NURSING AND HEALTH PROMOTION: AN EXPLORATION OF PRE-REGISTRATION NURSING STUDENTS' PERCEPTIONS OF THE CONCEPT

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by

Lesley Vernon

Department of Health Studies, Brunel University

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ABSTRACT

Considerable conceptual confusion exists regarding the meaning of health promotion, yet nurses are called to be leaders in the movement. Pre-registration nursing curricula have been designed purporting to incorporate health promotion principles. In the United Kingdom this change in nursing education has been called Project 2000. Empirical evidence in the United Kingdom suggests that nurses perceive health promotion from an individualistic biomedical perspective.

Chapters 1- 4 explore the philosophical and social origins of the concept. It is argued that this is evolutionary, rooted in health education, derived from ancient Greek philosophy. The development of health promotion theory and application to nursing is examined through the development of nursing theory in the United States. Critical comparisons are made by review of national and international literature relating to the focus of health promotion in nursing.

Chapters 5-11 contain the main body of the thesis. Three longitudinal case studies investigate Project 2000 nursing student's perceptions of the concept. Three intentions aim to determine the students' health beliefs and values of health promotion on entry to nursing, to establish if any changes in their perceptions of health promotion could be attributed to the philosophical shift from intervention to prevention in nurse education and healthcare generally, and finally to develop an instrument to be used to measure changes in perception as part of curriculum evaluation. The results of the study are reported and contextualised by the influence of teachers, the curriculum and the climate of change in healthcare at that time. The properties of the instrument and the implications for its purpose are addressed. Weaknesses in the design of the strategy are examined.

The thesis concludes with a review of the evidence presented. More recent conceptual development is examined. Final conclusions lead to recommendations for further refinement of the instrument, by development of psychometric properties.

CONTENTS

PREFACE

During recent decades "health" and the promotion of "healthy" living has become a topical issue both politically and culturally. Whether they perceive it as being important or otherwise, few people living in western societies can claim to be unaware of the espoused benefits of being able to live a healthy life. Although not strictly the domain of health professionals, since the National Health Service Act in 1974, health promotion has become an integral aspect of healthcare (Rodmell and Watt 1986). This is a consequence of the of the prevailing world-wide view that a purely biomedical approach to health and healthcare, compared with social and economic factors, has had relatively little effect in reducing mortality and morbidity in preventable diseases (Mckeowan 1976, Morgan et al 1985). From an epidemiological and sociological perspective, it is also recognised that inequalities and variations in health still exist (Townsend, Davidson and Whitehead 1988; Townsend, Phillimore and Beattie 1988; DOH 1995).

The form of healthcare now advocated by the World Health Organisation is one based on an "ecological systems model". In westernised societies, aspects of environmental protection, personal prevention and primary healthcare are re-emerging and acknowledged as being important to health (Luker and Ashton 1991). Traditionally the biomedical model of healthcare has been dominant in the education of everyone in the caring professions. However, because of the change in emphasis from intervention to prevention, health promotion is one of the disciplines that are now thought to be essential in the education of a new generation of healthcare workers.

Yet, despite the rhetoric, considerable conceptual confusion exists regarding the meaning of health promotion. Attempts at clarification of the concept have been made over the past ten years (Tones 1984; Baric 1985; Rodmell and Watt 1986).

However:

> *"What remains relatively unresearched (unexplored) are the perceptions, activities and knowledge base of those working within those institutions concerned with the delivery of health promotion programmes and policies" (Bunton and Macdonald 1995).*

This is particularly the case in nursing. Nurses have been hailed as potential leaders in the health promotion movement (WHO 1986; DOH 1989). Nursing organisations have generally responded enthusiastically to these exhortations. In Canada a health promotion lead has been adopted by the Canadian nurses Association. In Australia and the USA nursing education is focused on health promotion.

In the United Kingdom, health promotion is first on the list of competencies identified in the Nurses, Midwives and Health Visitors Act (1979). These being to:

- *"advise on the promotion of health and prevention of illness.*
- *recognise situations that may be detrimental to the health and well being of the individual"(DHSS 1979).*

Project 2000 courses have been implemented as the vehicle for change in pre-registration education for nurses in the United Kingdom. Curricular are supported by guidelines for the inclusion of health promotion content (ENB 1990).

Professional nursing organisations have recognised the scale of the contribution nurses could make in promoting better health and preventing illness (RCN 1991). This, is attributed to the plurality of the profession and the consequent diversity of settings in which nurses practice. The RCN (1991) also emphasised the potential political power nurses have in the field of health promotion stating:

> *"It is our hope that nurses will themselves persuade service managers and politicians to take forward these ideas and policies. With 1000 nurses in every parliamentary constituency nurses can be a powerful force for change working across the political spectrum to promote health for all" (RCN 1991).*

The call for academics to become involved in identifying the role of nurses in health promotion (Gott & O'Brien 1990a; Maben & Macleod Clarke 1995) has met with limited response. What there is reflects the general confusion regarding understanding of the concept (Gott & O'Brien 1990a; Macleod Clarke 1992; Vernon 1992). There is also an indication that understanding of the concept is entrenched in the traditional approach rather than the more modern or new paradigm approach to health promotion which is attributed to an, "assumption of a common understanding of the term" (Maben & Macleod Clark 1995).

Central to this thesis is the recognition that healthcare and the education of healthcare workers is in the throes of major reorganisation. Nursing and midwifery education has only recently moved into higher education, consequently this situation is not surprising. It is argued that it may be some considerable time before a clear picture of the contribution nursing makes to health promotion can be identified.

This study was undertaken with the intention of contributing to a body of knowledge that can be used to determine a structure for nursing in the health promotion movement. Twelve chapters attempt to define this role through four levels of analysis which trace:

- The social history of the concept
- The philosophical origins of the concept
- Current validity of the concept
- The practicalities of the concept.

This was carried out through documentary evidence, evaluation of the relevant literature and a three year empirical study of pre-registration students' perceptions of health promotion. This empirical work had three intentions:

- to determine pre-registration nursing students' perceptions of the concept of health promotion

- to try to find out if there was any change in these perceptions as a result of their Project 2000 programme

- to develop a tool to evaluate the integration of the health promotion content of the curriculum

Chapter 1 explores the historical and philosophical development of the concepts of health and health promotion from lay, academic and professional perspectives. It is revealed that the concept of health has diverse and contested meanings, which are both socially and culturally determined. These in turn influence perceptions of health promotion. It is also revealed that health promotion is an evolutionary concept, developing from health promotion, which is rooted in ancient Greek philosophy. Formal recognition of the concept by the WHO in the 1970s paved the way for strategic development for health policy. Examination of the European Strategy for Health For All and the then UK government response revealed ideological differences in interpretation of the concept. The ideological similarity between the WHO and strategic development in the 1997 Blair government is acknowledged, but not examined since at the time of writing statute had not changed. It is argued that by incorporating the philosophical foundations for practice within a Health For All framework, health professionals will begin to understand the roles and boundaries of the variety of disciplines working in this sphere. Conflicting ideologies should not be a barrier to progress. Ultimately this should have a significantly positive effect on the quality of care being given.

Chapter 2 considers the practical and moral issues regarding the implementation of health promotion principles. Two key areas for ethical consideration are identified, firstly the notion of distributive justice is explored and dilemmas associated the creation of economic equity between primary prevention and cure are discussed. Intervention ethics and the selection of appropriate strategies are explored. Problems

encountered in the evaluation of health promotion are also discussed. Possible solutions are explored through a critique of the development of health promotion theory and an examination of models of health promotion. The following conclusions are drawn in that, it is essential for professionals to take account of the social and personal values of individuals as part of any needs assessment, prior to the planning and implementation of any activity. This needs to be done in conjunction with a close scrutiny of their own value systems. At a strategic level, an eclectic approach to planning may be appropriate. With regard to evaluation, until recently the philosophy of the UK government appears to have been in conflict with that of the WHO. In this context evaluation seems to have been considered from a short-term quantitative perspective, related to the reduction of mortality and morbidity, due to ill health caused by damaging behaviour. As a result, evaluation strategies aimed at reducing inequalities are limited. Theorists too, are critical of the foundations of knowledge in health promotion. Further systematic enquiry utilising various methods is the only way forward for theoretical development. There is a political dimension to health promotion, but this does not mean to say that conflicting value systems or ideologies should be a barrier to progress. These differences should be viewed as an opportunity for dynamic and innovative thought and progression.

The previous chapters were concentrated on concept clarification from a broad perspective. In chapter 3 the development of health promotion in nursing is discussed. The historical development of the biomedical model of healthcare is traced and its influence on nursing is considered. The decline of this influence is explored in the light of the development of nursing as an academic discipline. The development of nursing theory in relation to health promotion in the United Kingdom and USA is also discussed.

It is concluded that the decline of the biomedical model of health has allowed health promotion to re-emerge, and in theory create opportunities for nursing to develop an expertise in this discipline. However, government policy prior to 1997 dictated a conservative approach to health promotion. Despite the rhetoric supporting nursing in this arena, it did not appear to have a prominent role. This is attributed to government support for doctors, which is also reflected in legislation.

Chapters 4 considers the focus of health promotion in nursing. Policy development introducing this role in nurse education in the United Kingdom is examined The literature relating to the development of health promotion in nursing in the United Kingdom is reviewed and compared with the American and Australian literature. This demonstrated that nursing research in health promotion was limited. Although empirical work indicated that nursing students perceive it as being important, there is no clear indication that they understand the concept, or its implication for their role as future practitioners. In the light of the changes occurring in nurse education it was concluded that this line of enquiry should be continued and developed.

Chapter 5 gives an account of the development of concepts methods and research tools. The results of an exploratory small-scale investigation of student nurses health beliefs and perceptions of health promotion are reported. This provided the foundation for strategy and design of the main study.

Chapter 6 describes and justifies the strategy adopted in the research reported in this thesis. A research design involving a three-phase longitudinal study of students in three colleges of nursing. Methods of triangulation, and concepts of reliability and validity designed to strengthen and support results are discussed. In relation to data collection, earlier work in the development of questionnaires was developed further and re-tested for reliability and validity. The results of pilot work indicated that the

design was robust in methodological terms. This provided the foundation for the work, to whose analysis and interpretation, the main body of this thesis is directed.

Chapters 7-11 are the presentation of the three year longitudinal study exploring pre-registration nursing students' perceptions of health promotion. Chapter 7 provides a profile of all of the student population. The data are examined in the context of the respective institutions in which the students were situated, comparisons are made to determine the similarities and differences between the groups. This includes an analysis of the students' age, gender, ethnicity, social class and educational achievement.

The analysis revealed that the total student population consisted of young, middle-class women of above average educational attainment. It was also established that there were some significant differences between the groups, in that one college appeared to reflect the type of student traditionally accepted into colleges of nursing in teaching hospitals, while the student population in the other two colleges tended to be slightly older, less well educated, and of mainly lower middle class social origins, this was also a reflection of the general trend in the recruitment of nursing students at that time.

Chapter 8 proceeds to examine the students' perceptions of the importance of health promotion in nursing. It continues with an examination of their beliefs about the importance of learning about health promotion and concludes with an exploration of their interpretation of the construct. At each point in time perceptions are reported and observed differences between the schools tested for significance. Changes over time are then compared and measured for significant change. Finally emerging salient factors are presented and discussed. Throughout this chapter a framework for analysis derived from an examination of the initial baseline data is utilised. Significant changes over time were also calculated.

Initial interpretation of the data indicated that students perceived health promotion on entering nursing within an individualistic framework focusing on personal responsibility for health and lifestyle. As a result of their educational programme this perception changes and the prevention of disease and behaviour change in relation to changing lifestyles become significant aspects of the role of the nurse. Multivariate factor analysis supports this change. This part of the analysis also reveals a two factor model: factor 1 is associated with the theoretical underpinnings of health promotion, factor 2 attempts to define health promotion in nursing.

Chapter 9 explores why differences between the schools occur. The focus of the analysis is on the culture of organisations and teachers' perceptions. In this chapter the influence of educational ideology on educational organisations is discussed. Although it is acknowledged that nursing education is bureaucratic, to some extent all educational organisations are bureaucratic, but it was demonstrated that these colleges of nursing were functioning within different ideological contexts. However the transition from the health service into higher education was a factor that had very wide ranging, and in one case drastic effects on these organisations. The culture of these organisations was led not by ideology, but by the transition into higher education. Teachers gave no clear accounts of what was taught in the name of health promotion, which was perhaps an underlying indication of their lack of conceptual clarity. Conflict was also apparent in relation to this new paradigm approach to healthcare, which could possibly place the care of acutely ill people at risk.

Chapter 10 explores deeper reasons for the teachers lack of conceptual clarity, through focus group discussion. An overview of the methodological problems encountered in this method of enquiry is presented. The analysis demonstrated that the teachers were generating their own definition of the type of health promotion that nurses on adult branch programmes should be able to engage in on registration. The

key to this was the philosophical approach to their nursing practice, which they perceived as being embedded in health.

In chapter 11 the intention was to examine that part of the student learning experience within the curriculum documents pertaining to health promotion, in order to identify any areas in the planned learning experience that influenced the students' conceptualisation. Relevant policy documents influencing curriculum design and content are also examined. This provides several explanations for the results of the analysis of the student data. They also account for the teachers general lack of perceptual clarity and frustration with what should be taught in the name of health promotion.

Chapter 12 provides a summary of the empirical findings, it sets this in the context of recent research and conceptual development and ends with an examination of the role of nurses in health promotion. The strengths and methodological weaknesses in the design are reviewed.

The study commenced with the idea that the instrument could make a formidable contribution to illuminative evaluation. As the work progressed, and as nursing education evolved and matured this opinion is revised. The conclusion is reached that an instrument is required to make an effective contribution to evaluating changes in large groups of students, while meeting the stringent requirements of quality assurance, in demonstrating effective outcome measures. Further refinement and analysis is required in the development of psychometric properties which could be an effective measure of achieving competence in this important area.

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CHAPTER 1

THE CONCEPT OF HEALTH PROMOTION

In the preface to this work it was acknowledged that health promotion was an essential competency for admission to the nursing register. It was also demonstrated that considerable conceptual confusion exists in both the nursing and the health promotion literature regarding the meaning of the concept. Little attempt has been made in the nursing literature to clarify the concept (Maben & Macleod-Clark 1995). Empirical evidence also indicates that nursing practice and education in this sphere continues to be dominated by biomedicine (Gott & O'Brien 1990a; Lask, Smith & Masterson 1994; Maben & Macleod-Clarke 1995). This is not a specific problem for health promotion and nursing. Marsland (1993) describes the "unhelpful" confusion surrounding the concept of social education and demands a rigorous analysis and clarification of these concepts by professionals involved in the discipline. He states this is imperative if the discipline is to develop and the quality of secondary education to improve.

> "without the tough thinking which this conceptual work requires, the youth service is unlikely to survive the harsh times which are only just beginning. Nor will it deserve to survive if we fail in this task. For it is surely an essential characteristic of all professional work that professionals think, hard and systematically about their work and their clients' needs. On this basis they seek to organise their practice in terms of coherent principles, and they judge their own and their colleagues' work in terms of rational criteria of evolution derived from them. They are not afraid to let the public look hard at their work and the principles that justify it. In other words professionalism absolutely demands of its practitioners hard and honest thinking" (Marsland 1993).

Similar principles can be applied to health promotion and nursing and Maben and Macleod-Clark (1995) are equally vehement in their demands for rigorous clarification of the concept. The method of analysis they offer is based on Rodgers

(1989) "evolutionary cycle," which is eclectic, in that it incorporates the views of various philosophers. This "modern" approach they argue, submits that concepts are abstractions expressed either in discursive or non-discursive forms, thus, "through socialisation and reported public interaction, a concept becomes associated with a particular set of attributes that constitute the definition of a concept" (Rodgers 1989).

This approach is pragmatic, the influences of the cycle are namely; significance, use and application. The definition they espouse certainly clarifies the language utilised in the World Health Organisation's (1986) definition of health promotion:

> "Health promotion is an attempt to improve the health status of an individual or community, it is also concerned with the prevention of disease, though this is not its' only purpose, as health is not merely the absence of disease. At its broadest level it is concerned with the wider influences of health and therefore with the policy and legislative influences of these. Health education, through information giving, support, advice and skills training is part of the necessary pre-requisites to health promotion, attempts to raise the issue in question and fosters an ability to cope with illness or disease. More radically, health promotion is in itself an approach to care through empowerment, equity, collaboration and participation, and may involve social and environmental change" (Maben & Macleod Clarke 1995).

The authors rightly acknowledge that the definition ignores the empirical reality of nurses' perceptions of health promotion. They also state that the analysis ignores the more traditional conceptualisation of the 1980s as the literature, and the resulting conceptualisation has moved on. Health education is perceived by the authors as a pre-requisite to health promotion and the process of education is described in the traditional manner of information giving, support, advice and skills training.

Given that nursing has made so many assumptions regarding the meaning of health promotion, in conjunction with the turmoil the profession faces in the light of

ongoing social and political change, these views are contestable. While the model for analysis utilised proposes some guidance for the change in preparation of future nurses, a definition which does not attempt to explore the historical origins of the concept, and leaves gaps in knowledge, will not provide a sound theoretical framework in which nurses can develop their expertise.

This study, rather than utilising a model which does not entirely fit the type of exploration that is proposed, will adopt a more rigorous approach that instead, asks questions about the concept. This approach is influenced by a model proffered by Marsland (1993). While acknowledging the importance of use and application in concept development, he seems to reject the purely "modern" approach reaffirming the depth of understanding to be achieved through an examination of the historical context. Four levels of analysis are therefore proposed, namely:

- **The social history of the concept.**

This explores questions about, the origins of the idea, who first used it and with what meaning, how and why has it changed since its inception. For what reasons and with what effect?

- **The philosophy of the concept.**

Implicit distinctions require to be made here and then either justified or rejected.

- **The current validity of the concept.**

Here, questions about utilisation are asked, for example, are the people who use it powerful, influential or marginal groups? Do our clients, colleagues or paymasters use it? Do they understand or believe in it? If not why not?

- **The practicalities of the concept.**

This part of the analysis (in the context of this study) should ask questions about how or what is taught in the name of health promotion, how is it integrated into the curriculum and whether students are competent health promoters once they are qualified.

The remainder of this chapter will be devoted to an examination of the historical and philosophical development of health promotion. The concept will be explored from both lay and professional/academic perspectives.

The Social History of the Concept of Health Promotion.

Health Promotion is frequently described as a new discipline; this is not so. It has evolved from health education, which has its roots in the classical Greek view of health. This view is holistic and is described as the degree to which individuals are capable of achieving harmony in their lives (Rodmell & Watt, 1986; Nijuis & Van Deer Maesen, 1994). The philosophical development will be discussed elsewhere in the chapter.

The Concept of Health

In accordance with the principles of social enquiry, we commence with an exploration of the concept of health. The literature from the past twenty years or so indicates that defining health has been the focus of much academic investigation. Studies have been carried out by researchers from various backgrounds in order to find a common definition that could help professionals improve their practice. Social anthropology has played a major role in attempting to define health. These studies have concentrated on looking at health beliefs from both lay and professional perspectives.

Lay Interpretations.

Herlizch investigated the beliefs about health and illness of middle-class people in France in 1973. Her conclusion was that her subjects thought of health as something "internal," which they could control, and illness was associated with "external"

causality which was beyond control. She also identified three distinct themes from her data, which she describes as :

- *health in a vacuum:* the absence of disease;
- *health as a resource:* the physical ability to maintain health and resist illness;
- *health as an equilibrium:* balance, harmony, the notion of well-being.

A further study of elderly people in Aberdeen (Williams 1983) identified similar dimensions in health.

Studies in the United Kingdom (Pill & Stott, 1982; Calnan & Johnson,1983; Blaxter, 1990) explored the relationship between health beliefs and social class. The prevailing conclusion is that middle-class people have a more positive perception of health in that they tend to control their health by being active, keeping fit and using preventive health services. They also tend to possess multidimensional concepts of health, which could be dependent on age and gender as well as class (Blaxter, 1990). Working class people, on the other hand, tend to view health negatively, in terms of "not being ill," and "getting by" despite disease. To summarise, from a lay perspective, there is no finite definition of health. Peoples' views vary according to their age, social class, economic status and cultural background.

Dictionary definitions reflect a change in perceptions of health over time, for example, the Oxford Dictionary (1998) offers definitions of health which are generically described as wholeness, the sound condition of the body in terms of freedom from disease and vigour, healing or cure, spiritual and moral soundness, welfare, safety and deliverance. When these definitions are compared with those of the 1966 Collins Westminster Dictionary, health is defined as being associated with the soundness and general condition of the body, wholeness and freedom from disease, it seems safe to conclude that these multidimensional concepts of health are now firmly embedded in western culture.

Professional Interpretations of the Concept of Health.

Professionals working in healthcare, while having their own perceptions influenced by culturally determined beliefs and values, may be able to view health more objectively. As long ago as 1947 the World Health Organisation defined health as "a state of complete mental and physical well-being, rather than solely the absence of disease" (WHO 1947). This definition is frequently quoted and often accepted at face value, but it is widely criticised, mainly because it denies the dynamic nature of health. However, it does address the spiritual, emotional and societal aspects of health.

Advocates of the health promotion movement often describe their work as constituting a decisive break from a traditional medically dominated model of health (De Leeuw 1989). They have sought more far reaching and sometimes esoteric models of health. Seedhouse (1986), for example advocates health as being a foundation for self-actualisation. A eudemonistic model is also proffered, based on Aristotle's (1953) ideas about happiness which he says is an "activity of the soul" Russell (1991).

However, Kelly (1990) argues that while health promoters have long searched for a decisive break with a traditional medical model of health, the wrong break has been made. The rationale they use to support their argument is the post-modern view of society. Thus it seems appropriate to explore these meanings.

According to Giddens (1992), post modernity as a sociological, philosophical, and cultural notion has many meanings. However, in this context it refers to the major social disjunction that has occurred in various aspects of cultural and scientific endeavour in the twentieth century. It is basically a critique of modernity's reliance

on the belief that knowledge and science are inextricably linked and that science is able to produce ultimate truth or human happiness (Baumann, 1996).

Reality is not rational, but chaotic and uncertain (Best and Kellner, 1991). In post-modernity, rationality and irrationality merge along with truth, falsehood, lay beliefs and expert (biomedical, high-tech, scientific) modernist knowledge. In contrast, health promotion, which is community based and self-empowering reflects late or post-modernism. This new paradigm approach acknowledges that health is a quality of individuals and groups that is defined by them and cannot always be measured according to purely scientific principles. When viewed in this context the WHO definition of health does not seem so idealistic, but rather forward thinking (Kelly 1990).

What is refreshing about Kelly's (1990) analysis is that it does not denigrate either the social or the biomedical models of health. He refers to them as being based on causal epistemology. This means that bad outcomes have bad precursors, to use a medical metaphor, the task of both medical and social scientists is to identify ways of controlling or eliminating the pathogen. Therefore, the definition should not be totally disregarded.

The post-modern approach does not view health in terms of models or systems. Antonovsky (1987) challenges us not to address the origins of the disease through a risk factor analysis, but to address the origins of health. People cannot be categorised as healthy or "normal" or diseased and "deviant." In this dichotomy Antonovsky (1988) says there is no room for the chronically disabled, mentally handicapped, or those being in a state of disease, such as having cancer or heart disease, or functioning in everyday life.

Therefore, according to Antonvsky (1998), we should think "salutogenically," that is, instead of assuming an individual's normal state as being one of homeostasis, it is more sensible to think of the normal state of affairs for the human organism to be one of entropy, disorder and disruption of homeostasis. He suggests that no-one can be either healthy or ill, but somewhere on a "health-ease-disease" continuum.

> "we are all somewhere between the imaginary poles of total wellness and total illness. Even the fully robust, energetic, symptom free, richly functioning person has the mark of mortality: He or she wears glasses, has moments of depression, comes down with flu, and may well as yet have non-detectable malignant cancer cells. Even the terminal patient's brain may be fully functional" (Antonovsky 1979).

What Antonovsky is proposing is that the curative aspects of disease should not be denigrated, but that other ways of achieving health are explored. For example, the availability of surgery such as hip replacement should not be questioned, but what also requires understanding is how people cope with situations. Why do some people make good recoveries while others don't. All the factors or variables that enable a person to move along this continuum require exploring. It is not so much a question of how stressors can be redirected, but how individuals adapt or learn to live with dis-ease (Antonovsky, 1979).

Clearly, from both lay and professional perspectives health is a multidemensional concept. In reality none of these dimensions can be taken as discrete entities, they are interdependent. The main conclusion drawn from this discussion is that it is important for practitioners, managers, policy makers, educationalists and the public to communicate their beliefs and understanding of health, so that they can work together to promote health more effectively.

Defining Health Promotion.

Any interpretation of health promotion is dependent on whether one adopts a "structuralist (collective) or "individualist" (lifestyle) approach to health (Bunton & Macdonald, 1992). A structuralist interprets health as being determined by the environment in which people live and work. As such, health promotion has a political dimension. An "individualist" views health as the responsibility of the individual, and dependent on the lifestyle people adopt, regardless of their environment. Therefore, ill-health could be described, respectively, as the consequence of poverty, and social deprivation, or of the unhealthy and harmful habits people have, such as drinking too much alcohol and smoking, eating "junk food," and not participating in any form of exercise.

Bunton and Macdonalds' explanation is useful in beginning to understand what is meant by health promotion. However, studies have repeatedly demonstrated that interventions aimed at changing individual "unhealthy lifestyles" and ignoring peoples' social lives have been unsuccessful (Rodmell & Watt, 1986; Ewles & Simnett, 1990; Beattie, 1992; Williams et al., 1993). All they do is induce feelings of rebelliousness and guilt and a sense of moral failure, for these reasons they have been called "victim blaming." Therefore, further clarification of the concept is necessary.

The Debate Concerning Health Education and Health Promotion.

There is a wide literature regarding the meaning of health promotion. The greatest area of confusion and debate lies between the understanding of the meaning of health promotion and health education and it is here that problems in the clarification of the concept lie (Sutherland 1979; Rodmell & Watt 1986; Gott & O'Brien 1990). Dictionary definitions of the nouns "promotion" and "education" also reveal startling contrasts in the meaning of these words. For example the Oxford Dictionary (1998)

defines "promotion" as the act of promoting someone or something. It is the act of an individual being promoted to a higher position, or the publicisation or marketing of a product by the advertisement of its' merits, or it is an entertainment or sporting event which is staged for profit. "Education" on the other hand is defined specifically in relation to children, incorporating activities such as; schooling, teaching, instruction, coaching, training, drilling, priming, informing, indoctrination, edification, cultivation, preparation, rearing, nurturing and fostering. Whereas people who are educated are defined as being literate, scholarly, knowledgeable, enlightened, cultivated and refined. (Oxford Dictionary 1998). Seemingly, these definitions reflect the passage of a student through the more structured educational process of pedagogy to the more flexible and self-directed process of androgogy (adult learning) as described by Knowles(1978).

The Meaning of Health Education and Health Promotion.

In this debate Seymour (1984) feels that the aims of these notions are the least discussed, yet most fundamental aspects of the dilemma. He states quite simply that the purpose of both is to improve health. The World Health Organisation (1985), in explaining the structure of the European Targets for Health For All By The Year 2000 defines the pre-requisites for health as being, "peace, adequate food and income, safe water, sanitation and a satisfying role in society." None of this can be achieved without "strong political and public support." They also describe the aims of improvement in health as being to ensure "equity in health," adding, "life to years, health to life and years to life" (WHO 1985:6). These views on equity and inequalities in health are also reflected in the United Kingdom in the Black Report (1982; cited by Townsend & Davidson 1988), and in the most recent Acheson Report (1998).

In considering the questions "What is health education.? What is Health Promotion?" Baric (1985) reflects the World Health Organisation's (1969) notion of health education. This focuses specifically on people and actions. He states that it is:

> "concerned with raising individual competence and knowledge to use the healthcare systems and understand its functions. It is also concerned with raising awareness about social political and environmental functions that influence health" (Baric 1985; cited by Linney 1990).

The inherent implication in a paternalistic statement such as this is that, information and guidance is given to individuals to improve their health, then the decision to take action is their own responsibility (Cork 1990). Tones (1984) describes health promotion as an overarching concept which incorporates health education, as well as the environmental, legal and fiscal measures designed to promote health.

The Similarities Between Health Education and Health Promotion.

In exploring these similarities, it is necessary first of all, to consider the shift in focus in approaches to health education that occurred during the 1970's and 1980's. This is viewed in the context of the practice of health promotion professionals. Rodmell & Watt (1986) concur with Sutherland (1979), in that the concept is as old as Plato's Republic.

According to Bertram Russell in his History of Western Philosophy (1991), Plato's ideas for the "construction of an ideal commonwealth", based on notions of justice and equity, besides being the precursor of eugenic principles, also laid the foundations for the power structures associated with elitism, such as the Jesuits in Old Paraguay and the Communist party in the US.S.R.

Plato constructs society by dividing people into three classes, the common people, the soldiers and the guardians. It is only this last group who have any political power. In the first instance they are elected as fit to rule by the legislature and thereafter by heredity, although upward and downward mobility as defined by talent is not ruled out. In order to achieve the desired level of harmony some form of social engineering is required associated with educational, economic, biological and religious strategies. For example, regarding education, gravity, decorum and courage are the desired requirements.

> "There is to be rigid censorship from very early years over the literature to which the young have access and the music they are allowed to hear. Mothers and Nurses are to tell their children only authorised stories" (Russell 1946).

With regard to music, only simple harmonies expressing courage temperance and a harmonious life were to be allowed. The training of the body was also very austere, only roasted fish and meat being allowed and certainly no sauces or confectionery. Plato thought that people brought up on this regime would have no need of doctors (Russell 1946). Russell argues that Plato proposes a thorough going communism for both the guardians and the soldiers;

> "The guardians are to have small houses and simple food; they are to live as in a camp, dining together in companies; they are not to have private property beyond what is absolutely necessary. Gold and silver are to be forbidden. Though not rich, there is no reason why they should not be happy; but the purpose of the city is the good of the whole, not the happiness of one class. Both wealth and poverty are harmful, and in Plato's city neither will exist" (Russell 1946).

