondents how they saw the functions of the various categories, their replies confirmed my own impressions.

A spokesman for the Nursing Council even appeared confused about the supposed merits of the different courses. When I asked whether the respondent believed that an enrolled nurse could be left in charge of a ward instead of a registered nurse, the reply was: "Yes, and this often happens. These nurses usually prove to be very competent." Taking the question a bit further, I asked whether he could see an enrolled nurse taking over from a nurse with a degree. "I wouldn't like to comment on that. I think you should ask the professors...." Did he think that the diploma course was sufficient to equip a nurse fully?" "Well, let us say that a degree nurse holds a higher qualification - but not a higher qualification in nursing. The other courses they do at university just give them a wider view, greater insight, and so on."

Other respondents did not want to discuss the degree nurses as they were expected to function on the wards. They clearly saw a different role for them after graduation. As one matron said: "We need that calibre of nurse although she very seldom stays in the wards. They usually go off into teaching, counselling or research, you know." Another matron agreed: "They are very valuable graduates, but they have been stimulated and so could never handle the routine, dull work on the wards. We don't expect them to stay here, though. There's enough scope for them elsewhere."

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A spokesman for the Nursing Council even appeared confused about the supposed merits of the different courses. When I asked whether the respondent believed that an enrolled nurse could be left in charge of a ward instead of a registered nurse, the reply was: "Yes, and this often happens. These nurses usually prove to be very competent." Taking the question a bit further, I asked whether he could see an enrolled nurse taking over from a nurse with a degree. "I wouldn't like to comment on that. I think you should ask the professors...." Did he think that the diploma course was sufficient to equip a nurse fully?" "Well, let us say that a degree nurse holds a higher qualification - but not a higher qualification in nursing. The other courses they do at university just give them a wider view, greater insight, and so on."

Other respondents did not want to discuss the degree nurses as they were expected to function on the wards. They clearly saw a different role for them after graduation. As one matron said: "We need that calibre of nurse although she very seldom stays in the wards. They usually go off into teaching, counselling or research, you know." Another matron agreed: "They are very valuable graduates, but they have been stimulated and so could never handle the routine, dull work on the wards. We don't expect them to stay here, though. There's enough scope for them elsewhere."

The blurring between nursing assistants' functions and the work that minimally trained staff (for example, domestic workers who are upgraded on an in-service basis) could do seems to be considerable. Several of the respondents from City Hospital mentioned the use of domestics to perform very basic tasks, and stressed that this had become necessary because of the extreme shortages in the nursing assistant category. Perhaps the most telling of all these comments came from a very defensive spokesman for the Nursing Council: "No! These domestics may not work as nurses or *assistants*. If you have a very sick patient who needs feeding, for example, the domestic may not do that. That is nursing and it must be done by a nurse or a proper assistant nurse."

5. SUMMARY

In this chapter we have examined what I call a lack of tight formal organisation at the nursing education level. We have seen, for example, that a number of different routes of entry into nursing exist, and that the reasons for the introduction of these courses have often been due to compromises between nurses interested in professionalisation and those trying to provide nursing services. I have contended that the lack of formal organisation in this context, evidenced by the lack of standardisation of training, probably stems from the absence of a clear definition of nursing as a role. Because so many conflicting images of nursing exist among nurses themselves, there is no clear idea about the kind of nursing education that a nurse requires.

A similar process of "bargaining" between people trying to "upgrade" entrance requirements and those needing sufficient students and pupils to provide services was observed. Again, a lack of tight formal organisation was evident in the frequent changes made in this regard.

In the third section, I argued that the recent changes in the curricula for student and pupil nurses have often seemed to be made for "cosmetic" rather than practical purposes. In other words, the authorities often seem to be more concerned with the

appearances of a "professional" educational course, than with one which will surely help nurses to do their jobs better.

We saw that the curriculum changes are having very marked effects on the careers of students, and that many premature resignations can probably be assigned to the extremely high failure rates (around 20 per cent) in subjects like Anatomy and Physiology.

Another aspect of "formal organisation" - the existence of specific entrance requirements (Millerson, 1964: 28-29) - was also examined. In this case, I argued that the very general minimum entrance requirements currently operating in nursing (e.g. Standard 10) are too vaguely defined to be meaningful. We saw that students with commercial subjects and poor aggregates in matric are far more likely to have difficulty with the theoretical aspects of their courses than students who achieved good marks in "academic matrics". In the same way, we saw how pupil nurses who had Standard 10 were much more likely to succeed in their studies than those who met the current "minimum entrance" level of Standard 8. I suggest that such discrepancies between abilities of recruits and the demands of the courses should have been noticed by nursing authorities and that something should have been done to rectify the situation. In the absence of tight formal organisation, however, the problem has been allowed to manifest for many years.

Finally, we studied the responses of interview respondents, and saw that most of them directly involved in nursing education felt some degree of antagonism towards the apparently irrational or extreme changes in educational policy.

In the final, concluding chapter (Chapter 7), I shall relate these findings to the manpower situation studied in Chapter 4. Before I do that, however, let us examine the hypothesis that there is no "community" of nurses. I have hinted in this chapter at the "bargaining process" which seems to occur between

professionalisers and service-providers or administrators. In the next chapter, I shall develop this thesis much further, in order to see whether the lack of tight formal organisation in nursing education can in fact be attributed to problems at a more fundamental level.

CHAPTER 6: THERE IS NO COMMUNITY OF NURSES: THE DIVISIONS WITHIN NURSING ARE DEEP AND FUNDAMENTAL.

1. INTRODUCTION

In section 5 of Chapter 3, I described at some length the rather unusual manner in which this particular hypothesis was generated. Those problems notwithstanding, I do believe that this is the most fundamental hypothesis of all. In other words, I hope to show how many of the divisions in nursing can ultimately be traced back to the lack of a sense of community among nurses themselves. For the purposes of this work I define a sense of community as being an awareness among members of nursing of a sense of identity and of shared values. (Goode, 1957: 194-200).

Using the same format as in the previous two chapters, I shall present data from sources over which I had least control first, and then progress to data from sources over which I had relatively greater control.

2. DATA FROM FILES

2.1 *Evidence of the existence of bureaucracy*

Using the method of content analysis of the personnel files covering a forty year period, I was able to trace changes in the format and organisation of the files. My hypothesis was that nursing is undergoing a process of "bureaucratisation", and the assumption underlying the use of content analysis of the files was that this process would be reflected in the files which can be viewed as symbols of the nursing community. The kinds of changes one would expect would be evidence of increasing standardisation and uniformity of individual forms, more rigid organisation of these forms in the files, and a definite increase in the volume or bulk of the files.

I found the files of the early 1950s to be very poorly organised - there were no separate folders for assessments or leave forms and pages were filed with absolutely no system[1]. Also, the files were very thin - there was a minimum of forms and duplicates. By 1958, the organisation of the files had improved somewhat; separate folders were included to make the whole file more systematic. And by 1963, the files were very full of forms and very regimentally organised. For example, all the sick leave forms are included in a special folder filed at the back of each file. This has continued until the present.

While a very general analysis of the contents of the files does give some indication of the amount of bureaucratisation, I found an even sharper indicator to be the number and origins of some of the more important forms which are filed. Table 47 below shows the changes over the years: a cross indicates the presence of a form which was designed by the authorities at City Hospital itself (in other words, an internally devised form) and two crosses means that such a form was filed in the particular year and that form was one of the official Provincial Administration's ones[2]. The last two rows can be used as a summary: "Total crosses" gives an indication of the extent of Provincial influence, and "Total Forms" shows how many of the eleven major forms used in 1980 were present in earlier years.

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(1) For example, a sick leave form would be followed by an application form and a practical assessment form, and then another sick leave form ....

(2) It was quite simple to tell whether a form was an internal one or a Provincial one - all of the latter are numbered TPA K3 or TPA 156, etc. (In the very early files, the heading used was "Hospital Service Department, Transvaal").

TABLE 47. Changes in *Contents of Files* and Origins of Forms at City Hospital, 1950-1979[1]

	YEAR						
	1950	1956	1958	1963	1965	1977	1979
FORMS							
Application form	X	X	X	X	XX	XX	XX
Medical Report[2]	XX	XX	XX	XX	XX	XX	XX
Sick leave forms	XX	XX	XX	XX	XX	XX	XX
Confidential ward reports	X	X	X	X	XX	XX	X
Resignation form	X	X	X	XX	XX	XX	XX
Hospital Kardex sheets		X	X	XX	XX	XX	XX
Procedure file[3]		X	X	X	X	X	X
College assessment forms			X	XX	XX	XX	X
College Kardex sheets[4]				XX	XX	XX	XX
Salary advice file					XX	XX	XX
Matron's interview form						X	X
TOTAL CROSSES	7	9	10	15	19	20	18[5]
TOTAL FORMS	5	7	8	9	10	11	11

From this table we can see at a glance that not only has the total number of forms increased steadily over the years, but the number of externally-devised, provincial forms has also increased[6].

(1) Source: content analysis of personnel files at City Hospital Archives. Note: The forms have not changed since 1979.

(2) All students have to be declared physically fit before they are appointed: the staff doctor completes an examination and signs a "Medical Report".

(3) Long lists of practical procedures which the nurse should be competent at performing are ticked off and signed by a registered nurse who has taught or supervised the procedure.

(4) Tutors at college fill in the number of lectures given, test results, etc. for each student, and on *completion* of the course, these are filed at the hospital.

(5) *Note that the decrease* in this year is due to the authorities' decision to design an internal (and more relevant) form for both college and ward assessments.

(6) It is interesting to note that the only provincial forms used in 1950 were the Medical Reports and Sick Leave forms: the physical health of nurses has always been strictly controlled by the authorities.

The only break in this pattern occurred in 1979 when the authorities at the hospital and college decided to design new assessment forms for evaluation of students on the wards and in college. This was done because they had been finding the provincial forms to be largely irrelevant[1].

On the basis of these findings, I accepted the original hypothesis that nursing is undergoing a process of bureaucratisation, and took this as evidence that there is a group of "bureaucrats" based at Provincial headquarters in Pretoria which is exerting influence on nursing as a whole.

2.2 Evidence of the existence of professionalisers

Given that drives for professional status often focus on educational factors (Becker, 1970: 87; Carr-Saunders & Wilson, 1933; Glaser, 1966: 26; Katz, 1969: 62-63; Pavalko, 1971: 26), I decided to do content analyses of the personnel files over forty years to determine how much filing space has been allocated to educational data over the years. The research hypothesis here was that the drive for professional status has increased over the years, and the assumption underlying the method was that this process would be reflected in an increasing amount of educational data being recorded in the personnel files.

In the earliest file I located - that of a "probationer" (student nurse) who began her training in 1941 - the only form of any educational relevance was a single foolscap page headed:

"City Hospital: Preliminary Training School[2]
Probationer's Report"

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(1) For example, the college assessment form used in 1974 was only 39 per cent relevant - the rest of the form was left blank by the tutors.

(2) The preliminary training school (or PTS) was the period spent by all students in college learning the most basic nursing skills, ideally before doing any practical work on the wards. Once a student has completed PTS she is considered to be in some way responsible for her actions and she may call herself a nurse.

One of the five headings on the fo. was "Book work", and typed in under that were data about tests written during the preliminary training school. The total area devoted to this educational information was 80 cm^2, and that represented the only record in the entire file that had anything to do with education. There were no references to school results, highest standard achieved, attendance at nursing lectures and so on. We can safely assume from this that a probationer's academic history and performance was considered to be of secondary importance in the 1940s.

In the files of the early 1950s the situation remained much the same, except that the Preliminary Training School Report had four separate headings for educational data: "Written Tests", "Written Exams", "Oral and Practical Tests" and "Oral and Practical Exams". As in earlier years, however, there was no reference to school education, no detailed assessments of academic performance by tutors, no record of lecture attendance.

In 1956, the files contained the first cardboard summary sheet or Kardex, and use of the Kardex forms has continued since then. Although the amount of Kardex space allocated to educational data is quite considerable as a total - 159,38 cm^2 - an analysis of that space shows that these data were not considered to be of prime importance.

The only reference to school concerned 1,6 cm^2 in which the last standard passed was recorded. A large section - 88,55 cm^2 - is allocated to marks obtained in college tests, but this space was never used by the authorities. And finally, 69,23 cm^2 was devoted to results obtained in Nursing Council examinations.

The only other forms in the files that referred in any way to educational matters were the testimonials supplied by headmistresses to vouch that a girl would "be a credit to the nursing profession" or was "bound to succeed in her chosen career"...

By comparing these early files with those currently in use it is possible to see at a glance how the authorities' attitudes towards educational data have changed over the years. The table below shows these changes and the last two rows provide an overall picture of the progress[1].

TABLE 48. Changes in Recorded Educational Data in Nursing Files 1941-1978[2]

	YEAR					
	1941	1956	1958	1963	1974	1978
CRITERIA	cm^2	cm^2	cm^2	cm^2	cm^2	cm^2
Std. of education	-	1,60	1,60			
Date achieved	-	-	-	45,08	44,16	34,96
School subjects	-	-	-			
School symbols	-	-	-			
Educational certificate	-	-	-	+	+	+
Attendance at college	-	-	-	40,80	38,28	47,52
[illegible] Kardex forms	-	-	-	+	+	+
College marks (tests)	80	88,55	88,55	-	19,50	18,00
College assessments	+	-	+	+	+	+
SANC exam results	-	69,23	69,23	19,72	34,98	74,36
SANC individual subjects	-	-	-	-	-	+
TOTAL KARDEX SPACE DEVOTED TO EDUCATION	80	159,38	159,38	105,60	136,92	174,84
TOTAL "MINUSES"	9	8	7	2	1	0

(1) The larger the area devoted to education (measured in square centimetres) and the fewer the minuses, the greater the emphasis on educational data in a particular year.