From this insight into Plato's views of society, it can be seen that health education could be construed historically as a form of social control, or at least benign paternalism.

In the United Kingdom its roots are perceived as being in the 19th century public health movement, culminating in the 1848 an 1875 Public Health Acts, and becoming

institutionalised within the National Health Service by the 1974 Act (Rodmell and Watt, 1986). This legislation was responsible for the destruction of local authority public health departments. Accountability of those health workers such as public health doctors and community nurses, midwives and health visitors, who had been traditionally involved in health promotion, was transferred to the Health Service, leaving environmental health within the remit of local authorities. As a result health education became a conventional practice "set within a medical model, founded on principles of behaviourism and individualism." (Rodmell & Watt 1986:2).

Ashton and Seymour (1986) argue that people only come into contact with health workers at certain times in their lives, such as in pregnancy, childhood and old age. The impact they can have in terms of traditional health education, which is about informing people on how to use services and improve compliance in treatment is questionable. In terms of promoting the merits of good health by enlightening informing, nurturing and thus empowering people, through the new paradigm approach even more questions are raised.

The "New Public Health"

It was as part of the shift in paradigm from a biomedical to a social and environmental model of health, that the concept of health promotion emerged. This was in Canada in 1974. The then Minister for health and welfare, Lalonde produced a report "A New Perspective on the Health of Canadians" which is best described as the catalyst for the re-emergence of the nineteenth century public health movement in developed countries. The Lalonde report introduced into public policy for the first time the notion that all causes of death and disease could be divided into four discrete elements:

- inadequacies in healthcare provision;
- lifestyle and behaviour factors;

- environmental pollution;
- biophysical characteristics;

The basic message was that critical improvements in the environment (structure) and in behaviour (lifestyle) could bring about a significant reduction in premature death. The aim of the new public health was to improve the health of populations. It went beyond a recognition of the purely biological aspects of health and illness causation.

The Acheson Committee (1988) described this as "the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society." The new public health views individuals in a social, cultural and physical environment which is the central conceptual base for health promotion (Kickbush, 1985). It aims to enable interventions to be made based on "common life" situations and/or life chances of certain groups rather than on interventions made at specific diseases (Kickbush, 1985). At international, national and local levels, it involves the reorientation of public, corporate and health services by the creation of healthy public policies, meaning that policies should be proactive, focusing on prevention rather than cure.

The recurring themes in the literature are now on participation, collaboration and empowerment. For the healthcare professional, participation means that it is not enough to decide on a form of treatment or care and give it, but that individuals should be actively involved in any decisions or choices that are made. Collaboration can be interpreted as lay people and professionals from different disciplines working together as equal partners in order to tackle health problems. This, in turn can be interpreted as facilitating and enabling people to become empowered in taking control of their health.

Resulting from the growth of the public health movement, social scientists, community activists and educationalists have become increasingly involved in health promotion. This is because the disciplines underpinning the knowledge base of health promotion (natural sciences, social sciences, economics, ethics, epidemiology and the media) are similar to those supporting the various professions in health and social care. For these reasons health promotion is described as the unifying thread that has brought these fields of study together, in an attempt to develop new approaches to improvement in health (Bunton and Macdonald, 1992).

Health For All 2000

The desire for a new public health movement was expressed by a series of initiatives by the World Health Organisation, the first of these being the WHO Assembly at Alma Ata (1978). This is where the concept of health promotion was formally introduced. Its main focus was a commitment to primary healthcare, community participation and intersectorial collaboration. All member countries were signatories to these principles of "Health For All 2000."

Following this initiative, the international strategy was launched. Various nations of the world were banded into regions with their own specific targets to achieve. The UK is a member of the European Region. The thirty eight European targets are aimed at improving both individual and public health. In explaining the structure of these targets, the WHO (1985) defines the prerequisites for and aims of improvement in health as follows:

Figure 1-1

The Prerequisites for health	**The aims of improvement in health**
A satisfying role in society	Equity in health

Peace	Adding life to years
Adequate food and income	Health to life
Safe water and sanitation	Years to life

Health Promotion was defined as "the process of enabling people to increase control over and improve their health." In this context health is viewed as a resource for living rather than an end in itself (Ashton and Seymour, 1998

In their discussion document of the concept and principles of health promotion, the World Health Organisation defines it as representing a "unifying concept" for those who recognise the need for change in ways and conditions of living in order to promote health. Health promotion represents a:

> "mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future" (WHO 1984).

Implicit in this statement, besides the focus on people and action is the notion of a healthier future, rather than the more static concentration on individual behaviour. Publication of this document paved the way for a series of international conferences, the first of these being in Ottowa, Canada in 1986. The result of this was the charter for action, namely the creation of:

- healthy public policy
- supportive environments
- strong community action
- personal skills
- reoriented health services (WHO1986).

The Ottowa Charter defined three main intentions which professionals could utilise in beginning the process of helping people to take control over their own lives. These are described as advocacy, mediation and enablement. This means that any public policy should be designed to determine positive rather than negative consequences

for health. The political obstacles to the adoption of healthy policies in agencies such as, housing, agriculture, taxation and transport should be recognised and removed.

However, health promotion efforts are not perceived as the sole responsibility of governments; communities must be involved and empowered to take responsibility for health. To do this they need information and other resources in order to be able to identify their needs, set priorities and begin to work towards solutions to their problems.

Within the NHS this has been achieved, to some extent by the work of the public health directorates in health authorities, who publish annual reports based on epidemiological data collection utilising quantitative and more sensitive qualitative methods. The aim is to plan and commission health services that reflect local needs, through what can be called "community profiling" or "community diagnosis." The WHO's Healthy Cities Programme is a series of national networks based on the idea of multisectorial working or healthy alliances. The intention here is to bring together a small number of European cities to collaborate in working to produce models of good health promotion practice in urban environments. Ashton and Seymour (1986) provide a very thorough and illuminative analysis of their work in the Liverpool Healthy Cities Project.

The UK Government's Response to Health Promotion

The shape of health promotion within the NHS has been determined by a series of White Papers: *Prevention and Health: Everybody's Business* (DHSS, 1976); the Griffiths Report (DHSS, 1983); *Promoting Better Health* (DOH, 1987); *Working for People* (DOH, 1989a); *Caring for Patients* (DOH, 1989b). The Griffiths Report was responsible for the introduction of general management principles into the NHS.

These last two White Papers provided the framework for the NHS and Community Care Act (1991) which introduced the concept of the internal market into the NHS.

With the 1997 change in government further legislation is on the agenda with the publication of the *New NHS: Modern and Dependable* (DOH, 1997); and *Saving Lives: Our Healthier Nation* (DOH 1998). At the time of writing the statute had not changed although recommendations were being implemented such as the abolition of the internal market. In essence this strategic development bears a closer correlation with the WHO (1985) principles than previous legislation.

One of the main aims of the NHS and Community Care Act (1991), and in line with the Ottowa Charter, was for the UK government to place the issue of primary healthcare and health promotion on the political agenda. The main intention here was to shift the emphasis from an illness service, to one offering to prevent disease and disability. However, the preferred model was one that was general practitioner led and based on screening for individual risk factors and health and lifestyle advice which, it is argued, is not in keeping with the philosophy of the WHO (Williams *et al.*, 1993).

The GP contract offers financial incentives for providing health promotion services. These incentives are banded according to the type of service offered. For example, a minimum fee is charged for checking the height, weight, blood pressure and urine of new patients to a practice. Further remuneration is offered for the provision of more formal clinics, such as those for well women, contraception, asthma, diabetes and smoking cessation. The weaknesses inherent in this lifestyle approach to health promotion have already been addressed. However, it is apparent that the preference

for this approach is due to the fact that, because it has the merit of producing quantifiable results, it fits quite well within the market culture of the NHS.

Having established that recent policy decisions in this country do not entirely reflect the WHO policy of health promotion, it is necessary to explore the definition in more detail by examining some of the problems associated with it. The main problem seems to be concerned not so much with the definition itself, but with the interpretation. For example, it is argued that, although the WHO's definition and approaches to health promotion acknowledge medicine as part of the process, the predominance of the social model of health and illness could also be limiting. An enthusiasm for de-medicalising explanations for illness causation can lead to an unhelpful conflict between medical and social models of health and illness.

It is more use useful to utilise Antonovsky's (1979) claim that behavioural and medical science should focus on system survival. In terms of health promotion, this means that critical questions should be asked about why particular individuals or societies are able to withstand the effects of poor economic and social conditions, environmental pollution and self-harm. The debate between the social and medical model is irrelevant if the contribution made by medical and behavioural sciences are equal and emphasis is placed on system survival rather than breakdown (Kelly 1990).

There are also problems associated with target setting, regarding the orientation towards action for change in the future. For example, Kelly (1990) acknowledges the problems encountered by the Healthy Cities projects in devising indicators to

measure future changes of state. By placing a target of a 15% reduction in specific a specific disease in a particular community by the year 2000, a future improved state of health is implied. However, community profiles often show that ordinary people are much more concerned with the problems of everyday life (Kelly, 1990).

There is also a view that the WHO's (1986) definition pays scant attention to the importance of the contribution of sciences of behavioural or social change, such as, sociology, psychology and social psychology. While no one person can be an expert regarding the range and depth of knowledge in these disciplines, when any health promotion initiative is planned, regardless of the level, it is important that attention should be given to the models of behavioural and social change that will be utilised (Kelly, 1990).

The "Health of the Nation"

With these factors in mind, it should be somewhat easier to view the emergence of the previous government's Green Paper (1991) and White Paper (1992) on the Health of the Nation in a more sympathetic light. The White Paper focuses on five key areas for change up to, and beyond the year 2000. These are:

Heart disease and stroke
By the year 2000 reduce

- heart disease and death rates in people under 65 by at least 40%, and among people between 65 and 4 by at least 30%;
- the death rate from stroke among people under 75 by at least40%;
- the number of people smoking by a third.

Cancer
By the year 2000 reduce

- the number of people smoking by a third;
- the rate of breast cancer deaths among women invited for screening by at least 25%;
- the incidence of invasive cervical cancer by approximately 20%.

Mental illness
By the year 2000 reduce

- improve significantly the health, social functioning and quality of life of people who are mentally ill;

reduce the national suicide rate by 15%.

Sexual Health
Reduce

- the national incidence of gonorrhoea by at least 20% by 1995;
- the proportion of drug users who report needle sharing from a fifth in 1990 to no more than a tenth in 1997;
- by at least half the rate of conceptions in under-16s by the year 2000.

Accidents
By 2005 reduce:

- the rates of accidental deaths among children and elderly people by a third;
- the rates of accidental deaths among young people aged 15 to 24 by at least a quarter (HON 1992).

The document also identifies four "risk factor" or target areas where strategies for change should be focused, these being:

- smoking
- diet and nutrition
- blood pressure
- HIV/AIDS

When implemented by the then conservative government this strategy was criticised by opposition parties for ignoring the existence of poverty and inequalities in health Williams et al., 1993). Professional organisations have been equally critical. The Royal College of Nursing, in response to the Green Paper identified several weaknesses in the document which are not addressed in the strategic document such as:

- Targets within some of the key areas are addressed too narrowly.

- Targets where relevant should make provision for different levels of compliance for different ethnic groups, socio-economic groups or genders.

- Reducing the total incidence of disease in the nation is welcome, but attempts should be made to reduce differentials between groups.

- Resources must not be diverted from those areas where no targets are to be set.

- Targets should be finalised in the light of local circumstances, and the resources needed to make progress towards targets must be controlled locally.

However the Royal College of Nursing's understanding of health promotion appears suspect in that their statement suggests that arrangements should be made "for different levels of compliance" for different groups of people, suggesting that some people are more submissive, yielding and obedient than others, rather than more empowered than others.

What the White Paper did represent was an advance in that particular government's thinking on public health issues, but it still tended to be disease orientated. It was also long on descriptive analysis and short on outlining effective ways in which it could be implemented. For example, although a target of a 30% reduction in heart disease and mortality from stroke was set, along with targets to reduce smoking to 22% and 21% in respective male and female populations, no suggestions were made regarding the financial and human resources necessary in order to achieve them.

The document also indicated an understanding of the relevance of a collaborative approach to health promotion. At both national and local levels, agencies were acknowledged as having a responsibility to work together to implement the strategy. It was recommended that they should have clearly defined and common aims. Agencies involved ranged from environment, transport, energy and education through to the Health and Safety Commission, local authorities and the voluntary sector. However, despite this shift, there was still a strong emphasis within the document on changing individual lifestyle and behaviour.

To summarise, health promotion is about creating change. It is the responsibility of international, national and local governments and organisations to enable people to lead healthier lives, by creating environments which empower them to do so. A multiplicity of agencies and professionals with diverse philosophies of health and health promotion are involved in this work. For these reasons it is a complex and challenging discipline. Because of the conflict and lack of consensus regarding the meaning and intended outcomes of health promotion, it is often difficult for health professionals to identify how they can work effectively. In order to begin to establish a framework for practice, it was suggested at the beginning of the chapter that, at its simplest level, practice was determined on whether a structuralist or lifestyle approach was adopted. What emerges, though, is that at whatever level professionals are working they cannot work in isolation. Communication is one of the major components of this discipline and notions of collaboration and partnership are key themes.

It is concluded that by basing their philosophy for practice within this framework of "Health For All," health professionals - whether working in acute hospital or community settings - will begin to understand the roles and boundaries of the variety

of disciplines working in this sphere. Conflicting value systems or ideologies should not be a barrier to progress. Ultimately this should have a significant effect on the quality of care and service being given, not only to the well, but also to those who are chronically sick and disabled.

CHAPTER 2

THE PRACTICE OF HEALTH PROMOTION

The controversial and challenging nature of health promotion, and some of the problems subsequently associated with this discipline emerged in the previous chapter. It appears that this is because, within formal healthcare systems, the change in priority from curative to preventive services, conflicts with traditional values and beliefs about healthcare. Downie et al (1991) provide an analysis of the values involved. We now turn to consider how these problems may be overcome. This is through an examination of the models of health promotion most frequently referred to in the literature.

Problems in Health Promotion

There are two main areas of concern within health promotion. The first is associated with resources and is described as distributive justice, or the task of creating an economic balance between primary prevention, promotion and cure (Lambert and McPherson, 1993; Yeo, 1993). In short, in an ideal world where money was no object, there would be no problem in resourcing preventive services aiming to improve the health of populations over time. However, the reality is that these aims have to be considered in conjunction with current problems and can be contextualised by asking such questions as:

"Given the choice, should we abandon help for some of those who are already sick in order to increase the future health of those who are well?" (Lambert and McPherson 1993)

The second problem is associated with intervention ethics, which can be dissected into two further categories. These are problems associated with the selection of appropriate strategies and questions about evaluation.

Selection of Appropriate Strategies

From a moral stance, health promotion interventions can be described as ranging from voluntary, to non voluntary to coercive. The methods used by professionals to try to change behaviour can be described as persuasive, manipulative and coercive (Faden, 1987). The problems encountered when using these methods is that they can be perceived negatively and construed as social engineering. The role of intervention ethics is to evaluate strategies to ensure that their impact on people's health is not limited or offended (Yeo 1993). This is not easy and issues of moral justification must be considered.

For example, action to reduce motor vehicle accidents has concentrated on introducing legislation to reduce risk factors associated with lifestyle, such as the wearing of seat belts and speed restrictions (Locker 1991). It can be argued, from a liberal perspective, that such legislation restricts an individual's choice and less effort has been made to control advertising which displays images of cars and driving in a counterproductive way; speed is portrayed as being sexy, exciting and glamorous, the car is a status symbol. However, national government advertising campaigns to drive safely and wear seat belts failed to effect any behavioural change, but legislation has had an impact on reducing mortality and morbidity from road traffic accidents. What is significant here is that there is strong public support for legislation (Naidoo, in Rodmell and Watt 1986). Therefore, in terms of moral justification, although legislation can restrict some people's freedom, it is acceptable to adopt a utilitarian approach, because it is for the common good.

Coercion, the subtle manipulation of behaviours deemed unacceptable or unhealthy by professionals, such as smoking or exceeding sensible drinking limits, can be regarded as morally indefensible. The argument that this latter approach does make people aware of their health is not valid, especially when foundations for the implementation of such strategies are unsupported by reliable empirical evidence (Lambert and McPherson 19993). The debate surrounding the validity of research into safe drinking limits is one such example (Gronbaek et al 1994). More recent studies relating to the food industry and the quality of genetically modified food are also questionable (Lacy, 1995). The sort of questions that need to be asked in this context are:

- Who are the people who adopt unhealthy behaviours?
- What makes people adopt unhealthy behaviours?
- Why do some people and not others adopt unhealthy behaviours?

By endeavouring to elicit answers to questions such as these, it should be possible to begin to develop services that can support people through change.

Problems Associated with Evaluation

Evaluation is an essential part of any health promoting activity, being based on incorporating sound research principles into the planning process. However, problems are associated with methodologies. In the UK, it seems, this is because the philosophical foundations for health promotion conflict with those of the WHO. In the UK (until the recent changes in government and legislation), policy has indicated a preference for an individualistic approach to health promotion. In this context health evaluation is considered in short-term outcome measures, related to the reduction of morbidity and mortality due to ill-health caused by damaging behaviour.

The WHO European Strategy for Health For All states that in the Year 2000 the difference in health status between countries and groups of people within countries should be reduced by at least 25% (Power 1994). This should be achieved by

improving the level of health of disadvantaged nations and groups. Because of this latter belief in the notion of a healthier future, health promotion evaluation should adopt a multi-method approach to measure the process impact and outcome of long-term social or behavioural change (Downie et al 1991). This could be through a framework of action research or longitudinal studies.

The problems encountered in utilising these methods however, are associated with difficulties in controlling external variables such as the time lag involved in observing the impact of various preventive strategies. For example, if a community physiotherapist sets up an exercise group in a local leisure Centre as part of a "healthy heart" initiative, and there is a reduction in mortality and morbidity in coronary heart disease in that area, it does not follow that this is the cause of the improvement. One of several other variables could also have had an impact.

The lack of systematic evaluation in health promotion activities in the NHS has been attributed, by some to the fact that strategies tend to be influenced by political ideology (Lambert and McPherson 1993). However, this is a sterile argument, politics will always dominate what is evaluated and how and whether or not recommendations are acted upon (Downie et al 1991).

The lack of scientific rigour in health promotion evaluation need not be perceived as a problem if methods are not viewed solely in quantitative terms and the randomised control trial is not the "gold standard." Downie et al (1991) argue the case for a phenomenological approach based on a variety of methods, stating that they do not insist on experimental rigour in situations where it is not justified. Health promotion programmes should not be restricted to the demands of evaluators to "carry out the plans no matter what;" they should rather be encouraged to develop to their full potential. The diversity of talent and expertise of the researchers and practitioners and researchers implementing these programmes should be acknowledged and developd.

Practical Approaches to Health Promotion

A fierce debate has raged for some considerable time regarding the adequacy of the theoretical foundations for health promotion (Beattie,1992). Models of health promotion are considered unscientific because their underlying philosophy is unsound. This may well be, as Rawson (1992) identifies, because theorists have either scrutinised other disciplines for a scientific foundation, or concentrated on justifying the ideological basis of health promotion. However, it is recognised that most models have evolved from typologies devised by health educationalists to provide structure to their work. Consequently their perceptions are influenced by their practice orientations.

Early attempts to classify approaches to health promotion were made by health educationalists who wished to demonstrate the shift from individual to collective and societal action to improve health. Coutts and Hardy (1985) discuss five models of health promotion namely:

- The medical model
- The educational model
- The media model
- The community development model
- The political model

These are very similar to those of Ewles and Simnett (1986), who decline to use the term "model", preferring to look at health education in terms of perspectives or approaches. They also analyse their objectives for health promotion in terms of aims intention and method.

Figure 1 -2

Ewles and Simnett's Five Approaches to Health Promotion

Approach	Aim	Intention	Method
Medical	Freedom from medically defined disease	To prevent or ameliorate ill health	Persuasion: Women to use family planning clinics
Behaviour Change	Change attitudes and behaviour.	To adopt healthy lifestyles.	Promoting the idea that smoking is anti social. Teaching people to stop smoking.
Educational	Give knowledge & ensure understanding of health issues.	Based on notion: people will act on informed decisions.	Information is value free. Encourage exploration of own values.
Client-centred	To work with clients so they can identify own values.	People make own decisions according to own values.	Professional is a facilitator, withdrawing as group matures.
Social change	To change the environment.	Empowerment	Political & social action:, both locally and nationally.

Besides demonstrating the change in focus from individual to collective action, Ewles and Simnett (1992), identify the change in the professional role from informer and educator, to facilitator as power is transferred to the client or the group. From a sociological perspective Beattie (1992) is critical of these typologies. Because they are not grounded in sociological theory it is not possible to develop or test them any further. However, Ewles and Simnett (1992), besides giving a descriptive review of their approaches also provide a critical review of their relative strengths and weaknesses. It is also important to acknowledge that the methods they describe are derived from health education. Consequently they are grounded in a range of psychological and educational theories.

Beatties's concern regarding the paucity of sociological analysis in health promotion led him to develop a theoretical model which is influenced by C.W. Mill's system of cross-clarification and Bernstein's (1974) concept of codes and control (appendix 1) This structural map defines the different strategies in terms of two bipolar dimensions, the mode of intervention and the focus of intervention. The authoritative/negotiated dimension compares with the debate regarding the paternalistic "top-down" type of social intervention, versus the participatory or "bottom-up" approaches (Ewles and Simnett 1992; Beattie, 1992).

In his analysis of this model, Beattie (1992) describes the cluster of health persuasion techniques as having their origins in the 19th century temperance campaigns as well as the propaganda campaigns in the two world wars which focused on venereal disease and better eating. These strategies have been popular with successive governments since then, as well as the Health Education Authority (the first AIDS campaign being one such example). This is despite the dubious effects of these approaches (Beattie 1992).

Strategies for legislative action for health originate from the nineteenth century public health movement. Again, Beattie gives useful examples of studies demonstrating the dramatic influence these measures have had on health, the most remarkable being the Clean Air Act in 1956. He continues to support this ecological approach at policy level in the adoption of no-smoking and healthy eating policies. Added to this could be the current legislation relating to health and safety at work through recent EU directives, notably the manual handling policies. Beattie also warns, though, that there are dangers of "collective authoritarianism" if reform is focused too much on achieving health itself, without considering the problems or needs of the wider community.

At an individual level, approaches used in personal counselling for health are rooted in the humanistic psychology of Carl Rodgers (1969). Beattie highlights the contribution these techniques have had in agencies in the NHS and voluntary sector. He describes their use in general practice, psychiatry and mental health nursing, the Family Planning Association and Relate. They have also been adopted in the professional training of teachers, healthcare professionals and social workers.

Beattie describes the community development or public health approach as the most recent, the strategies used here being self-help, community oriented health outreach and community action. Despite his criticism of the lack of theoretical grounding for health promotion, in this instance, he contributes nothing more to the discussion than Ewles and Simnett (1992). However, while acknowledging the dynamism and opportunities available to create change through community development, Beattie is also realistic in concluding that it is debatable whether local action can ever do more than "achieve marginal victories in the face of larger social inequality" (Craig et al., 1982 in Beattie 1992).

In the development of this construct, Beattie (1992) identifies how social enquiry can be of use in the future. Consequently, he highlights the conflicting policy debates within the field. Like other theorists (Rodmell and Watt, 1986; Rawson, 1992), he is aware that the range of conflicting and sometimes antagonistic value systems that are a product of a pluralist society, can be inhibiting in the development of health promotion as an effective discipline. He stresses the importance of confronting these issues so that practice is developed in a more open and constructive way (Beattie, 1992). Beattie's contribution in refining and clarifying the concept is important. However, his model, although useful still presents as compartmentalised and because of this fragmented perception, only contributes partially to the debate.

Tannahill (1985) a public health doctor, appears to be aware of the problems associated with the diverse nature of the meaning of health promotion, even before Beattie. He encapsulates the problem by saying that it had **"acquired so many meanings as to become almost meaningless."** In conjunction with Robert Downie, professor of Moral Philosophy at Edinburgh University, he developed a model for defining and "doing health promotion." This is represented as seven overlapping spheres or domains of health promotion aimed at disease prevention and the promotion of positive health namely:

Figure 2-2

The Seven Domains of Tannahill's Model of Health Promotion

- Preventive services: immunisation, screening, case finding.
- Preventive health education: education to influence lifestyles plus encouragement to take up services.
- Preventive health protection: fluoridation of water.
- health education for preventive health protection: lobbying for seat belt legislation.
- Positive health education: to influence behaviour, such as, encouraging productive leisure pursuits that promote fitness and well-being.
- Positive health protection: no smoking policies in the workplace.
- Health education aimed at positive health protection: raising awareness and securing support for these measures at public and policy levels. (Downie et al., 1991).

A key influence in the development of Tannahill's model was Tones'(1984) concern that, ethically, rather than empowering individuals or communities, health promotion could be interpreted as an attempt at "social engineering" through the adoption of mass media persuasion tactics. Tones argues that such approaches need to be accompanied by health education programmes that "operate synergistically" with one another. Tannahill does not perceive health promotion in purely structural or individual terms, but rather as "overlapping spheres of activity" which are not

mutually exclusive. These spheres of health education, prevention and protection, all contribute to the goal of health promotion.

Clearly Downie et al. (1991) perceive health education as being at the core of health promotion and not part of an evolutionary process. They also see communication as an essential element of these processes. At a planning level, in determining priorities for action, community development is identified as a major component of health promotion. In proposing their integrated approach to health promotion planning, they identify empowerment as an important theme, arguing that it is necessary for "comprehensive programmes of health services and health protection" to "be tailored to the needs of the people and the places concerned."

These views concur with those of the research Unit in Health and Behavioural Change at Edinburgh University (1989). In their discussion of health promotion through community development they state that:

> "Changes in public health which require alteration or modification of individual habits will only happen through understanding of the nature and context of human behaviour. Health promotion and health education provide an outside climate which influences the direction of behaviour change, but they are unlikely to trigger such changes when based on a "rational approach". The most efficacious is community development. Only when people's lives become less strained, and adaptive and coping processes reasonably untaxed will people be likely to think about changes in behaviour."

This chapter has considered practical and moral issues regarding the implementation of health promotion principles. It appears essential for professionals to take account of the social and personal values of individuals as part of any needs assessment, prior to the planning and implementation of any activity. This needs to be done in conjunction with a close scrutiny of their own value systems.

In reviewing the various approaches to health promotion, at a strategic level, it may not be appropriate to adopt one particular method. As has been demonstrated, there are areas of interelatedness and overlap, an eclectic approach may well be more helpful. Once the common aim or strategy has been determined, the appropriate tool or method can be utilised, dependent on the level and environment where the professional is working.

Problems with evaluation have been explored. Until recently the philosophy of the UK government appears to have been in conflict with that of the WHO. In this context evaluation seems to have been considered from a short-term quantitative perspective, related to the reduction of mortality and morbidity, due to ill health caused by damaging behaviour. As a result, evaluation strategies aimed at reducing inequalities are limited. This is a pity, as much could be learned by identifying strategies that are effective.

Although methodological complications are associated with both action research and longitudinal studies, this does not preclude such structures from being integrated into strategic planning. Theorists too, are critical of the foundations of knowledge in health promotion. Further systematic enquiry utilising various methods is the only way forward for theoretical development. There is a political dimension to health promotion, but this does not mean to say that conflicting value systems or ideologies should be a barrier to progress. These differences should be viewed as an opportunity for dynamic and innovative thought and progression.

The analysis, so far has concentrated on concept clarification and the implications for the healthcare professional from a broad perspective. The implications for nursing require examination.

CHAPTER 3

THE DEVELOPMENT OF HEALTH PROMOTION IN NURSING

In this chapter the development of health promotion in nursing is discussed. The historical development of the biomedical model of healthcare is traced and its influence on nursing is considered. The decline of this influence is explored in the light of the development of nursing as an academic discipline. The development of nursing theory in relation to health promotion in the United Kingdom and USA is also discussed.

Nursing has been described as pluralist profession (White, 1988), in that it incorporates various disciplines (general nursing, mental health, mental handicap, childrens' nursing, midwifery and health visiting), who work in a variety of environments. Ideas about the importance of nurses teaching their patients and clients about the effect of good nutrition, hygiene or health, have existed since Florence Nightingale wrote her "Notes on Nursing" (1859). Traditionally health education, has been perceived to be the main responsibility of community nurses, with health visitors taking the lead (Jamieson Report, 1956). This was confirmed by the report of the Council for the Education and Training of Health Visitors (1967). In 1978 Alwyn Smith wrote in his History of the Nursing Profession:

> " It is probable that the greater part of the formally intended health education provided within the NHS is provided by health visitors."

However, this study is focusing on the perceptions of pre-registration nursing students perceptions of health promotion. Until the Project 2000 (1986) recommendations for nursing began to be implemented, the majority of new entrants to nursing received most of their practical experience in hospitals. This loss of the educative role of nurses requires further exploration.

From an historical perspective, it appears to be explained by the emergence during the 18th and 19th centuries, of the dominance of the biomedical model of healing which became the accepted approach to healthcare in western industrialised societies (Morgan et al 1985). This approach, according to Williams (1989) and Tudor-Hart (1990), is influenced by classical liberal theory, which has it's roots in the writings of political philosophers and social theorists such as Jeremy Bentham and John Stuart Mill who were living and writing in England at that time. Classical liberal theory perceives individuals as essentially solitary, self sufficient and self-determined human beings, who, in theory, could exist independently of social relationships. This idea about human nature has been called abstract individualism. It implies that people are ontologically prior to society and that human nature is therefore pre-social; that is, the dispositions of individuals are assumed to be present prior to, and independent of social contact.

In her analysis of the social and political movements which made the dominance of biomedicine possible, Stacey (1988) argues that biomedicine became centrally organised and legitimised by the state. With the establishment of the General Medical Council in 1858, doctors became leaders of all other healthcare workers. This Stacey (1988) attributes to the fact that medicine, as opposed to nursing and midwifery, was essentially a male dominated profession. This feminist view is useful, and is supported by nursing historians. Abel-Smith (1977), in tracing the development of both nursing and midwifery emphasises that these professions had different social origins to medicine. Besides physicians (who were men), originating from the middle classes, they were also better educated than nurses (who were women). Nursing, in conjunction with Florence Nightingale's "lady nurses" or "good women", was only beginning to be perceived as a suitable occupation for women who had not, or did not, wish to be married.

This patriarchal, biomedical view of nursing, with its emphasis on cure, rather than prevention, was extended to nurse education. Nurses were trained rather than educated. They were expected to perform a series of tasks on their patients; to follow orders rather than make decisions. Doctors were also prominent teachers on training programmes, placing emphasis on the disease process of body systems. Maggs (1983) in his work on the Origins of General Nursing supports this;

> "The hospital discipline containing a hierarchy of duties and personnel worked with the formal training programme to justify even the menial jobs of cleaning and polishing, and transform them into the art and science of nursing. The reward held out to the woman involved in this process was the status of the certificated general nurse. Whether that status was worth the long years of training could only be judged by what happened to the certified nurse after she qualified" (Maggs 1983 pp109).

In fact as Maggs emphasises, the main thrust in the development of nursing in the UK at that time was one of professionalisation. The conflict between Florence Nightingale and Mrs. Bedford-Fenwick who wished nursing to be regulated and recognised as a profession is well-documented (Abel-Smith 1977). Maggs (1983) refers to this as "occupational imperialism," by a class of women who would normally have been secretaries or teachers (the "white blouse workers"), being attracted to general nursing. This professional domination, with the psychological, social and caring aspects of nursing was ignored until the publication of the Royal Commission on Nursing in 1972 (The Briggs Report). In 1977 the General Nursing Council finally recognised the importance of the social and behavioural sciences in the understanding of health and disease. An emphasis was also placed on health promotion as part of patient care.

The Decline of the Influence of Biomedicine in Nursing

This decline has been attributed to several factors. For example, Williams writing in 1983, thought that the following factors were important in the change.

- The claim for equality between doctors and nurses which reflected the changing relationship between men and women in the culture.

- The changing work of the nurse, resulting from changes in medical technology. This meant that nurses became involved in monitoring complex machinery and carrying out difficult procedures were not seen as menial tasks, the idea of sacrifice was redundant. Since these procedures required technological skill, they required assertion of self in creative and innovative action.

- Finally, developments in the United States, where education had moved to graduate status, and therefore influenced thinking in this country, were thought to be important. (Williams 1983).

These first two arguments are weak, the claim for equality between doctors and nurses is more to do with professionalisation than culture and gender differences. For instance, the growth of the feminist movement and more equity in education between men and women has led to there being more women doctors. However, although the gender ratios for junior doctors are about equal, the medical establishment continues to be thoroughly male-dominated (Salvage 1990). This trend is mirrored in nursing, less than one in ten people doing nursing work are men, yet they dominate senior positions in nursing (Clay 1988). With regard to nurses work in relation to the extension of the role in monitoring machinery and performing complex procedures, it is argued that nurses perform these tasks to the detriment of their role in health promotion.

However, the influence of the developments of nursing in the United States has had an impact in this country on the delivery of care, as well as affecting government and professional policy decisions. Further enquiry is necessary to ascertain whether this has had an effect on the decline of the influence of biomedicine on nursing, consequently allowing health promotion to flourish.

In the 1960's the American nurse Virginia Henderson crystallised changes in nurses' beliefs, attitudes and value systems in her definition of nursing.

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death), that he could perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as help him gain independence as rapidly as possible" (Henderson 1969).

This brought attention to the view that the role of the nurse was not only to give care to the sick, but also to act as an agent in helping people to determine their own needs (Williams 1983). There is also emphasis on participation in identifying needs in the process of nursing. However, evidence of the influence of individualistic classical liberal theory still exists. The focus is still on the individual and does not address the social context of health and illness.

Henderson's model of nursing, based on fourteen activities of daily living, in theory, influenced the move away from the task and procedure orientation within a medical model to the process, patient centred orientation as identified within the nursing process. This is carried out in five stages, namely;

Figure 1-3

Five Stages of the Nursing Process

- Data collection.
- Needs assessment and problem diagnosis.
- Planning of nursing care.
- Implementation of planned care.
- Evaluation of care (GNC, 1977)

Webb (1983) and Coutts and Hardy (1985), also perceive this framework as being the health education framework which is integral to nursing care.

This influence of American thought on nursing in the United Kingdom is accepted in the acceptance of the nursing process by the General Nursing Council in 1977.

> "The concept of the nursing process provides a unifying thread for the study of individual nursing care and a helpful framework for nursing practice" (GNC Educational policy 1977).

Since then, throughout the late 1970's and 1980's, American academic nurses have

dominated in the development of theories and models of nursing which have been used in this country with varying degrees of success.

Tomey (1994) traced the evolution of the development of nursing theory. She perceived nursing theory as a product of the professional growth process of nurse leaders, administrators, educators and practitioners, who saw the limitations of the theory of other disciplines (such as biomedicine), in predicting or explaining nursing outcomes. These leaders, she claims, sought to establish a sound basis for nursing management, curricular practice and research.

In this analysis of the work of twenty seven nursing theorists a classification of the theoretical foundations of knowledge is developed. Classification in this manner Tomey (1994) argues, add context in that they can be considered in relation to the structure of nursing knowledge. She organises these theories into three types of knowledge based on their predominant characteristics as a theoretical work in nursing. The first type is nursing philosophy, these include early works that have contributed to nursing knowledge through the provision of direction or form for later development, and also include work that reflects more recent expansion in the areas of human science and its methods.

The second part of the classification contains the work of those nurses whom she considers important in the development of conceptual models, these they call the grand theorists, or pioneers in nursing. These works according to Tomey (1994), are comprehensive and include those aspects of human beings, such as their health and the environments with which nursing is concerned. Thus providing direction for education and research.

The third type are the middle-range theories developed from other academic disciplines, earlier nursing philosophies or grand theories. Middle-range theory has a

narrower focus than grand theory and is more concrete in terms of its level of abstraction. Thus, they are more precise, answering specific questions relating to nursing practice. They specify such factors as the age, health condition and location of the client, as well as the nursing intervention (Tomey, 994). This classification is as follows:

Figure 2- 3

The Evolution of Nursing Theory

Philosophies	**Conceptual Models**	**Theories**
Nightingale	Orem	Peplau
Wiedenbach	Levine	Orlando
Henderson	Rogers	Travelbee
Abdella	Johnson	Riel-Sisca
Hall	Roy	Mercer
Watson	Neuman	Barnard
Benner	King	Leininger
		Parse
		Fitzpatrick
		Newman
		Adam
		Pender

Considering that the original work of some of these theorists is extremely complex, the author offers this work as a starting point for students of nursing theory. However, it is not totally inclusive, for example Roper, Logan and Tierney's (1985) model of nursing is not included in this edition. This is the most frequently used model of nursing in the United Kingdom, although Tierney (1994) concedes that health promotion is not of interest to her (unpublished letter to researcher 1994). Neither would some nurses consider themselves to be either philosophers or theorists. It is extremely doubtful whether Florence Nightingale considered herself in this light. However, this is acknowledged by the author.

With regard to the efficacy of nursing models in health education, the American nurses Riel and Roy (1980) reviewed a sample of nursing models and analysed a case study as a starting point for comparing the implications of the different kinds of models. Those selected were;

- The Roy adaptation model.
- Johnson's behaviour systems model.
- Orem's self-care model.
- Riel's interaction model.
- Peplau's developmental model.

The first similarity noted was that each case study presentation focused on patient behaviour, but observation of patient behaviour had a different significance in each model. This resulted in differences in interpretation when recording the data base. From the data base, the five models produced different nursing diagnoses and goals. However, they also found that nursing practices were similar, although the means of intervention was different. What is of significance in relation to health promotion, is that, only four of the five models identified health education as a nursing activity. In fact an examination of the beliefs or definitions of health of the theorists in Tomey's (1994) classification, revealed that not all based their theoretical assumptions on any definition of health, health being implicit in their theories as one of the goals of nursing.

Riel and Roy (1980), conclude that it does not matter which model is used because the practice is the same. They allow for the reality of nursing being compromised by current practice and that they may have to devise interventions accordingly. This view is accepted by another American nurse. Smith (1991), writing about nursing's unique focus on health promotion, identifies the value of nursing models as being their flexibility, attributing this to the different concepts of health held by the various authors. Consequently, she says, different models can be applied to people in different situations. Obviously, this could be useful considering the various health beliefs held by different members of society. However, this possibility could be problematic in that it is acknowledged that little health education takes place in hospitals outside of research projects (Wilson-Barnett 1983), if health is not articulated in nursing theory, then there is every possibility that health promotion will be overlooked.

A different point of view is offered by the British nurse and academic, Phillip Burnard. He advocates caution regarding the use of nursing models in health promotion. He refers to Crawford's (1977) notions of "Healthism" and "Lifestylism," stating that because all nursing models focus on individualism, if used without recognising that there are some areas of people's lives over which they have no control then they will be unsuccessful. However, some nursing academics have specifically developed nursing theory within a health promotion framework. These are now considered.

The Work of Betty Neuman

Betty Neuman's clinical nursing background was in mental health. The philosophical foundations for the development of her model for nursing are shaped by this experience and influenced by knowledge from several related disciplines notably; Gestalt psychology, the philosophical views of de Chardin and Bernard Marx and Selye's (1974) definition of stress (Neuman 1982). The model also incorporates general systems theory (Bertalanfy (1968), as well as Caplan's (1964) model of primary, secondary and tertiary prevention.

Health is a major construct in Neuman's theory, which she perceived as a dynamic relationship between illness and wellness:

> "Optimal wellness or stability indicates that total system needs are being met. A reduced state of wellness is the result of unmet system needs. The client is in a dynamic state of either wellness or illness, in varying degrees at any given point in time" (Neuman 1995).

Systems theory is utilised in the model by representing the person as a client/patient system that ranges from the individual, family group or social issue. This client system is a dynamic composition of relationships affected by physiological, psychological, sociocultural and spiritual factors. The client system is viewed as

constantly changing. It is an open system which operates interactively with the environment (Freese et al 1986).

Neuman's (1982) beliefs about nursing were holistic and she describes nursing as "a unique profession that is concerned with all of the variables affecting an individual's response to stress". The basic assumptions of this model are as follows:

Figure 3-3

The Foundation of Neuman's Model

- "Although each individual client or group as a client system is unique, each system is a composite of common known factors or innate characteristics within a normal, given range of responses contained within a basic structure.

- Many known, unknown, and universal environmental stressors exist. Each differs in its potential for disturbing a client's usual stability, or normal line of defence. The particular interrelationships of client variables - physiological, psychological, sociocultural, developmental and spiritual - at any point in time can affect the degree to which the client is protected by the normal line of defence against possible action by a single stressor or a combination of stressors.

- Each individual client system has evolved a normal range of response to the environment that is refried to as a normal line of defence, or usual wellness/ stability state. The normal line of defence can be used as a standard from which to measure health deviation.

- When the cushioning, accordion-like effect of the flexible line of defence is no longer capable of protecting the client system against an environmental stressor, the stressor breaks through the normal line of defence. The interrelationship of variables - physiological, psychological, sociocultural, developmental and spiritual - determine the nature and degree of system reaction or possible reaction to the stressor.

- The client, whether in a state of wellness or illness, is a dynamic composite of the interrelationships of variables - physiological, psychological, sociocultural, developmental, and spiritual. Wellness is on a continuum of available energy to support the system in an optimal state of system stability.

- Implicit within each client system are internal resistance factors known as lines of resistance, which function to stabilise and return the client to the usual wellness state (normal line of defence) or possibly to a higher level of stability following an environmental stressor reaction.

- Primary prevention relates to general knowledge that is applied in client assessment and intervention in identification and reduction or mitigation of possible or actual risk factors associated with environmental stressors to prevent possible reaction. The goal of health promotion is included in primary prevention.

- Secondary prevention relates to symptomology following a reaction to stressors, appropriate ranking of intervention priorities, and treatment to reduce their noxious effects.

- Tertiary prevention relates to the adjustive processes taking place as reconstitution begins and maintenance factors move the client back in a circular manner toward primary prevention.

- The client as a system is in dynamic, constant energy exchange with the environment." (Neuman 1995)

Clearly health and health promotion are central to this nursing model. The validity and relevance of her work is also proven at a practical level in that it has been adapted for nursing education as well as in a variety of clinical situations. It also adapts well to a variety of cultures and is the most frequently used model for public health nursing in the United States and Canada (Lowry 1995). In the UK Clarke (1989 in Kershaw and Salvage 1989), developed a model for health visiting based on Neuman's theory. The literature also indicates that it is one of the three most frequently used models in nursing research (Louis 1995), this is despite original criticisms that the concepts utilised were too broad (Neuman 1992). It has also been stated that it provides an ideal framework for health initiatives to address the "WHO goal of Health for All by the Year 2000", and has been used for the structuring of the WHO Collaborative Center for Primary Health Care Nursing in Maribor, Slovenia (Neuman 1995).

The Work of Nola Pender

Nola Pender's clinical and academic experience is in human development, experimental psychology and education. Her scholarly work in what she says was then a "a virtually unexplored field" began in the mid-1970s. She is particularly interested in "health promoting behaviour" (Pender 1996). In 1975 she first published "A Conceptual Model for Preventive Health Behaviour", which formed the basis for a study of how individuals made decisions about their own health care in the context of nursing. In 1982, the first edition of "Health Promotion in Nursing Practice" was

published. It was here that her health promotion model of nursing first appeared. Since then the model has been refined and revised with the third edition being produced in1996 (Pender 1996).

Pender's work, is an attempt to depict the multidimensional nature of persons interacting with their environment in the pursuit of health. Several constructs are integrated into the model from expectancy-value theory (Feather 1982) and Bandura's (1997) theory of social learning, now known as social cognitive theory (Pender 1996). Pender (1996) says that although the health promotion model is similar in construction to the Health Belief Model (Becker, 1974), it is not limited to explaining behaviour, neither does it include "fear" or "threat" as sources of motivation. She acknowledges the lack of success that avoidance-orientated models of health behaviour have had in motivating healthy lifestyles with people who perceive themselves to be invulnerable. The Health Promotion Model was developed to encompass behaviours for enhancing health and as such was based on the following assumptions:

Figure 4-3

The Foundation of Pender's Model of Nursing

- "Persons seek to create conditions of living through which they can express their unique human health potential.
- Persons have the capacity for reflective self-awareness, including assessment of their own competencies.
- Persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability.
- Individuals seek to actively regulate their behaviour.
- Individuals in all their biosychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.
- Health professionals constitute a part of the interpersonal environment, which exerts influence on persons throughout their lifespan.
- Self-initiated reconfiguration of person-environment interactive patterns is essential to behaviour change" (Pender 1996).

Pender's (1987) model consisted of the following cognitive-perceptual factors which are defined as "primary motivational mechanisms", these are modified by demographic personal and situational characteristics which are predictive of a result of participation in health promoting behaviour in the presence of a cue to action. The main characteristics of the model are listed below:

Figure 5 - 3

Health Promotion Model (Pender 1987)

Cognitive-Perceptual Factors	Modifying Factors	Participation
• Importance of health	Demographic characteristics	
• Perceived control of health	Biological characteristics	
• Perceived efficacy	Interpersonal influences	Cues to action
• Definition of health	Situational factors	Likelihood of
• Perceived health status	Behavioural Factors	engaging in health promoting behaviours
• Perceived benefits of health promoting behaviours		
• Perceived barriers to health promoting behaviours		

This model has been used extensively as a framework for research aimed at predicting health promoting lifestyles and specific behaviours among diverse groups of people. This has included studies carried out by independent researchers. For example Weitzel (1989) utilised the HPM in a prediction of the health-promoting lifestyle of a multicultural population of 179 blue collar workers. In this study four cognitive-perceptual variables were tested; the importance of health, perceived control of health, perceived self-efficacy and perceived health status. The modifying demographic variables were, gender, age education and income. Within this study, the model was most successful in predicting nutrition behaviour.

Pender has also continued to refine the model and she has directed a series of studies within the Institute of Nursing Research in the USA. These have been with, working adults, older people, ambulatory cancer patients and people on a cardiac rehabilitation programme. A series of further studies have focused on predicting or

explaining peoples' behaviour in relation to exercise Pender (1996). The consequences of this have been further refinement, and she continues with her research to test the efficacy of the model.

Certainly, in comparison with Neumann's model, Pender's (1987) model does have an individualistic focus, and for this reason has been criticised by some British nursing academics (Rush, 1997; Burnard, 1991), nevertheless it has some merit in terms of it's predictive properties. It is the understanding and interpretation of the model by practitioners that requires careful deliberation, if it is to be utilised successfully.

So far, the discussion has suggested that there has been a paradigm shift from the biomedical model of nursing care to a more client-centred approach. The influence of American thought has had some impact on the delivery of nursing care, but the effect on the development of health promotion in nursing in this country is still limited. The reasons for this are not adequately explained.

Consequently, it is necessary to take a wider view and consider the contribution of the critics of classical liberal theory in conjunction with examination of policy decisions influencing the re-emergence of health education and health promotion in nursing.

The Debate Challenging the Efficacy of Biomedicine

The beginning of serious debate challenging the efficacy of biomedicine began in the mid 1960's. The prevailing view then was that biomedicine had made a major contribution to the decline in mortality in the previous one hundred years. Morgan et al (1985) in their exploration of sociological approaches to health and medicine refer to Talbot Griffith's (1967) work, which specifically attributed this fall in death rates to the development of hospital obstetric services and vaccination against smallpox.

McKeowan's (1979) historical demographic study of the decline in mortality from infectious disease in England and Wales seriously challenged these views. His conclusion from this detailed analysis was that the contribution of medical science was overemphasised. For example, to support his challenge he demonstrates that the number of drugs known to be effective against infectious diseases before the advent of the sulphonomide drugs in the 1930's was negligible. Also, most of the decline in infectious disease occurred before effective immunisation against diphtheria, pertussis, tetanus and tuberculosis became available. (Mckeowan, 1979; cited in Morgan et al., 1985).

Mckeowan (1979) thought the main reasons for the decline in infectious diseases from the mid nineteenth century on were due to such public health measures as improved nutrition, sanitary conditions and water supply (McKeowan, 1979; Ashton and Seymour, 1989). In order for this decline to continue Mckeowan champions the cause for higher priority to be given to changing the social environment. At the same time he emphasises the need for an individualistic approach to be made in changing behaviour. He sees this as being through education.

Morgan et al., (1985) are critical of McKeowan's analysis in that it does not pay enough attention to the problem of achieving a paradigm shift in healthcare. They state that once the medical and scientific worlds were aware change was needed, a positive response would follow. They state that he :

> "overlooks the vested interests built into professional structures and institutional arrangements which serve to maintain the dominance of curative medicine."

This may be so, but it is necessary to consider that, although this work was published in 1979, this detailed analysis took place over a period of time when the autonomy, veracity and power of medicine and "science" were only beginning to be challenged.

Further challenges to the dominance of biomedicine as a social construct in the 1970's and 1980's are offered by various authors (Illich, 1971; Szaz, 1971) and feminist academics (Oakley, 1980; Stacey, 1988), all agreeing that the medical profession's power in controlling health and illness has been used to extend and intervene in areas of life which had not traditionally been the concern of doctors. It is useful now, to explore these challenges in the framework of the medicalisation thesis.

Oakley's (1980) work on childbirth supports this view. In this study she demonstrates how medical criteria regarding place of delivery and use of various forms of intervention (such as caesarean section and epidural anaesthesia), have increasingly replaced personal choice, consequently reducing womens' control over the delivery. Also, the adverse effects of some forms of intervention (such as post-natal depression and puerperal psychosis) are sometimes overlooked.

Illich's (1985) notion of iatrogenesis extends this feminist view of the medicalisation of everyday life. He describes three levels of iatrogenesis, as being clinically, socially and structurally determined. Although he acknowledges the contribution of chemotherapy, for example, in the treatment of pneumonia and some sexually transmitted diseases, he also concurs with McKeowan (1979) in that:

> "Analysis of disease trends show that the environment is the primary determinant of the general health of any population" (Illich 1975:17)

However, although Illich (1975) views the medicalisation of life as a result of increasing bureaucracy and professionalisation in medicine, an alternative view has gained prominence. Szaz (1970), focusing on psychiatry, views medicine as a way of controlling disruptive behaviour. He differentiates between contractual psychiatry, in which a patient has the freedom to initiate and terminate an encounter, and institutional psychiatry as creating a collective society by applying the label of mental illness to behaviours which do not conform to the norm. Therefore the medicalisation

of life and biomedicine itself are seen as a form of social control (Morgan et al., 1985).

These influences are now discussed within the context of the prevailing Conservative political thought pertaining to health promotion in the first half of the 1990s. The Alma Ata declaration (1978) identified primary healthcare as the key in achieving health for all, which for reasons already stated, could be seen in this country as being entrenched in the medical model. The United Kingdom government, besides being signatory to the 1985 agreement, do not appear to have acknowledged the action strategies of the Ottowa Charter (1986).

The United Kingdom policy for health promotion, Promoting Better Health (1987), still identified primary healthcare as the prime mover in health promotion, but primary care is interpreted within a biomedical context and doctors as natural health promoters. Tudor Hart (1989), also perceives the better educated new kind of doctor as being the leader in this field. These views are reinforced by the National Health and Community Care Act (1991), which offered financial incentives to general practitioners for providing health promotion services. However, Calnan (1986) identified the confusion general practitioners were experiencing regarding the nature of health promotion activities. This lack of interest and knowledge about health promotion is also reflected in the North East Thames Regional Strategy (1992). For instance a statement is made by a doctor in a supposedly progressive practice in the region, intimating that health promotion is not cost effective because its outcomes cannot be measured. Nowhere in this document is there a reference to the contribution nurses make to health promotion.

Emphasis in the white paper "Promoting Better Health"(1987), is also on the prevention of disease due to an unhealthy lifestyle. While acknowledging responsibility for raising individual awareness in maintaining good health, the government sees this as the extent of their responsibility. No mention is made of the

need to promote well-being through the wider delivery of community care or public health measures. The vision of the Department of Health and Social Security would confirms these views, despite the fact that the white paper, "Working for People" (1987) advocates a collaborative approach to planning packages of care and support in the community. However, as Morgan et al., (1985) state, this social approach to health requires change both within and beyond the healthcare sector, which may often conflict with other aims and interests.

In this chapter it has been demonstrated that the decline of the biomedical model of health has allowed health promotion to re-emerge, and in theory create opportunities for nursing to develop an expertise in this discipline. An examination of the development of nursing theory indicates support for the potential for nursing to develop in this area. However, government policy dictates a conservative approach to health promotion. Despite the rhetoric supporting nursing in this arena (WHO, 1986; RCN, 1991), it does not appear to have a prominent role. This is attributed to government support for doctors, which is also reflected in legislation.

CHAPTER 4

THE FOCUS OF HEALTH PROMOTION IN NURSING

This issue is addressed here by examining policy formulation introducing this role in nurse education in the United Kingdom. The literature relating to the development of health promotion in nursing in the United Kingdom will be compared with the American and Australian literature, since in both these countries nursing has been incorporated into higher education.

Policy Development in the United Kingdom.

Between 1974 and the middle 1980's in the United Kingdom, health education was the preferred concept. The Health Education Council, before its transformation into the Health Education Authority, organised a series of conferences for nurses to explore;

> "matters to do with the place, growth and development of health education within nursing practice" (Randell 1982: Appendix 2)

Concern regarding the lack of health education in the nursing curriculum had also been expressed by both nurse educationalists and health education officers in some health authorities. Consequently health education officers began to work with nurse teachers to facilitate their utilisation of student centred teaching strategies, which were more appropriate to the teaching of health education (Ewles and Simnett 1985).

Meyer (1986), describes, how in partnership with a local health education officer, she implemented a health education theme into the pre-registration curriculum in a school of nursing in England. Kilgour and Logan (1985) and Mayhew (1986) describe

the development of similar collaborative ventures in Scotland. However, the models used in these instances were focused on behavioural change, disease prevention, the emphasis being on patient teaching.

Besides the influence of current thought at that time, there appear to be two other main influences encouraging these innovations. The first being the Nurses, Midwives and Health Visitors Rules Approval Order (1983), which listed ten competencies to be achieved by nurses at the end of their training. The first two being to:

> A) Advise on the promotion of health and prevention of illness.
>
> B) Recognise situations that may be detrimental to the health - well being of the individual (appendix 3)

Whether any significance is attached to the fact that these are the first two on the list is unclear. Gott and O'Brien (1990) are critical of these competencies, in that too much emphasis on the individual, to the detriment of the social context of health. This is fair comment, but within nursing there is a strong argument to support individualism, nurses are the largest group of healthcare workers and have the most contact with patients, clients. Most of this is on a one-to-one basis (McCleod-Clarke and Webb 1985); RCN 1991). As the previous discussion emphasised, there is also a role for individualism in health promotion, through supporting and giving appropriate advice.

Psychology supports and informs this view. For example, studies examining the recovery of women from breast surgery demonstrate a positive correlation between recovery, social, professional and financial support (Metthis 1982; Kincey and Saltmore 1988). Therefore, with regard to these competencies, it is argued that although they do not go far enough in recognising the dimension of empowerment in

health promotion, they do reflect the professional body's understanding of health promotion at the time they were devised and written.

The most dramatic change to occur in nurse education, however, was government acceptance of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's proposals for reforming nurse education (UKCC 1986). This was known (and referred to hereinafter) as Project 2000. To a greater extent Project 2000, removed the service contribution traditionally made by student nurses. It was intended to imbue them with student status, thus giving the lead to educationalists, rather than service providers.

The UKCC (1986) document states that this "new nurse" will be competent and prepared to make specific interventions to "enhance the health and well-being of patients and clients and should be fully accountable for the care given" (UKCCC 1986). This being through:

Figure 1-4

The UKCC (1986) Competencies for Project 200

A) Obtaining knowledge and skills to meet health and sickness needs in a particular area of practice.

B) Identifying social and health implications of physical and mental handicap or disease and pregnancy and child bearing for the individual, his or her friends, family and community.

C) Having knowledge of normal development of life from the fetus to the elderly adult.

D) Appreciation of research as an aid to practice.

E) Being professionally accountable and committed to continuing education and development.

F) Developing helpful, caring relationships with patients, clients, their families and their friends.

G) Knowing about the law as it relates to practice.

H) Being able to work in a multidisciplinary team.

I) Being able to identify health learning needs of patients and clients and be involved in health promotion.

J) Enabling clients to progress from varying degrees of dependence to independence, or to a peaceful death (UKCC 1986).

These competencies require comparison with the World Health Organisation's (1986) principles which are summarised thus:

Health promotion is concerned with:

Figure 2-4

The WHO (1986) Principles of Health Promotion

A) Involving the population as a whole in the context of their everyday life, rather than focusing on people at risk of a particular disease.

B) Directed on action towards the determinants or causes of ill health.

C) Combining diverse but complimentary methods in approaches.

E) Aiming particularly at effective and concrete public participation.

F) Involving health professionals, particularly in primary care in the important role of enabling and nurturing health promotion (WHO 1986).

Given that Project 2000 was intended to prepare nurses to meet the challenges for changes in healthcare, it appeared that, a well defined agenda had been set for the development of health promotion within nursing. In the light of this change the context of the role of the nurse at this time is examined.

A Review of the Literature

When this study began the literature regarding health promotion and nursing in the United Kingdom was scarce (Gott and O'Brien 1990; Latter et al 1992). Empirical work into health promotion practice was concentrated on nurses and doctors working

in primary care (Saunders et al 1988; Williams and Boulton 1983; Catford and Nutbeam 1983).

As previously stated health promotion is an evolutionary concept, therefore the literature pertaining to health education and nursing requires examining in order to demonstrate how far this ideological shift affected thought at that time. The literature revealed that the main body of nursing research had focused on nursing practice and education. Early work focusing on patient teaching, developed into a debate regarding the differences between patient education and patient teaching. Concepts of teaching and education are grounded in psychological educational theories of teaching and learning, for example Skinner (1953); Brunner (1966);Knowles (1978); Rogers (1978) and Gagne (1985), these are viewed on a continuum, ranging from the behavioural, advocating a formal teacher-centred approach, to humanistic theories encouraging student-centred learning. There are also parallels here with models of health promotion.

Early empirical work, such as Hayward's (1975) seminal study of pain relief, identifies the psychological benefits patients experience when given information by nursing staff. Work by Skeet (1970), Roberts (1975) and Wilson Barnett (1981), also indicated that although patients required information about their treatment, in order to cope with anxiety and participate in care, this need was frequently unmet. They remained ignorant and anxious about what they should do (Wilson-Barnett and Osborne 1983). Research also focused on patient compliance to drug regimes and "cardiac" or "diabetic" teaching.

In their metanalysis of the efficacy of patient teaching (in the united Kingdom and in North America) Wilson-Barnett and Osborne (1983) establish that as well as needs

not being met, patient teaching utilising didactic methods of information giving, was unsuccessful. In reality patient teaching did not happen very often either. The reasons for this being that nurses felt unprepared for this role, these were the findings of a large survey of American nurses views on teaching (Pohl 1965). Similar reasons were identified in the UK thirteen years later, although nurses reported that information giving in preparation for surgery as a high priority for care, in reality, they had little time for this. The reasons why are not entirely clear, but were attributed to lack of communication skills, confidence and knowledge (Hockey, 1978).