(2) The files have not changed substantively since 1978. Source: content analysis of personnel files at City Hospital archives.

From this table we can see that although the Kardex sheets used in the 1950s had a large amount of space devoted to ecuational data, the files contained virtually no other forms pertaining to education. (That is why there were many "minuses" in those years). Also, as I mentioned earlier, the largest section (8",55 cm^2) was never actually used by the authorities in those days.

If we examine the last three columns, however, (1963-1978) the trend is very clear: the total area of the Kardex sheet devoted to education increased steadily, and the amount of confirmatory information in the files also grew. This trend in the files can, I think, be seen as a reflection of the drive for professionalisation in nursing: more and more of the limited filing space is being allocated to data about education in general and nursing education in particular. Indications of this concern with professionalisation can, in turn, be taken as evidence of the existence of another group within nursing: the "professionalisers".

2.3 Evidence of the existence of vocational professionalisers

Knowing what an important role education of novices plays in the drive for professional status, I initially assumed that everyone involved in nursing education would be a "professionaliser". The comments made by several tutors during interviews made me realise how naïve that assumption was, and the factor analyses of some of the assessment forms in the personnel files provided objective evidence to support the idea that tutors constitute a marginal group: vocational professionalisers.(1)

(1) I am using the term "vocational" to refer to concerns with service aspects of nursing, as opposed to educational or organisational aspects. In other words, "vocational professionalisers" are people who find themselves in jobs which suggest professionalisation, but with attitudes of concern for nursing service.

The assumption underlying the method of factor analysis of assessment forms was that the qualities which were considered important to assess in a student nurse would give some indication of the orientation of the designer of the form.

At first I analysed all the forms which have been used by ward sisters at City Hospital to assess student nurses. Four different forms have been used over the last thirty years, two designed by the matrons and staff at the hospital, and two designed by provincial authorities in Pretoria. I classified each of the qualities assessed into two groups: those reflecting a vocational orientation (i.e. the nurse as a gentle handmaiden to the doctor) and those reflecting a more professional orientation. The results are shown in Table 49.

From this table it is evident that there is a large core of very conservative, vocational qualities which are still considered to be important in a nurse - just as they were thirty years ago. In the 1979 form, designed by matrons at City Hospital, the percentage of vocational qualities is much lower, but that is not because the number of these was decreased, rather because professional qualities have been added to the core of vocational qualities like courtesy, industriousness, neatness and co-operation.

Evidence of vocational elements in the assessment forms used by ward sisters were not surprising, considering the typically vocational role that student nurses are expected to fulfil in their ward duties. I was surprised, however, when I analysed the assessment forms used by the tutors in college to evaluate the progress of students in their formal studies.

Until as recently as 1978, tutors were using the same forms as the ward sisters, and were simply recording "not applicable" next to many items like "respect for property",

TABLE 49 Student nurse qualities assessed by ward sisters at City Hospital 1950 - 1979 (1)

QUALITIES	YEAR			
	1950	1965	1973 (2)	1979
1) Vocational:				
Punctuality	X	X	X	X
Neatness of person	X	X	X	X
Truthfulness	X			
Kindness	X	X	X	
Accuracy in obeying doctors' orders	X	X		
Memory	X			
Co-operation	X	X	X	X
Industriousness	X			X
Courtesy	X	X	X	X
Dignity	X			
Sympathy	X			X
Reaction to criticism	X	X	X	
Sense of humour	X			X
Nursing skill	X	X	X	X
Amenable to discipline		X	X	X
Systematic		X	X	
Economical		X	X	
Respectful of property		X	X	X
Accessibility to patients				X
2) Professional				
Responsibility	X	X	X	X
Interest	X	X	X	X
Powers of observation	X	X		X
Initiative	X	X	X	X
Flexibility	X			X
Ability to teach juniors	X	X	X	X
Ethical standards	X			X
Learning ability		X	X	X
Leadership		X	X	X
Dependability	X	X	X	X
Consistency				X
Non-judgmental attitudes				X
Ability to discuss inter-personal relations				X
Ability to assess ward situation				X
Enthusiasm				X
Application of learning				X
TOTAL QUALITIES ASSESSED	22	20	18	27
NUMBER & PERCENTAGE "VOCATIONAL"	14 (64%)	12 (60%)	11 (61%)	11 (41%)
NUMBER & PERCENTAGE "PROFESSIONAL"	8 (36%)	8 (40%)	7 (39%)	16 (59%)

(1) Source: Factor analyses of ward assessment forms filed in personnel files in archives of City Hospital. The forms were changed in the years indicated.

(2) Note the similarity between the 1973 and 1965 forms: both were official provincial forms (1950 and 1979 were internally devised at City Hospital). The only difference is that in 1973 the qualities were listed under the headings: "Human Relations", "Performance" and "Personal Qualities".

TABLE 49 Student nurse qualities assessed by ward sisters at City Hospital 1950 - 1979[1]

QUALITIES	YEAR			
	1950	1965	1973[2]	1979
1) Vocational:				
Punctuality	X	X	X	X
Neatness of person	X	X	X	X
Truthfulness	X			
Kindness	X	X	X	
Accuracy in obeying doctors' orders	X	X		
Memory	X			
Co-operation	X	X	X	X
Industriousness	X			X
Courtesy	X	X	X	X
Dignity	X			
Sympathy	X			X
Reaction to criticism	X	X	X	
Sense of humour	X			X
Nursing skill	X	X	X	X
Amenable to discipline		X	X	X
Systematic		X	X	
Economical		X	X	
Respectful of property		X	X	X
Accessibility to patients				X
2) Professional				
Responsibility	X	X	X	X
Interest	X	X	X	X
Powers of observation	X	X		X
Initiative	X	X	X	X
Flexibility	X			X
Ability to teach juniors	X	X	X	X
Ethical standards	X			X
Learning ability		X	X	X
Leadership		X	X	X
Dependability	X	X	X	X
Consistency				X
Non-judgmental attitudes				X
Ability to discuss inter-personal relations				X
Ability to assess ward situation				X
Enthusiasm				X
Application of learning				X
TOTAL QUALITIES ASSESSED	22	20	18	27
NUMBER & PERCENTAGE "VOCATIONAL"	14 (64%)	12 (60%)	11 (61%)	11 (41%)
NUMBER & PERCENTAGE "PROFESSIONAL"	8 (36%)	8 (40%)	7 (39%)	16 (59%)

(1) Sources: Factor analyses of ward assessment forms filed in personnel files in archives of City Hospital. The forms were changed in the years indicated.

(2) Note the similarity between the 1973 and 1965 forms: both were *official* provincial forms (1950 and 1979 were internally devised at City Hospital). The only difference is that in 1973 the qualities were listed under the headings: "Human Relations", "Performance" and "Personal Qualities"

"kindness to patients" and so on. In 1963, for example, 48 per cent of the assessment was irrelevant, and in 1974, fully 61 per cent of the items were not applicable in the college situation.

Towards the end of 1978, tutors from the college met with hospital matrons and decided to design an assessment form for exclusive use in the college. This was a very important step to take, because for the first time it was being recognised that the nurse as a student in the true sense of the word requires attributes very different from those required of the nurse as a nurse in the practical situation.

When I heard of the decision to design a "relevant" form for college, thoughts of "professional" qualities which had been encouraged when I was a student in a degree programme came to mind: resourcefulness, originality, ability to criticise and synthesize, use of questioning..... But none of these items were included on the new college assessment form; vocational elements are as abundant as they are in the ward forms. Although the new form is a vast improvement in as much as the items assessed are all relevant, only two of the eleven qualities can be called "professional": participation in class and learning ability. The other items are either frankly vocational (neatness, co-operation and amenability to discipline) or very parochial (attention in class, use of study time). (See Appendix 6).

I concluded therefore, that although the professionalisers are focussing on nursing education, this does not necessarily imply that nursing educators themselves are active professionalisers. They seem to me to be caught between two loyalties: although they are implementing the reforms in nursing education, their sympathies often lie with the service-providers and hospital administrators. I have therefore called this marginal group the vocational professionalisers.

3. DATA FROM QUESTIONNAIRES

3.1 Evidence of the existence of vocational bureaucrats

As we shall see in the next section when interview results are discussed, the matrons and *nursing administrators* I interviewed in Johannesburg made their feelings about professionalisers quite clear. I tentatively classified this group of nurses as "vocational bureaucrats" - administrators who are overwhelmingly concerned with staffing their institutions.

Confirmatory evidence of the existence of such a group was made possible by analysing the results of the mailed questionnaires, all of which were completed by matrons or senior nursing administrators. Their opinions about nursing education (the realm of professionalisers) proved to be very informative.

In Question 4 of the questionnaire (see Appendix 2) respondents were asked to indicate whether they thought that *particular subjects* should be taught in more, the same amount, or less detail than was currently prescribed for student nurses by the Nursing Council. The *results are shown* in Table 50.

TABLE 50. Questionnaire respondents' opinions regarding subjects in the curriculum for general nurses

Subject	Opinion Expressed			Total[1]
	Requires more detail	Satisfactory	Requires less detail	
Chemistry/Physics	3	14	11	28
Microbiology/Parasitology	2	19	7	28
Anatomy	4	19	5	28
Physiology	3	20	5	28
Pathology	3	24	1	28
Social sciences	6	20	2	28
Nursing science & art.	8	20	0	28
Total	29 (15%)	136 (69%)	31 (16%)	196(100%)

(1) Three respondents did not complete *this question as they felt* that they had been out of touch with nursing education for too long, so each subject was evaluated by 28 people, giving a total of 196 evaluations.

From this it is evident that pathology enjoys the greatest approval, with 86% of respondents expressing satisfaction with the detail in which it is taught. Next came the social sciences, nursing and physiology - each with 71 per cent of respondents expressing satisfaction.

The subjects which are, in the opinion of the respondents, being taught in too much detail are chemistry/physics (39 per cent of respondents would like a decrease in the detail) and microbiology/parasitology with 25 per cent wanting a decrease.

The fact that three respondents stated that they had been "out of touch" with nursing education for too long to offer an opinion made me wonder about some of the other respondents who were working in non-training hospitals. Only 10 of the 31 respondents were actually working at training schools for student nurses. In retrospect, I should have provided respondents with a breakdown of the curriculum to study before answering the question. As it was, however, I was able to separate the responses of matrons not working at training schools to see whether their opinions differed markedly from those who are directly involved with nursing education.

TABLE 51. Perceptions of questionnaire respondents working in training schools contrasted with those in non-training schools

Nature of "votes"(1)	Place of employment		Total votes
	Training school	Non-training school	
Votes to increase any subject	1 (1%)	28 (22%)	29 (15%)
Votes of satisfaction	54 (77%)	82 (65%)	136 (69%)
Votes to decrease any subject	15 (21%)	16 (13%)	31 (16%)
Total votes	70 (99%) N = 10	126 (100%) N = 18	196 (100%)

(1) Each respondent could "vote" seven times - once for each subject. Note that the frequencies represent those votes, and that there were 10 respondents working at training schools and 18 working in non-training schools.

There is a small to moderate association between the variables ($\phi = 0,28$) and the differences are significant ($\chi^2 = 15,5$; d.f. = 2; $p < 0,01$). We can therefore conclude that respondents working at training schools and aware of the curriculum requirements are much less likely (1%) than those working in non-training schools (22%) to want an increase in the theoretical component of the curriculum.

With regard to individual subjects, the matrons at training schools were fairly united: fully 50 per cent of them wanted a decrease in chemistry/physics; 40 per cent wanted anatomy decreased; 30 per cent wanted physiology decreased; and 30 per cent wanted microbiology/parasitology decreased.

The comments offered in response to question 5 of the questionnaire were also interesting. Fourteen of the 31 respondents replied to the open-ended question (six of them were working at training schools), and two major themes emerged.

The first theme concerned the "excess" of formal teaching prescribed in the diploma curriculum. Eight respondents raised this issue (57 per cent of those who commented in question 5; 26 per cent of total respondents), and some of their statements were:

- "We need less formal teaching, more bedside teaching."
- "Too much is crammed too soon. The curriculum is too full."
- "There is too much formal teaching."

The second major theme concerned the "gap" which is seen to exist between theory and practice in nursing education. Five respondents raised this (36 per cent of those who commented; 16 per cent of total respondents), and examples of their statemen

- "We must correlate theory with practice."

- "Perhaps more could be done to bridge the gap between theory and practice."
- "The nurses have a superficial knowledge of too many subjects which seldom if ever are needed in the practical situation."

In general, the results from the analysis of the questionnaires show that the matrons and nursing administrators around the country are far more concerned with the service needs of their institutions than with the *educational needs* of the students. Their solution to the present conflict between *these needs would be to decrease* the theoretical content of the nursing course. The fact that no-one made comments in favour of upgrading the curriculum indicates that these respondents would probably agree with the matrons I interviewed in Johannesburg who see the recent curriculum changes as cosmetic attempts by the Nursing Council to make a point about the "professional" status of nursing. In any event, I saw the opinions of the questionnaire respondents in favour of "more bedside teaching" and less formal theoretical teaching as evidence of their "vocational bureaucratic" orientations.

4. *DATA FROM INTERVIEWS*

4.1 Evidence of divisions within the nursing community

The interviews I had with pure bureaucrats and professionalisers were fairly predictable as far as their definitions of themselves and others were concerned. For example, the bureaucrats in Pretoria who are charged with computing staff establishements or *dealing with the civil servants'* salaries were typically "bureaucratic" in their evasions, *referrals*, and routines. And the professionalisers (spokesmen for the Nursing Council and people involved in university education of nurses) were predictably outspoken in favour of professionalising changes in nursing.