The authors concluded that patient teaching, although an interactive process where learning should take place, requires reassessment. Patients predispositions for learning need to be acknowledged through a "sensitive assessment" of information needs. Thus Wilson-Barnett and Osborne (1983), redefine patient teaching as patient education.

These earlier studies stimulated further enquiry. Syred (1981), in her consideration of reasons for this abdication of health education, concluded that nurses were poorly trained in communication and assessment skills. Later work by McCleod-Clark (1983), indicated that nurses spent only 10% of their time in communication with patients.

An obvious solution to this problem was to introduce elements of teaching and learning into the curriculum. McCleod-Clark (1985) focused on teaching communication skills in pre-registration education, which she considered an essential component of health education in nursing. However, Luker and Caress (1989) and Gott and O'Brien (1990) challenge the assumption that all nurses should be effective health educators. While acknowledging that teaching is highly skilled work, they

point out that most research into patient teaching in both practice and education has been conducted by educationalists. Theories of teaching and learning presume that people are healthy. They argue that nursing research, in its attempt to move away from the "medical model" of care, has ignored the physiological barriers to effective patient education.

Luker and Caress (1989) cite the plight of renal patients to support their contentions in this debate, stating that in many clinical situations, the continued survival of patients is dependent on their being able to undertake measures and procedures to maintain their physiological integrity. As Daurgirdas and Ing (1998) and Magowan (1975) argue, fluid and electrolyte imbalance represent serious problems for these people. Consequently, it is imperative to educate them to ensure that they are able to practice procedures to maintain their biochemical equilibrium, while understanding the potential physiological consequences of not being able to carry out these procedures effectively.

> "In such circumstances the primary goal of patient education must be the attainment of physical results. Psychological comfort is a secondary aim" (Luker and Caress (1990).

Luker and Caress (1990), offer a more facilitative approach to the solution of the problem. They propose patients participating in self-directed learning through computer assisted learning packages, these are proven to be effective when used with people with learning disabilities, physical disability and sensory impairment (Levine and Britten 1973; Rippey et al 1987). They also suggest an alternative solution is the American model of developing specialist nurses in health education:

> " It is certainly the case that nurses may be a valuable source of information for patients, about particular drugs or post-operative procedures for example. However, it is our contention that patient education implies something more comprehensive, for which specialist skills are required. Nurses may be able to give information, but are they adequately prepared to assess whether this

information is received and understood and what is necessary if not"(Luker and Caress 1990).

Gott and O'Brien (1990), are particularly critical of McCleod-Clark's (1986) research on communication, and lifestyle education in relation to smoking cessation. They state that while communication skills are quite rightly an essential component of health education work, she does not distinguish health promotion from health education and for these reasons assumptions are made in that:

- "health education and health promotion are one and the same thing;
- health promotion is only about getting people to do healthy things;
- people can and will change their behaviour because a nurse tells them to.
- Work of this type colludes with the victim-blaming approach.....ignoring the political, economical and social pressures that make people behave as they do; it lays the blame for risk-taking entirely at the door of the individual" (Gott and O'Brien 1990).

Health Promotion and Nursing

The literature suggests that health education was perceived as the most appropriate function of the nursing role in this country. Research in North America has provided similar information in that health education was not originally perceived as being an integral part of the delivery of care. However, American thought appeared to be in advance of that in the United Kingdom. This could be because nursing education has been an all graduate profession for some considerable time.

The American nurses Moore and Williams (1984), in reviewing the nursing literature related to health promotion, maintain that it is essential to respond to the strong societal trend for health promotion. They conclude that while a significant overlap exists between health promotion and illness prevention, strategies for health promotion can be applied in a variety of settings in which nurses are employed. They

appear to adopt a broader view of the concept than seemed to be the case in this country.

Another American nurse educationalist, De Bella-Baldigo (1984), claims that health promotion is as essential for quality care as other nursing skills. In order to facilitate learning of these skills in the context of healthcare planning, she devised and evaluated a community simulation game for first year undergraduate nursing students. In her opinion this strategy was successful in motivating students in the preparation for the, legal, political and financial aspects of their health promotion role. Similarly Richardson et al (1990) give an account of nursing based and health oriented curriculum development.

Nursing research in this country was still attempting to gain insight into qualified nurses perceptions of health promotion. These studies are now considered. Gott and O'Brien (1990) intended to shed some light into nurses perceptions and orientation towards health promotion themes and goals, in terms of the situation in which they were working. The study was funded through a Department of Health Post Doctoral Research fellowship and the results are frequently cited in the nursing literature. They began by exploring the national and international frameworks of the health promotion movement, and demonstrated that not only were there confusions within and between health promotion policies but that there were also contradictions and divergencies between the policies of different organisations.

Their sample population included nurses working in the community such as district nurses and health visitors, school nurses, hospital nurses and occupational health nurses. The focus of these nurses' work in health promotion, apart from the health visitors, was coronary risk reduction. Overall the study took place within seventeen

health centres, five hospitals, five manufacturing locations and one private health company in five health authorities in England and Wales. A total sample of 65 nurses participated in the study. The researchers state that they felt it important to include clients perspectives and forty service users were recruited.

The research aimed to demystify the "taken for granted, commonsense frameworks in which conceptions and perceptions were currently embroiled". They did not begin from the premise that nursing work could indicate how health promotion should be practised, but enquired how particular practices come to operate under the auspices of health promotion. A qualitative approach, based on inductivist methodology was adopted (Gott and O'Brien 1990).

Data collection consisted of interview, observation and the collection of supportive information. The researchers did not adopt a prior definition of health in the interviews, but investigated how the perceptions and practices of the nurses connected with the major principles of health promotion philosophy. A critical case approach to the analysis was adopted. Data were not organised according to the nursing discipline to which the nurse belonged but the type of health promotion work in which the respondents were engaged.

The results of this work were revealing in that, although the aims of the study intended no conclusions to be drawn on the extent of the nurses health education practice, the data from their interviews and observations do allow insight into the area. Gott and O'Brien (1990) observed that nurses, regardless of discipline, tended to separate nursing from health promotion, and that the latter was entirely comprised of lifestyle advice. The authors comment that, in general, the philosophical principles of partnership, and participation, in which practice should be grounded had not found

it's way on to the nurses' agenda. Although the research was not specifically designed to distinguish between different work settings, nurses remained "locked into routinised systems and practices" (Gott and O'Brien 1990). The focus of their work was entirely on the individual, for example they state that the health visitors in the study were :

> "all involved in providing services on a group as well as an individual basis. These group efforts ranged from baby clinics and parent and toddler groups in all of the districts to a healthy retirement group in one of them. In most cases it would be stretching a definition to say that these efforts constituted work with groups since they tended to fall more into the category of work with several individuals at the same time. Group sessions tended to operate as vehicles through which health visitor staff could fulfil their predefined duties..... or transmit predefined messages about health issues" (Gott and O'Brien 1990 b).

In discussing the reality of any prospect for change the researchers comment that the reasons for this individualistic focus are due to the constraints placed upon the nurses by their terms of employment, and their own commitment to the provision of personal services. They argue that although Project 2000 programmes may herald the "desirable reform" of educating rather than training nurses in health promotion skills, that it could be hampered by the lack of adequate preparation by nurse teachers, consequently there is an urgent need to re-examine the evolution of health promotion. By this they mean that it is necessary to examine what nursing is creating in the name of health promotion and to consider, whose interests are being served by that creation. Only then, they argue will nursing be in a position to participate in the vision represented by health promotion (Gott and O'Brien 1990c).

While this study is worthwhile, what is disappointing, considering the frequent citations in the literature, is the lack of rigour in the publication of these results. The authors disseminated their findings widely, both in the nursing and health promotion press. A paper was also presented to the RCN in 1989, although the date of the conference is not recorded on the original paper.

The first phase of the project, which presented the results of the literature review was published in Health Promotion International, which is an academic journal, as such it can be assumed that the paper had been subjected to peer review. An amended form of this and the results of the study were also published as a series of three articles in the Nursing Standard. This is a Royal College of Nursing Publication intended for a wide audience of nurses. At the time these papers were published it appeared that the editorial focus was more populist than scholarly. These last papers stimulated interest, but in no way provided an analytical report that enabled a detailed critical review.

In comparing all three sources of information omissions were discovered relating to the design of the study and the reporting of results. In the paper presented to the RCN, the total sample population is originally eighty two. The authors state that the subjects were initially interviewed individually and in groups. However because one group was large (seventeen members in all), it was excluded from the data analysis, the reason being that the amount of data generated was unmanageable. No further comment or reflection on this problem is made, neither was it reported in the Nursing Standard articles. It would appear that such problems had not been anticipated in the original research design. Another problem was the complete omission of a report on the results of the patients views of the nurses role in health promotion. For these reasons, therefore, it would seem, that although their results are interesting, and have been influential, the analysis is incomplete.

Obviously it would have been appropriate to critique the original report and during the course of this study repeated attempts were made to contact the authors. No acknowledgement was made to any of these requests. This was disappointing, since there were no avenues in which to explore these issues in more depth. However,

despite these seeming methodological weaknesses, the work makes a significant contribution to the body of knowledge then available.

One small scale study (Johnston 1988), was the only other example of research into the role of hospital nurses in health promotion in this country. This was directed towards the extent to which health promotion was offered to patients in hospital. It concentrates entirely on lifestyle advice. Johnston (1988), interviewed fifty randomly selected patients on a surgical ward prior to discharge. These interviews revealed a distinct lack of advice given by medical and nursing staff on lifestyle prior to discharge. An examination of each patient's nursing notes revealed that no changes in lifestyle advice had been noted.

Another limitation to this study was that it was focused on a single site, Johnston (1988) herself comments on this, agreeing that wider empirical work was preferable. In addition, the study's definition of health was exclusive in that it was narrowly confined to lifestyle advice. Latter et al (1992) in critiquing the study say some inclusion of nurses' views about the extent of health promotion advice given may have resulted in different picture, depending on the congruence of what constitutes health promotion and lifestyle advice.

This concentration on health education in nursing is perpetuated by Latter, Mcleod-Clarke, Wilson-Barnett and Maben (1992). This influential group of nursing academics were currently engaged in a large scale study of health education in nursing. The focus of this was nurses' perceptions of practice in acute settings. This was in recognition that there was a need for a national overview of the extent of current health education, practice on acute wards. The intention being that the results would enable good practice in this area. The authors also acknowledged that relations

between perceptions and the reality of practice are questionable. In their introduction to the study they justify the use of the term health education as opposed to health promotion in that: "in the context of current acute sector nursing practice, the use of the term health education is more appropriate" (Latter et al 1992). This also seems to reflect the interest and influence wielded by two of the researchers previous work (Wilson-Barnett 1983; McCleod-Clark 1985). The authors also adopt a pragmatic stance toward health promotion in nursing stating that the reasons for the interest at that time was due to:

> "Political emphasis on productivity, competitiveness in the market place and attempts to restrain health service costs also force an acknowledgement that education for health is essential in today's society" (Latter et al 1992).

Such a utilitarian rationale from influential figures in nursing in the United Kingdom is extremely disappointing. The statement is devoid of critical analysis, in assuming that the only desirable outcome is a more cost effective health service, it denies that health promotion is an integral and worthwhile part of the nurses' role.

In the first stages of this study a postal survey design was utilised. A questionnaire was sent to the most senior nurse members of each district health authority in England. The research question was focused on the extent to which health education activities were integrated into acute practice settings. These activities were identified as:

- patient education
- information giving
- lifestyle advice
- encouraging family participation in care

The majority of responses (73% n=142), showed that the respondents thought that health education activities were generally a feature of practice on acute wards. However, on the majority of wards, they were only seen as partially included in some

areas of practice. The analysis also indicated that all the activities specified were positively correlated. Subsequent stages of the study included practitioners views of their health education practice, followed by a third observational phase and the consequent realistic implications for practice. At the time of writing these results were not available.

In Australia the transfer of nursing education into higher education was complete by the mid 1980's, the curricula for these courses being based on a model of health. Research in nursing education led to the publication of studies that focused on nurses perceptions of health promotion. During this transition Kelly (1983) completed a study based on students' role, perceptions and ideal expectations of their role. The role of the health educator was one of these. The perceptions of forty three first and third year students on a traditional hospital based course were compared. Kelly reports that there were significant differences between the first and third year group, however, her overall sample size, casts doubt on the reliability of any statistical significance in these results. The researchers findings were interesting in that in both groups there was a 59% agreement that the students were too busy giving physical care to carry out any other role. The study concluded that institutional influences appeared to affect the ideal professional goal in relation to the role (Kelly1983).

Donaghue et al (1990) undertook a three year longitudinal study of two cohorts of undergraduate students. The intentions of this study were twofold; the first was to determine if students of nursing in a university programme commenced the course with a perception that health promotion was a nursing function, the second to discover whether this perception changed. The total sample consisted of 590 students comprising 503 women and 75 men (12 respondents were unspecified). The students were divided into two cohorts in order to provide comparative data on entry behaviour.

Data collection was by open-ended questionnaire. Students were asked to describe the functions of a nurse. Demographic data was limited to gender and age. The baseline data was collected prior to the first lecture of the academic year and subsequent data collected at the beginning of each academic year.

Content analysis revealed that the function of health promotion was perceived to be important by the students on entry to the programme and was within the most frequently mentioned functions, this frequency had declined by the third year. Donaghue et al (1990), do not suggest that this decline may be due to the influence of curriculum content, but that it may be attributable to social or institutional variables that are thought to have some influence on role perceptions.

Given that this study was longitudinal, and as such had the potential to allow for a highly specific analysis of change, these conclusions are very inconclusive. This is attributable to weaknesses in the overall design of the research. The research questions are limited in that all that is required of students is to describe the functions of nursing, as such health promotion is only described as a role. The data collection therefore is limited to this one task. No further attempt is made to find out exactly what the students attributed to that role. The analysis is also superficial in that although content analysis revealed that there were several roles that the students identified, and that change is observed, no further enquiry is initiated. The results of the study are limited to the reporting of descriptive statistics, and the observed change is not tested for any statistical significance. More reliable and conclusive findings could have been elicited had the design been more sophisticated. As a result this study appears to have been a missed opportunity, but one of the problems associated with reviewing published literature is that without access to the original source, it is not possible to form any other conclusions from this critique.

While demonstrating that nursing research in health promotion was limited at this time, this review of the literature reinforces the view that it is important to continue to clarify nurses perceptions of health promotion. Although education research has indicated that nursing students perceive it as being important, there is no clear indication that they understand the concept, or its implication for their role as future practitioners, who may be working outside a hospital environment once they are qualified.

CHAPTER 5

BACKGROUND TO THE STUDY: DEVELOPMENT OF CONCEPTS, METHODS AND RESEARCH TOOLS

This chapter reports the results of an exploratory investigation of student nurses health beliefs and perceptions of health promotion. The decision to undertake this research was stimulated by the call for educationalists to be involved in curriculum development in health promotion, in conjunction with the aforementioned lack of empirical work. This study took place over a four month period, from November 1991, until March 1992, in a college of nursing and midwifery education attached to a teaching hospital in central London (Vernon 1992).

Rather than hypothesise that student nurses perceive health promotion within a biomedical framework, the main intentions were to discover what student nurses thought health promotion was and to try to ascertain if there was any change in their perceptions during their three year training. Another intention was to determine if there was any change to specific curriculum content. Although, the approach was from an inductive method of enquiry as proposed by Glaser and Strauss (1967), Silverman's (1989) argument for the combination of both quantitative and qualitative methods in strengthening the design and improving the generalisability of the results of qualitative research, was influential. Polit and Hungler (1993;334) argue that "many areas of enquiry can be enriched through judicious blending of qualitative and quantitative data." This is known as multimethod research. Consequently the method of investigation was based on both inductive and deductive methodologies.

The Sample.

A nonprobability sampling methodology was utilised. The population was total of 452 student nurses on a traditional modular (pre-Project 2000) course, leading to the

professional qualification of Registered General Nurse. The sample, therefore was opportunistic and cross sectional consisting of a group of 22 new entrants who commenced their training in November 1991. Data collected form this cohort formed the baseline for comparison with other groups. The second group of 21 students had almost completed their first year. Theoretical and clinical experience had been combined in medical, surgical, mental health and elderly healthcare modules. During the elderly healthcare module they had also experienced one week in community settings, in which they had spent time with district nurses and health advisors for the elderly. They had also visited day centres and sheltered accommodation for the elderly.

The third group of twenty students were half way through their second year and had completed modules in maternity and child healthcare. During this latter module they had been on observational visits with school nurses and health visitors. The fourth group of 19 were commencing their third year and preparing for their final examinations. They had experienced revision sessions where they had the opportunity to compare and contrast strategies for health promotion and education, as well as examining their own role in this context. (The aims of these particular modules are explained in Appendix 4). The fifth and final group of 24 students had completed their final assessments

Data Collection

Data collection was by questionnaire consisting of 12 items (appendix 3). Because there was no existing instrument that had been previously used and tested for these purposes at this time, the questionnaire was designed by the researcher. Issues associated with reliability and internal consistency will be discussed in the following chapter. However some rationale for the design and construction of the questionnaire are necessary at this point.

The Development of The Questionnaire

The first two questions related to the student's health beliefs. Because it is recognised in psychology that individual beliefs and attitudes are important in the development of behaviour (Rosenstock 1974; Fishbein and Ajzen 1975; Becker 1977), open-ended questions relating to students' own beliefs and the perceived importance of health promotion were asked. An attiduninal score using Likert-type rating responses was utilised to ascertain attitudes towards health promotion.

Towriss (1986), in his critique of Fishbein and Ajzen's model of reasoned action, argues employing belief statements supported by the experimenter are subjective and open to bias, consequently they are not as reliable as constructing questions that are based on the subjects' beliefs. This criticism could be levelled at this attitudinal score. However, the intention of the study was not predictive therefore in this instance the use of "modal salient beliefs" (Towriss 1986), representing the existing theoretical constructs of health promotion, as identified in Ewles and Simnett's (1986) approaches and Beattie's sociological model was appropriate.

There is also evidence suggesting that the existence and quality of health is culturally and socio-economically determined (Blaxter 1990; Calnan and Johnson 1985; D'Houtard and Field 1985;) A question relating to these issues was included. Consequently, a question relating to the importance nurses attached to being aware of current affairs was included. Another open-ended question was included relating to involvement in politics.

Moser and Kalton (1971) advise that demographic data and personal details, although easy to answer, can influence the response rate to self-completing questionnaires, and should be included at the end. This first draft was piloted on a group of 22 students (Appendix 5)

Administration Of The Instrument.

The amended questionnaire was administered by the author to each group of students. The first cohort completed the questionnaire before they received their first lecture, subsequent groups completed the questionnaire at allotted times when they were in college preparing for, or consolidating clinical experience. This method for self-completion of the questionnaire was adopted in preference to postal survey or by completion in their own time, in order to have some control over the response rate.

There were problems associated with bias by adopting this method, however, this was eliminated as far as possible by explaining the research intentions and emphasising confidentiality and reinforced provision of individual written information (appendix 5). It was also possible that the researcher could be considered a confounding variable since she was known to the students. This issue was addressed in the context of "trust worthiness" as suggested by Lincoln and Gubba (1985). It was reasonably certain that they would respond honestly since their written evaluations of the taught sessions on health related topics were usually quite forthright.

Response Rate.

A total of 106 questionnaires were distributed, 97 were returned giving a response rate of 91.5%. The eight questionnaires not completed were from the two most senior groups. Two students in the third, had requested to be absent at the time the questionnaire was completed. They were asked to complete them in their own time, but despite being contacted two weeks later, there was no positive response. In the finalist group of 24, only 17 were in the college on the day that the questionnaire was administered.

Other responses from the students were extremely surprising and encouraging. They ranged from messages of goodwill written on the questionnaires, to expressions of interest in the subject being verbalised in requests for more teaching, and requests for

careers advice. These "spin offs" are important in the context of the reliability of the construction of the questionnaire (Oppenheim 1992).

Analysis.

Both qualitative and quantitative methodologies were used to analyse the data. However, the quantitave analysis did not utilise SPSS, the reasons for this being that this facility was not widely available at the time, and given this was a small-scale study, testing for significance was inappropriate (Moser and Kalton 1989). Multiple response replies to open-ended questions were systematically coded and categorised by methods used in the grounded theory and content analysis literature (Glaser and Strauss 1967; Couchman and Dawson 1990). In order to guard against bias and enhance the validity of the study, the scores were scrutinised by an independent reviewer.

Since change was being measured over time and between the groups, and because open-ended questions can generate a multiplicity of responses, the raw scores for each most frequently mentioned response were divided by the number of student in each group completing the questionnaire, producing the mean score for each group. It should also be noted that percentages have been rounded and in some instances may not total 100%

Demographic Data

Gender

Of the 97 students only eight were men. Two in the foundation course sample, one in the first year, three in the second year, one in the third year and one in the finalist group. This 1:8 ratio of male to female students was representative of other groups in the college and higher than the national average for men in nursing (1998).

Age.

The mean age of the four groups is displayed in Table 1.

Table 1 - 5

Mean Age and Age Range of Total Sample

	Mean	Range
Foundation Course	21	18-26
First Year	24	19-34
Second Year	25	20-40
Third Year	23	20-29
Finalists	25	21-30

The age range of students in the first and second years is higher due to the fact that there were two student over 30 years in this group.

Social Class

A review of the socio-economic background of the sample revealed that they were entirely derived from social classes 1, 2 and 3.

Table 2 - 5

Distribution Of Social class According To Parental Occupation

	Class 1	Class 2	Class 3	Total
Foundation Course	4	11	7	22
First Year	11	8	2	21
Second Year	6	8	6	20
Third Year	4	8	5	17
Finalists	6	6	5	17

The preponderance of students belonging to social classes 1 and 2, could be a reflection of the fact that colleges of nursing serving London Teaching Hospitals have a higher status than those serving district general hospitals (Abel-Smith 1988). They therefore attract and select more academically able students.

Academic Achievement.

This supposition was supported by the analysis of the students' educational achievement.

Table 3 - 5

Academic Achievement of Students

	FC	1st Year	2nd Year	3rd Year	Finalists
Higher Degree	1	0	0	0	0
1st Degree	3	1	1	1	1
Diploma	0	1	2	0	1
A Level	9	14	10	10	8
GCSE/O Level	9	4	6	4	6
DC Test	1	0	1	2	1
Total	22	21	19	17	17

N.B. the second year total is less than the total sample since one student did not submit this information.

The minimum educational requirements for nursing education are five GCSE/O Levels at grade C and above, or equivalent overseas qualifications or the DC test. The DC test is a measure of an individual's ability to cope with the intellectual demands of nursing education. It is available to applicants without the appropriate educational qualifications. It was commissioned by the United Kingdom Central Council for nursing, Midwifery and Health Visiting and formulated by the educational psychologist Dennis Child, after whom it is named. The figures in Table 3 indicate the wide rang of educational achievement obtained by these students, with over 50% exceeding the minimum entry requirements.

There appeared to be no correlation between academic achievement at degree and diploma level and higher social class. There did appear to be some association between social class, A levels and age. Of the nine students with A levels in the foundation course, six were aged between 18-20 years. These six were from social classes 1 and 2. of the fourteen in the first year, all were aged between 19 and 20 years and were from the same socio-economic background, with six of the total of ten being aged between 19 and 20 years of age. The picture is similar in the second year, with a total of ten students having A levels. All of these were in social classes one and two, eight were aged between 19 and 20 years. The picture is not quite so clear with respect to the third year group. Although eight of a total of ten students with A

levels belonged to social classes one and two, only two were aged 20 and 21 years, the rest were older. Findings are similar in the finalist group, in that of a total of eight with A levels, six belonged to social classes one and two, but only four were aged 21 or 22 years.

On examining the data relating to work, students tended to report having a variety of experiences. Three separate patterns emerged which were separated into healthcare, social care and work involving contact with the general public.

Table 4 - 5

Previous Work Experience

	FC	1st Year	2nd Year	3rd Year	Finalists
Healthcare	15(68.2%)	4(19.0%)	5(25.0%)	3(17.6%)	2(11.8%)
Missing	7(31.8%)	17(81.0%)	15(75.0%)	14(82.4%)	15(88.2%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Social Care	7(31.8%)	8(38.1%)	6(30%)	8(47.1%)	6(35%)
Missing	15(68.2%)	13(61.9%)	14(70.0%)	9(52.9%)	11(64.7%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
The Public	9(40.9%)	11(52.4%)	14(70.0%)	13(76.5%)	14(82.4%)
Missing	13(59.1%)	10(47.6%)	6(30.0%)	4(23.5%)	3(17.6%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
n = 97					

N.B. These figures indicate that a multiplicty of responses were elicited, indicating that some students had worked in diverse service areas.

To summarise, the total sample group were from a predominantly middle class background, with a high standard of education. Previous work experience was in care settings with the elderly and people with learning disabilities or mental illness, work in pubs, shops, restaurants and offices was also reported.

Health Beliefs.

The open-ended questions relating to health beliefs were analysed using Blaxter's (1990) nine definitions of health (appendix 6)

In her work on health and lifestyles in the United Kingdom, Blaxter found that people expressed multiple concepts of health which varied by lifestyle and gender. These students also expressed a similar variety in their written responses. The figures presented in table 5 represent the frequency and percentage of students in each cohort mentioning each concept, "health as a reserve is not mentioned at all.

Table 5 - 5

Health Beliefs of Total Sample

	FC	1st Year	2nd Year	3rd Year	Finalists
Not Ill	4(18.2%)	4(19.0%)	5(25.0%)	6(35.5%)	3(17.6%))
Missing	18(81.8%)	17(81.0%)	15(75.0%)	11(64.5%	14(82.4%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Despite Disease	1(4.5%)	0	0	0	0
Missing	21(95.5%)	21(100%)	20(100%)	17(100%)	17(100%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%
Healthy Lifestyle	16(72.7%)	14(66.7%)	12(60.0%)	7(41.2%)	9(53%)
Missing	6(27.3%)	7(33.3%)	8(40.0%)	10(58.8%)	8(47.%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Physical Fitness	15(68.2%)	11(52.4%)	10(50.0%)	3(17.6%)	9(52.9%)
Missing	7(31.8%)	10(47.6%)	10(50.0%)	14(82.4%)	8(47.1%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Social Relations	0	0	0	1(5.9%)	0
Missing	22(100%)	21(100%)	20(100%)	16(94.1%)	17(100%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Energy, Vitality	2(9.1%)	0	0	0	0
Missing	20(90.9%)	21(100%)	20(100%)	17(100%)	17(100%)
Total	22(100%)	21(100%	20(100%)	17(100%)	17(100%)
Means to an End	0	0	1(5.0%)	0	1(5.9%)
Missing	22(100%)	21(100%)	19(95.0%)	17(100%)	16(94.1%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Well-being	7(31.8%)	7(33.3%)	7(35.0%)	7(41.2%)	7(41.2%)
Missing	15(68.2%)	14(66.7%)	13(65.0%)	10(58.8%)	10(58.8%)
Total	22(100%)	21(100%)	21(100%)	17(100%)	17(100%)

n = 97

The figures clearly indicate that the sample's health beliefs concur with Blaxter's work. This predominantly middle-class group of young women tended to describe a multiplicity of reasons for being healthy, such as, not being ill, taking regular exercise and describing active participation in sport.

Notions of well-being are mentioned by the third year group as frequently as lifestyle, which tend to reflect Blaxter's (1990) findings about older women having more complex beliefs. She also identified this trend in middle age, whereas the mean age of this group is only 23 years. This trend persists in the finalist group, although they too mention physical fitness as frequently as lifestyle. There was no indication that the health beliefs of the male students in the total sample focused more on physical fitness than lifestyle, but then there were few men in the sample.

Of the foundation course sample, only four thought they were unhealthy. Their reasons being, participating in regular exercise. All except one said they smoked, one mentioned that living in an area with high carbon monoxide emissions was a reason for being unhealthy. One student, (one of the three graduates in the group), felt that she could not say whether she was healthy or unhealthy, stating:

> "I am answering both questions together as I consider myself to be somewhere between "healthy" and "unhealthy." I do smoke, about fifteen cigarettes a day, sometimes more, sometimes less and don't really do much exercise, except walking. But on the other hand, I don't drink very often and in the main try to eat healthy food, that is low fat spread instead of butter, grilled food, salads etc."

This description of what is healthy and unhealthy is typical of the total sample's health beliefs. The notion of balance and the ability to perceive the concepts both positively and negatively becomes more pronounced with seniority.

In the first year group, of a total of twenty one, nine thought they were unhealthy. Lifestyle behaviours were the most frequently mentioned reasons, with two students providing illuminating descriptions of their lifestyle at that time:

> "I smoke, I do not maintain a healthy lifestyle. I work unsociable hours, do not get enough sleep, eat irregularly at a restaurant and canteen frequently. My job is stressful. I quite often feel exhausted when I get home".

Similar feelings are expressed by another student:

> "Because I smoke fifteen to twenty cigarettes a day. I do not eat a balanced diet (due to living alone) and I do not do any sport or exercise apart from walking. I am overweight too!"

These ideas about being unhealthy, and adopting what they perceived to be unhealthy behaviours could possibly be because these students had recently completed two emotionally and physically tiring clinical placements in mental health and elderly healthcare. They had also experienced night duty for the first time and were about to take their first year examination. There also appears to be some association with age, since six of the nine who reported that they were leading unhealthy lifestyles were younger.

These manifestations of stress had dissipated by the second year. This could be explained by the fact that maternity and childcare modules (recently completed), were more enjoyable and less physically demanding than those experienced by the first year group. Of the four who stated that they were unhealthy, drinking too much alcohol was mentioned, as well as, smoking, eating the "wrong foods" and not exercising. One thought that overweight could contribute to health problems in the future, although he did not specify what they might be.

The analysis of these three groups reveals an emerging picture relating to the student's ability to discuss healthy and unhealthy behaviours, which appear linked to maturity and life experience. More students in the third year sample appeared to identify (or felt more comfortable in revealing) that they indulged in healthy and unhealthy behaviour. From a total of 17 in the group, sixteen stated reasons for being healthy, fourteen tempered these responses with reasons for being unhealthy. Notions of actively doing something to change their behaviour also emerged. For example one student states;

> "At present I don't feel very healthy. I'm anaemic, run-down etc. Cough which hasn't gone for weeks. But actively changing diet and stopping smoking, to hopefully improve situation".

Another student demonstrates awareness that cognition alone, without motivation, is not effective in changing behaviour.

> "Generally I have no particular health problems, although there are things I would change about my lifestyle if I had the motivation".

This is further clarified by another statement:

> " I know I am not as healthy as I could be. I smoke etc. But I am happy with my general health as I am able to do all the things I want to do....."

This ability to define and balance positive and negative aspects persists in the finalists group. However it is not as prominent. From the descriptions of why they thought they were unhealthy, only seven gave reasons for being unhealthy as well. The same barriers to pursuing a healthy lifestyle also emerge which is crystallised in one particular response.

> "Partly due to working shift hours and nights, therefore erratic eating habits, stress at work and living in polluted London are also unhelpful to my levels of health, but I counteract these with getting out of London and exercising".

Although this response to reasons for being unhealthy is considerably less in the finalist group than in the third year group, this is attributed to several reasons. The first being, that having had recent tuition regarding health promotion strategies, awareness of these issues was reinforced. They were possibly more motivated to discuss these issues. Another factor could be attributable to the fact that they had to write a health promotion assignment.

The reasons for the smaller response from the finalist group could have been lack of interest since their training was complete. Their tutor confirmed these thoughts. Conversation with her revealed that they were feeling negative about the entire course as well as being anxious about obtaining future employment in nursing.

The Importance of Health Promotion in Nursing.

There was a unanimous positive response to the first part of the question. In relation to the second part, asking subjects for reasons for their responses, four themes emerged, which were common to the entire sample. These themes and the percentages of students identifying these themes according to their position on the course are presented in table 6.

Table 6 - 5

The Most Frequently Mentioned Reasons For It Being Important For Nurses To Learn About Health Promotion.

	FC	1st Year	2nd year	3rd Year	Finalists
To prevent Illness	10(45.5%)	4(19.0%)	7(35.0%)	3(17.6%)	3(17.6%)
Teach, Educate, Advice, Information	3 (13.6%)	4(19.0%)	4(20.0%)	9(52.9%)	6(35.3%)
Missing					
Total					
Help Individuals Adopt Healthy Lifestyles	4(18.2%)	4(19.0%)	0	2(11.8%)	1(5.9%)
Missing					
Total					
Reduce strain on the NHS	3(13.6%)	2(9.5%)	5(25.0%)	1(5.9%)	0
Missing	2(9.1%)	7(35.5%)	4(20.0%)	2(11.8%)	8(41.0%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%

n = 97

Of the total sample 29.3% thought that it was important to learn about health promotion in order to prevent ill health. But as table 6 indicates it was seen as being more important in the foundation course. A similar proportion 28.3% seemed to believe that health promotion involved teaching and educating by giving advice and information. This was mentioned more frequently by the third year and finalist students, than the foundation course and first and second year groups. Helping individuals adopt healthy lifestyles was seen as being important by 17.4% overall. This was thought to be more important in the foundation course and first year groups. A resulting reduction in strain on NHS resources due to unnecessary hospital admission, was also mentioned by 25% of students, but not at all by the finalist

group. The validity of this table as portraying an indication of what factors student nurses perceive as being important in health promotion is dubious. Responses to this question, even allowing for "dross" as described by Field and Morse (1985), were varied. Answers involved a multiplicity of views. Although these four themes were mentioned by the majority of groups, the numbers are small and do not entirely reflect the shift in perceptions, which repeated reading of the data seems to indicate. A more illuminative analysis seemed appropriate.

Besides the responses common to all groups, the foundation course, tended to have a more global concept of health. This was based on notions about health in relation to a healthier future, it was also perceived as being a fundamental human right. The following examples give some indication of these ideas:

> " If we learn about health promotion, then we can pass it on to friends, people in general, so everyone would be more aware and it would help informing a healthy population."

> "Then we will be able to teach future clients and patients about health and give advice to anyone who asks for it"

In conjunction with these views, ideas about enabling and empowering were also present, examples of these being:

> "Because I think it is important to encourage people to learn about health and how to improve it, so they can take some control of their well-being. it is important for people to have the knowledge to help themselves. A healthy population has results in many other areas too."

> "Because by promoting good health and educating people in prevention will help individuals to help themselves and to understand what aspects can cause ill health."

> "Health promotion is a very important aspect in preventing illness that affects everyone. it helps people to be more aware of the things they can do to avoid becoming unwell in certain situations. Everyone is entitled to health education."

In comparing these responses with other groups (apart from one response from a second year student), these ideas do not re-occur. Dustagheer (1989), in evaluating

the health based curriculum in this college of nursing found that the curriculum intentions were distorted by the dominance of the medical model of nursing in the clinical areas. This was compounded by the fact that doctors controlled the decision making process in regard to patient welfare.

This influence seems to emerge in the first and second year groups. For example, a first year nurse states that health promotion is important because:

> Many people are prepared to change their lifestyles if advised by a doctor (especially), or a nurse."

However, although there is a trend towards a more individualistic and "top-down" approach indicated in the responses of these groups, there is also an awareness of the issues involved. This could possibly be explained by the fact that these first and second year nurses had recent practical experience in the community as part of their clinical allocation. They state:

> "It is important for the public to know what one should do to suit their health needs.
>
> "Health promotion is important because of the shift towards nursing in the community. People should be aware of "sensible" healthy lifestyles for their own good, especially if they have a medical condition. It is also important in the ward environment - preparing for discharge."
>
> "Because, due to research, new health promotion ideas are always changing and it is, therefore, extremely important to have up-dated information to incorporate into our role as health educators (patient education)."

These views would appear to indicate that curriculum content could be having some effect on cognitions, although what happens in practice is uncertain. However, an indication that some change from a "top-down" approach to patient education could be construed from the following statements from the first and second year groups:

> " It is difficult with elderly people to change the habits of a lifetime, but having some knowledge, you can express yourself better, without sounding that you want them to change their lifestyle"
>
> "Nurses should promote health on an individualistic basis to their patients, therefore they need to learn about it to do it effectively."

However, five other students perceive their role as being in a much wider context, expressing such views as:

> "As family, friends and patients look to our advice and guidance. People feel, I think, that nurses are easier to confront, or ask questions about health than doctors. Health promotion is such an important factor in life and living to reduce health problems."

One response also reflects a quite humanistic and empathetic understanding of health promotion:

> "Patients and nurse (especially in-patients), spend such a great deal of time talking together and nurses are in a unique position to share knowledge and discuss patients' feelings and needs about their own health."

The integration of health promotion into the professional role became more pronounced with the finalist group. Strategies they also saw as being the most useful tool for them were advising, giving information and teaching:

> "I believe that its part of our role to provide patients with the information and support to allow them to take responsibility for their own health and educating them to be aware of their own health and well-being"

> "It's important to teach health issues for the future of our patients and their children."

From this analysis, it can be seen that there could be a change. This ranges from a view of health promotion in the foundation course that would appear to reflect that of the WHO (1986), to amore individualistic view in the first and second years, reflecting current political thought. Strategies for patient education, which students seem to perceive as being the main focus of their role in this context, range from the biomedical, through a behavioural change, to an educational approach.

Comparison of answers to this question with the third year sample appeared to indicate that students perceived health promotion as being an integral part of their professional role, but it was definitely set within an individualistic framework. Of the total of seventeen in the group, eight specifically mentioned teaching, educating and informing on an individual basis as being an essential part of their role. Examples of such statements are:

"To be an effective nurse a vital ingredient, is the ability to teach others about health."

"Nursing is becoming more health orientated and it is necessary for us as professionals to have knowledge of health promotion so that our clients can benefit from this."

The humanistic trait was still evident in this group, examples of which are:

"To be able to give people the best possible chance to achieve a healthier lifestyle. It helps when you feel good inside."

"We have to share our knowledge with patients, in a hope that they will adopt a healthier lifestyle. Thus decreasing some diseases."

Notions of enablement and empowerment were also displayed in this group, along with an acknowledgement of the social context of health and illness.

To conclude, it would seem, on entering training students perceive their role in health promotion as being important because they have quite idealistic, notions about preventing illness, as well as being instrumental in helping to maintain and create a healthier population.

These ideals are not as apparent in the first and second year groups, a more pragmatic and individualistic focus emerges, the emphasis being on patient education. This view reflects the emphasis placed on patent education in the nursing literature (Wilson-Barnett and Osborne1983; Latter et al 1992). Curriculum content appears to be influencing perceptions in that, as well as being taught about patient education, they are beginning to acknowledge the social structure of health and illness. They are aware of the importance of patient education in discharge planning, as well as describing effective "bottom -up" strategies for health promotion. Notions of the importance of the provision of support to family and friends is also evident. Again the curriculum content could be influencing perceptions. By the time the students have completed their training however, health promotion is described more frequently as being an integral part of the professional role.

Attitudes.

Further light was shed on student perceptions of the concept with the analysis of the attitudinal scale. Scaglion (in Kane 1990), in his discussion of the analysis of quantitative data remarks that, in sociology, large sample sizes are preferable in order to reduce sampling error, as well as confirming that observed relationships are not due to chance. Moser and Kalton (1989), acknowledge the complexity of the concept of attitudes. In outlining the scaling techniques for measuring the direction and extremity of attitudes, they cite Likert scales as having a higher reliability, than other scales, in that they require fewer items to reach a given scale of reliability. Moser and Kalton (1989) state that to test any attitude scale for significance, without the use of a computer and appropriate software packaging is difficult.

As previously stated this was a small scale study and testing for significance was inappropriate, the most that could be achieved in this analysis was the identification of trends. The five point continuum for the entire scale ranged from 1, strongly agreeing with the item, to 5, strongly disagreeing with the item.

Table 7 - 5 Item 1

Doctors and nurses know a lot about health and illness. Therefore, people should do as the professionals tell them. If they don't and they become ill, it is their own fault.

	FC	Year1	Year 2	Year3	Finalists
Strongly Agree	0	1(5.0%)	0	1(5.0%)	1(5.9%)
Agree	12(54.5%)	4(19.0%)	4(20.0%)	5(29.0%)	3(17.6%).
Unsure	6(27.0%)	5(23.6%)	3(15.0%)	0	1(5.9%)
Disagree	4 (18.5%)	9(42.9%)	12(60.0%)	8(48.1%)	7(41.2%)
Strongly Disagree	0	2(9.5%)	1(5.0%)	3(17.9%)	5(29.4%)
Missing	0	0	0	0	0
Total n = 97	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)

These figures seem to indicate that there could have been a change over three years. Twelve students (54.5%) of the foundation course, agreed with this statement. Six (27%), were unsure and only four (18.5%) disagreed. By the end of the first year

views have changed, with nine (42.9%) and two (9.5%), students either disagreeing or strongly disagreeing with the statement. This attitude seems to peak in the second year, with 60% of the sample group disagreeing with the statement. In comparing the third and finalist scores, there would appear to be a strengthening of attitude, in that although the totals of 48.1% and 41.2% indicate no overall change. Slightly more students strongly disagree with the item. in the second year than in the third year. What is also interesting is that although Moser and Kalton (1989) state, subjects are more unlikely to respond to extremes on a scale, in this instance (apart from the foundation course) these students do.

Item 2 of the scale, as indicated in Table 8, elicits a similar response. This could be interpreted as demonstrating that, students entered training with these views and that there was no change over three years.

Table 8 - 5 Item 2

Health promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

	FC	1st year	2nd year	3rd year	Finalists
Strongly Agree	8(36.7%)	7(33.3%)	9(45.0%)	10(58.8%)	5(29.4%)
Agree	14(63.3%)	12(57.1%)	10(50%)	7(41.2%)	11(64.7%)
Unsure	0	1(4.8%)	0	0	0
Disagree	0	0	1(5.0%)	0	0
Strongly Disagree	0	0	0	0	0
Missing	0	1(4.8)	0	0	1(5.9%)
Total n=97	22(100%)	20(11%)	20(100%)	17(100%)	17(100%)

A similar picture is illustrated in item 3 of the scale.

Table 9 - 5 Item 3

Nurses need to understand about peoples' different economic, social and cultural backgrounds so that they can be effective health promoters.

	FC	1st year	2nd Year	3rd Year	Finalists
Strongly Agree	15(68.2%)	14(66.7%)	11(55.0%)	12(70.6%)	10(58.8%)
Agree	7(31.8%)	7(33.3%)	5(25.0%)	5(29.4%)	5(29.4%)
Unsure	0	0	0	0	2(11.8%)
Disagree	0	0	0	0	0
Strongly Disagree	0	0	0	0	0
Missing	0	0	4(20.0%)	0	0
Total n = 97	22(100%)	21(100%)	20(100.0%)	17(100%)	17(100%)

Although issues relating to the validity and reliability of the scale will be addressed in the following chapter, it seems that some justification for using these items is required at this point.

It could be argued that because there is very little variation in the distribution of responses across these two items, they serve no useful purpose in measuring attitudes and should be discarded (Moser and Kalton 1989). As already mentioned, the sample population are homogenous and predominantly middle-class. The responses to these particular items may well be reflecting middle-class attitudes. Moser and Kalton (1989), also argue that ordering the scores on an item depends on whether "strongly approved" indicates a favourable or unfavourable attitude and that it is advisable to have a roughly equal number of positively and negatively worded items on a scale. Table 10 refers to the responses to item 4 and is negatively influenced.

Table 10 - 5 Item 4

Giving advice and supporting people so that they can make choices about their lifestyle is commonsense.

	FC	1st Year	2nd Year	3rd Year	Finalists
Strongly Agree	4(18.2%)	2(9.5%)	4(20.0%)	8(47.1)	0
Agree	13(59.1%)	8(38.1%)	13(65.0%)	9(52.9%)	9(52.9%)
Unsure	3(13.6%)	4(19.0%)	1(5.0%)	0	3(17.6%)
Disagree	2(9.1%)	7(33.4%)	2(10.0%)	0	5(29.5%)
Strongly Disagree	0	0	0	0	0
Total n = 97	22(100%)	21(100%)	20(100.0%)	17(100%)	17(100%)

When the responses in this table are compared with those in Table 8, it is seen that some confusion exists regarding understanding of the concept. There is a higher positive response to the statement that health promotion is about advising and giving information so that people can make decisions. Yet giving advice and supporting people so that they can make choices is also rated positively as being commonsense.

When these two response rates are reviewed in conjunction with the themes emerging from the open-ended questions pertaining to perceptions of health promotion, teaching and educating through giving advice and information is perceived as being important. This is in that, it is the most frequently mentioned category for the whole group. There is reference to the supporting role in the probing questions. Yet Table 10 of the score would indicate that this is not thought to be important. A further and somewhat confusing dimension emerges when item 5 of the scale is examined.

Table 11 - 5 Item 5

Nursing is mainly concerned with giving "hands on" care.

	FC	1st Year	2nd Year	3rd Year	Finalists
Strongly Agree	0	1(4.8%)	1(5.0%)	3(17.6%)	0
Agree	10(45.5%)	2(9.5%)	3(15.0%)	1(5.9%)	4(23.5%)
Unsure	5(22.7%)	1(4.8%)	3(15.0%)	1(5.9%)	0
Disagree	1(4.5%)	16(76.1%)	11(60.0%)	11(64.7%)	11(64.7%)
Strongly Disagree	6(27.3%)	1(4.8%)	0	1(5.9%)	2(11.8%)
Missing	0	0	1(5.0%)	0	0
Total n =97	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)

This item, illustrates that there could have been a shift in attitude from the polarised view in the foundation course between nursing being mainly concerned with practical care (45.5%) and not being mainly concerned with giving practical care (27.3%). In the first year sixteen (76.1%) of the group thought nursing was not mainly concerned with giving "hands on" care. In the second year this falls to 60% with an equal proportion, 15% either agreeing with, or unsure about the statement. However, the score disagreeing with the item had risen in the third year and finalist groups, with an equal distribution 64.7% in both sample groups.

The final part of the scale relates to the wider political issues surrounding health promotion, but is couched in terms of awareness.

Table 12 - 5 Item 6

Because they are involved in health promotion, nursed should take an interest in current affairs.

	FC	1st Year	2nd Year	3rd Year	Finalists
Strongly Agree	3(13.6%)	2(9.5%)	8(40.0%)	8(47.1%)	2(11.8%)
Agree	16(72.8%)	18(85.7%)	9(45.0%)	9(52.9%)	13(76.4%)
Unsure	3(13.6%)	1(4.8%)	2(10.0%)	0	2(11.8%)
Disagree	0	0	1(5.0%)	0	0
Strongly Disagree	0	0	0	0	0
Total n = 97	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)

The distribution in this table also appears uneven, in that, the responses are positively clustered with 90% of the total sample strongly agreeing or agreeing with the statement.

It could be concluded that, student nurses attitudes about their role in health promotion seem change over a three year period. In the foundation course there is a tendency towards the biomedical view of health promotion and nursing. Health promotion is mainly concerned with giving advice and information. Social, economic and political factors are thought to be important, as is the awareness of current issues relating to health promotion. However advice and support are not perceived as being integral to the role. During the first and second years there is a change from the biomedical victim-blaming approach, although giving advice and information is still seen as being important. A dichotomy seems to exist between the fact that, although 64% of the third year and finalist groups agree that they should be giving advice and information, the supportive element, recognised in psychology as being an important element in bringing about behaviour change, is thought to be commonsense, and therefore not an essential element of skilled nursing care. There is no change at all in attitudes regarding socio-economic and cultural issues involved in health promotion.

Involvement in Politics.

The last item had specifically linked health promotion to awareness of current affairs. The question relating to involvement in politics had been left open to determine if the students could make links for themselves. Responses to these questions revealed very mixed views.

The responses were examined in the context of what Hardy (in White;1986) describes as the professional reality of politics. This can be interpreted as the personal level of politics that can have an impact on individuals as they progress through life, and the

environment outside the individual where social and professional influences are brought to bear. Responses were divided into groups indicating personal and professional responses.

Table 13 - 5

Should Nurses Be Involved In politics?

	FC	1st Year	2nd Year	3rd Year	Finalists
Personal	13(59.1%)	10(47.6%)	7(35.0%)	7(41.2%)	8(47.1%)
Missing	8(36.4%)	8(38.1%)	10(50.0%)	10(58.8%)	6(35.3%)
No resonse	1(4.5%)	3(14.3%)	3(15.0%)	0	3(17.6%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
Professional	13(59.1%)	10(47.6%)	10(50.0%)	12(70.6%)	5(29.5%)
Missing	8(36.4%)	8(38.1%)	7(35.0%)	5(29.4%)	9(52.9%)
No response	1(4.5%)	3(14.3%)	3(15.0%)	0	3(17.6%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
n = 97					

Ten students did not respond to this question, one in the foundation course, three in the first year, three in the second year and three in the finalist groups, several identified both tenets.

The figures show that in the foundation course and first year groups, the distribution of views is equally divided between responses relating to being politically active at a professional level and those who thought involvement should be on a personal level. Evidence of influence of curriculum content is not apparent here. By the second year, there is a move towards students thinking that it is necessary to be politically active at a professional level. This response rate is interesting when compared with the same group's score on the scale relating to current affairs (Table 12). Although the difference is small, this is the group who appeared less sure whether it was important to be aware of current affairs because they were involved in health promotion, although they were also the first group to state a strong preference for that item.

This trend, demonstrating the view that nurses should be politically active at a professional level strengthens in the third year, this could be due to the influence of the curriculum content. However, this trend was reversed in the finalist group. Why this occurs is unclear, it could be for aforementioned reasons, but considering there was a 100% response rate to previous questions and seven had not responded to this question, it could be concluded that the reversal of this trend is due to the dissonance created because politics is such a contentious issue within nursing.

Because of this lack of clarity, the data was re-examined, looking first of all at the responses of those taking the "personal" view. Two further themes emerged, these being that, any involvement in politics should be outside work and that any involvement could only have an adverse effect on patient care and relationships with clients and colleagues.

Table 14 - 5

Personal View Of Politics

	FC	1st Year	2nd Year	3rd Year	Finalists
Outside Work	5(22.7%)	8(38.1%)	5(25.0%)	3(17.7%)	3(17.6%)
Adverse effect on care	8(36.4%)	2(9.5%)	2(10.0%)	4(23.5%)	5(29.5%)
Missing	9(40.9%)	11(52.4%)	13(65.0%)	10(58.8%)	9(52.9%)
Total n = 97	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)

The view that involvement in politics could have an adverse effect on care was ranked higher by the foundation course than the first and second year students, who tended favour the personal perspective. This trend was reversed in the third year group and strengthened even more in the finalist group, appearing to reflect Clay's (1989) concern that nurses feel threatened by active political involvement.

When the response of the students who thought nurses should be politically involved were analysed, the two themes that emerged were in the context that policy decisions

had a direct effect on healthcare and that nurses' involvement could have a positive effect on healthcare.

Table 15 - 5

Professional View of Politics

	FC	1st Year	2nd year	3rd Year	Finalists
Policy affects care	11(50.0%)	8(38.1%)	4(20.0%)	9(52.9%)	1(5.9%)
Positive effect on care	2(9.1%)	2(9.5%)	6(30.0%)	3(17.6%)	4(23.5%)
Missing	9(40.9%)	11(52.4%)	10(50.0%)	5(29.5%)	12(70.6%)
Total	22(100%)	21(100%)	20(100%)	17(100%)	17(100%)
n = 97					

What could be deduced from these figures is that, although there was a tendency for students who thought they should be politically active to be more concerned with policy in the foundation course sample, this diminished in the first and second years, but strengthened in the third year. This could be attributed to the fact that the political implications for health promotion had recently been addressed in tutorial groups. However the trend did not persist in the finalist group. The theme focusing on the positive effect of political activity could have on patient care strengthened in the second year but receded again in the third year (which could also be attribute to aforementioned reasons), it rose again in the final year, but when the positive and negative effects of politics on patient care were compared (Table 14), conflict re-emerged and the negative aspects of political activity on patient care predominated.

To determine how students who thought it important for nurses to be involved in politics perceived this link with health promotion, the "professional" responses were re-examined. Of the thirteen responses in the foundation course who thought it important to be politically active, eleven indicated that they were aware of the differences between party politics and being politically active from a point of view of being active by joining or participating in the activities of a professional organisation, through such statements as:

"Health is not divorced from the political climate. Health is a reflection of the political state. As nurses we play an important part in that system - regardless of whether we are in a political party or not."

"Nurses need to be fairly represented and have a say in major government proposals concerning the NHS."

Of the two who commented on patient care, this was related to practical care on the wards. Similar views were indicated by the first year group. Awareness of wider policy implications only was indicated by one student.

"Nursing in the 1990's is a political issue - it raises questions as to the equality of health, economics, equal opportunities and equal pay and promotion."

The two respondents who related political activity to patient care also made direct links with health promotion, for example:

"Changes in government and leadership will effect the country's economy and therefore, the type of lifestyle people lead. Nurses need to be aware of this as it will effect the type of health promotion we give and how much people can afford to change."

In the second year ideas about professional organisation had disappeared, but specific policy issues such as housing and benefits were thought to be relevant to political activity and nursing by one student, campaigning against reduction in the quality of patient care by another. Notions of patient advocacy also emerged. Only one specific activity related to health promotion was made, this focused on the prevention of harmful behaviour.

"I feel that nurses should make their feelings known about cigarette and alcohol advertising, which are products detrimental to the nation's health."

The third year groups' responses were particularly interesting, indicating that curriculum content had some impact. Empowerment of nurses as well as their role as an advocate were mentioned, the following statement being a particularly articulate representation:

"The NHS affects every single person at some time of their life and nurses are the backbone of it. As the government controls or directs the NHS, nurses

> have a responsibility to make their views known, as they have a unique insight into the NHS."

The social context of health and illness were also discussed in relation of reducing inequalities in health.

However, these notions are not mentioned by the finalist group. Political activity through professional organisation was mentioned as well as patient advocacy. A tone of disillusionment and frustration also seemed to pervade, characterised the following statements:

> "Nurses need to be aware of political influences as our careers and our patients' health is affected by politics."

> "I think it is a very difficult subject, I believe everyone should be entitled to prompt treatment if they are ill."

To conclude, despite the complexity of this latter part of the analysis. Nursing, politics and health promotion, did not seem to be interrelated activities in this population. Some, but a very small proportion were able to relate the political dimension of health promotion to nursing. Views appeared initially to be equally divided between those who thought involvement was a personal decision and should occur within the realms of private citizenship and those whose perception of political activity was integral to nursing. Although more students in the foundation course and first year groups thought it was important to be politically active in policy and decision making, this view had changed in the third and final year. Political involvement outside work was seen as the more preferable option. Those in the finalist group thinking it was acceptable as part of the professional role, related professional political activity directly to having a positive effect on patient care. However politics and health promotion were not frequently mentioned.

Summary

This study had three intentions, the first two being to attempt to ascertain how students perceived the concept of health promotion and to try to find out if there was any change in these perceptions over a three year period. The third was to determine if curriculum content related to theories and practical application of health promotion strategies could have influenced any changes in perception that could have occurred.

The instrument designed to measure change was a self-completion questionnaire. Open-ended questions were utilised to explore health beliefs and perceptions of health promotion. Attitude change was measured using Likert type rating response categories.

The sample population was predominantly female and of middle-class socio-economic origin. No attempt was made to collect demographic information relating to ethnic origins. This was because there were relatively few overseas students or students from ethnic minority groups in this college, the majority lived in the south east of England and home counties. The idea of "race" and "racism" evoked very strong emotional responses when discussed in classroom settings. To include a question relating to ethnicity would serve no useful purpose and could have an adverse effect on the overall response rate.

The students'' mean age ranged from 21-25 years. Previous work experience showed they had all been involved in voluntary or paid work in health and social care, or in work in service industries where they need to make use of interpersonal and communication skills. The skills and experience they brought to the course could be indicative of potential ability to make health promotion an integral and effective part of their future role.

The health beliefs of the sample correlated with Blaxter's (1990) definitions of health. There does appear to be a change in these beliefs over three years, physical fitness and healthy behaviour associated with lifestyle being the most frequently mentioned reasons for being healthy by 68% and 72% receptively in the foundation course. These figures decline in the first and second years, while the third year group perceive not being ill (35%) and well-being (35%) as being more important than physical fitness. The finalist group, however, while mentioning physical fitness and lifestyle equally as frequently (52%), also mentioned well-being (41%) as often as the third year group. As mentioned previously Blaxter found these notions of well-being emerging in middle-age. It is concluded that this tendency to voice more mature beliefs could be attributed to experience during training, whether this is due to specific curriculum content is unclear.

On comparing these findings with given examples of why the students thought they were unhealthy, it is the effect of the stressful nature of "nursing work," in conjunction with working unsociable hours on shiftwork and night duty, that some students perceived as being barriers to their health. These views were most prominent in the first year group. Nine students from this group of 21 expressed reasons for being unhealthy. Given that they had recently completed physically and emotionally tiring clinical allocations, submitted a written summative assessment and were about to sit an examination, any positive reinforcement of health promotion principles through practical experience in the community seems to be negated.

The only instance where specific curriculum content was thought to have some influence on students' beliefs was in the third year. As already stated, the theoretical content was reinforced at this stage in preparation for a written assignment relating to health promotion. This concurred with Donaghue's (1990) findings about student nurses' perceptions of health promotion as a nursing function. In their longitudinal

study they compared data from two cohorts of undergraduate students, they found that in the second year both cohorts thought health promotion was more important than other functions. They remark that this situation is understandable, since the function had been reinforced with a self-directed clinical experience related to community attitudes to a healthy lifestyle.

There was a 100% positive response rate supporting the view that it was necessary for student nurses to learn about health promotion. This also compared favourably with earlier studies that nurses thought information giving and patient teaching was important in nursing (Pohl 1965: Hockey 1978). This view though was only prevalent at the end of the course, the foundation course generally, thought it was important to learn about health promotion in order to prevent illness (45%) and help individuals adopt healthy lifestyles (18.2%), this view had reversed in the third year and finalist groups, with giving advice and information(52.9%:35.3%) being perceived as being important.

Silverman (1989) says, qualitative research methodologies can be flawed in that:

> "The critical reader is forced to ponder whether the researcher has selected only those fragments of data which support his argument" (Silverman 1989;140),

However, it also provides substance for the quantitative information. Students describe global, altruistic perceptions of health promotion on entering nursing. The shift from these notions of being instrumental in helping create healthier populations in the future give way, by the second year to a more individualistic focus. This is related to giving advice and information. Some responses, but only five in the third year, describe a more enabling and participative approach to health promotion which could be likened to Ewles and Simnett's (1992) or Downie et al's (1990) models. However these students ideas appear to be set within an individualistic health education framework.

The reason for this change could be explained by the fact that individualised care and holistic care of the individual are an integral part of nursing theory and practice (Burnard 1992). Specific curriculum content could have some influence in raising awareness about information giving and advice in relation to discharge planning but this is all.

Weaknesses in the design of the attitude scale have been acknowledged. What could be concluded from this analysis and appears to be substantiated by previous studies is that there does seem to be a shift from a biomedical perception over three years. In the foundation course 54.5% of the sample agreed with the item relating to the dominance of the medical model, compared with 17.6% of the finalist group. This attitude change is rapid, only 19% of the first year group agreed with this item.

It appears then, that nurses commence their education with the belief that the nurses role in health promotion is about giving advice and information. Behaviour change is a matter of individual responsibility. They acknowledge that it is necessary to have information regarding the socio-economic and cultural background of their patient/clients. However, giving advice and supporting people so that they can make choices is commonsense (and therefore not integral to nursing). Students also seem to enter nursing with the view that it is necessary to have an awareness of current affairs because they are involved in health promotion. None of these attitudes appear to change over three years.