It was the interviews with people who I have subsequently categorised as marginal groups - either vocational bureaucrats or vocational professionalisers - which proved most enlightening. In the case of vocational bureaucrats, I had totally underestimated their animosity towards the professionalisers; and in the case of vocational professionalisers, I had underestimated their considerable sympathy with service-providers in nursing.

This sympathy became very clear in two interviews with people actually providing nursing education at the moment. The following comments were made by a senior member of the staff at one of the nursing colleges:

"A girl might get sick and miss a few days in college. Then I, knowing that she's been sick and dying people on the ward, must ring up and say, 'Nurse X needs five psychology lectures'... It seems a bit ridiculous! But we have to give so many lectures - it's laid down by the Nursing Council."

Later on, in response to a question about how new students could be protected from emotional upsets during their first months on the wards, this same educator stated:

"Unfortunately there is very little we can do when we're so short-staffed on the wards. We just have to send them off and hope for the best. We can't protect everyone. You've just got to have the hands(1) on the wards."

Note this lady's use of "we" to include college staff and hospital staff: her identification with the service-providers is almost complete.

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(1) The phrase "the hands" was used several times by several different vocationally oriented respondents to refer to nurses in their capacities as service-providers or workers. This confirmed for me that these authorities perceive students far less as students per se than as mere workers.

Another educator involved with the teaching of nursing assistants made the following very "vocational" statement:

"You know, I've just been sick myself recently, and I can't tell you how fabulous the assistants were. I couldn't wait for them to come on duty - they were the ones who really made you feel comfortable. And isn't that what nursing is really all about?"

These and similar statements by people I had initially expected to be professionalisers by virtue of their associations with the education of nurses, made me realise that there is a marginal group of nurses who are philosophically placed between the vocational nurses and the professionalisers and I called them "vocational professionalisers".

The other group of nurses who surprised me were those working at the headquarters of the "professional association" of nursing in Pretoria - the South African Nursing Association. I had expected them to be vociferous professionalisers, and indeed, on first glance they were. But on closer examination of some of their views, I was forced to reconsider their classification.

One respondent, for example, after making bold statements about how nurses need to be educated to "move with the times", and how nursing education must be removed from service institutions entirely, then showed a very conservative attitude when the issue of salaries for nurses was raised:

"After the Budget announcement, the Association made a public statement that we were satisfied and felt that nurses had received a fair share of the total increases announced .... On the whole, I was very pleased with the increases. After all, we can't expect to be equal overnight. We've got to be patient - they're doing their best for us."

This blind faith in some higher authority who appeared to be showing benevolence towards nurses seemed to me to indicate that there might be some distinctly vocational elements in the so-called professional association. My reservations were confirmed when the following quotation appeared as the conclusion of one of the Association's publications on Nursing Service (1975: 20):

"South African nurses have always delivered quality health services in the past and shall continue to do so in future. It is therefore well to remember the following:

> 'Why were the saints saints?' someone asked.
> And the answer came:
> 'Because they were cheerful when it was difficult to be cheerful and patient when it was difficult to be patient. They pushed on when they wanted to stand still, and kept silent when they wanted to talk. That was all.'"

With this kind of evidence, I was satisfied to define a *separate* group of nurses - vocational professionalisers - who are involved in professionalising work but whose attitudes on certain issues are distinctly conservative or vocational.

The second marginal group, vocational bureaucrats, consists largely of matrons and administrators in hospital settings. These people are bureaucrats or organisers in their work, but their attitudes on several issues reflect their vocational - as opposed to professional - orientations. The people I interviewed at City Hospital were unanimous in their condemnation of *professionalising* changes in nursing. The following statements were made by four different people all holding senior administrative posts at the hospital.

"I have a name for the people on the Nursing Council who are always pushing for changes in nursing. I call them 'the ivory tower girls' - they're full of ideals, and they

speak beautifully about freeing the students from service commitments and so on - but why are we nursing? To provide a service, of course. I get called all sorts of names by them - they say 'You've got TPA[1] stamped all over you.'"

"These girls come here to nurse, but the syllabus seems to be pushing them up to degree levels ... It's crazy."

"I think that a lot of the theory is only included in the curriculum so that people can say 'Look what the nurses are studying these days.' It's no wonder that people don't apply to come nursing when they see all the physics, biochemistry and all the other subjects they're supposed to study. They just get scared off!"

"Well really, I think they are going overboard with the education side of nursing.... A lot of the students think, 'We didn't come here to get some degree or something; we want to work with sick people.'"

From these statements I think that the service-related orientations of these people, and their resentment of what they see as harmful professionalising reforms in nursing, are evident. As I see it, these vocational bureaucrats feel very bitter about being virtually powerless in the decision-making process which is having an enormous effect on their ability to adequately staff their hospitals, and yet being totally responsible for providing a service in their institutions. If they did have any say in the course that the process of professionalisation should take in South African nursing, I have no doubt that they would be greatly in favour of halting or even reversing the process.

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(1) TPA stands for Transvaal Provincial Administration - the authority charged with providing hospital services, among other things. The implication is that the respondent's sympathies clearly lie with service needs of hospitals rather than educational needs of student nurses.

5. SUMMARY

In this chapter I have tried to provide evidence to support the basic hypothesis which suggested itself to me during the experience survey: that there is no community of nurses. Indeed, I believe that there are a number of different groups or factions within nursing, all pulling in different directions.

The first of these groups can be called "bureaucrats". These are largely Pretoria-based administrators who have been responsible for increasing bureaucratisation of nursing services over the years.

The second group, "professionalisers", have also been increasingly active in recent decades, as evidenced in Table 48 and in the discussions of curriculum changes, minimum entrance requirements and so on, dealt with in the previous chapter. This group of nurses wants to see nursing with increased status and prestige as a result of increasing professionalisation.

The third group consists of a marginal group, "vocational professionalisers" or people who work in jobs that one would expect to encourage professional orientations (e.g. tutors, people working at the Nursing Association), but whose sympathies tend to lie with nursing service or vocational elements.

Finally, we discussed the existence of another marginal group, the "vocational bureaucrats" - hospital and nursing administrators who are very service oriented.

In the final chapter, we shall examine these groups and their effects on nursing in more detail.

CHAPTER 7: CONCLUSION

1. DISCUSSION OF RESULTS

In Chapter 4 we saw that there are indeed manpower problems in nursing, both locally at City Hospital and nationally in provincial hospitals around the country. However, even a brief look at the nursing literature over the last fifty years reveals that staff shortages are by no means a new phenomenon. The following, for example, are some titles of journal articles and the year of publication culled from the reference list in Yett's (1975) book:

"The crisis in nursing" (1930)
"Nurses needed" (1937)
"The shortage of nurses" (1945)
"Shortages are acute" (1947)
"Action to relieve nursing shortage" (1951)
"Shortage of nurses: no solution in sight" (1970).

While these titles refer to overseas problems, Searle (1965: 263) makes it quite clear that South Africa was never exempt from the ubiquitous "crisis". She states: "In 1944 it was estimated that South Africa needed 20 000 nurses on the basis of 1:500 population. The available registered nursing force in 1944 was approximately 8 000 ... Thousands of beds stood empty all over the country. In June 1947, there were 2 300 beds closed out of a total of 6 678 in Transvaal hospitals."

In view of these kinds of figures, one wonders whether the word "crisis" can justifiably be used to describe the chronic manpower problems in nursing.

The current manpower shortages should therefore be seen as an "acute-on-chronic disease", caused largely by the economic upswing in South Africa in the late 1970s. As salaries and

opportunities in other sectors improved, so nurses were attracted out of nursing, and potential recruits were drawn towards better-paid, less demanding jobs which were easily available. I shall return to this theme in the next section when the economic framework is discussed in more detail.

The particular form of the current problems was however, of interest. At City Hospital, although the staff situation in most categories was unfavourable, the major problems were in the student and pupil nurse and the nursing assistant categories. The latter can, I think, be explained in purely economic terms: nursing assistants are very poorly paid and relatively unskilled, and would be the most susceptible to opportunities in other sectors. I spent some time, however, wondering about the reasons for the shortages in the student and pupil categories[1]. (As I later discovered, it was also the student and pupil categories which were hardest hit in the provincial hospitals included in the questionnaire survey.) That [illegible] the study of the nursing education system became so [illegible].

This aspect was covered in Chapter 5, and the educational policies of the 1970s were examined in some depth. This was the first time that clear evidence of the *service versus education* dilemma in nursing became available. We saw that there were two opposing forces at work: one pushing for degree courses, higher minimum entrance requirements and increased theoretical components, and the other pushing for vocational courses, lower entrance requirements and more practical components in nursing education.

It appeared that not only did the interests of various people differ, but their perceptions of nursing as an occupation differed markedly as well. So many different images of nursing are held

(1) As we saw in Table 5, for example, the percentage of posts in this category at City Hospital dropped from 68% to 58% over just one year (1980 to 1981).

and the nurse's role is so loosely defined (nursing is everything that no-one else will do!) that people quite *naturally* have failed to clearly define the kind of education and training that this intangible worker requires[1]. If people agreed on the precise role of *the nurse, then* their images of nursing would be more consistent and the number and nature of the training courses necessary would be clearer. As it stands, however, the only way that people have been able to reach any form of consensus has simply been to add more courses to the official routes of entry into nursing, *so that we now* have five separate ones.

The study of the student files revealed quite clearly that there is a problem in the gap between academic suitability and theoretical requirements in nursing - *a problem which manifests* at the manpower level. In other words, students who are accepted for courses are often unable to cope with their *studies. This* dilemma would seem to have a fairly obvious solution: either the entrance requirements must be raised, so that only academically suitable candidates are *admitted*, or the theoretical requirements must be decreased, so that most students currently accepted are able to manage.

Why, then, has neither of these options been implemented, I wondered. This was when I began to realise that the lack of consensus in nursing was a severe problem. For the "force" which had been pushing for more theory, higher entrance requirements and so on, would not condone a *rationalisation of the* "educational standards" by decreasing the theoretical requirements. And in the same way, the "force" which had been pushing for vocational *courses*, lower entrance requirements and less theory, would not condone an increase in the entrance requirements.

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(1) *This problem of* role definition is not new. In his book, Abel-Smith (1960: 181) mentions a working party appointed in Britain in the 1950s "to examine such questions as 'What is the proper task of the nurse?', 'What training is required to equip her for that task?'".

It was at this stage that I had to come to terms with these nebulous "forces". What was I meaning by that term? And why did they seem to be so powerful yet so opposed? After I had initially become aware of the existence of several different "camps" within nursing during the interviews I conducted, I began to look for ways of verifying this impression. I found the bureaucratic files and questionnaires very useful in this process, and trust that the data presented in Chapter 6 have been adequate to substantiate the existence of several sub-groups within nursing.

At this point I must refer to the work of Strauss and Bucher (1971), who develop the idea that professions are in reality little more than "loose amalgamations of different segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history" (Strauss and Bucher, 1971: 10). They developed this notion in contrast to functionalist approaches which view professions as relatively homogeneous communities, whose members share identities, values, and definitions of roles and interests.

In their analysis, Strauss and Bucher isolate several values which segments of a profession often do not share, including work activities (consider the variety of tasks from research to teaching to administration which passes as "medicine", for example), techniques (consider the division within psychiatry about electrical and chemical therapy versus psychoanalysis, for example) and colleagueship (a radiologist may, for example, have more in common with radiographers than fellow doctors).

While I agree that the functionalist approach to professions is often simplistic, and that various segments do indeed exist within all professions and semi-professions that I know of, the argument I have presented in Chapter 6 must be seen in a different light. For I am suggesting divisions at a more fundamental level: as we shall see, I propose that these divisions are in fact tearing the occupation apart.

In summary, the major groups within nursing and the lines of conflict between them can, I think, be represented as follows.

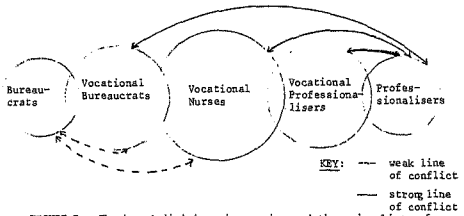

FIGURE 8. The broad *divisions in nursing* and the major lines of conflict between them.

As figure 8 shows, at the one extreme we have "bureaucrats" - full time administrators *divorced from immediate service needs* of hospitals who are employed by the provincial authority to ensure the best possible coverage *of staff in all the provinical* hospitals for the lowest possible cost to the province. The lines of conflict between the bureaucrats and *vocational-bureaucrats* (essentially matrons who are administrators immediately concerned with service needs of their hospitals) and between the *bureaucrats* and vocational nurses (those who actually provide nursing service on a day-to-day basis) are fairly weak at the moment. The matrons and nurses know that it is not really insufficient posts or positions for staff which is causing the manpower problems, but insufficient applicants to fill those posts already available.

Nevertheless, I have heard many sisters complaining about "Province's" lack of sympathy for the nurses and two of the matrons I interviewed - almost in a defensive amnesia about the root cause of their staffing problems - complained that the people from provincial headquarters were taking a long time to determine new staff establishments (the number of official posts for all categories of nursing staff) for the resited hospital. "We are just trying to fit old curtains into a new house until they calculate our new needs," one said.

Figure 8 shows that the major *lines of conflict seem* to emanate from the group represented on the extreme right - the professionalisers. It is essentially the South African Nursing Council which controls nursing in *South Africa:* it lays down admission criteria, the minimum length of training, subjects to be studied; it defines what acts nurses may perform and what constitutes disgraceful conduct; *and it keeps registers* and rolls of all practising nurses in the country. The authority clearly lies here - with people who can afford to divorce themselves from immediate *service considerations* in their capacities as Council members[1].

The *data presented* in Chapters 5 and 6 show that the Council's policies have caused considerable conflict between professionalisers and nurse educators (vocational-professionalisers) and *between professionalisers* and matrons (vocational-bureaucrats). My own experience as a nurse has afforded me every opportunity to hear the views of vocational nurses as well. They are *almost* uniformly scornful of the Council's policies concerning student education. "The students are never in the wards anymore!" and "They come here with their heads full of *useless theory which is* never needed on the wards," are the kind of comments that get passed between sisters over tea. My firm impression is that these lines of conflict are very strong; *that this is the* major cause of the ill-feeling between various groups in nursing.

Although I have not *indicated any other lines* of conflict, it must not be assumed that members of other groups always agree. Matrons often complain about the staff at college, for example, and ward sisters *often blame their matrons* for staff shortages and so on.

I do believe, however, that when one looks more deeply at the total situation in which all these groups are unhappily participating, then the accusations which are made can be seen for what

(1) The SANC consists of 30 members, some nurses, some doctors, some paramedics and some lay people. Thirteen (43%) are appointed by the Minister of Health, five (17%) are designated by Administrators of the four provinces, one (3%) *is designated by the SA* Pharmacy Board, one (3%) is designated by the SA Medical and *Dental Council, and 10* (33%) are elected by South African nurses.

they are: misplaced anger with the absent and all-powerful professionalisers who have caused the contradictions in nursing.

For it is my contention that many of the problems with which nursing finds itself today can be traced back to this major source of conflict between "ivory tower" professionalisers and other sub-groups in nursing which are fighting to ensure sufficient and well-trained (wo)manpower to provide the nursing service which the country demands. Manpower shortages, in the student and pupil categories especially, are largely caused by the nursing education policies, which in turn are largely a reflection of the lack of consensus or community among nurse leaders.

And underlying all this is the issue of nursing's semi-professional status. If nursing were a profession, surely salaries would be high; there would be high status and prestige, there would be clearer job descriptions and therefore greater consensus on educational needs; and there would be a greater amount of common interests on central issues, so that the inevitable sub-groups which occur in every occupation and profession would at least pull in the same general direction...

But before it is assumed that I am attributing all the manpower problems within nursing to the nursing education system and ultimately to the lack of "community" and semi-professional nature of nursing, let us try to locate the data in a broader economic context.

2. Placing the data in a broader economic context

As I mentioned in Chapter 1 when the objectives and relevance of the study were outlined, this work was designed to give some idea of some of the issues affecting nursing as an occupation. It is clearly beyond the scope of this work to provide an exhaustive analysis, and I was able to follow leads which only presented themselves during the course of the research. Because the emphasis in all the media reports was on simple economics, and because the data sources, methods and research settings I used

lent themselves to other emphases, issues of salaries and service conditions have been almost totally excluded from discussion so far.

This must not be interpreted as tacit approval of the present economic situation of nurses. On the contrary, I would be the first to call for radical changes in that sphere. The point is simply that economic explanations may not be sufficient to explain the current manpower problems. As I have mentioned, I see the present situation as an "acute-on-chronic attack". Figure 9 below depicts both the chronic contributing factors and the acute ones(1). As I see it, a solution to the chronic problem requires radical economic changes; while the acute problem could be ameliorated by changes at the educational level.

Looking at Figure 9, we see that the ongoing, chronic manpower problems can really only be changed at the economic level. If salaries were substantially improved, staff at all levels would be attracted, selection of candidates could be stricter and wastage would consequently drop.

At the acute level, however, we see that there are two major causes for the acute problems. The economic cycle is out of the control of nurse leaders, and recruitment is expected to improve once opportunities in other sectors decrease. The educational policies within nursing are amenable to immediate change, however. One possibility would be to increase the minimum entrance requirements thereby excluding the academically unsuitable candidates. While this makes theoretical sense, if the whole problem is viewed at once, it can easily be appreciated that this action in isolation would only exacerbate the shortages of students and pupils. Any raising of standards in nursing education would have to be accompanied by substantial improvements in salaries, status and conditions of service, if we are hoping

(1) Please note that I am forced to limit the model proposed in Figure 9 to the situation at "white" hospitals. My insight into and experience of the problems among black nurses are altogether too sketchy to include here.

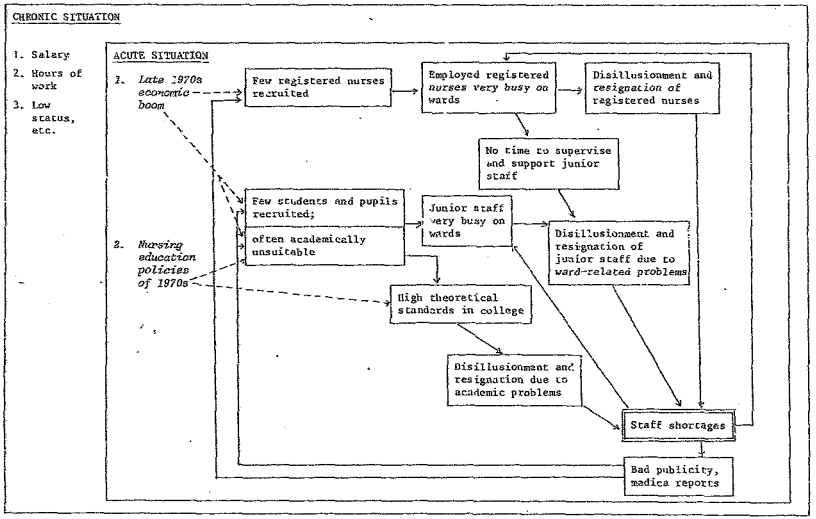

Figure 9. Factors affecting manpower shortages in "white" hospitals: a model

to attract academically capable recruits. Nursing has to compete with all the other occupations and professions for the best recruits[1].

This means that the only possible place left to break the cycle depicted in Figure 9 would be to decrease the theoretical requirements expected of students. Given the very active process of professionalisation that has been embarked upon by the "professionalisers" in nursing, it is hardly surprising that this action has received virtually no discussion.

The deadlock at the economic level (which does nothing to relieve the chronic problems), and at the educational level (which fails to relieve the acute problems) has left administrators in an unenviable position. Some of them have had to close wards, some have upgraded domestic staff, some have resorted to hiring staff from nursing agencies at higher rates of pay, some are negotiating for permission to hire black nurses to fill "white posts" ... These are the desperate attempts of people caught in a downward spiral trying to reverse the trend.

How has the current crisis situation been allowed to develop? In order to answer that question we need to look even deeper and try to locate the nursing situation in South Africa in a larger social, economic and political context.

3. Locating the data in the South African socio-economic-political structure

I believe that nursing must be viewed as one part of the larger health sector, which in turn is part of the larger society. This relationship plus the health sector's intersections with other sectors is illustrated in Figure 10.

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(1) No amount of decrying the "materialism" or "lack of dedication" of modern women will change this fact. Women are no longer left with the limited choices of nursing or teaching as careers, and if we are going to a) attract and b) maintain high quality recruits, we have to come to terms with these realities.

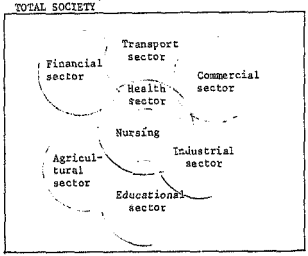

Figure 10. Nursing's relation to the health sector, other sectors and the larger society

As happens with all sectors, the strengths and weaknesses of the larger society find reflection in the health sector and in nursing. In South Africa, therefore, if we seek to understand nursing, we need to study the nature of the total society.

At the economic level, South Africa is a capitalist state, and it is a characteristic of capitalist economies that services like health and education are classified as "non-productive sectors" and receive little sympathy from "productive" or income-generating sectors. To a large extent, the capitalist emphasis on profit and economic productivity may explain the lack of attention that service-providers have received in the way of salary increases and improved conditions of work.

At the political level, South Africa is sharply divided along racial lines. This division finds clear reflection in the health sector and in nursing. For example, we have separate hospitals for different racial groups; separate training schools; separate registers and rolls and so on These factors together with some of the social issues raised below account for the fact that "nursing problems" cannot be studied without separating the

issues of "white nursing" from those of "black nursing" as I have unfortunately been forced to do in this study.

At the social level, there are a number of factors operating in the larger society which affect nursing to a great extent. Sexism results in nursing, a predominantly "female occupation", receiving even less concern and consideration than other service sectors like teaching. Elitism, which I define as a form of upward social mobility designed to distance members of the elite from the mass of "ordinary" people, is prevalent, and nursing provides a route especially for black women whose opportunities in other occupations are still somewhat limited. This may account for the excess of applicants at black nursing schools we discussed in Chapter 4. Professionalism is highly prized in society, and trade unions have been viewed as working class concerns and more recently (with the emergence of black labour unions) as somewhat subversive organisations. This might explain why nurses despite the most obvious provocations, have resisted unionization and remained loyal to the idea of "professional negotiations" through the Nursing Association.

These, then, are some of the societal factors I see reflected in the South African nursing situation. I find this context useful for explaining some of the apparent inconsistencies and injustices within nursing.

4. Nursing - in a perpetual process of professionalisation?

I have argued throughout this work that a reasonable place to begin analysing nursing in South Africa is to use the concept of "semi-profession". In Chapter 3 I presented a fairly detailed account of sociological writings on this subject. In Figure 5 I presented Pavalko's occupation-profession model with my own ideas of the positions that nursing had achieved on each of the dimensions.

An assumption which seems to be uncritically made by all the authors I discussed in Chapter 3, is that semi-professions can

"progress" and eventually become fully fledged professions. The alternative term "profession in process" is used by some authors, and strongly implies that such occupations are in the process of moving towards the *professional pole* of the continuum.

While this assumption may well apply to particular occupations which I have not studied in any detail, I would like to end this study by posing what seems to me to be an important question for nurses everywhere.

If we accept that nursing is a semi-profession - and this is by no means widely accepted among nurse-leaders at least - are we justified in assuming that one day nursing will achieve full professional status? Or is there something in the history (for example, nursing's strong links with religious and altruistic motivations; its female composition; its development as provider of assistants or even "handmaidens" to doctors; its relatively low status) and the nature of nursing (the fact that much nursing can be performed by untrained people like relatives of patients; the "dirty work" element of much nursing care; the dependence of nurses on doctors' orders for so much of their work) that combines to make nursing forever a semi-profession? Are nurses being pulled onto a course of professionalisation where the end-point can never be achieved? Is nursing doomed to be in a perpetual process of professionalisation?

5. Some suggestions for future research

I conclude this study by making a few suggestions for future research.

First, a few ideas which stem directly from the limitations of this work as I indicated in Chapter 1. First, a phenomenological study of the views of practising nurses themselves would be very valuable. How do they feel about the "crisis", and what defenses have they developed to deal with it. Second, I pointed out that this study can in no way be viewed as an adequate account of "South African nursing" as a whole. As I have

continually emphasized, the situation among black nurses urgently requires further study. Qualitative and quantitative data in this regard would be invaluable. Third, this study was limited to provincial hospitals, so the manpower situation in private institutions requires further study.

Nurse leaders all seem to be unanimous (in their public statements at least) in their conviction that nursing is a "profession". Seldom does an opportunity go by without the word "profession" being used to describe nursing[1]. I personally have never intuitively accepted these claims, and since studying the issue from a sociological viewpoint, am convinced of nursing's "semi-professional" nature. I think it would make a fascinating area of research to find out what the mass of practising nurses think of the issue. Do they feel "professional", or do they resent all the public statements and feel cheated because they know that all the benefits of professional status are denied them, although none of the benefits of unionization are realised.

Another area of interest I have been aware of for a while now concerns the attitude of nurses and nurse leaders to the new marginal group of "Primary Health Care Nurses" who are trained in diagnosis and treatment of disease. These nurses, who are closely approaching doctors in their day-to-day work, seem to be eliciting a lot of insecurity among their colleagues. It is my belief that nurses have for so long tried to create a meaningful niche for themselves as "professionals in their own right", that this new category of nurses is viewed as a threat because they may actually be accepted as fellow professionals by doctors. Hence the inordinate amount of preaching that Primary Health Care Nurses get subjected to about how "a nurse is a nurse and will always be a nurse" and so on. This "hunch" of mine needs research, however.

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(1) As Katz (1969: 71) has noted: "Few professionals talk as much about being professionals as those whose professional stature is in doubt".

Another area of research could be to investigate the notion of a "perpetual semi-profession" as I have outlined in the previous section. Are there other examples of such semi-professions? If a semi-profession is doomed never to achieve full status, what alternative rewards can be offered members to keep them motivated? Is "professional organisation" more appropriate than unionisation in such cases?

Finally, the most obvious suggestion for future research must be that should any intervention occur to alter the present situation outlined in Figure 9 earlier in this chapter - for example, if there are considerable changes in the nursing education policies, or if staff shortages are relieved by using national servicemen, or if salaries are substantially improved - then further research should be done to assess the impact of that intervention. I hope that the present study will provide future researchers with some useful baseline data.

These are just a few ideas for future research. As so often happens when a study is completed, I almost wish I could begin again now with all the insights I have gained during this work. However, it is to be hoped that this work has provided some useful information about nursing for those in positions of leadership, and a framework to analyse and understand nursing for all the nurses who have never had the opportunity to look critically at the occupation and its organisation.

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Girls Are Returning to Nursing Again. The Star, 16 January 1982, p. 2.

APPENDIX 1

INITIAL LETTER OF INTRODUCTION TO QUESTIONNAIRE RESPONDENTS

University of the Witwatersrand, Johannesburg

1 Jan Smuts Avenue, Johannesburg, 2001, South Africa
Telephone 39-4011, Telegrams "University", Telex 8-7330 SA

DEPARTMENT OF SOCIOLOGY

19th March, 1981.

Dear Matron

re: Assistance with research project into the "nursing crisis".