When items 2, 4 and 5 of the scale are compared, it could be construed that some confusion in understanding of the concept exists. Giving advice and information is seen as being part of health promotion, yet giving advice and supporting people is commonsense. For example in the foundation course 59.1% of the group agreed with

this latter statement, the attitude seems to strengthen by the third year, with 47.1% and 52.9% of this sample group strongly agreeing or agreeing with the item. On completion of their training 52.9% of this group still agree with the statement.

When these scores are compared with the item regarding nursing being mainly concerned with giving "hands on" care, the confusion appears more obvious. Of the foundation course sample, 45.5% thought this was the main focus of nursing. There is another rapid change at the end of the first year, with only 9.5% of this group thinking this is so. By the third and final years 64.7% of both sample groups disagree with this item.

In attempting to explain the reasons for this confusion, Gott and O'Brien's (1990) work is useful. They too identified conceptual disparity among qualified nurses with, "proper" nursing work consisting of tasks and health promotion consisting of advice work and lifestyle counselling. The nurses in their study felt it was within their remit to tell people what was wrong with the way they lived and what they should do about it. Yet the student nurses in this study appear to think this is not what they should be doing. This lack of clarity could be viewed positively, in that, although the study has not been able to detect any direct focus in students' perception of their role, there has been a move away from a biomedical view of health promotion and nursing, even if this is set within an individualistic health education framework.

This lack of clarity could have been due to the educational process, as well as the fact that although the curriculum was health based, it was not explicitly underpinned by the WHO (1978) Health For All philosophy. Other variables such as the conflict between the teaching in the college, and the reality of clinical practice (Wilson-Barnett and Osborne, 1983; Dustagheer, 1989), in conjunction with the

conflict among teachers regarding what is taught in the name of health promotion (Willott, 1989).

Although a trend towards a positive attitude about nurses being aware of current affairs was identified, the response to the question regarding involvement in politics revealed a polarity of views which shifted towards the "personal" rather than the "professional" over time. These political views appeared to reflect the conflict surrounding nursing and politics. Students in the sample population were generally unable to make links about the political implications of health promotion principles. Again there are similarities here with Gott and O'Brien's (1990) work, they attribute responsibility for this to the profession, educators and the government. Previous discussion in this chapter inclines towards concurrence with this conclusion.

Strengths

The strength of this initial exploratory study was that in using both quantitative and qualitative methodologies it was possible to engage in a deeper and more critical analysis through a comparison of the variables that emerge in the different types of data.

Limitations

There are several limitations the first being the cross sectional design. Another weakness is the homogenous nature of the sample, they certainly did not appear to reflect the educational background, social class or ethnicity of student nurses nationally. Therefore, in terms of generalisability, these findings, despite some of them being supported by the literature are not generalisable in quantitative terms.

The reliability of the instrument is also questionable. This was a small scale sample and as such it was only possible to carry out univarate analysis of the quantitative data. It was possible to some extent to test for external reliability by submitting it to independent review. The themes generated by the qualitative data were also scrutinised independently. However more formal testing is required.

Conclusion

The pertinent question now was, how could the outcome of these intentions be measured? The first cohorts of Project 2000 were about to qualify. Their progress had been carefully monitored by the teaching institutions as well as the English National Board for Nursing, Midwifery and Health Visiting. At this time there was very little information in general circulation regarding the evaluation of these courses. Health promotion is described as a unifying concept. If it was to be incorporated successfully as an integral part of nursing, it seemed likely that a tool such as this could be developed for use as part of the evaluation process in the nursing curriculum.

CHAPTER 6

THE MAIN STUDY: STRATEGY AND METHODS

The previous chapter identified several methodological weaknesses in this first exploratory study. On this basis, a strengthening of the process was required, by extending the survey to a much wider sample of students. Further reworking and refinement of the questionnaire was obviously essential. The key objectives were to;

- determine pre-registration nursing students' perceptions of the concept of health promotion.

- to try to find out if there was any change in these perceptions in the course of their Project 2000 programme.

- to refine and develop a tool that could be used to evaluate the integration of the health promotion content of the curriculum.

In this chapter, the overall design of the main study is presented, the ever present issues of reliability and validity are addressed and the methods utilised in the development of the student questionnaire are discussed.

The Design Of The Study

In order to meet these intentions and address the aforementioned methodological problems, a wide-ranging research strategy was clearly required. This strategy needed to include ways of not only measuring changes in students' perceptions of the concept over time, but to include the influence of other variables, namely the teachers, and the curriculum. Questions needed to be asked about the values that the teachers placed on health promotion in the nursing curriculum. In order to determine whether what was

taught in the name of health promotion matched the design of courses, philosophies and curricula also required examination. Thus, a framework was developed on the basis of current thinking on appropriate deductive and inductive strategies and an examination of the relevant literature.

Triangulation was the strategy utilised in order to meet these intentions. Triangulation as a research strategy was first mentioned by Campbell and Fiske (1959), who described it as a combination of methods in the study of the same phenomenon (Denzin 1978). Four types of triangulation are described by Denzin (1978) namely:

1. Data Triangulation - Whereby researchers not only triangulate methods, but also data sources, that is, they use as many sources as possible in their analysis.
2. Investigator Triangulation - Consisting of several as opposed to single observations of the same object. Denzin (1978) identifies three sub-sets of data triangulation which are; a) time, b) space, c) person.
3. Theory Triangulation - The use of multiple rather than single perspectives in relation to the same set of objects. Data can then be approached with multiple hypotheses in mind so that various theoretical views can be examined to assess their relative power.
4. Methodological Triangulation - This involves triangulation within methods, such a the use of a questionnaire containing several scales to measure the same unit, and triangulation between units, using different methods to measure the same unit (Denzin 1978; cited by Corner 1991).

There are problems, however, associated with conducting this type of research. According to Denzin (1978) these difficulties are associated with finding a method with which two different theories can be assessed, the difficulty in finding several methods of approaching the same problem, in conjunction with cost and time implications. Further shortcomings associated with this approach are difficulties in replication, and the danger of the study lacking focus.

However, Mitchell (1986) says these limitations are counterbalanced if four principles are adhered to, in that:

1. The research question is clearly focused.

2. The strengths and weaknesses of selected methods are complementary.
3. Selection of methods is dependent on the nature of the phenomenon under investigation.
4. Evaluation of the approach should be incorporated into the design (Mitchell 1986, cited by Corner, 1991).

If these principles are seriously acknowledged, multiple triangulation offers flexibility and a deeper understanding of the problem that is not always available with more simple designs (Mitchell 1986) .

The framework for the data collection consisted of an overall longitudinal panel design. The main value of such design is that it has the ability to demonstrate trends or changes over time. Panel studies are preferable to trend or reflective studies since the same participants are used to provide the data. Consequently they supply more information because the researcher is in a better position to examine patterns of, and reasons for change. The investigator can identify those who did or did not change, and then isolate the subgroup who did not change (Polit and Hungler (1993).

However, there are problems with longitudinal studies: the most widely recognised of these are attrition and organisational change (Polit and Hungler 1993; Burns and Grove 1995). Attrition is problematical since the views of those who drop out of the study may differ in many respects from those who continue to participate. However, due to the structure of Project 2000 Programmes it was decided to collect data from the students over a period of thirty six months at critical points in the programme, at the beginning of the course, during the induction period, before formal education commenced. In the absence of any control group, the data collected at this stage would be the baseline for identification of change. The mid-point would be at the end of the common foundation programme, on completion of generic studies in health and nursing. The final stage was to be in the last week of the course, once

students had completed both the clinical and theoretical aspects of their respective branch programme and all coursework had been submitted. Figure 1 provides an outline of the structure of Project 2000 courses.

Figure 1 - 6

The Structure of Project 2000 Programmes

Common Foundation Programme

18 months

Branch Programme

18 months

Entry to the Professional Register

Award of an Academic Qualification

In deciding to collect data at three points in the programme, some of the problems associated with attrition would be addressed. It was anticipated that there would be a nucleus of subjects participating at all three points, others only participating at two points, either in the middle, or end of the course, therefore it would be possible to compare any changes in perception with the main core group.

Organisational Change

The problems associated with organisational change require comment here, since at the time the study commenced nursing education was experiencing tremendous upheaval which had implications for the sampling methodology utilised. In the document "Project 2000: A New Preparation For Practice), the UKCC (1986) outline the patterns of educational organisation and finance in England, Northern Ireland, Scotland and Wales. Since this study was conducted in England it is this organisational structure that is discussed. At this time NHS healthcare was administered by 192 District Health Authorities organised into fourteen regions. There were also special health authorities managing hospitals with postgraduate

medical schools. In the majority of District Health Authorities there was a school of nursing and midwifery. At that time, the ENB approved 168 schools of nursing and 152 schools of nursing and midwifery. This had reduced drastically since the early 1970's when there had been a massive rationalisation of schools of nursing with 600 being regrouped to form those 168. In 1986 several Regional Health Authorities were in the process of submitting proposals for further rationalisation of schools of nursing and midwifery, although none had been accepted by the government and statutory bodies at that time (UKCC, 1986).

The implementation of the NHS and Community Care Act (1991) paved the way for the transition of nursing into higher education, and increased the momentum of change. Any rationalisation programme in any organisation initially attracts some reduction in human resources. There is a wide literature on organisational change which is not referred to here, other than to indicate that it was in the context of this period of change that this study took place. It certainly influenced decisions that were made in relation to selecting an appropriate sampling methodology.

Sampling Methodology

This was driven by several other factors, which were, to some extent interrelated. The first being the time factor involved in the design and planning of the study. The original intention was to complete the research in five years. Thirty six months was required for the data collection. Sufficient time was also required for analysis and reporting of findings. Thus, constraints in selecting an appropriate sampling methodology were immediately apparent.

The second factor was in obtaining a large enough representative sample to sustain a longitudinal study. The literature suggests that there are two ways of addressing this

problem. The first relates to probability sampling methodologies and suggests either random sampling or cluster sampling methods (Burns and Grove 1995). Initially cluster sampling methodology was selected in favour of random sampling. However, this was also problematic not only in terms of time in relation to gaining entry to organisations (Wilson-Barnet, 1983), but also in accessing large enough sample groups in the branch programmes, other than in the adult branch programme.

Initial investigation indicated that the numbers of student nurses in training on branch programmes other than the adult branch programme were small, throughout the United Kingdom. The ENB Annual Report 1994/5 indicates that there were a total of 805 students registered on the common foundation programme at this time but they did not publish figures for the intended branch programmes. The UKCC (1986) also identify the very small numbers of students following courses in mental health, children's nursing and mental handicap nursing throughout the United Kingdom. Therefore it seemed difficulties would be encountered in gaining sufficiently large samples of students on other programmes to make valid statistical comparisons.

Finally, non probability sampling methodology was utilised and an opportunistic sample was selected. This was facilitated through the development of professional contacts with senior nurse educationalists in various parts of the country. This networking enabled access to three colleges of nursing. One in central London and where the previous study had been completed (School A), one in the home counties (School B) and one in the north west of England (School C). The final total student sample consisted of one hundred and fifty eight students; fifty six from a college of nursing in central London, forty six from a college in the home counties and fifty two from a college in the north west of England. The final selection criteria was that only students who intended to qualify as Registered Nurses (Adult Health) would be

selected. In order to humanise the data fictitious names were assigned to each school; school A was called Blackstone, school B, Waverly and school C, Chiswell.

Certainly in terms of generalisability, this total sample population appeared problematic and a control group was not available due to the different settings in which the research took place, however the baseline data from the first survey of the total sample was used as a control. This is not necessarily seen as a weakness in the research, but a reflection of the principle that the research design should fit the study and not vice versa (Oppenheim, 1992).

It was also more realistic to sacrifice the possibility of a slightly larger data set in order to focus the study on students undertaking the adult branch programme. This was not merely because of the previously mentioned problems related to the sampling methodology, but also, because it appeared that this is where there was the biggest problem associated with the paradigm shift in health promotion and nursing. Not only do recent studies indicate that students who register as general nurses complete their training encapsulated in a traditional model of health education, but from an historical perspective, general hospital nurses find it difficult to refocus the care they give from creating dependency, to independence in their patients. Abel-Smith (1960) summarises the problem in his now outmoded view of nursing:

> "Illness creates dependency: The sick need not only medical treatment, but personal service. The provision of this service and the administration of the treatment which the doctor prescribes are the two basic duties of the nurse" (Abel-Smith 1960).

Maggs (1983), describes how general nurses have exploited that dependency to maintain and develop an occupational supremacy which has become central to both lay and professional perceptions of nursing.

Given the current situation regarding the professionalisation of nursing, it can be argued that the development of new roles and their accompanying responsibilities, such as the nurse practitioner and the specialist practitioner, will perpetuate the dominance of biomedicine and dependency on the medical profession. Many of the tasks/roles being undertaken by nurses working in hospital and community settings, such as the administration of intravenous drugs or cervical cytology were the responsibility of doctors. There is some evidence to suggest that nurses perform these tasks better and that clients/patients prefer nurses to do them (McKie 1993). However, this does not necessarily indicate that nurses are becoming more autonomous in their practice. Without a sound theoretical framework to underpin and direct their practice they will remain confined within the narrow boundaries defined by Abel-Smith (1960), administering the treatment prescribed by the doctor. Health promotion may not be or become an important part of the role of nurses trained in Adult Branch Programmes, despite the philosophy for the new paradigm in nursing.

Survey Methods and Data Collection.

A process of triangulation was utilised. Data was collected via questionnaire from both students and teachers. They were designed to collect both qualitative and quantitative information. The student questionnaire was administered by the researcher at the beginning and end of each common foundation programme as well as at the end of each adult branch programme. The teacher's questionnaire was distributed utilising a postal method. In order to illuminate and verify the data from the teacher's survey, focus groups were also conducted with college staff. Key questions in this phase were developed from the qualitative data collected from the questionnaires.

Relevant historical, demographic and educational data was collected by literature review, examination of appropriate curriculum documents, educational programmes and informal interviews with senior staff in each college.

Both qualitative and quantitative methodologies were used to analyse the data from the questionnaires. An open system of coding was used. Multi-response replies to open-ended questions were systematically coded and categorised according to the methods used in the grounded theory and content analysis literature (Glaser and Strauss 1976; Couchman and Dawson 1990). In order to reduce bias and enhance construct validity, themes generated from the qualitative data were further coded and independently reviewed by two experienced nursing academics, one of whom was academically credible in health promotion. Once these categories had been confirmed and recoded, the resulting database was analysed utilising the Statistical Package for the Social Sciences (SPSS).

The phases of the study are outlined in figure 2. However in reality, these phases overlapped and interrelated.

Figure 2 - 6

Phases of the Main Study

Phase 1 - The Students	**Phase 2 - The Teachers**	**Phase 3 - Documents**
Selection of sample	Selection of sample	Data collection:
Questionnaire development	Questionnaire development	Curriculum documents
Pilot study	Pilot study	Timetables
Data collection	Data collection	Programmes
Data analysis	Questionnaire analysis	Assessment strategies
	Focus group preparation	Data analysis
	Focus group study	
	Data analysis	

Reliability and Validity

Data quality is very important in research in the health sphere (Bowling, 1991). The two main dimensions are reliability and validity. Reliability is defined as the "consistency with which a measure assesses a given trait" (Oppenheim 1992). There are also a number of formulas for assessing reliability namely; alternate forms split-half and Cronbach's alpha, and factor analysis, and from the world of ethnography, triangulation. Inter-rater reliability is defined as the consistency of classification as measured by two or more different raters using the same instrument on the same measurement occasion (Waltz et al, 1991). Both these measures were appropriate at different stages in the study for measuring the reliability of the instrument. Inter rater reliability studies were carried out on both questionnaires during the pilot stages of the revised questionnaires, and during the main study. Factor analysis and the application of Cronbach's alpha was utilised to test for internal consistency of the attitude scale in the final analysis of all the student data.

Validity

Validity is defined as the extent to which an instrument measures what it claims to measure (Oppenheim, 1992). There are a number of approaches to assessing validity which are content, concurrent, predictive and construct validity. According to Oppenheim (1992), Content validity aims to establish that items or questions are a well balanced sample of the content domain to be measured. Concurrent validity, indicates how well the test correlates with other, well validated methods on the same topic. Predictive validity, is intended to show how well the test can forecast some future criterion such as job performance, and construct validity shows how well the test links with a set of theoretical assumptions about an abstract construct such as intelligence.

Since there were no other validated instrument to compare correlates, concurrent validity was rejected. Similarly, predictive validity was not considered appropriate since the methods used in the data collection and analysis were not intended to predict behaviour. Streiner and Norman (1989), address the methodological problems in testing for construct validity stating that there is no single experiment to "prove" a construct. Construct validity is a continuous process of learning more about the construct and making new predictions, and generating theory. This was certainly an area that was intended to be addressed in the design of the research.

Content validity can be measured by the judgement of expert raters (Smith, 1975). However Oppenheim (1992), is sceptical of expert help in exploratory pilot work, others have also thought it to be unquantifiable and mainly a refined form of face validity. Nevertheless, it was considered useful to use "expert help" at this stage, not merely as a way of cutting corners but as another method of validating the results of the pilot studies of the questionnaires.

As already stated, triangulation involves the comparison of information about the same topic, but is obtained from different sources, different methods or different investigators (Fielding and Fielding, 1986; Silverman 1989). However, it should not be used to undermine a particular point of view, but to complete the picture of reality. This was the intention in incorporating this method into the overall design of the study.

The Development of the Questionnaires

Two questionnaires were used, the first to collect data from the students, and the second to collect data from the teachers. The questionnaire pertaining to the student data was developed from the instrument utilised in the first pilot study. It was

designed to measure any changes in the student's perceptions of health promotion as they progressed through their course.

The second questionnaire was developed with two distinct intentions, the first to use the results of the survey to identify the teachers perceptions of health promotion, it's importance in the curriculum, as well as identifying what they should be taught in the name of health promotion. The second property was to use the data to formulate a topic guide for focus group discussion. It was anticipated that the results of this analysis would strengthen the student data in terms of validity and reliability. Copies of the draft and final questionnaires for both students and teachers are in appendix 7.

Issues relating to the length and the presentation of the questionnaires also needed to be addressed. Although, there is a view that the length of a questionnaire is not as important as presentation and maintenance of interest (Oppenheim 1992), it is also argued that long questionnaires can produce boredom and therefore introduce bias (Moser and Kalton 1978). For these reasons the first questionnaire was short. With regard to the current study, questions were asked of course co-ordinators in the sample locations about the time required for completion of the questionnaire, since the slots that could be allocated on the programmes were limited. Therefore, from a pragmatic perspective, it seemed wise to extend it only as far as was absolutely necessary.

The Development of the Student Questionnaire

Exploration of concepts and attitudes in self-completed questionnaires calls for subtlety (Oppenheim, 1992). This was the intention in the design of the original questionnaire. However, that item analysis, revealed there were elements in the structuring of the questions that were ambiguous, consequently affecting measurement of the concept. In conjunction with a senior nurse education manager

and a colleague with experience in health promotion and nursing the questionnaire was reviewed and restructured.

The original design was grounded in the modular framework advocated by Oppenheim (1992). In order to evaluate the validity and reliability of this method of measurement it was decided to continue with this design. The first two questions had intended to elicit health beliefs and were modelled on Blaxter's (1990) Survey of Health and Lifestyles, they elicited responses congruent with Blaxter's findings.

The second question relating to why students thought that they were unhealthy had produced some interesting qualitative data. Blaxter (1990) had found that the poorest and most disadvantaged were more likely to assess their health as poor, the youngest students who could be thought to have a more external locus of control also reported their health as being poor. While this was interesting it did not necessarily reflect the student's perceptions of health promotion, but rather the influence of the "apprenticeship" model of nurse education. For these reasons it was omitted.

The third question was concerned with whether the students thought they should learn about health promotion and was also related to their future professional role. It was structured in two parts, the first being binomic and the second being open, requesting written information. However, the response rate had not been consistent. Subsequently these first three questions were restructured, the first question was a four point value item relating to how important it was to learn about health promotion, this was rated on a scale of 1-4 ranging from 1 - of no importance to 4 - very important. Question two was open-ended asking reasons to be for the answer to the previous question, and was designed to elicit perceptions of health promotion. The third question was concerned with eliciting health beliefs. However, on this

occasion, rather than asked to assess or describe their own health the wording was more subtle, in that the students were asked to describe the concept of "being healthy," as in the WHO (1948) definition of health.

The original scale relating to student perceptions of health promotion, was composed of five items. It was not designed to have psychometric properties but rather to measure the concept of health promotion. The statements were based on current theoretical perspective of health promotion and were couched in terms that were directed from the authoritative professional perspective, towards the progressive, participatory empowerment model of health promotion (Beattie 1992;Tones 1984). A question related to perceptions of nursing and health promotion was also included.

The item analysis using a Likert-type response rate in the previous study, had revealed confusing elements that were difficult to analyse, this it seemed, was because the statements were too indirect and that the concept of health promotion was not apparent. Attention needed to be drawn back to what was being measured, namely the role the nurse in relation to health promotion (Oppeneheim 1992).

There was general agreement that the first two questions on the scale were measuring what they were designed to measure and that as far as it was possible to discern the wording was clear. The third question, however relating to the theoretical underpinnings of health promotion had caused confusion because it was measuring several constructs. These were separated into three discrete items.

Oppenheiem (1992) and Moser and Kalton (1978) think that in terms of wording it is useful to use vernacular and lay terms to elicit responses, this was the intention here, but further clarification was required. The fourth item had been constructed with the

intention of trying to discern, not only if health promotion was viewed in the context of a more enabling and empowering model, but more crucially to ascertain if there was any movement in perception over time. This was felt to be important, but the wording "commonsense," was considered unhelpful, despite this being attributed to explanations of "basic nursing care" (Blane,1991; Melia,1987). After much deliberation and philosophical discussion the question was changed to the more rational statement, "Giving advice and supporting people so that they can make choices is an essential element of health promotion."

Similarly the question relating to nursing stimulated discussion. The term "hands on" care had intended to represent the clinically based, task orientated approach to care that is identified in the literature as a populist representation of nursing (Wilson-Barnett and Macleod-Clark 1993). This was deemed to be an appropriate statement, but also required an additional statement to identify any relationship between the values placed on nursing and health promotion.

The wording on the final item was not changed. It had been included to try to ascertain if students thought it was important to view health promotion in context, it could also be compared with the items relating to theoretical constructs underpinning health promotion, it was also intended to be analysed in relation to the questions relating to the political more radical elements of health promotion. Although doubt about the wording and clarity of this item was expressed it remained unchanged. It was thought at this time construct analysis of the final data would identify further ways of clarifying the meaning inherent here, and would generate the evolution of more meaningful questions.

One further item was added, intended to elicit the strength of the students' perceptions of their role in health promotion, the wording was factual and direct, it was anticipated, that rather than leading, or providing a socially acceptable response, it would provide clarity and meaning to the scale.

The question relating to politics was also separated into two questions, one being binomal and asking whether nurses should be involved in politics, and the following being open and asking for reasons. As already stated this was intended to elicit any perceptions relating to the political nature of health promotion.

The remaining six questions dealt with personal and demographic information. There was no problem associated with their position in the questionnaire, yet certainly there were problems in the layout and structure. The question relating to educational achievement had elicited a variety of qualifications that needed categorisation in order to facilitate coding. Three further questions were included relating to educational achievement. Those questions relating to age, gender and social class had not been problematic and remained unchanged. A question relating to ethnicity required inclusion. Given the contentious nature, of such questions, two were finally included one relating to country of birth and the second asking subjects to describe their ethnic origins. In order to prevent a poor response to these questions an explanation for the inclusion of these questions preceded this part of the questionnaire (Oppenheim 1992; Moser and Kalton 1989). (see appendix 8 for final questionnaire).

The Development of the Teachers' Questionnaire

Questionnaires are often designed to suit the study's aims and the nature of the respondents. Certainly teachers are different from students. The same questionnaire

could not be given in entirety to the teachers, as one remarked during informal discussions; "You wouldn't get much worthwhile out of us, as we would all know the right answers." The development of the questionnaire for the teachers was also designed with different objectives. These were:

- To find out how important they thought it was for student nurses to learn about health promotion.

- To determine the teachers understanding of the concept of health promotion.

- To use the results of the data collected from this instrument to generate themes that were intended to be used in focus group discussions at a later stage in the study.

Therefore this questionnaire was not solely a measure, but an instrument for triangulation, eliciting information to generate rich and illuminative data that would in turn support the reliability and validity of the student data, thus producing credible research (Denzin and Lincoln, 1994).

This questionnaire consisted of ten questions, the design was similar to the student questionnaire, in that the modular approach was utilised. The first four questions related to the concept of health promotion. The first question relating to the value attached to the importance of learning about health promotion. The remaining three were all open questions designed to collect qualitative data and asking questions about health beliefs and their interpretation of the meaning of health promotion.

The remaining six questions were designed to collect factual demographic details. Questions were asked relating to gender, ethnicity, age, professional and academic qualifications. A question relating to the subjects taught and the length of time in employment as a teacher were also included (see appendix 8 for final questionnaire).

The Validity and Reliability of the Questionnaires

The validity and reliability of the questionnaires was regarded as essential for two reasons, although the student questionnaire was designed to measure changes in students perceptions over time, there was also a developmental element in that it was anticipated that it could possibly be used as both a formative an summative evaluation tool.

Reliability

The revised questionnaire for students was also subjected to inter-rater reliability testing in both the pilot and main stages of this study. Because the it was administered by the researcher, this was perceived as an essential component in the reduction of bias. Testing for internal consistency of the scale was carried out on the student questionnaire on completion of the final data collection. The questionnaire for teachers was also tested for inter rater-reliability at the pilot stage. The coding documents are included in appendix 8.

Content Validity of the Student Questionnaires.

The method for assessing both construct and content validity of the student and teacher's questionnaires was to formulate a content validity index. These indices consisted of two scoring grids incorporating each item on the scale. A team of three nurses with professional and academic qualifications in nursing and health promotion were to be given these grids in conjunction with copies of the research proposal and the questionnaires. Ratings were requested on the following dimensions:

- How did each question reflect the intentions of the research proposal?

- How well did the questions relating to the construct of health promotion represent the concept of health promotion?

- What additional questions could have been included that could improve the quality of the data to be collected.

- What improvements could be made to existing questions?

Prior to the execution of this procedure, the inventories were piloted by two nurse teachers with experience in these research methods, amendments were made in the light of their comments. The inventories were then distributed to a team of three senior nursing academics, one with an international reputation in nursing and health promotion, the other two were both experienced senior nurses and academics. A four point rating scale was used to indicate whether an objective was mostly relevant, relevant, partly relevant, or not relevant. This procedure cited by Lyn (1986) was used to calculate the number of raters who can be in disagreement on any item on a significance rating at a 95% level to be upheld. Lyn (1986) considered an adequate number of experts to be five with lower and upper limits of three and ten. For the three raters, one rater may disagree with one question/item without questioning the validity of the content or constructs. When two question the content validity of the same items they are not considered valid.

Results

The results of this exercise are contained in appendix 9. None of the items in either the student questionnaire or the teacher questionnaire were rated as being non content valid and can be considered as being content valid at 50/50 or 100% according to Lynn (1986). However, it was felt these results were spurious, especially in relation to the items on the student questionnaire relating to the political nature of health promotion. One rater had negatively rated these two items, but offered no advice in helping to resolve the problem, this may have been resolved had there been more raters. Rather than alter the questions, as stated previously, Streiner and Norman's (1989) recommendations for the development of construct validity were followed, thus these questions remained unchanged at this stage

Pilot Investigation of the Data Collection Instruments.

Pilot studies on both questionnaires were carried out in a college of nursing in central London independent from the college in the study. Fifteen students from two cohorts of a total of 120 following Project 2000 programme were randomly selected. Every fifth person on the alphabetical class registers was selected and asked to complete the questionnaire at an allotted time on their programme. This was not a random sample of the total student population, but a random selection of students in the college at that time. The questionnaire was administered by a teacher with experience of these particular research methods who was fully briefed on the design and methods of administration of the instrument. We both scored the results and compared and discussed our results for inter- rater reliability.

The purpose of this pilot was to ascertain whether the questions were clearly understood, to detect any ambiguities and to ensure that the data was analysable. The results are displayed in Appendix 9. As a result of this, pilot, it appeared that in fact the questions were clear and the data analysable. The questions that were considered problematic were answered in a manner indicating that meaningful correlations could be made. For example, one student who strongly agreed with the statements that students should take an interest in current affairs, and that health promotion was an important element of the nurse's role, also indicated that she did not think nurses should be involved in politics, but in the question asking her to give her reasons for that response said;

"Our role is to help patients achieve optimum health and not in ruling the country."

Since the decision had been made to include only students on the branch programme, the question relating to the which course they intended to follow was excluded. Alterations were made to the presentation, in that the font size was increased rendering it more legible a section was included to facilitate open coding methods and the size of the tick boxes was increased.

A similar procedure for piloting the teacher's questionnaire was carried out. There were at that time one hundred teachers in this college and every fifth name on the alphabetical list was selected. In all 20 questionnaires were distributed to teachers, including the principal of the college, eighteen were returned, giving an overall response rate of 90%. The content of the questions seemed to be clear, only one response to the demographic data received a negative response, in that comments were made regarding the irrelevance of collecting data on age and ethnicity to professional groups. Helpful comments were made regarding the layout and presentation of the questionnaire.

To conclude, this chapter has described and justified the strategy adopted in the research reported in this thesis. In terms of research design it involved a three-phase longitudinal study of students in three colleges of nursing, with a substantial sample of 153. In relation to data collection, earlier work in the development of questionnaires was developed further and re-tested for reliability and validity. The student questionnaire focused on determining health beliefs, the perceived importance of learning about health promotion and their perceptions of the concept, in relation to their role as nurses. The aim of the teacher's questionnaire was to determine their understanding of the concept and it's importance in the curriculum. It was also intended to be a vehicle for the provision of a framework for focus group discussion.