I am an ex-nurse busy doing a Masters degree in Medical Sociology at the University of the Witwatersrand. My research topic is "the nursing crisis", and the focus of the work so far has been on one of the hospitals in Johannesburg. In order to establish whether my findings are typical of other South African hospitals or unique to Johannesburg, I would very much like to gather some comparable data from a sample of hospitals.

Your hospital is one of forty which I randomly selected, and so I would like to send a very brief questionnaire to you within a week or two. Part 2 of this consists of six questions which I would very much like you, as matron, to answer, and Part 1 consists of two tables which could be completed by one of your administrative staff. Table 1 concerns recruitment figures for student nurses, and may not be applicable in your hospital. Table 2 requires data about your staff establishment and actual posts filled in the various nursing categories.

Could you please leave a message with your secretary stating the name of the person who would complete the table(s) in Part 1, and I will telephone her in a few days time to get it. Thereafter, the questionnaire with a covering letter and a stamped, addressed envelope will be posted and should reach you within a week.

I can assure you that all information will be treated in confidence and that you and your hospital will enjoy complete anonymity in any reports relating to the research. Since I have had to limit the sample to only forty hospitals in the whole country, I am sure you can appreciate how imperative it is that I get accurate responses from all of them. Your assistance in this project will therefore be greatly appreciated.

Thank you very much.

Yours sincerely,

Meryl Hammond.

Miss M. Hammond.

Any further enquiries may be addressed to:

Research supervisor:

Prof. P. Zarnita.

University of the Witwatersrand, Johannesburg

1 Jan Smuts Avenue, Johannesburg, 2001, South Africa
Telephone 39-4011, Telegrams 'University', Telex 8-7330 SA

DEPARTMENT OF SOCIOLOGY

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Thank you very much.

Yours sincerely,
Meryl Hammond.
Miss M. Hammond.

Any further enquiries may be addressed to:

Research supervisor:

Prof. P. Zernita.

APPENDIX 2

COVERING LETTER TO QUESTIONNAIRE RESPONDENTS AND QUESTIONNAIRE

University of the Witwatersrand, Johannesburg

1 Jan Smuts Avenue, Johannesburg, 2001, South Africa
Telephone 39-4011, Telegrams 'University', Telex 8-7330 SA

DEPARTMENT OF SOCIOLOGY

26th March, 1981.

Dear Matron

re: Request for assistance with nursing research project.

For the last twelve months I have been doing research on the so-called "nursing crisis" for my M.A. degree in Medical Sociology at the University of the Witwatersrand. I am particularly interested in this problem as I am a recent nursing and midwifery graduate myself. The focus of the work so far has been on one of the hospitals in Johannesburg where I have made extensive use of personnel files. The monthly statistics concerning staff establishment, and interviews with various matrons, hospital administrators, tutors, and officials at the Nursing Council and Association have also been most helpful.

As the research is now in the final stages, I would very much like to compare some of the findings concerning manpower problems with the situations in other hospitals. It has often been said that the "crisis" is limited to the commercial centre in South Africa - Johannesburg, and although I have plenty of casual reports to the contrary, I cannot make any definite statements about the extent of the problem without your assistance.

I would therefore be very grateful if you could ask
to complete the two tables in Appendix 1. I believe that all the figures requested should be immediately available from your routine hospital statistics. Thereafter, if you personally could complete Appendix 2 and then return both sections in the enclosed addressed and stamped envelope as soon as possible, that would be a great help to me.

I assure you that the results will be treated confidentially, and that you and your hospital will enjoy complete anonymity in the research report and any subsequent publications.

Thank you very much for your time and concern. I look forward to receiving your reply in the near future.

Yours sincerely,
Murryl Hammond.
Miss M. Hammond.

Research supervisor:

Prof. P. Zernits.

APPENDIX 1

INFORMATION ABOUT MANPOWER AT ..... HOSPITAL.

Kindly complete the following two tables.

1) Recruitment of student nurses (excluding midwifery, degree, and pupil enrolled nurses; including only students registered for the diploma in general nursing or an integrated diploma course in general and/or midwifery and/or psychiatric nursing.)

No. students recruited in:	YEAR OF RECRUITMENT 1979	1980	1981
JANUARY			
FEBRUARY			
TOTAL FOR WHOLE YEAR			

2) Staff establishment (number of authorised posts) and posts actually filled in various categories at January and July each year.

STAFF CATEGORY	DATE Jan. 1979		Jul 1979		Jan 1980		Jul 1980		Jan 1981	
	Staff established	Staff in post	Staff established	Staff in post	Staff established	Staff in post	Staff established	Staff in post	Staff established	Staff in post
Full-time senior sisters										
Full-time sisters										
Part-time sisters and senior sisters										
Staff nurses (enrolled nurses)										
Student and pupil nurses ⊛										
Nursing assistants ⊛ and pupils										
.....										

⊛ If you keep separate figures for these groups, please cross one out and use the blank space provided.

APPENDIX 2

COMMENTS (To be completed by the chief matron if at all possible; if not, by one of the senior nursing administrators, please.)

1) Please tick the appropriate block, where 1 is "vitally" and 5 is "marginally".
I THINK THE FOLLOWING INDIVIDUALS/ORGANIZATIONS AFFECT NURSING:

	VITALLY		MODERATELY		MARGINALLY
Minister of Health	1	2	3	4	5
Directors of Hosp. Servic.	1	2	3	4	5
S.A. Nursing Association	1	2	3	4	5
Minister of Finance	1	2	3	4	5
S.A. Medical and Dental Council	1	2	3	4	5
Vocational guidance teachers	1	2	3	4	5
S.A. Nursing Council	1	2	3	4	5
Medical Association of S. A.	1	2	3	4	5
Any other	1	2	3	4	5

2) In the recent media reports about nursing problems, many voices have been heard. Who do you think is best equipped to state the case for nurses most successfully a) in public statements and b) in private negotiations? Please number your first three choices in each column using the numeral 1 for first choice and 2 and 3 for second and third choices respectively.

	a) Public statements	b) Private talks
S.A. Nursing Council	☐	☐
Individual nurses	☐	☐
Individual doctors	☐	☐
S.A. Nursing Association	☐	☐
Informal groups of nurses	☐	☐
Medical Association or Council	☐	☐
Any other (specify)	☐	☐

cont. overleaf

APPENDIX 2

COMMENTS (To be completed by the chief matron if at all possible; if not, by one of the senior nursing administrators, please.)

1) *Please* tick the appropriate block, where 1 is "vitally" and 5 is "marginally".
I THINK THE FOLLOWING INDIVIDUALS/ORGANIZATIONS AFFECT NURSING:

	VITALLY		MODERATELY		MARGINALLY
Minister of Health	1	2	3	4	5
Directors of Hosp. Services	1	2	3	4	5
S.A. Nursing Association	1	2	3	4	5
Minister of Finance	1	2	3	4	5
S.A Medical and Dental Council	1	2	3	4	5
Vocational guidance teachers	1	2	3	4	5
S.A. Nursing Council	1	2	3	4	5
Medical Association of S. A.	1	2	3	4	5
Any other	1	2	3	4	5

2) In the recent media reports about nursing problems, many voices have been heard. Who do you think is best equipped to state the case for nurses *most* successfully a) in public statements and b) in private negotiations? Please number your first three choices in each column using the numeral 1 for first choice and 2 and 3 for second and third choices respectively.

	a) Public statements	b) Private talks
S.A. Nursing Council	☐	☐
Individual nurses	☐	☐
Individual doctors	☐	☐
S.A. Nursing Association	☐	☐
Informal groups of nurses	☐	☐
Medical Association or Council	☐	☐
Any other (specify)	☐	☐

cont. o Loaf

APPENDIX 2 cont.

3) Are you personally on any of the S.A.N.C. ad hoc committees or a branch member of S.A.N.A. etc? If so, why do you view it as an important role?
If not, how do you view such "professional" participation?

4) Please tick the appropriate box regarding aspects of the general nursing curriculum.

	a) Should be taught in more detail	b) Satis	c) Content should be decreased
CHEMISTRY/PHYSICS	☐	☐	☐
MICROBIOL/PARASITOLOGY	☐	☐	☐
ANATOMY	☐	☐	☐
PHYSIOLOGY	☐	☐	☐
MEDICAL PATHOLOGY	☐	☐	☐
SOCIAL SCIENCES	☐	☐	☐
NURSING SCIENCE AND ART	☐	☐	☐

5) Do you have any general comments on nursing education (i.e. the formal teaching)?

6) Using the numeral 1 in the brackets to indicate the most significant cause of nurses' disillusionment with practice, and 6 to indicate the least significant cause, please rank the following:

LOW STATUS ( )

SALARIES ( )

LACK OF CAREER OPPORTUNITIES ( )

INCONVENIENT HOURS OF DUTY ( )

FEELINGS OF WORTHLESSNESS COMPARED WITH DOCTORS AND PARA-MEDICS ( )

FRUSTRATION THAT IDEALS CANNOT BE IMPLEMENTED DUE TO "RED TAPE", RULES etc ( )

Thank you very much. If the person who has completed this is not the chief matron, please state your rank.

Rank: .....

APPENDIX 3

LETTER OF REMINDER TO LATE QUESTIONNAIRE RESPONDENTS

University of the Witwatersrand, Johannesburg

Dear Matron,

re: Reminder about a study into the nursing situation in South Africa.

Some weeks ago, I sent a letter of explanation and a questionnaire to this address, but have, as yet, not received a reply. It is quite possible that the original correspondence did not reach you because it was addressed to individual matrons who may no longer be working. It is also possible that you did receive the letter but have been too busy until now to reply.

May I ask you please to give this matter your urgent attention as I am just waiting for these results before handing in my thesis. In case you never received or have mislaid the first letter, a copy is enclosed here. If you have already posted a reply, please disregard this reminder.

Thank you for your assistance - I do appreciate your help.

Yours,
Merryl Hammond.

Merryl Hammond.
Merryl Hammond.

APPENDIX 4

KARDEX SHEETS IN CURRENT USE AT CITY HOSPITAL FOR STUDENT AND PUPIL NURSES

P.P.H. 766 XY

IDENTITY NUMBER / IDENTITEITSNOMMER
SURNAME / VAN
CHRISTIAN NAMES / VOORNAME

FILE NUMBER / LêER NOMMER

RACE CLASSIFICATION / RASSEKLASSIFIKASIE
NATIONALITY 17 / NASIONALITEIT
HOME LANGUAGE 12 / TUISTAAL
LANGUAGE MEDIUM / MEDIUM VAN ONDERRIG
SCHOOL / SKOOL
HOSPITAL / HOSPITAAL
COLLEGE / KOLLEGE
UNIVERSITY / UNIVERSITEIT

PAST / VERLEDE

SEX / GESLAG: XX 5
MARITAL STATE / HUWELIKSTAAT: XX
DATE OF MARRIAGE / DATUM VAN HUWELIK: XX
DATE OF DIVORCE / DATUM VAN SKEIDING: XX
DATE OF REGISTRATION / DATUM VAN REGISTRASIE: XX
DATE OF DISCHARGE / DATUM VAN ONTSLAGNEMING: XX
REASON FOR LEAVING / REDES VIR VERLATING: XX

Institution Abbreviation / Inrigtingsafkorting
Age at Child was by School Leaving Standard or Age / Ouderdom by Skoolverlating Standard
Date of Admission / Datum van Toelating
Date of Discharge / Datum van Ontslagneming
Reason for Discharge / Rede vir Ontslagneming
Class / Klas
Year / Jaar

NAME OF SCHOOL / NAAM VAN SKOOL 22
EDUCATIONAL CERTIFICATE / SKOOLSERTIFIKAAT 21 XX
DATE OF MEDICAL-DENTAL CERTIFICATE / DATUM VAN MEDIESE/TANDHEELKUNDIGE SERTIFIKAAT 12 XX

	Subjects Passed / Vakke Geslaag 23	Symbol / Simbool	Subjects Failed / Vakke Gedruip	Symbol / Simbool
1	XX	XX	XX	XX
2				
3				
4				
5				
6				
7				

25 Position / Rangorde / Standing / Posisie / Subjects / Vakke: Weighting / Weging / Standing / Posisie / Subjects / Vakke: Outstanding / Onderstreep

NAME OF NEXT OF KIN / NAAM VAN NAASTE BLOEDVERWANT 31
RELATIONSHIP / VERWANTSKAP
ADDRESS / ADRES
PHONE NO. / TELEFOON NR.

NAME OF RELATIVE / FRIEND (LOCAL) / NAAM VAN FAMILIELID / VRIEND (PLAASLIK)
RELATIONSHIP / VERWANTSKAP
ADDRESS / ADRES
PHONE NO. / TELEFOON NR.

S.A. MEDICAL COUNCIL REG. NO. / S.A. MEDIESE RAAD REG. NO.
S.A. MEDICAL / DENTAL BOARD / TANDHEELKUNDIGE RAAD: REGISTRATION / EXCLUSION OF LEARNING / REGISTRASIE / UITSLUITING VAN LEERLING
U.S.A. MEDICAL / DENTAL BOARD / TANDHEELKUNDIGE RAAD: REGISTRATION / EXCLUSION OF LEARNING / REGISTRASIE / UITSLUITING VAN LEERLING

CLASSICS / KLASSIEKE TALE / VERLEDE TALE A / VERLEDE TALE B / DATE OF JOINING ASSOCIATION / ANNUAL SUBSCRIPTIONS / DATUM VAN TOETREDING VAN VERENIGING / JAARLIKSE INTEKENGELDE

1 2 3 4

5 ANNUAL / JAAR / VERLOF

From / Van	To / Tot	Days / Dae
TOTAL / TOTAAL 32		

Study / Vakansie Leave Only / Slegs Vir Studie Verlof

From / Van	To / Tot	Days / Dae
TOTAL / TOTAAL		

31 SICK LEAVE / SIEKTE VERLOF

From / Van	To / Tot	Days / Dae
TOTAL / TOTAAL		

32 ATTENDANCE AT COLLEGES / BYWONINGS AAN KOLLEGES

Session / Sessie	From / Van	To / Tot	Total no. Days Attended / Totale Aantal Dae Bygewoon
1 1ST			
2 2DE			
3 3RD			
4 4TH			
5 5TH			
6 6TH			
7 7TH			
8 8TH			
9 9TH			
10 10TH			
TOTAL / TOTAAL			

BLOCK LEAVE / BLOK VERLOF

From / Van	To / Tot	Days / Dae
TOTAL / TOTAAL		

PHOTOGRAPH / FOTO

33 MEDICAL EXAMINATION / SAWG EKSAMEN

First Year / Eerste Jaar

Date / Datum	Hb% / Vergl. II	Urinalysis / Urinontleding	Remarks / Aanmerkings

Second Year / Tweede Jaar

Date / Datum	Hb% / Vergl. II	Sp. Gr. / Soort. Gew.	Albumin / Albumien	Sugar / Suiker	Visual Acuity / Visuele Skerpte

Third Year / Derde Jaar

Date / Datum	Hb% / Vergl. III	Urine Albumin / Urien Albumien	Sugar / Suiker	Sp. Gr. / Soort. Gew.

Fourth Year / Vierde Jaar

Date / Datum	Hb% / Vergl. III	Urine Albumin / Urien Albumien	Sugar / Suiker	Sp. Gr. / Soort. Gew.

3 blocks left all (same as above)

RESIDENCE OF TRADITIONAL OFFICIANTS / VAN OFFISIANTE 36

	Sex / Geslag	Number / Getal	Total / Totaal
MEDICAL PRACTICE / MEDIESE PRAKTYK	Male / Manlik		
	Female / Vroulik		
EMERGENCY NURSING / NOODVERPLEGING	Male / Manlik		
	Female / Vroulik		
OBSTETRICS / VERLOSKUNDE	Midwife / Vroedvrou		
	Obstetrician / Verloskundige		
GYNAECOLOGICAL / GINEKOLOGIESE			
PLASTIC OR BURN SURGERY DEPT. / CHIRURGIE OF BRANDWONDE AFD.			
ORTHOPAEDIC HOSPITAL / ORTHOPAEDIESE HOSPITAAL			
OPHTHALMIC / OFTALMIES			
PAEDIATRICS / PAEDIATRIES	Medical / Mediese		
	Surgical / Chirurgies		
PREVENTIVE AND PROMOTIVE HEALTH CARE AND FAMILY PLANNING / VOORKOMENDE EN BEVORDERENDE GESONDHEIDSORG EN GESINSBEPLANNING			
OTHER / ANDERS			

TUBERCULOSIS / TERINGSIEKTE			
ANTE NATAL / VOORGEBOORTE			
CANCER WARD / KANKERAFD.			
LYING-IN WARDS / KRAAMKAMERS			
Number of Wards Examined Ante Natal / Aantal Wyke Ondersoek Voor Geboorte			
Number of Absent Without Leave / Aantal Onwettige Afwesendes			
Number of Patients Delivered / Aantal Bevallinge Onder Toesig			
Number of Maternal Deaths / Aantal Moedersterftes			
HOSPITALS / HOSPITALE			
DISTRICT / DISTRIK			
Number of Maternal Readmissions / Aantal Moederlike Readmissies			

We Live to Wo... / Aantal Gevalle Verloor / Aantal Lewendes na Ander Verpleeg / HOSPITAL / HOSPITAAL

206

CLINICAL INSTRUCTION AND PRACTICA — KLINIESE ONDERRIG EN PRAKTIKA

T.P.H. 173 K1

Date/Datum		Ward No.	Medics Medical			Surgical Chirurgiese			Gen. G.P.D.	Theatre	Paediatric Pediatriese		Other (specified	Leave/Verlof			Block				
From/Van	To/Tot	Saal No.	Male Mans	Female Vrouens	Infec. Aansteek	Male Mans	Female Vrouens	Gynae Gin.	Organ. Bullep	Operate-seal	Medical Mediese	Surgical Chirur.	Ander Spesialiteer	Vac. Vak.	Sick Siek	Broke Onder-breek	Blok				

APPENDIX 5

CLINICAL ASSESSMENT FORM IN CURRENT USE FOR STUDENT AND PUPIL NURSES AT CITY HOSPITAL

JOHANNESBURG HOSPITAL

SURNAME _____ RANK _____

CHRISTIAN NAMES _____

_____ NEE _____

PERIOD OF REPORT: FROM _____ TO _____

WARD OR DEPARTMENT _____

GENERAL REMARKS: (must be completed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

SIGNATURE OF ASSESSOR SIGNATURE OF STUDENT

_____ _____

DATE DATE

_____

SIGNATURE OF MATRON IN CHARGE

_____

DATE

P.M.O.

APPENDIX 6

COLLEGE ASSESSMENT FORM IN CURRENT USE FOR STUDENT AND PUPIL NURSES AT CITY HOSPITAL

R.C. ALEXANDER COLLEGE OF NURSING

CONFIDENTIAL REPORT

HOSPITAL: .....

SURNAME: ..... RANK:.....

CHRISTIAN NAMES: .....

DATE OF APPOINTMENT: .....

PERIOD REPORTED ON: FROM:..... To .....

BLOCK: .....

YEAR OF TRAINING: .....

SCALE.

7. Excellent
6.
5.
4.
3.
2.
1. Very poor

1.) Attention in Class

7 6 5 4 3 2 1

Remarks .....

2.) Participation in Class Discussions or activities

Actively Participative 7 6 5 4 3 2 1 Indifferent Reticent

Resourceful

Remark .....

3.) Ability to Learn

7 6 5 4 3 2 1

Remark .....

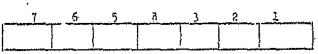
4.) Willingness to Learn

7 6 5 4 3 2 1

Remark .....

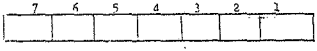
2/.....

5.) Use of Study Time in College



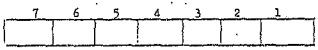
Remark .....

6.) Co-operation with Tutors



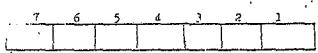
Remark .....

7.) Interaction with Colleagues



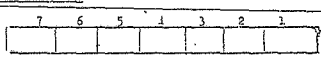
Remark .....

8. Manners and General Behaviour



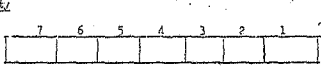
Remark .....

9.) Reaction to Discipline



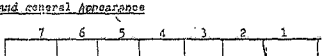
Remark .....

10.) Punctuality



Remark .....

11.) Neatness and General Appearance



Remark .....

3/.....

-3-

Class Aggregate: .....

Student's Test Marks .....

.....

.....

.....

Aggregate: .....

Attendance Role .....

General Remarks:

Date: ..... Signature of Person making report .....

I ..... have read this report.

Signature of person reported on .....

APPENDIX 7

SOME RELEVANT NEWSPAPER HEADLINES

Patients say 'no' to coloured nurses

Own Correspondent

CAPE TOWN—A measure introduced at Groote Schuur Hospital to beat infectious staphylococcus has

fice, of Health, Dr R J Coogan said: "This was a case of extreme apartheid. We couldn't change the whole staff structure because of such a complaint

The nursing drop-outs: survey tells why they do it

Tribune Reporter

HALF the student nurses who drop out do so in their first six months of training.

According to a survey

ly routine tasks only. Balanced against this are a number of costs which are incurred by hospitals to employ these persons."

Included in these costs is recruitment, selection, orientation, training,

RDM 17/2/81 p11

Nursing board 'not satisfied'

By GERALD REILLY
Pretoria Bureau

THE Board of the South African Nursing Association was "not satisfied" with the overall 12% salary increases for nurses, the president of the

advised by the Minister of Health, Dr L A P A Munnik, that certain critical categories of nurses would get increase of up to 20%.

"But we can't say which

Star 15-1-81 p2

Black hospitals short of nurses and radiographers

Medical Correspondent

Some black hospitals in

expected to resume soon.

Dr Ton Nash, super-

(Sana) conferences in Kempton Park this week

Star 8/4/81 p5

Nurses 'need not know so much'

Potential nurses were being lost to the profession because they were expected to know too much, said a Cape Town doctor writing in the SA Medical Journal.

The doctor said nurses were taught too many things that were not necessary for the making of a good nurse.

"Nursing is a noble profession; there is no need to mix it with the medical profession which is what is happening today. It is preached constantly that the nurse should know enough to be able to observe in her patient those signs and symptoms which will make it possible for her to cope with an emergency before it arises.

"Surely this is the duty of the good doctor who attends to his patients regularly. Is it his duty to tell the nurse to look out for certain changes in the patient and report these to him at once."

Nurses who cared for children and those who worked in intensive-care wards needed special training. They should be able to obtain special certificates proving them capable of looking after patients in special wards or under certain special conditions.

The doctor added: "For basic training the syllabus should be worked out so that anybody with commonsense should be able

to pass the examination, in very much the same way that doctors are first of all required to pass the basic examination and only after that start specialising in the different fields of medicine."

He was sure the SA Nursing Council should be able to work out a simplified but practical course for nurses.

A spokesman for the SANC commented: "I cannot see the council drop-

COMMEN

The Star

Apartheid in the face of death

THE story of Mr David Neppe, at his dying father-in-law and Johannesburg Hospital provides an unhappy vignette of life in in private hospitals for whites, but not in provincial ones. Lunacy that even in the face of death an apartheid rule should lients of care.

swer to the crisis in usval hospitals is to at apartheid, as Natal decided to do. The f black nurses is much Nursing is still a cupation in the black but there are facilining only a fraction o apply. Step up those et blacks fill the va- in white teaching hos- South Africa will be f two favours — re- racial injustice, and nsible use of all its ills.

Groote Schuur nursing sisters lash out at working conditions and new pay rates

Sunday Tribune 18th May 1980

By Tony Spencer-Smith

PATIENTS at Groote Schuur Hospital are at serious suffering because of a "said one

Sunday Express 18th May 1980

Hospital may go for all-race staff

THE Chief Medical Superintendent of the Johannesburg Hospital is making up his mind whether to push for integrated staff as the only way to beat the shortage of nurses.

Nurses interviewed there this week will back him on integration and patients said in a recent Sunday Express survey that they would prefer integration to being short of staff.

The superintendent, Dr Neville Howes, said this week: "It is an aspect that I am thinking about at the moment. I am doing my own investigation."

Dr Howes said he would decide, once he had completed the investigation, whether to recommend integration to the provincial authorities.

The Sunday Express has established that several wards are unused because of the staff shortage.

The problem has led to a shortage of beds and staff in the casualty department, and this is one of the main causes

WHITE NURSES BACK IDEA

BY ANGELA

Star 10/2/81 p2

'Catastrophic decline' warning on hospitals

By Bob Kennaugh
Medical Correspondent

A catastrophic decline in South Africa's medical

time rates, inconvenience compensation for certain branches of nursing and a scarcity allowance for specialised nurses.

dropped in our hospitals, including the major teaching hospitals.

"Unless some or all of these measures are adop-

He said the nursing shortage was a much more complex situation than it appeared. Medical services were being duplicated in

hospitals for dif-
ace groups and
both costly and
ary.
nurses should be
same salaries as
nd all nurses
receive pay
of up to 50
o put them on a
their colleagues
y, he said.

r

twatersrand."
or Tobias has
nurses' salaries
e improved and
provincial and
hospitals should
nurses.
den Heever said
were offered to
ses in white hos-
as would be at-
the cities, put-
train on health
country areas.

Star 6/2/81 p3

Johannesburg Hospital hit by 'terrible' nursing crisis

By Bob Kennaugh
Medical Correspondent

Doctors fear the multi-million rand Johannesburg Hospital is being brought to its knees.

Several Rand hospitals including the Johan-

of nurses is critical. It is terrible. There is an acute bed shortage; basic X-ray procedures, for example chest X-rays, are being delayed and the number of specialised radiographic procedures reduced. Doc-

required admission would have to be treated at home.

"Casualty officers are expressing concern about the legal implications of the crisis. Will they receive indemnity from

Star 25/3/81 p11

Row over nurses' increase

Own Correspondent
DURBAN — Nurses have

from all the city's hospitals are expected to at-

nister of Health, Welfare and Pensions, Dr Munnik, said an average increase of 12 percent would be granted to nurses from April 1.

Opposition spokesmen on health yesterday urged

Dr Munnik to begin an in-depth, urgent inquiry into nurses' working conditions.

Dr Marius Barnard, PFP MP for Parktown, and Mr Sam Moss, PFP MPC for Parktown, wel-

comed the salary
for nursing sist
added that all
should be given e
and opportunities.
"The question
the increases halt
dus of nurses fr
vincial hospitals
tract student nurse
Mr Moss.
Nursing authori
unhappy about as
their "new deal"
already negotiatin
Dr Munnik.
Professor C
Searle, president
South African Nur
sociation, said tha
nurses had sco
many respects by
given special rec
on salaries, there w
satisfaction about

Sunday Times 25/5/80

Nurses' unmentionables

THE refusal by the Administrator of the Transvaal, Mr Willem Cruywagen, to disclose nurses' salaries is another example of the arrogance of power which has overcome the Nationalists as a result of their overlong tenure in office.

It is not Mr Cruywagen's money which pays provincial salaries, but the taxpayers'.

Considering the level of nurses pay, it is easy to understand why the Administrator doesn't want to mention them in public.

Tribune 11/1/81 p4

Nurses...birds of a dying species?