There are certainly ways in which the design and instrumentation deployed might have been further strengthened. Nonetheless it seems to be a robust study in methodological terms in that:

- the structure is large-scale;
- the design has all the benefits of a longitudinal approach;
- the instrumentation has been carefully tested.

This is the basis of the work, to whose analysis and interpretation, the main body of this thesis is directed.

CHAPTER 7

PROFILE OF THE STUDENT SAMPLE

In this chapter a profile of all of the student population is presented. The data are examined in the context of the respective institutions in which they were situated, and comparisons are made to determine the similarities and differences between the groups. This includes an analysis of the students' age, gender, ethnicity, social class and educational achievement. Testing for statistically significant differences were made by application of the Kruskall-Wallis test for several independent samples, and the Mann-Witney test for two independent samples with $p<0.05$.

The Geographical Location of the Colleges

Blackstone was a college of nursing and midwifery in central London and at that time was funded by North East Thames Regional Health Authority. It was a product of the amalgamation of two schools of nursing in London Teaching Hospitals in the 1980s and had a historical tradition of training nurses since the 1860's. The students' clinical experience in hospitals was to be gained in four hospitals which were all within close proximity to each other and the College, all the classroom teaching took place within the main college building. Community nursing experience was gained in the local Community NHS Trust. This made access to all the areas where teaching took place relatively easy. Central London also has a plethora of voluntary organisations attempting to address the health and social needs of its diverse population. A wide network of organisations were involved in providing what were called "non-institutional" placements for students in their Common Foundation Programme. At the time the study commenced this College was in the initial process of becoming integrated into one of the colleges of London University. The course that these students were following was validated by the University.

By contrast, Waverly was situated in the home Counties north of London and was part of Oxford Regional Health Authority. This College of Nursing and Midwifery had also experienced rationalisation in the 1980s and was the product of the amalgamation of several small schools of nursing throughout the county. Clinical experience for these students took place in four hospitals all between ten and fifteen miles apart, two in rural areas and the other two in the main towns in the county. Classroom teaching was centralised on two sites in the environs of the District General Hospitals in the two main towns. Community nursing experience was provided by two community NHS Trusts in the area. In the absence of the multiplicity of voluntary and non governmental organisations in this locality, an imaginative use of the occupational health services in large business organisations had also been utilised for students to gain additional observational experience of health care in their Common Foundation Programme. Negotiation for transfer to higher education was in progress with two universities in the region, their Project 2000 course had also been validated by one of them.

The location of Chiswell was in some ways similar to Waverly. The College was situated in the main town in a county in the north west of England, bordering onto North Wales and Merseyside. This College was in the final stages of transfer into higher education and the College had become integrated into a College of Higher Education affiliated with the largest University in the region. The main educational site was located in this College on the outskirts of the town. The common Foundation Programme was co-ordinated and taught from this centre, but the branch programmes were accommodated on the hospital sites. Clinical experience was provided in four widely dispersed hospitals in the area. Community nursing experience and observational placements for students on the common foundation Programme followed a similar pattern to Waverly.

The Students

According to the curriculum documents for each school, approval had been granted by the English National Board for Nursing Midwifery and Health Visiting for two intakes per year to commence a pre-registration course leading to the award of a Diploma in higher Education (Adult Nursing) with the professional award of Registered Nurse (Adult Health). The student numbers for these cohorts is as follows:

Table 1 - 7
Cohorts and numbers of students approved for training in each institution per annum

School	March	September
Blackstone	60	60
Waverly	50	50
Chiswell	58	58
TOTAL	168	168

One cohort of students from each school commencing in March 1994 and one in September 1994 were surveyed over a three year period at three points in their programmes; at the beginning of the common foundation programme, the end of the common foundation programme and on completion of the branch programme once they had completed all their clinical and theoretical assessments. These points are referred to throughout the study as, Time 1, Time 2 and Time 3.

Response Rates

Of a possible total sample of 168 students from each of the three cohorts, a final sample of 153 students was surveyed at the first wave. This represented the total student population at that time and the response rate was determined as being 100%. On comparing the response rates at times 2 &3 as illustrated in table 2 it can be seen that there is a sequential reduction in total response from 100% to 77.8% to 65.4% or an overall 34% total reduction in response. This clearly reflects one of the main problems in longitudinal design. Burns and Grove (1995) in discussing the problems of longitudinal design in the context of epidemiological studies, attribute the problem

to a bias in the selection of subjects due to long-term commitment, as well as the loss of subjects due to mortality. However, here the problem appears to be related to one of commitment in that there was an insignificant overall attrition rate of students in any of these courses. Figures were also adjusted for students who had transferred from one branch programme to another. It appears that the key reason for students not being in the room at the time the questionnaire was administered were due to illness, compassionate grounds, attending job interviews (in their final year), or else not going to college that day.

Table 2 - 7

Response Rates

Response Rates	Frequency
Time 1	153(100.0%)
Time 2	119(77.8%)
Time 3	101(65.4%)
n	153

Another reason for the lower response rate at Time 3 in Chiswell was due to the fact that in the branch programme ten students had been separated from the main cohort, they had been taught and allocated clinical experience in a hospital twenty miles away. The implications of the logistics involved in obtaining data from this group had not been fully realised during the planning stages for this final phase of the data collection. Indeed, it was not apparent that the students had been separated until the time of the last survey. At her suggestion, questionnaires were left with the lecturer facilitating the main group, she offered to organise their distribution. An arrangement was made for the completed questionnaires to be returned by post in the next two weeks. However they did not materialise. A subsequent telephone conversation indicated that this plan, had been too difficult to execute.

Gender

One hundred and fifty two out of the total of 153 responded to this question. The

gender distribution of the sample was 130 (85%) women and 22 (15%) men. Table 3 shows the distribution of men and women students in each school.

Table 3 - 7

Gender Distribution of Students in Each School

	Blackstone	Waverly	Chiswell
Men	10(17.2%)	6(14.0%)	6(11.5%)
Women	48 (82.8%)	36(83.7%)	46(88.5%)
Missing	0	1(2.3%)	0
Total n = 153	58(100%)	43(100%)	52(100%)

This distribution of men to women in each school is fairly equable. The ENB does not publish figures based on the gender distribution of students. From its embryonic database at that time, the UKCC (1986) concluded that of the total population of nurses in training in the UK 10% were men, but only 6.7% were in training at that time as Registered Nurses (that is first level nurses), with the majority of these being in mental handicap (25%) and mental health nursing (32%). The remaining 3.3% were training to be second level (enrolled) nurses. The numbers in this sample correlates more closely with a ratio of 2:10. As the UKCC (1986) state, the collection of useful manpower information for nursing and midwifery staff is extremely difficult, what is available is generally unreliable. Therefore, although the numbers in this sample correlate with a ratio of 2:10, it is difficult to assess accurately whether this rise reflects a national trend. However, it was not thought that this proportion of men to women should have a significant impact on the results of this analysis. The more rational conclusion is that the majority of this sample are women and historically, general nursing has been a female dominated occupation.

Age

There was a 100% response rate to this question. There was a wide variation in age ranging from 17-48 years with a mean of 23.4 years and a standard deviation of 6.99. The mean age for all students in all three colleges is as follows:

Table 4 - 7

Mean Age of Students by College Location

School	Mean	Std Deviation	n
Blackstone	22.6	5.16	58
Waverly	24.2	8.27	43
Chiswell	23.73	6.68	52

These figures are similar to those in the first study. The age range of this sample population appear at first to be slightly higher than those published by the UKCC (1986). In their profile of students in training for registration as first level nurses, prior to the implementation of Project 2000 courses, almost three quarters of first level nurses were under 21 and only 5% were under 30. A closer examination of these figures reveals that 54.4% of the total sample were aged under 21 years, only one student (0.4%) in Waverly, was under 18, 31% were aged 21 to 30 and 15% were over 30, indicating that these students were slightly older. Without the means to compare these figures with more recent statistical evidence it is hard to say whether the age range of these students was higher than the national average.

Education

The level of educational achievement was varied. The minimum educational requirements for entry to nurse education were described in chapter 5, these requirements had not changed. What had been recommended was that:

> " Formal entry requirements for courses leading to registration with Council should be such as to encourage entry from a broad ability range, and to attract into the professions persons from diverse backgrounds. The Project Group considers that the present entry requirements set by Council for first level nurses offer flexibility for broad entry via the rout of possession of a specified number of "O" levels, via the route of possession of an acceptable equivalent, or via the route of success in Council's educational test. The experiments which council has endorsed concerning access courses, and which are described in its Annual Report 1984-5, if successful and continued, will offer, a further route to entry" (UKCC 1986).

This change in thinking about non-vocational training is reflected in general education, with the development of non-vocational qualifications for students who were not academically inclined. Initial observation of the data indicated that these changes should be reflected in the data analysis. Consequently, the data was classified and scored on a scale relating to minimum and maximum achievements, as well as overseas qualifications. Seven discrete levels of achievement were identified.

In order to make the data analysis more manageable, the acceptable qualifications that closely related to the traditional entry requirements were included in these categories and are:

1 DC test, CSE, GCSE.
2 DC test, CSE, GCSE plus other equivalent qualifications such as NVQ qualifications.
3 5 GCSE/ O levels.
4 5 GCSE/O levels plus other equivalent such as BTEC
5 GCSE A level
6 GCSE A level plus degree
7 Overseas equivalent.

The cumulative response rate to the question relating to education was 99.4% with one student not responding. The frequency distribution for these subjects is identified in table 5.

Table 5 - 7

Frequency Distributions of Educational Achievement - Total Sample

Education	Frequency
DC Test, CSE, GCSE	3(2.0%)
DC Test, CSE, GCSE, Other	11(7.2%)
5 GCSE/O Level	46(30.1%)
5 GCSE/O Levels, Other	13(8.5%)
5 GCSE/O Level/A Level	61(39.9%)
GCSE/A Level/ Degree	10(6.5%)
Overseas Equivalent	8(5.2%)
Missing	1(0.6%)
Total	153(100%)
n = 153	

From this it is seen that 39.3% achieved the minimum educational requirements and 5.2 % had equivalent overseas qualifications, these were mainly Irish Higher Leaving Certificates. The majority of students possessed more than the minimum requirements with 8.5%(13) having 5 GCSE subjects plus a BTEC qualification; 39.9% (61) having A levels and the remaining 6.5%(10) being graduates. No attempt was made to categorise these degree subjects since perusal of the raw data indicated that the majority were in humanities or social sciences, it was concluded that the small number of graduate students would have no statistical significance on the final outcome of the study. What was interesting to note however, was that seven of these graduate students were from Blackstone, while the students who had entered nursing with educational qualifications other than the traditional GCSE/GCE qualifications apart from one, all were from Waverly and Chiswell, there were no graduate students in Chiswell. The profile across the schools is as follows:

Table 6 - 7

Profile of Students With Non-Vocational Qualifications

Qualification	Blackstone	Waverly	Chiswell
NVQ	1	1	1
BTEC	2	5	7
OND	0	1	0
HND	0	1	0
Degree	7	3	0
Total	10	11	8

Although three Waverly students were graduates, the overall profile equates more closely with Chiswell in that they had similar numbers of students with NVQ and BTEC qualifications. Waverly also had one student with an Ordinary National Diploma and another with a Higher National Diploma, both of these being in health studies. The conclusion to be drawn from these figures, is that Blackstone students tended to be better educated, a feature of teaching hospitals that is historically and empirically acknowledged (Dustagheer 1989; Maggs 1983), while Waverly and Chiswell students, although not as well educated in conventional terms, were

reflecting the recommendations of the original UKCC (1986) Project Group, in that they were attempting to broaden access to nursing by selecting and recruiting students from a less traditional pool.

These observed differences were then tested for statistical significance. Since the data had realised non of the assumptions of normal distribution, non parametric tests were used. The Kruskal-Wallis test for the measurement of several independent samples indicated that there was a significant difference in educational achievement between the schools with $p<0.05$ (Chi squared = 12.589 at 2df). Further exploration using the Mann Whitney test for two independent samples indicated that there was a highly significant difference between Blackstone and Chiswell with $p<0.05$ ($z = 3.634$ 2 tailed p value 0.00). It had also been noted that 40.1% of the total sample had been educated to A level standard. There was no significant variation in educational achievement between the schools regarding GCSE or equivalent entry requirements. There were significantly more students with A levels in Blackstone and Waverly than Chiswell. These results are s displayed below.

Table 7 - 7

Students With A Levels

Blackstone and Waverly	z = -2.632 with 2 tailed p value 0.008
Blackstone and Chiswell	z = - 3.042 with 2 tailed p value 0.002
Waverly and Chiswell	z = - .261 with 2 tailed p value 0.794

Ethnicity

For the reasons mentioned in the previous chapter two questions had been asked relating to ethnicity. In the first the students were asked to state their country of birth and in the second they to describe their ethnic origins.

Country of Birth

A cumulative response rate of 99.3% was achieved with 152 of the 153 students

responding to this question. The frequency distributions are shown in table 8.

Table 8 - 7

Where the Students were Born - Total Sample

Country of Birth	Frequency
United kingdom	129(84.6%)
Republic of Ireland	15(9.4%)
Africa	5(3.3%)
Other	3(2.0%)
Missing	1(0.7%)
Total	153(100%)
n =153	

These figures are interesting, in that there were very few students born outside the United Kingdom the majority of these 9.4% being from the Irish Republic. Table 9 indicates that Waverly accounted for the majority of Irish students (18.6%), there were 5 (8.7%) Irish and two African students in Blackstone.

Table 9 - 7

Where The Students Were Born - In Each School

Country of Birth	Blackstone	Waverly	Chiswell
UK	51(87.9%)	32(74.4%)	46(90.4%)
Irish Republic	5(8.7%)	8(18.6%)	2(3.8%)
Africa	2(3.4%)	1(2.3%)	2(3.8%)
Other	0	2(4.7%)	1(2.0%)
Total	58(100.0%)	43(100.0%)	52(100%)
n = 153			

Ethnic Origins

However, it is more useful to consider these figures in conjunction with the responses to the question asking students to describe their own ethnic origins (table 10). Interestingly enough, when the questionnaire was first administered some students did not understand the term ethnicity and asked for clarification. Others made guesses and appeared to confuse the term with perceptions of "normality," stating that they were "normal", or religion making comments such as "Church of England, but not

regular church goers." No such comments emerged at subsequent stages of the data collection.

It was observed that the overall response rate also fell to 88.3% with 18 not responding to this part of the question. This may be because they didn't understand the question, or that the subject area was indeed too contentious or sensitive (Oppenheim 1992). This problem was not apparent in the piloting stages.

Table 10 - 7

How Would You Describe Ethnicity? - Total Sample

Ethnicity	Frequency
White/British/European	120(78.4%)
Irish	9(5.9%)
African	1(0.7%)
Other	5(3.3%)
Missing	18(11.7)
Total n = 153	153(100%)

Although the overall numbers of students who were either born overseas or reported themselves to be from ethnic minority groups was very small. Comparison between the schools (table 11), indicated that there were no students in Chiswell from any ethnic minority groups, four students in this group had said that they had been born in either Africa or the Irish Republic, and one had been born in Borneo, yet they all described themselves as white, or British. While there are no discrepancies in Blackstone regarding reported ethnicity and country of birth, in Waverly eight students stated that they were born in the Irish republic, yet only four described their ethnic origins as being Irish. The one student in Waverly who was born in Africa reported her ethnicity as African, and three others described their ethnic grouping Asian although only two stated they were born overseas.

Table 11 - 7

Ethnicity of Students in Each School

Ethnicity	Blackstone	Waverly	Chiswell
White/British/European	42(72.5%)	31(72.1%)	47(90.4%)
Irish Republic	5(8.6%)	4(9.3%)	0
African	2(3.4%)	3(7.0%)	0
Other	0	1(2.3%)	0
Missing	9(15.5%)	4(9.3%)	5(9.6%)
Total n = 153	58(100%)	43(100%)	52(100%)

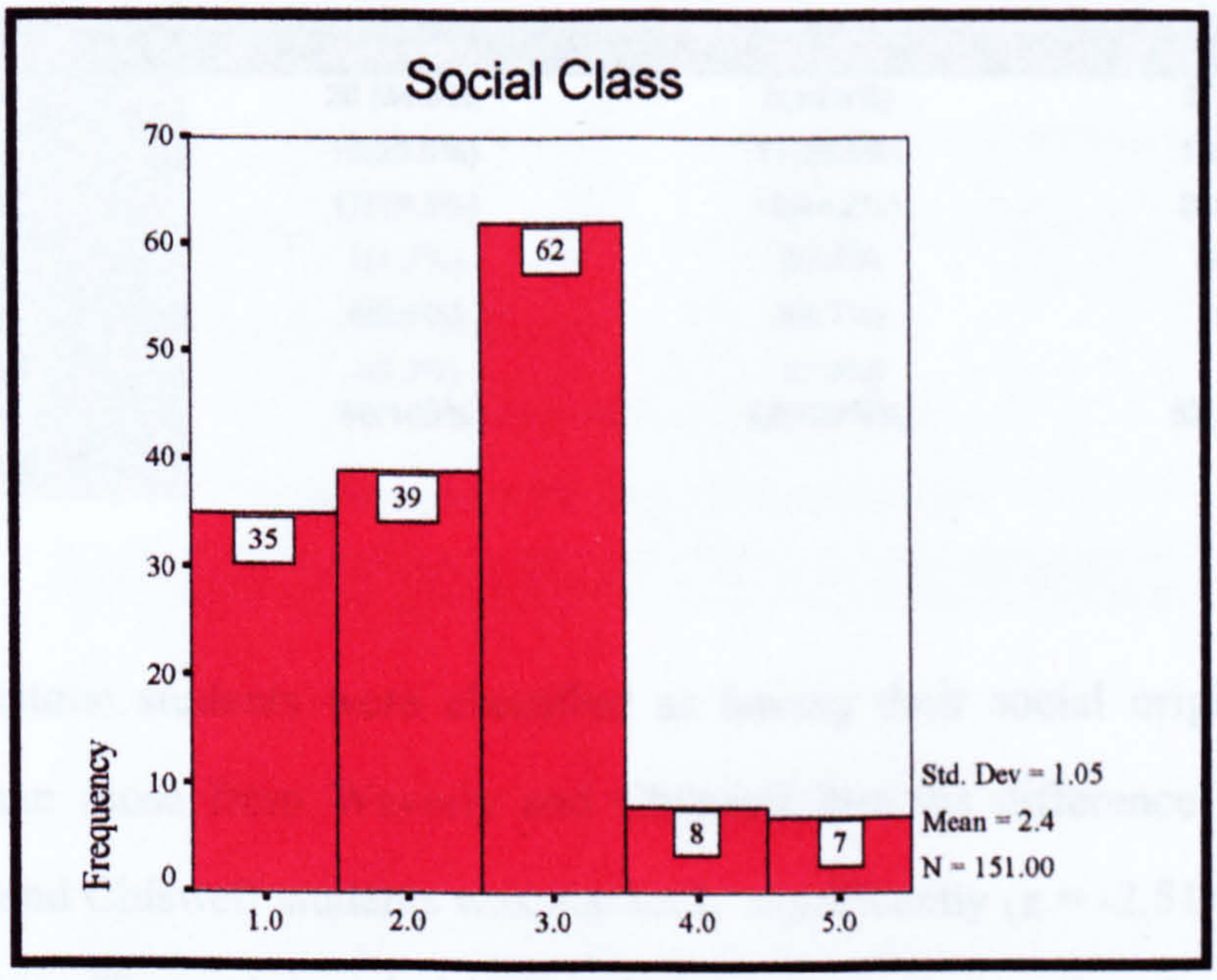
Social Origins

Data relating to the social origins of the sample was obtained by asking students to report the occupation of both parents, with the student's father's occupation denoting social class. If only one parent's occupation was recorded this response was coded, regardless of gender. These were then compared with, and organised according to the Registrar General's classification. This methodolgy was utilised for the following reason, in that although the Registrar General's classification of class is frequently used in social research Marxist theorists are critical in that it does not explain the generation of inequalities in the structural dynamics of society, it only describes the results, (Nichols,1979). Some women students were likely to be married and could have recorded the occupation of a spouse to denote social class, this was deemed to be an inappropriate method since it would have produced spurious results.

There was a 98.7% to this question with only 2 students not responding and a mean score of 2.42. The frequency distributions are demonstrated in table 12.

Table 12 - 7

Distribution of Social Origins Of The Total Sample



Clearly, the sample did not meet any of the assumptions of a normal distribution curve. The majority, 41.1% originating from Social Class 3 (according to the Registrar General's classification). However, given that the sample consisted mainly of women, the distribution does correspond with what is known historically about the social origins of women entering lower professional occupations (Witz in Robinson and Richardson 1993).

It was also observed, that a relatively large proportion belonged to social class 1 (35, 23.2%) and social class 2 (39, 25.8%). When the social origins are analysed further (table 13), there are significant differences in the distribution of the students' social origins between the schools (Chi squared = 6.970 at 2df).

Table 13- 7

Social Origins of Students Between Schools

Social Class	Blackstone	Waverly	Chiswell
One	20 (34.5%)	8(18.6%)	7(13.5%)
Two	15(25.9%)	11(25.5%)	13(25.0%)
Three	17(29.3%)	19(44.2%)	26(50.0%)
Four	1(1.7%)	2(4.7%	5(9.6%)
Five	4(6.9%)	2(4.7%)	1(1.9%)
Missing	1(1.7%)	1(2.3%)	0
Total	58(100%	42(100%%)	52(100.0%)
n = 153			

More Blackstone students were classified as having their social origins in social classes 1 than those from Waverly and Chiswell, but the difference between the Blackstone and Chiswell students was markedly significantly (z = -2.51 with 2 tailed p value 0.012). Thus it is concluded that although the majority of students originated from social classes two and three, there were more significantly more students belonging to social class one in Blackstone than in Chiswell.

Employment Profile Prior To Entry To Nursing

The students' work experience was similar to that of students in the previous study. Regardless of educational attainment, age or social background many reported a multiplicity of experiences in health and social care in either NHS or non governmental organisations, such as working with the elderly in NHS hospitals or private nursing homes, with people with learning disabilities and with children. They also reported having worked in service industries such as hotel and catering, pubs, shops, offices and factories.

Due to the diversity of these experiences it was not possible to code the data in terms of paid or unpaid work or for that matter different types of healthcare settings. It was more appropriate to generate manageable categories reflecting work within or

outwith healthcare, or a combination of both. Four categories were identified, the first was related to employment solely in health and social care settings, the second determined the number of students who had experienced in work within health and social care and other service industries, while the third identified those with experience in other service industries, a fourth category was utilised to elicit students reporting having no work experience at all.

Table 14-7

Employment Profile - Total Sample

Work	Frequency
1 Paid & unpaid health & social care	70(45.8%)
2 Paid & unpaid health & social care & other work	57(37.3%)
3 Other work	20(13.1%)
4 No reported employment	6(3.8%)
Total n = 153	153(100.0%)

The results displayed above indicated that in fact 45.8% of the sample had worked in health and social care, 37.3% had been employed outside these environments. Only 13.1% had not experienced work within health and social care settings, and 3.8% reported not having worked at all. Five of these six students reporting no work experience were all aged between 18 and 19 years, there was one 45 year old. With regard to the younger students, it could be construed that they were recent school leavers, who did not regard voluntary work or "work experience" schemes at school as worthy of mention. This seemed likely, since re-examination of the responses revealed that some of the younger students mentioned working in hospitals on pre-nursing courses, voluntary ambulance work or voluntary work with charities such as Age Concern. The response from the older student is surprising, but may be because work involved as a mother caring for children or elderly relatives was not perceived as being important. This may certainly be so since other mature students

mentioned the unpaid work they had done with regard to childcare and housework, in conjunction with paid employment.

The overall pattern of work reported work experience appeared to indicate that there was very little difference between the schools (table 15). There were indeed no statistically significant variations in these patterns of employment prior to entry to nursing.

Table 15-7

Employment Profile Between The Schools

Employment	Blackstone	Waverly	Chiswell
Paid & unpaid health a social care	25(43.2%)	21(48.8%)	24(46.2%)
Paid & unpaid health & social care/other	22(37.9%)	14(32.6%)	21(40.4%)
Other work	9(15.5%	5(11.6%)	6(11.5%)
No work reported	2(3.4%)	3(7.0%)	1(1.9%)
Total n = 153	58(100%)	43(100%)	52(100%)

Summary

This analysis indicated that the overall student population was fairly homogenous, consisting of predominately white lower middle class women. The feminist literature, both in the USA and the UK, has explored the gender differences in access to the professions for many years (Doyal, 1979; Witz 1993). For example, Witz (1993) offers a useful analysis of gender segregation at work. Gender segregation in the workplace accounts for the concentration of men and women into different places of work occupations and jobs (Reskin and Padavic, 1994). There are two dimensions of occupational segregation; horizontal segregation describes the construction of occupational hierarchies as gender hierarchies. In Britain about one quarter of occupations are typically female, with the majority being typically male (Hakim

1993). Women tend to work in a narrow range of occupations such as, secretarial work, hairdressing, catering, cleaning, welfare and health. Vertical segregation illustrates how men tend to predominate in higher-level occupations such as middle and senior management in both professional and managerial work.

While this analysis useful, it also needs to account for the movement towards the regenderisation of occupations since the 1970s. Witz (1993), describes how typesetting and compositing became resegregated in the 1970's, changing from being a female dominated to a male dominated occupation with the development of computer technology and information systems. She also cites examples of the hospital pharmacy in Britain becoming more vertically segregated as women tend to become "ghettoised" into lower practitioner niches, while male pharmacists tend to dominate senior posts which combine with professional and managerial skills (Crompton and Sanderson, 1989). This is equally true of medicine and nursing where there is an equally inverse proportion of men to women in senior positions.

Walby (1997), argues that there has been a significant change in the distribution of women in the occupational structure since the 1980's in Britain, with women achieving higher levels in professional and managerial occupations with the number of women increasing by 55% compared with only 33% of men. This Walby (1997) attributes to women becoming better educated. This analysis is interesting in the context of the analysis of the gender, ethnic grouping and educational achievement of this sample. It would appear that the sample reflects a rather horizontal view of gender segregation in terms of their occupational structure.

However, while there are similarities between the groups, there are also differences. There was a wide distribution in age across the total sample ranging from 17-48 years

of age, with a mean of 24.61 years. Comparison between groups revealed that, in Blackstone, the mean was 22.6 years, in Waverly 24.2 years and Chiswell 22.73 years. The picture for educational achievement was also similar in many respects. But, although the majority of students had achieved far more than the minimal educational requirements for entry to nursing, there were very few graduates and these tended to be in Blackstone. Of those students who had A levels, a statistically significant number were in Blackstone. Waverly and Chiswell appeared to be adopting a less traditional approach to recruitment, with more students having BTEC qualifications, which for entry purposes can be equated with A levels. Very few of the students had overseas qualifications and those that did were predominantly from the Irish Republic.

In fact, the proportion of students reporting to belong to ethnic minority groups was very small. No figures are available in which to determine whether this is significant. The ENB only began to monitor and publish figures of students from ethnic minority groups in 1997/98. The ENB Annual Report for these years also revealed how ad hoc these arrangements were and consequently how unreliable these figures were. For example, of the total number of 7,905 students in England enrolled on Adult (General Diploma) programmes at this time, 3,479 were classified as white, 3981 were "not specified" (the ENB's words), and only 435 of the total number of students in England enrolled on these courses were identified as belonging to a particular ethnic group (appendix 10).

The very small number of students reporting their ethnicity as Irish, or having been born in the Irish Republic is also worthy of comment. Historically, nurses have been recruited from Ireland. Maggs (1989), in his study of the Origins of General Nursing between 1881 and 1921 remarks on this, and also notes that they tended to be recruited to the Poor Law hospitals rather than the Voluntary hospitals. He also noted that nurses at this time tended to conform to generally accepted patterns of female

migration in the nineteenth century. That is, there was a continuous movement from rural to urban areas, which were mainly short distances. Long distance migration was to large connurbations of commerce and industry.

Colleges of nursing have also continued to actively recruit student nurses from the Irish Republic, as well as from areas in Britain where there are large Irish immigrant populations. Yet, this picture does not emerge in this sample population. It is too simplistic to conclude that this sample was not representative of the nurses in training at that time. A further examination of the geographical location of the colleges is required.

Blackstone was a college of nursing in central London which served a local teaching hospital, although it also served the needs of the local population, which was very cosmopolitan and had a large Irish immigrant population, applications for entry to nursing were wide ranging and recruits were generally from outside London and conformed to the pattern of recruitment of better educated middle class women, that have historically been associated with the London Teaching hospitals. Waverly was a college in the home Counties. According to the course co-ordinator for these students, recruitment was generally from the local population, this is reflected in the data. Chiswell was interesting in that it was situated in the North west of England, very near to a large city with a long history of migration from Ireland. However, the college was situated in the main town of an adjacent and very prosperous county. Recruitment also tended to be mainly from the local population. These patterns of recruitment tend to follow Maggs (1989), observations of the 19th and early 20th century migration of women into recruitment in nursing. However, this still does not entirely explain the reasons why this sample was so homogenous.

The context of the change that was occurring in nursing recruitment needs to be addressed here. Certainly the number of initial entries to nursing on both traditional

and Project 2000 programmes for all specialities except children's nursing had fallen between 1990 and 1993 (ENB appendix 10). This is acknowledged by the NHS Executive. Gill Newton Head of NHS Workforce Planning and Education at that time, reported that, student intakes had been increased between 1994 and 1996 by 5% and 15%, with wastage between 1994 and 1995 averaging at 15%. Newton (1996) also stated that for every place on a Project 2000 course there were two suitable applicants. In order to maintain healthy levels of applications, institutions were being encouraged to concentrate on local recruitment, and target male and mature students. This paucity of students from Ireland may well reflect the changes in approaches to recruitment at that time, or from a more cynical perspective, these avenues of recruitment were not being exploited because recruitment to nursing was being reduced.