By William Saunderson-Meyer

I MAY be called Nightingale profession, but in South Africa the nursing species is definitely on the endangered list.

The countrywide intake of student nurses is well down on last year's figures and although official sources are tight-lipped, resignations in 1980 ap-

Nursing Association, the body which officially represents all nurses, seems to be too intent in negotiating with Senator Horwood about possible increases, to take any firm public stand on what

ed that standards were being jeopardised by inadequate numbers and quality of nursing staff.

Dr P. Heberden, principal medical officer at the Johannesburg Hospital, wrote: "The apathy and

than half its nursing complement. No applications have been received for the 15 student nurse posts.

• There is a shortage of nearly 1 000 nurses in the Cape Peninsula hospitals.

• The Germiston Hospital filled 70 student

its three years year it has five rses.

Boksburg-Benoni uid fill 54 posts ts a few years year it has eight rses.

sources point he drop-out rate udent nurses is 50 percent: One ng girls come to aining and find are often being at the deep end. esome respons- resign."

ansvaal Director al Services, Dr Grove, has said ppears that more ll have to shut

"official" reasons for nurses leav- profession, with lways well down. t, if it appears at en one speaks who have resign- message is clear- the secondary r resigning, such emotional stress, s, weekend work ast straw is the y low salaries.

borne out by a e over four years Hospital, where und that 95 per- he nurses leaving d salaries to be e.

rsing sister, who d all her training with honours, n interview: "I en I chose nurs- the hours would e. But for me the w was when my l a class reunion. as, the brightest he class, earning all the other

PATIENTS DIE IN NURSING CRISIS

Express 17/4/81 p1

By DEBRA CLEVELAND

PATIENTS have died at the Johannesburg Hospital because there were not enough nursing staff to give them adequate care and attention.

This allegation was made by nursing sisters and confirmed by a doctor at the hospital in the course of a major Sunday Express investigation.

THE HOSPITAL | CRISIS





The doctor, who wishes to

"I can tell you that both were salvageable and probably would have lived if they had been in either the inten-

Sunday Express 20/7/80. PS

South Rand Hospita battles valiantly alo

IT'S SHORT OF 99 NURSES, BUT DEDICATION WINS THE DAY

THIS WEEK the Sunday Express probed the anatomy of Johannesburg's South Rand Hospital — the one with little but guts to keep it going.

While other hospitals on the Reef say flu has cut their staff by up to 40%, South Rand struggles along — even without the flu — with only half the staff it should have.

I visited the hospital after reports that others throughout the Reef, already battling to cope with staff shortages, had been hit even harder as nurses and doctors went down with flu.



• Nurse Kathy Davis, 21, has a long hard day and ofte

The Star July 30, 1980: 7

READERS' VIEWS

ADEQUATE PAY FOR NURSES

The teachers, who get more remuneration than nursing sisters, appear to have breached their salary barrier successfully with threats.

May our authorities not overlook the nursing sisters who, on today's modern training, are equal to teachers and must work night, weekend and public holiday duties.

To keep our nursing services at top level

staff," said Superintendent Dr H A Broekman. There was no question of patients not getting the attention they needed.

"They work long and hard — but that's what nursing is all about," Matron Bredenkamp added.

"We miss our teas and our lunch, but it's OK if you enjoy nursing," said 21-year-old Kathy Davis, who will complete her training as a sister 1977, and has been there ever since. "We work about 12 hours overtime a week," she told us after handing out medicines in an almost empty ward.

Other nurses and sisters worked during one of their two days, but this was always voluntary, Matron Bredenkamp told me.

The eight scholars working at South Rand during their holidays had helped a lot, she said. They relieved nurses of "domestic" work, such as making beds, serving ten and meals, and feeding patients.

Pretoria, who pleted her second ing at the hos nursing — I've o

Why is the ho of staff?

"We just can't train. One of the picture of nurse painted of nurs light on nurses' seems to have off," Dr Broekm

Mr Sam Moss man on health in Provincial Coo

Stop the rot in our hospitals — doctor

LDM 5-2-81 12

By KERRY GIBSON

THE acting superintendent of Edenvale General Hospital said yesterday he felt morally obliged to disclose the full truth about the "dreadful situation" at his hospital, brought on by the shortage of nurses.

Dr George A Perling, who took up his post on January 1, was speaking at a nurses' merit award ceremony.

He appealed to hospitals to reveal the true conditions so steps could be taken to stop the rot.

"Having been at Edenvale for some weeks, I was already aware of the situation. Knowing I would be in charge of the hospital from January 1, I had started assessing the position," he said.

"The seriousness of this situation had already become apparent as far back as July 1980."

There were only 79 nursing staff out of an "establishment total" — the number required to run the hospital — of 179.

• The establishment total of assistant nurses was 60. Edenvale Hospital had 34.

• The establishment total of student nurses was 47, but the number had dropped drastically. There were, in fact, only 11.

"As the morale of many of our nursing staff was understandably low, and since I had overheard mutterings of sisters unable to run wards — without danger to the patients — with the staff allocated to them, I had no option but to take action immediately to try to keep the Edenvale Hospital open.

"This then became a hold,

22 cots).

Paediatric (16 cots and beds).

Creche for staff children.

The maximum number of adult beds they could keep open was 39. This allowed the staff which remained to operate on an adequate, but not fully staffed, basis.

The total number of beds and cots available in the hospital was 99.

• Radiography was to be available only during normal daytime working hours.

• Occupational therapy was dropped and physiotherapy confined to mornings only.

pation was for patients who needed treatment that could only be done in the hospital.

"These were the only conditions for admission and I am glad to be able to state that throughout this entire period no patient who required hospital treatment was refused admission," he said.

• All patients who had been in the hospital for a long time and who did not actually require hospitalisation were discharged.

• He met matrons of institutions for the elderly — there are many in the Edenvale area

have undertaken this

"Although obvious deriving causes of t situation regarding t and paramedic profe long-standing and de I feel even the little one of us can do migh situation.

"Each little effor part will help in term."

The morale of th staff rocketed to impr heights.

For example, man officers who had inte ing, changed their t the hospital now had

Express 16/11/80 p 7

A creeping cancer discontent is caus of hospital crisis

By ANGELA HAMMERSLEY

A HEALTH crisis of "incalculable dimensions" — which has dissatisfaction among nurses at its roots — is predicted by two senior medical men at Johannesburg Hospital.

The doctors are the principal medical officer of the hospital's casualty and polyclinic sections, Dr Peter Heberden, and the chief physician and Professor of

nursing staff in this country shown by the medical profession and the public are inexcusable.

"Trained nursing care is often inadequate or just not available.

Professor B
trary to the pr
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Hospital refle
under which

Low salaries still main caus of increasing staff shortage

Express 16/11/80 p 7

WITH warnings of an impending nursing crisis in mind, the Sunday Express this week set out to assess the situation at the Johannesburg Hospital.

This is what we found, and what we were told by members of a seriously depleted staff:

- Intake figures for nursing trainees at the hospital have decreased yearly for several years. This was confirmed by a member of the administrative staff who then refused to provide exact figures.

throughout the hospital. Many are sealed off.

- There is serious dissatisfaction among nurses and many of them at the hospital are thinking of resigning.

Nurses who spoke to us asked not to be named as policy states that only the superintendent of the hospital may speak to the Press.

Sister X has nine years' experience of hospital work behind her, and in addition to her general training, holds other diplomas and qualifications.

She intends to resign at the

getting out" while she was still young enough to take up a new field.

"I've decided I must have [illegible] nursing in the current situation," she said. "Young nurses are virtually forced to take up residence in the nurse's home.

"That's okay for a while, but when you see your friends buying cars and moving into their own flats and you realise you can't afford to do that, it's heavy.

"It [illegible]ts even heavier when you realise you're working much longer hours than your

friends and are often unable to join them socially because of that, and yet you're earning peanuts for it."

[illegible] at the hospital was terribly depressing. "There are resignations all the time and no replacements. It's not too bad going through a rough patch if you can see the light at the end of the tunnel."

Another young nurse felt the authorities traded on the fact that most nurses loved their vocation and didn't really want to do anything else.

"It's not going to work for

much longer," she s
firm believer in dedi
I also feel it shou
quately rewarded.

"They don't seem
that this is a capit
ety," she went on
have as much rich
else to get the best
can. It's no good pe
out though. People
feel 'disloyal' and
sional' when I say
that.

"It's nonsense. I
as loyal and as prof
a nurse can be — bu
in getting paid for it

Prof Barlow
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Hospital: "The
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"Nurses wil
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Prof Barlow
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crisis situation w
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suffer."

PFP would back teachers, nurses in strikes if...

Star 12/2/81 p 5

By Chris van Gass
Pretoria Bureau

The Progressive Federal Party would consider supporting strike action by teachers and nurses unless "satisfactory" salary increases were announced by the Government next week, the Provincial Council was told last night.

The leader of the opposition in the council, Mr Douglas Gibson, sounded this warning during an attack on the National Party-controlled administration which, he said, had let the teaching and nursing situation slip into crisis.

Mr Gibson said PFP policy remained against the idea of professional people striking. But when it came to large-scale resignations of teachers over pay, it appeared that

221

RDM 5-2-91 11.

Shock new facts o the hospital crisis

By KERRY GIBSON
and SUE ROBERTSON

A SENIOR doctor warned yesterday that there could be a total collapse of the medical and nursing structure in South Africa if nursing conditions were not im-

LACK OF NURSES MEANS WARDS ARE RUN BY SKELETON STAFF

Tribune 11/1/91 CV

STAFF SHORTAGI HITS ADDINGTON

ADDINGTON Hospital in Durban has been forced to close one of its private wards and some wards are being run by a skeleton staff because of the shortage of white nurses.

Tribune Reporter

although she had been nursing for 11 years. But her experience was not taken into account because it had

'High standards are now a luxury'

Express 11/4/81 p. 15

THE HOSPITAL CRISIS



By DEBRA CLEVELAN

THE current staff shortage at the Johannesburg General Hospital is so bad that "high standards are a luxury" according to nurses interviewed by the Sunday Express.

Because some nurses work 18-hour shifts with no break and no sleep, they could not give individual care and attention to patients, they said.

"We're virtually forced to work an enormous amount of overtime because you can't just knock off at the end of a day not caring about patients who might die due to the shortage.

"Some of the patients sent out of intensive care units have died because there hasn't been time for physiotherapy or further observation," one nurse said.

"As soon as they are off the critical list, they are referred to other wards, as their beds are desperately needed by other patients coming into intensive care."

She said this trend was heightened by serious motor accidents, stabbings and assaults, as the critically injured were referred to intensive Care by Casualty.

"If the beds are full, the unit cannot take any more patients. In these cases the patient is either referred to another hospital or to a general ward until there is room in the intensive care units."

Another nursing sister said the lack of radiographers added to the crisis.

"There has been a mass walkout of radiographers and it's [illegible] difficult to [illegible] staffed. They're trying to overcome the problem by using unskilled staff — termed domestics — who work as nurse aids and do mainly ward and mental work."

When asked how much responsibility was expected of these staff, she said it depended on the sister in charge.

"The nursing staff find them a real boon, and I would in most cases put far more responsibility on them than on a white-belt nurse (a junior nurse)."

She said this was in no way dangerous as they were always supervised.

Another sister said the predominant feeling at the hospital was one of tension and apathy.

"The staff are apathetic — almost an unintentional go slow campaign. Doctors and surgeons, even matrons, are saying 'we'll cope', but we find it exhausting.

"There is no value put on the job. Even if we are slack and apathetic, there's no way we'll be asked to leave.

[illegible] ters from a [illegible] rsonal and emotional [illegible] from the staff," she said.

A sister in one [illegible] intensive care units at [illegible] Johannesburg Hospital said the number of trained sisters in her unit had decreased dramatically during the past year.

"This means we cannot handle more than four patients," she said.

The nursing crisis is not confined to the Johannesburg Hospital, according to nurses from other hospitals on the Rand.

A cross-section of nurses from assorted hospitals agreed to discuss their grievances and desperation for the future of the nursing profession.

"It all comes down to money," they agreed.

"The whole thing is a vicious circle — the pay is too low to live on so nurses are leaving en masse. That leaves us to cover their work, as well as our own, so work conditions are exhausting — both physically and [illegible]



An intensive care unit at the Johannesburg Hospital . . . load becoming unbearable.

lives in a nur[illegible] ce because she cannot afford her own flat.

"And the 'perks' are laughable. The authorities claim they're attracting staff by offering low-rental board and lodging.

"When you've been working, fully trained, for a number of years, you expect to be earning enough to live where and as you choose. We feel trapped in an institutional environment because we can't afford to live elsewhere," she said.

Another nurse in the group said that if salaries were com-

222

'High standards are now a luxury'

Express 11/4/81 p. 15

THE HOSPITAL | CRISIS



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"We're virtually forced to work an enormous amount of overtime because you can't just knock off at the end of a day not caring about patients, who might die due to the shortage.

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● An intensive care unit at the Johannesburg Hospital . . . load becoming unbearable.

PATIENTS DYI
IN NURSE CRI

By WILLIAM SAUNDERSON-MEYER

PATIENTS are dying in some Transvaal provincial hospitals because the nursing shortage has led to a sharp drop in the quality of medical care.

Understaffed hospitals are using insufficiently-trained staff increasingly as a stop-gap measure. Nursing morale and standards are at their lowest and patients' lives are being endangered.

And with student nurse intakes also at their lowest, the crisis could worsen.

Untrained staff, who used to do mainly menial hospital chores, are taking charge of 20 bed wards and administering medical treatment because of the acute shortage of nurses.

The classified assistants, with only elementary medical training like taking temperatures, are being forced to do the medicine rounds, give injections, put up intravenous drips, and control complicated intensive care and cardiac monitoring equipment.

At the multi-million rand Johannes-

Nursing crisis causes deaths in Jo'burg Hospital

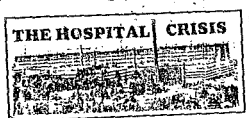
From Page 1

hospital under these circumstances, unless special provisions were made. I'm simply not happy with the safety margin here," he said.

A copy of this article was handed to the Superintendent of the Johannesburg Hospital, Dr Neville Howes. On behalf of the Sunday Express, I stressed the article was being handed to him so that he could study it in detail and point out where he felt the emphasis was inappropriate or inaccurate.

Dr Howes refused to comment on the claims made in the article. He said the report would harm the hospital's reputation and possibly affect the recruitment of nurses.

THE HOSPITAL CRISIS



tic post operative unit was reopened not because there were more staff to man it, but because the hospital staff asked for it.

The sister, as with other sisters, nurses and doctors approached at the hospital, were all anxious not to be identified and those who spoke to the Sunday Express said they were doing so only because of their concern for patients.

ations because they couldn't get the post-operative care they needed.

"The intensive care units were, and still are, desperately short staffed and couldn't take them into their units, so they placed them in general wards.

"The situation is so bad that sometimes when the nurses threaten to walk out, they're told to lower their standards."

Hospital shortages

hysiotherapist ...

arnard hits nursing crisis

Hospitals may have to

Staff shortage ... ck

Hospital crisis

The pressures nurses contend with

Nursing ... Mrs. ... Nurses

Salaamed ... nurses

Nursing crisis

This is why the

Tenants evicted to

If you want a

Recruiting blacks to

Natal to ... to nursing crisis

Said Nurses ...

break

nursing

barriers

One Correspondent

CAPE TOWN — Hospitals in Natal are to break race barriers in the nursing profession — in future there will be no bar on which race groups nurses may attend in.

This was revealed yesterday by Mr Frank Martin, Natal MPC in charge of hospitals following an informative meeting with the Minister of Health, Dr L A P A Marais, in Cape Town.

"The Minister would not commit himself to a policy statement on the issue either way, so we have decided that we will go it alone," Mr Martin said.

He said three more hospitals where Natal had already been forced to consider nurses of various race groups to attend to other races should maintain a full service, but "all I can say is that I am completely in the dark as to details."

The number of patients we have only had one complaint," he said.

"I believe no patient ... Johannesburg ... hospital has only about half of its requirements of nurses and disagrees, and the number of student nurses in your is disappointing.

Dr Hennie Geyer, chairman of Hospital Services in Pretoria, has intimated that the hospitals recruitment drive on the problem.

He suggested that to avoid further recruitment in the meantime, by ... several committees to ... several non-official members to enable ... them to ... a closely-knit refresher ... drive on the problem.

He said an urgent need to prevent further resignations in the profession, he had ... circulated to ... hospitals ... and ... to ... Nursing ... regulations ... relaxing ... [illegible] ... Mr Martin said, was the Director of Hospital Services. Dr Geyer ... were available for ... [illegible] ... Mr F Pretorius, Administrator in Pretoria, had been ... [illegible] ... because of the ... shortage.

... [illegible] ... Nurses in Natal ... course for nurses who are thinking of leaving or those who have left the profession.

He said emergency measures had to be taken when some sections in hospitals had to be closed.

Hospital superintendents had to report to him before the end of February on the progress of the campaign.

Mr Frank Martin, Natal MPC in charge of hospitals, has promised that in his province black nurses were nursing white patients and that discrimination was "not practised."

Parliament of Natal in 1960 of bitter memory is crystal clear. As soon as the white official enough she decided to ... a nurse and worked in ... hospitals during ... World War I

Library

Miss Jane Percival, she trained at Glasgow and was matron of the Queen Victoria Maternity Hospital for many years. It now has a ... in the library in memory ... [illegible] ... nursing ... were being brought down.

He said the Minister of Health, Dr Marais, would not commit himself to a policy statement on the issue either way — "so we have decided that (Natal will go it alone".

The Deputy Superintendent of the Johannesburg Hospital, Dr L. Robson, said she fully supported the Transvaal recruitment drive, but she would not comment on the dropping of racial barriers in Natal.

Matron

Matron Barbara Paul, who ... [illegible] ... since the house and its surrounding gardens is a fourth-generation South African ... the matron of the Victoria Hospital, Lydenburg, Cape, and also ... in Zambia and Natal.

Recently the nurses' home Northcliff Home, ... was renamed Cara House in honour of Miss Cara H ... Cara who as a Volunteer ... [illegible] ... [illegible] ... [illegible]

By Jane Perrett

Accommodation b

Nurses' call for talks on pay

the beginning of May, but the larger provinces, the adjustments could take some time.

Professor Searle assured nurses that all increases would be retrospective to April 1.

colleagues.

One point on which the association would like to see further improvements, was the salary of the commencing notch of newly qualified registered nurses.

"Provision has been made for a substantial gap between the top notch of the student scale, and that of the newly registered nurse," Professor Searle said.

"Although the starting notch of newly qualified nurses has improved, the association is still not satisfied with this scale because all other notches are affected by it."

This meant that the scale a registered nurse started on directly affected the salaries of all other nursing personnel with the exception of students.

An aspect of the new salary scales which pleased the association was that all categories of personnel would receive notch-for-notch benefits.

"A nurse's years of service will now be taken into account and not only the notch she has reached through qualifications and promotions," Prof Searle said.

This will greatly improve conditions for the nurses."

Allied Accommodation claimed they pressured clients to establish their accommodation needs but one young woman with a two-month-old baby was sent to the sister's home

NO REFUND

When a reporter called Allied Housing as a homeowner with property

Nurses' pay

Shortages Pay

Service to community

The nurses must be given

Nurses'

Shocking silence on pay

Questions of esteem, dignity

Questions of esteem and dignity are tricky. These are [illegible] worldly goods, [illegible] as much as they are [illegible].

[illegible] now have their [illegible], but have lost the long held advantages [illegible] patients. This [illegible] can be keeping in [illegible] waiting room, but [illegible] of work.

Conversely, the nursing profession, who have [illegible] made an unseemly fuss, do still have public esteem to the extent that tens of thousands of members of the public are pressing their greatest reward for their work.

The white-teaching profession, by and large, seems to have opted for the role of underpaid employee. Fair enough, and more bucks they will get, but no finger on the pulse of dignity of position.

What dignity?

A W Barnes

Linden.

[illegible] modern medicine increased technical being done by nurses sisters, South Africa ensure that the best

urses' pay goes

vincial scale

[illegible] pays, and this adjustment will stop many nurses in the private sector rushing to province.

"I have said provincial [illegible] as a guide.

[illegible] nurses have expected [illegible] increase at then [illegible] a lot otherwise [illegible] private hospitals [illegible] salaries because [illegible] the provincial increases," he said.

[illegible] also said that private nurses benefited more than their provincial counterparts from changed working hours and conditions.

[illegible] had been no increases in hospital [illegible] to accommodate [illegible] proposed rise in [illegible] salaries but a committee was looking into the matter and was expected to report soon, Mr Pandall said.

Professor [illegible] of the SA [illegible] said [illegible] come the fact that private hospitals are [illegible] with new salary scales.

"Nurses must [illegible] others [illegible] salary [illegible], but in this case I don't think it will have any effect on [illegible] nurses.

"The barometer has always been the public service scale and I don't think it will make much difference unless [illegible] more favourable grades are made by the private hospitals," she said.

Medical, nursing profes

Hospital pay: plea to Health Minister

Nurses

Nurses' fa[illegible] probed

Concern at

[illegible] staff

[illegible]uth African nursing staff

Thursday November 1 1979

Rebyane

It's time to stop grievances

[illegible]ederichs

A winsome smile for our readers comes from [illegible] Miss Johanna Magotine, who comes [illegible] Tladi, Soweto and is presently in Sta[illegible]

'Worked to death nurses' have no time to study

S.A. Med. Nurses

Poor physiology training

[illegible]ends 'Messiah' han[illegible]

Part-time nurses' fears allayed

—a challenge

S.A. Med. Nurses

Sister Mary

Sister Mary Ignatius O'Mahony talked to JENNY DYER about her new job as matron-in-chief of Baragwanath Hospital.

Nurses' salaries to get urgent attention

Head in the sand

Hospital

more for nurses

Nurse resigns to earn more as a waitress

...nurses
...nurses' pay petition supported

...nurses petition today
...nurses' pay petition gets support

£4 000 sign
SOS' call

...000 sign
...0 000

Nurses' salaries to get urgent attention

10 000 back ...

Head in the sand

Hospital

...nurses will date Lapa

SOS sees ...

Nursing ... pay needed says sisters

to get 18 pe... winning nurse

Nurse resigns to earn more as a waitress

...more for ... nurses

Own Correspondent

CAPE TOWN — A 19-year-old final nursing student who was "praying" nightly will run out of the end of the month to work as a waitress — and will earn almost R100 a month.

Miss Alison Hewitt, 21, a senior in the Royal Transkei Unit in Groot Schuur Hospital and incidentally one wearer of the "black veil and red cassock" outfit, is not a girl.

An employer has a bonanza. She completed a three-year Nursing Training course in Cape Town and then had one year's compulsory community service in the Transkei.

Miss Hewitt said before leaving Natal she had been offered a senior nursing post at the Queen Elizabeth Hospital in Bloemfontein, but she wanted to work at South Africa's only Natal hospital that performed her in turn the after-care, and that has been in the nursing profession for seven years and

her monthly take-home salary of R322 — about half what she was getting as a Diploma Nursing Sister in South Africa 11 months ago.

From that she has to pay out R125 for meals, to pay the rent on her accommodation that is provided.

"I can't even run a car on my salary now so I'd like to get a job where it would allow me to do that."

To avoid having to throw away the nursing qualifications entirely, she would prefer a job in any branch of nursing, even night sister within the municipal structure, working by day as a medical ward nurse-aide or for a nursing agency.

Until enrolling for the present study, Alison, who will be 22 on the 20th March at the hospital to help in her senior 19th month, had to work as a waitress at a hotel in Hermanus.

The last straight approached a fever as Miss Hewitt had the money in the bank to buy a second 125cc motor bike. Then I ad... like included.

...care in a hospital is dependent ...on adequate number of ...trained and experienced

...not cope with the ensuing

...red other reasons for the

...ended a neither nurses

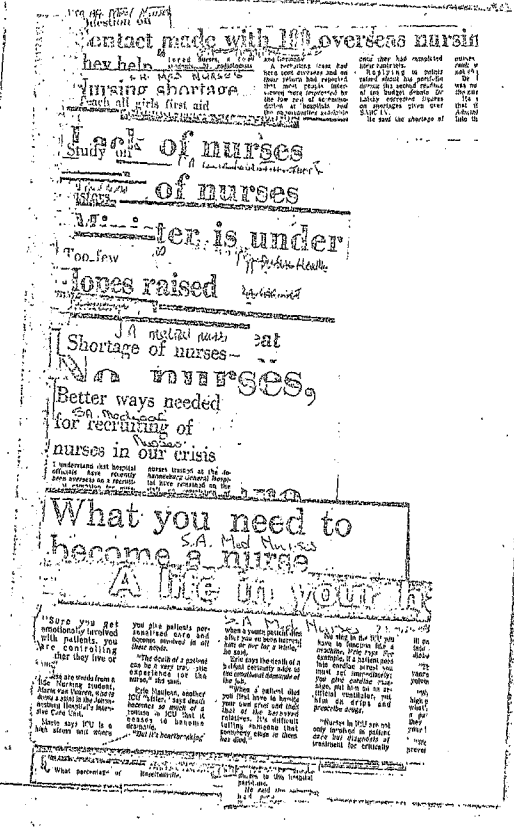
...ic at To'bui

...nurses by 16 percent and Black staff nurses by an average of 19 percent.

While medical superintendents are to get a R1 200 increase per annum to push their salaries to R11 220 a year, at the same time the salary gap between their Coloured and Black counterparts would be allowed to stay there, the same salary.

This will mean that a Black medical superintendent will receive an increase of about 22 percent, compared to the 20 percent of Coloured superintendents and the 19 percent for White superintendents.

...t, and the plight of pos...



Question on

Contact made with 100 overseas nursin

they help

Nursing shortage

Teach all girls first aid

Study on

Lack of nurses

Tasters

# of nurses

ter is under

Too few

Hopes raised

Shortage of nurses—

No nurses,

Better ways needed for recruiting of nurses in our crisis

What you need to become a nurse

A life in your h

"Sure you get emotionally involved with patients, you are controlling their they live or

Here are words from a Nursing student, Marie van Vuuren, who is doing a stint in the Intensive Care Unit.

Marie says ICU is a high stress unit where you give patients personalised care and become involved in all their needs.

"The death of a patient can be a very tragic experience for the nurse," she said.

Eric Nauleau, another ICU "killer," says death becomes so much of a reason in ICU that it ceases to become dramatic.

"But it's heartbreaking when a young patient dies after you've been nursing him or her for a while," he said.

Eric says the death of a patient certainly adds to the emotional demands of the job.

"When a patient dies you first have to handle your own grief and then that of the bereaved relatives. It's difficult telling someone that somebody else in them has died."

He sits in the ICU you have to imagine this a machine, Eric says. For example, if a patient goes into cardiac arrest you must act immediately: you give cardiac massage, put him on an artificial ventilator, put him on drips and prescribe drugs.

"Nurses in ICU are not only involved in patient care but diagnosis of treatment for critically

What percentage of

Recruitment.

Nurses.

S.A. Mod Nurses

S.A. Mod Nurses

S.A. Mod Nurses



Author Hammond Merryl
Name of thesis Nursing In Crisis: A Study Of Contributing Factors. 1982

PUBLISHER:
University of the Witwatersrand, Johannesburg
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