The employment experience of these students prior to entry to nursing is interesting, in that they do reflect the types of occupation that have been traditionally recruited to nursing (Abel-smith, 1960; Maggs, 1989), in that they had worked in care settings such as with the elderly, or people with learning difficulties. What is also worthy of note, is that, even if they had no previous work experience in caring environments they had experience of working in service industries, and in the type of unskilled or semi-skilled employment that is the usual domain of young people before moving into higher education.

All of the students were predominantly from social classes 1, 2 and 3. However, 51% from Blackstone, belonged to social classes 1 and 2, whereas in Waverly and Chiswell the majority were from social class 3, the difference in the number of students in social classes one and three between Blackstone is significant. Very few students were male although it was difficult to generalise here, it appeared that there were more than was considered the norm for men in nursing.

Thus, this analysis has revealed that the total student population consists of young, middle-class women of above average educational attainment. However, It has also been established that there appear to be some significant differences between the groups. Blackstone appears to reflect the type of student that has been traditionally accepted into colleges of nursing in teaching hospitals, while the student population in the other two colleges are, overall slightly older, tend to be less well educated, and of mainly lower middle class social origins, which is also a reflection of the general trend in the recruitment of nursing students at that time.

CHAPTER 8

CHANGING PATTERNS IN STUDENT PERCEPTIONS OF HEALTH PROMOTION

As is well documented in the health psychology literature, the perceived importance of a phenomenon, is an important antecedent to any behaviour change. By the same token, the perceived importance of the construct of health promotion, may be an important precursor of assessing the value that individuals place on health promotion.

The previous chapter defined the characteristics of the students. Here, the focus is on the process of unwrapping their perceptions of health promotion as they progress through their course. As stated in chapter two, the heart of any understanding or perception of health promotion is an analysis of health beliefs. Therefore the data presented identifies the students health beliefs and proceeds to examine their perceptions of the importance of health promotion in nursing. It continues with an examination of their beliefs about the importance of learning about health promotion and concludes with an exploration of their interpretation of the construct. At each point in time perceptions are reported and observed differences between the schools tested for significance. Changes over time are then compared and measured for significant change. Finally emerging salient factors are presented and discussed. Issues related to the possible reasons for any change are addressed in subsequent chapters. Throughout this chapter a framework for analysis derived from an examination of the initial baseline data is utilised. Testing for statistically significant differences continued to utilise the Kruskall-Wallis test and where appropriate the Mann Witney test. Significant changes over time were calculated by the application of the Friedman test for several related samples. In all instances the significance level was $p<0.05$. In all instances frequency distributions are presented as valid percentages.

Perceptions of "New Students"

What the Students Believed About Health

The students health beliefs were analysed using Blaxter's (1990) framework of nine definitions of health. The health beliefs of the total sample were initially surveyed and analysed at the commencement of their respective courses. Comparisons are made to elicit differences between the schools. Not unexpectedly multidimensional concepts were expressed. These were coded and categorised according to the order in the text in which they had expressed their ideas. The reliability scores for these categories can be found in appendix 11. The frequency distributions are presented in table 1. These multidimensional concepts are labelled and referred to as first, second and third beliefs.

Table 1 - 8

Time 1 - Total Sample.

What does "being healthy" mean to you?

Multidimensional Concepts of Health

Being Healthy Means	1st Belief	2nd Belief	3rd Belief
Not ill	41(26.8%)	1(0.7%)	0
Despite disease	4(2.6%	0	0
A reserve	4(2.6%)	0	2(1.3%)
Living a healthy life	66(43.1%)	16(10.5%)	0
Physical fitness	5(3.3%)	12(7.8%)	0
Energy & vitality	2(1.3%)	0	1(0.7%
Social relationships	2(1.3%)	0	1(0.7%)
Means to an end	4(2.6%)	3(2.0%)	1(0.7%)
Well-being	23(15.1%)	14 (9.1%)	6(4.1%)
Missing	2(1.3%)	107(69.9%)	142(93.8%)
Total n = 153	153(100.0%)	153(100.0%)	153(100.0%)

There was a 98.7% response rate to the question with all the students mentioning reasons for being healthy that approximated Blaxter's categories. These results were similar to the pilot studies. The fact that only 46(30.1%) of the total mentioned two and 11(7.2%) mentioned three reasons for being healthy also seemed to concur with her observations that younger people tended to express fewer dimensions of health. Although the students' age range was diverse, they were mainly young women and

this is reflected in their mean age, of 23.4 years. When the responses in the first column (1st belief) were examined. The most frequently mentioned categories were related to not being ill 41(26.8%), living a healthy life 66(43.1%) and well-being 23(15.1%). From these figures it would appear that students, on entering training perceived health from a biomedical perspective, but when the figures from those students expressing multidimensional concepts are examined, this explanation seems rather simplistic. A total of 82(53.6%) students also mentioned "living a healthy life" and 43(28%) feelings of "well-being" as reasons for "being healthy".

When comparisons between the school are made it was observed that there were differences as is demonstrated in table 2.

Table 2 - 8
Time 1 - Comparison of Schools
Multidimensional Concepts of Health

Being Healthy Means	1st Belief	2nd Belief	3rd Belief
Blackstone	**Blackstone**	**Blackstone**	**Blackstone**
Not ill	22(37.9%)	0	1(1.7%)
Despite disease	1(1.7%)	0	0
A reserve	3(5.2%)	0	0
Living a healthy life	24(41.5%)	5(8.6%)	0
Physical fitness	2(3.4%)	9(15.5%)	0
Social relationships	0	0	1(1.7%)
Energy and vitality	2(3.4%)	0	1(1.7%)
Means to an end	0	0	0
Well-being	4(6.9%)	7(12.1%)	0
Missing	0	37 (63.8%)	55(94.9%)
Total	58(100%)	58(100%)	58(100%)
Waverly	**Waverly**	**Waverly**	**Waverly**
Not ill	11(25.6%)	0	0
Despite disease	1(2.3%)	1(2.3%)	1(2.3%)
A reserve	0	0	0
Living a healthy life	13(30.2%)	2(4.7%)	0
Physical fitness	2(4.7%)	3(7.0%)	0
Social relationships	1(2.3%)	0	0
Energy and vitality	0	0	0
Means to an end	3(7.0%)	2(4.7%)	1(2..3%)
Well-being	12(27.9%)	5(11.5%)	2(4.7%)
Missing	0	30(69.8%)	39(90.7)
Total	43(100%)	43(100%)	43(100%)
Chiswell	**Chiswell**	**Chiswell**	**Chiswell**
Not ill	8(15.4%)	0	0
Despite disease	2(3.8%)	0	0
A reserve	1(1.9%)	0	0
Living a healthy life	29(55.8%)	9(17.3%)	0
Physical fitness	1(1.9%)	0	0
Social relationships	1(1.9%)	0	0
Energy and vitality	0	0	0
Means to an end	1(1.9%)	1(1.9%)	0
Well-being	7(13.6%)	2(3.9%))	4(7.7%)
Missing	2(3.8%)	40(76.9%)	48(92.3%)
Total	52(100%)	52(100%)	52(100%)
n = 153			

When the responses in the first column (1st beliefs; table 2) are compared, beliefs reflecting biomedical perceptions of health are mentioned more frequently by the Blackstonestudents 22(37.9%). However, students in all three schools mentioned

"living a healthy life" and "well-being", as well, with Blackstone and Chiswell favouring "living a healthy life" more frequently than the Waverly students, who described notions of "well-being" more often. These observed differences in their most frequently expressed beliefs (1st beliefs; column 1) were significant $p<0.05$ (Chi-squared = 9.612 at 2df). The application of the Mann Witney test indicated that the perceptions of the Blackstone students were significantly different to those of the students in the two other schools, as is indicated in figure 1.

Figure 1 -8

Results of Mann Witney U Test

Differences in Health Beliefs Between Schools at Time 1

Blackstone and Chiswell: $z = -2.396$ with a 2 tailed p-value of 0.025
Blackstone and Waverly: $z = -2.734$ with a 2 tailed p-value of 0.006
Waverly and Chiswell: $z = -0.959$ with a 2 tailed p-value of 0.337

At this stage it appeared that although a range of dimensions about health were embedded in the students belief systems, the Blackstone students, who were younger and better educated than those in the remaining schools, also held more biomedically biased views. Thus, although these first beliefs were the most dominant perceptions, this wider analysis suggested that there could be some polarity between these views.

In situations such as this Bryman and Cramer (1997) advocate collapsing and recoding the data and using contingency table analysis with Chi-square. They also emphasise that it is not always appropriate to follow recommendations slavishly, yet for several reasons this course of action was thought to be appropriate. Examination of the entire data set revealed that Blaxter's categories relating to health viewed as a reserve, means to an end, physical fitness, social relationships and energy and vitality, had consistently low scores over time. Patterns seemed to be emerging suggesting it was more appropriate to cluster and recode these items into categories representing a biomedical view of health, a more empowered perception relating to lifestyle and one relating to well-being as is indicated below:

Figure 2 - 8
Recoding of Variable Labels

From:	To:
1. Not ill 2. A reserve 3. Means to an end	1. Absence of Disease
1. Living a healthy life 2. Physical fitness	2. Lifestyle
1. Well-being 2. Social relationships 3. Energy and vitality	3. Well-being

The data was subsequently collapsed. All scores of 5 and below were incorporated into new value labels and recoded into two new variables. The resulting new frequency distributions are as follows:

Table 3 - 8

Revised Data - Total Sample

Time 1

What does "being healthy" mean to you?

Time 1	Being Healthy Means 1stBelief	Being Healthy Means 2nd Belief
Absence of disease	54 (35.3%)	3 (2.0%)
Lifestyle	71 (46.4%)	15 (9.8%)
Well-being	28 (18.3%)	21 (13.7%)
Missing	0	114(74.5%)
Total	153 (100%)	153(100%)
n = 153		

This distribution seemed to clarify these perceptions to some extent. It appeared that although students held fairly strong beliefs related to either the biomedical model of health or notions of well-being, beliefs relating to lifestyle were dominant at the beginning of the course. It was also observed that the general theme that was becoming more apparent was related to positive and negative perceptions of health, with some responses demonstrating a combination of these perspectives. There is a debate concerning the rationale for defining health in purely positive and negative terms, for example Seedhouse (1998) argues that positive and negative terminology is

meaningless, while Tannahill (1996) frequently alludes to these dimensions. Blaxter (1990) summarises the debate thus;

> "a dichotomy has traditionally been seen as the biomedical or scientific model of health, and a looser, more holistic model. These are sometimes falsely regarded as "medical" and "non medical" ways of looking at health. Crudely, medical knowledge is seen as based on universal generalisable science, and lay knowledge as unscientific, based on folk knowledge or individual experience.

She continues, stating that in western societies such interwoven perceptions are inevitable since people have been socialised into thinking, to some extent in biomedical terms. She adds that modern medicine is not completely welded, in practice, to pure science, and that holistic concepts are also embedded in medical philosophy. Certainly some interrelated perceptions were emerging in this sample. In order to verify these observations the data was collapsed into a single variable utilising the following labels.

Figure 3 - 8
Second Recoding of Data

1. Absence of disease and lifestyle
2. Lifestyle and well -being
3. Well - being

The subsequent frequency distributions were:

Table 4 - 8

Subsequent Recoded Variables - Total Sample - Time 1

Health Beliefs	Time 1
Absence of disease and lifestyle	103(67.3%)
Lifestyle and well-being	24(15.7%)
Well-being	26(17.0%)
Total	153 (100.0%)
n = 153	

These distributions indicated that the most dominant perception of health was one that was biomedically focused and based on notions of lifestyle or "healthism" (Crawford 1989). The application of Chi-square with $p<0.05$ indicated that there was a significant difference between the strength of these views, (Chi-squared = 79.569 at

2df) There were no variations in perceptions between the schools, neither were there any differences associated with social class, age or education. Thus it can be concluded that the beliefs held by these students do in fact concur with Blaxter's categories and that they also reflected the norms of people in westernised societies.

The Importance of Learning About Health Promotion

The data was obtained by asking the students to rate how important they thought it was to learn about health promotion on an ascending scale from; 1 of no importance, 2 not very important, 3 important, and 4 very important. They were also asked to give their reasons for their response to this question. These responses were also compared with those from the scale measuring their changes in perceptions.

There was a 100% response to the question pertaining to the value students placed on health promotion, with 30(19.6%) stating that it was important and the remaining 123 (80.4%) maintaining that it was very important, there were no negative responses. However, there were some differences between the schools in the strength of this perceived importance. The frequency distributions illustrated by table 5 indicate that fewer Waverly students thought it was very important to learn about health promotion in comparison with those from Blackstone and Chiswell.

Table 5 - 8

How important do you think it is to learn about health promotion?

Time 1 - Frequency Distributions Between Schools

Time 1	Blackstone	Waverly	Chiswell
Important	9 (15.5%)	14 (32.6%)	7 (13.5%)
Very important	49 (84.5%)	29 (67.4%)	45 (86.5%)
Total	58 (100.0)	43 (100.0%)	52 (100.0%)
n = 153			
Likelihood ratio		**6.028 2df p.049**	

These results were crosstabulated and Chi-square applied, with a significance level of $p<0.05$, the results displayed at the foot of table 5 indicate that this difference is statistically significant.

How the students defined health promotion

In order to gain insight into the students' underlying perceptions of the concept, they were asked to give their reasons for their response to the previous question. Themes were coded and categorised according to the literature on qualitative data analysis (Couchman and Dawson 1990; Glaser and Strauss 1967), and utilising a method described by Burnard (1991). They were categorised in a fairly straightforward manner, in that the most frequently mentioned words, such as "lifestyle," "prevention," and the "future" were coded and sorted. However, notions such as, "providing knowledge, in order to change behaviour", were an amalgamation of several constructs, such as, "giving advice," "helping to change attitudes", educating and teaching, which are all practical elements of health promotion. These themes were tested for construct validity as recommended by Streiner and Norman (1995).

Independent review was conducted by the same people assessing the content validity of the questionnaire, the results are displayed in appendix 10. Construct validity was assessed at 100%, however two reviewers identified a further construct associated with coping and another, considered whether the title "population perspective" was totally appropriate, however there was no consensus on a more adequate title and so it remained unchanged. The emergent themes are outlined below, some examples of the students' responses at this initial stage are included to illustrate their inherent meaning.

- **Personal responsibility for health.**
  Blackstone
  "People need to learn to look after themselves and stay healthy and not to do things that will endanger their health and well-being".

  Waverly
  "I'm not sure really, but I think everyone needs the chance to find out what more they can do to better themselves".

  Chiswell
  "So that you can be aware of how important it is to try to keep yourself healthy, and be advised on the best way to do so".

- **Enabling maintenance of a healthy lifestyle.**
  Blackstone
  "In order to understand illness we need to learn about health. I believe the role of the nurse will involve helping people to lead a healthy lifestyle, keep people healthy, rather than simply cure/care for illness".

  Waverly
  "So that everyone, not just nurses, but people around learn the importance of staying healthy, and the reasons for not abusing our bodies, and the effect we can influence on others".

  Chiswell
  It helps the individual to learn more about themselves and make the best of their health. Good health promotion could lead to healthier lifestyles".

- **Coping**
  Blackstone
  "Heart disease and stress etc. is on the increase, therefore it is necessary to learn how to be healthy, especially in such a demanding world."

  Waverly
  "It is very important for growth and survival!"

  Chiswell
  "Health promotion is for everyday life and everyday people."

- **Prevention is better than cure**
  Blackstone
  "May help to prevent illness and make most people's lives healthier and more enjoyable than before".

  Waverly
  " To prevent ill health, to make people more aware of preventive medicine".

  Chiswell
  "Good health is vital for a good life. It is better to promote good health and try to promote ill health rather than to cure it at a later stage".

- **A healthier future.**
  Blackstone
  "I think one of our key roles is as health educators to the public. Preventive medicine is of vital importance for the future".

  Waverly
  "Gives one an "all round" picture of health education, hopefully to improve in the future the public understanding and well-being".

Chiswell
"I think it is very important to learn about health promotion, so that society knows about health promotion and can pass it on to future generations".

- **Providing knowledge in order to change**
  Waverly
  "Knowledge of health promotion will enable us to help others and perhaps make suggestions on how to improve life".

  Chiswell
  "Because it affects people's health, that is, if they know what is healthy they might change".

- **Choice**
  Blackstone
  "Health promotion aims at providing choices in promoting a healthy lifestyle."

  Waverly
  "Health promotion provides choices in promoting a healthy lifestyle. Therefore, in order to promote it, we should know what is being promoted".

- **Cost to the NHS**
  Blackstone
  "It is very important to learn about health promotion, because from a nurses point of view, if we can keep people healthy it means that we spend less time and resources caring for healthy people than if they were unwell".

  Waverly
  "Because if an individual looks after his/her health they can improve their life and reduce costs for the health service".

- **Quality of life**
  Blackstone
  "Without learning about health promotion you won't be able to use your knowledge in the caring of others. Therefore it is necessary in order to care for patients and enhance their quality of life".

  Waverly
  "By learning about health promotion we will be able to educate the general public towards a healthier lifestyle, which would give them a better standard of life, and in the long term cost the NHS less money".

  Chiswell
  "Everyone needs to be aware and bettering their quality of life to its highest standard, it is good to have the knowledge to control your own health".

- **Population Perspective**

  Blackstone

  "It is very important, because it provides a basis for everyone's life. If people are unhealthy their lives are disrupted, changed e.g. work not possible. It would generally mean that our standard of living would drop".

  Waverly

  "I feel that it's very important so that we can enable our society to become a healthier one. Therefore we need to give people the information they need".

  Chiswell

  "It is important because that is what we are here to learn about, keeping the public, healthy and trying to prevent them from needing medical care".

As demonstrated above, multidimensional concepts were also apparent, in this data set. As the themes were categorised, it appeared that although one or two students mentioned more than three reasons, three was generally the maximum. These were also categorised into first, second and third reasons, according to the order they were mentioned in the text. The initial distributions are as follows:

Table 6 - 8

Time 1

Give Reasons For Your Answer To Question 1 Total Sample

Reasons	1st Reason	2nd Reason	3rd Reason
Personal responsibility for health	27 (17.6%)	1 (0.7%)	2 (1.3%)
Enabling maintenance of a healthy lifestyle	32 (20.9%)	3 (2.0%)	0
Coping	4 (2.6%)	0	0
Prevention is better than cure	43 (28.1%)	11 (7.2%)	2 (1.3%)
A healthier future	9 (5.9%)	2 (1.3%)	0
Providing knowledge in order to change	24 (15.7%)	29 (19.0%)	7(4.6%)
Choice	2 (1.3%)	8 (5.2%)	0
Cost	3 (2.6%)	5 (3.2%)	3(2.0%)
Quality of life	2(1.3%)	4 (2.6%)	2 (1.3%)
Population perspective	1 (0.7%)	4 (2.6%)	2 (1.3%)
Missing	5(3.3%)	86(56.2%)	40(88.2%)
Total	58(100%)	58(100%)	58(100%)
n = 153			

Of the total response rate (96.7%) two students refrained from answering the question and three responses were impossible to code. On examination of the order in which the items were most frequently mentioned, four dominant themes emerged (these all had high scores from ten upwards). "Personal responsibility for health" is mentioned by 27(17.6%) of the respondents, "Enabling maintenance of a healthy lifestyle" by 32(20.9%), "prevention is better than cure" by 43(28.1%), "providing knowledge" so that people are able to change their behaviour was mentioned by 24(15.7%). When the second column was examined "prevention is better than cure" and "providing knowledge", were the most frequently mentioned statements, indicating that these notions of prevention and enablement through the provision of knowledge are the most clearly defined perceptions of health promotion.

A similar method to that relating to the students' health beliefs was adopted to collapse the data and recode it into new variables. However it is pertinent here to describe the method that was used in more detail. Ten themes were originally identified, but, in the process of collapsing the data eleven more emerged namely:

- Personal responsibility & knowledge
- Prevention & knowledge
- Lifestyle and knowledge
- Lifestyle and prevention
- Personal responsibility & prevention
- Personal responsibility and lifestyle
- Population & knowledge
- Lifestyle & population
- Prevention & population
- Prevention & Quality of life
- Personal responsibility & population

Clearly these were combinations of, and variations on, the previous themes, and they required organisation into more manageable categories. Finally, five themes were generated, these were given value labels that were arranged in ascending order from 1-5, from individualistic notions of personal responsibility for health, through a

preventive model, to notions incorporating the importance of empowerment through knowledge and also reflecting a population perspective of health promotion. The resulting themes and the subsets that represent them are as follows:

Figure 4 - 8

Emergent Themes

1 **Personal responsibility for health**

2 **Enabling maintenance of a healthy lifestyle**
Lifestyle and prevention
Personal responsibility and Lifestyle

3 **Prevention is better than cure**
Personal responsibility and prevention

4 **Providing knowledge in order to change**
Personal responsibility and knowledge
Lifestyle and knowledge
Prevention and knowledge
Population and knowledge

5 **Population perspective**
Prevention and population perspective
Prevention and quality of life
Personal responsibility and population perspective

The resulting frequency distributions were:

Table 7 -8

Time 1

The Students Definition of Health Promotion -Total sample

Value Label	Time 1
1. Personal responsibility for health	8 (5..4%)
2. Enabling maintenance of a healthy lifestyle	21 (14.1%)
3. Prevention is better than cure	49 (32.9%)
4. Providing knowledge in order to change	71 (47.6%)
5. Population perspective	0
Total	149 (100%) n = 153

These figures indicated clearly that there were differences in the students definition of health promotion. When the figures are scrutinised a hierarchy of reasons emerges:

4. Providing knowledge to change behaviour
3. Prevention is better than cure
2. Enabling maintenance of a healthy lifestyle
1. Personal responsibility for health

The provision of knowledge and the prevention of disease are key elements of health promotion for these students. Although there was no significant difference in perception between the schools at this point in time, there was a highly significant difference in strength between these perceptions (Chi-squared = 107 at 4df). Therefore it is concluded that the students' perception of health promotion is set within a preventative educational model, although notions of empowerment rather than the individualistic focus on personal responsibility are more prevalent.

Exploring the Students Perceptions of Health Promotion

The main aim in asking questions relating to perceptions of health promotion was to determine if these perceptions were congruent with their definitions of health promotion. These responses were measured on a Likert-type response rating scale consisting of nine items. The five point continuum for the entire scale was rated from point 1, strongly agreeing with the item to point 5, strongly disagreeing agreeing with the item. Items one and seven were negatively worded while the remainder were positively worded, as recommended by Moser and Kalton (1989). At this point there was a 100% response to all of the items on the scale. For purposes of clarity the nine items on the scale are listed below.

1. Doctors and nurses know a lot about health and illness. Therefore, people should do as the professionals tell them. If they don't and they become ill, it is their own fault.

2. Health promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

3. Nurses need to know about peoples' different economic situations so that they can be effective health promoters.

4. Nurses need to know about peoples' different cultural backgrounds so that they can be effective health promoters.

5. Nurses need to know about peoples' social backgrounds so that they can be effective health promoters.

6. Giving advice and supporting people so that they can make choices is an essential element of health promotion.

7. Nursing is mainly concerned with giving "hands on" care. Such things as health promotion are secondary to this.

8. Because they are involved in health promotion nurses should take a special interest in current affairs.

9. Health promotion is among the most important parts of the nurses role.

The response rates identified in table 8, indicated that quite a large proportion of the students held traditional views of medicine and nursing, but significantly more repudiated this authoritative approach (Chi-squared = 95.595 at 4df). However, a distinct level of uncertainty was apparent.

Table 8-8 Item 1

Doctors and nurses know a lot about health and illness. Therefore people should do as the professionals tell them. If they do not, and they become ill, it is their own fault.

Time 1	Frequency
Strongly agree	5 (3.3%)
Agree	44 (28.8%)
Unsure	22 (14.4%)
Disagree	71 (46.3%)
Strongly disagree	11 (7.2%)
Total n = 153	153 (100.0%)

The distribution of responses were similar in all schools, significant differences were not detected.

Table 9 -8 Item 2

Health Promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

Time 1	
Strongly agree	52 (34.0%)
Agree	95 (62.1%)
Unsure	3 (2.0%)
Disagree	2 (1.2%)
Strongly disagree	1 (0.7%)
Total n = 153	153 (100.0%)

The picture regarding this statement is slightly different, in that, 52(34%) and 95(62.1%) of students, respectively, strongly agreed or agreed with the statement. An educational model of health promotion was therefore identified as being important. There were no differences between the schools.

The responses to items three, four and five as indicated in tables 10, 11 and 12 suggested that students were aware of the impact socio-econimc status and culture has on health. They were also aware of the importance of this knowledge in determining their success, or otherwise, as health promoters. There were no significant differences in the strength of these perceptions according to which school they belonged.

Table 10 - 8 Item 3

Nurses need to know about people's different economic situations so that they can be effective health promoters.

Time 1	
Strongly agree	68 (44.4%)
Agree	69 (45.1%)
Unsure	7 (5.3%)
Disagree	6 (3.9%)
Strongly disagree	2 (1.3%)
Total	152 (100%)
	n = 153

Table 11 - 8 Item 4

Nurses need to know about people's different cultural backgrounds so that they can be effective health promoters.

Time 1	
Strongly agree	62 (40.5%)
Agree	84 (54.6%)
Unsure	2 (1.3%)
Disagree	4 (2.6%)
Strongly disagree	1 (1.0%)
Total	153 (100%)
n = 153	

Table 12 -8 Item 5

Nurses need to know about peoples' social backgrounds so that they can be effective health promoters.

Time 1	
Strongly agree	57 (37.3%)
Agree	77 (50.3%)
Unsure	8 (5.2%)
Disagree	9 (5.9%)
Strongly disagree	2 (1.3%)
Total n =153	153 (100.0%)

Item six (table 13), intended to elicit notions of empowerment through advising and supporting people. There was an overall positive response of 88% with 50.3% of the students thinking that this was an essential property of health promotion. When compared with the responses to item 2, which represented an educational model of health promotion, it can be seen that this is the preferred approach. Again there were no variations between the schools.

Table 13 -8 Item 6

Giving advice and supporting people is an essential element of health promotion.

Time 1	
Strongly Agree	77 (50.6%)
Agree	73 (48.0%)
Unsure	1 (0.7%)
Disagree	0
Strongly disagree	1 (0.7%)
Total	152 (100%) n = 153

The responses to item 7 (table 14) were interesting in that health promotion was not perceived as being subsidiary to the practical elements of nursing. An element of uncertainty was also expressed by 22(14.4%) students, the same number expressed doubt with regard to the statement in item 1 of the scale, indicating that there is some confusion relating to the role of health promotion within nursing.

Table 14 - 8 Item 7

Nursing is mainly concerned with giving "hands on" care. Such things as health promotion are secondary to this.

Time 1	
Strongly agree	8 (5.2%)
Agree	14 (9.2%)
Unsure	22 (14.4%)
Disagree	97 (63.4%)
Strongly disagree	12 (7.8%)
Total n = 153	153 (100.0%)

This uncertainty could not be attributed to any particular students, apart from two, one in Blackstone and one in Waverly, these doubts were not expressed by the same students with regard to both items, neither were there any significant differences between the schools.

Table 15 -8 Item 8

Because they are involved in health promotion nurses should take a special interest in current affairs.

Time 1	
Strongly agree	18 (11.8%)
Agree	101 (66.0%)
Unsure	23 (15.0%)
Disagree	11 (7.2%)
Strongly disagree	0
Total n = 153	153 (100.0%)

The responses from item 8 above, suggest that the majority had the ability to detect the context of health promotion and link it to their role as nurses. However, there is also a level of uncertainty which is also similar to items 1 and 7 (tables 8 and 14). This reinforces the view that an element of confusion exists regarding the students understanding of health promotion. Again, no statistically significant differences between the schools were noted.

Table 16 - 8 Item 9

Health Promotion is among the most important parts of the nurses' role.

Time 1	
Strongly agree	26 (17.0%)
Agree	99 (64.7%)
Unsure	15 (9.8%)
Disagree	13 (8.5%)
Strongly disagree	0
Total n = 153	153 (100.0%)

This last item on the scale required students to ascertain whether or not health promotion is one of the most important elements of nursing. The picture presented is positive in that 26(17.0%) strongly agreed, and 99(64.7%) agreed with the statement. These observations are useful when compared with the question related to the value they placed on learning about health promotion (table 5). This item was rated positively with 80.5% reporting that it was a very important subject, yet they did not rate its' importance as an essential element of nursing as highly. The element of uncertainty was again evident, there were no significant variations between the schools.

The Political Nature of Health Promotion

The last two items on the scale, specifically linked health promotion and nursing to awareness of current affairs and attempted to confirm the importance of the role of health promotion in nursing. Two further questions were then asked with regard to the active involvement of nurses in political issues. This was not an attempt to predict whether or not the students would become actively involved in politics once they were qualified nurses, but to clarify if they were really aware that there are radical elements of both health promotion and nursing that are politically motivated.

The first question merely asked if nurses should be involved in politics. Clearly this was a problematic issue in that the overall response was only 87.6% but of these 90(58.8%) replied positively and 44 (28.8%) negatively. It was also observed that of

the nineteen who did not answer, 9(15.5%) were Blackstone students and 9(17.3%) were from Chiswell. The frequency distributions between the schools are as follows:

Table 17 - 8

Should Nurses be Involved in Politics?

Time1	Blackstone	Waverly	Chiswell
Yes	30(51.7%)	28(65.1%)	32(61.5%)
No	19(32.8)	14(32.6%)	11(21.2%)
Missing	9(15.5%)	1(2.3%)	9(17.3%)
Total	58(100%)	43(100%)	52(100%)
n = 153			

These observed differences were of no significant value. The results were, however, interesting when compared with the first study, where it was observed those students were not as politically aware when they began their course.

In comparing these results with the findings from the last two items on the scale, it could be deduced that these students were aware of the political nature of nursing. However, it was still unclear whether links with health promotion and nursing were identified. It was hoped that the final question asking students to give reasons for their answers to the previous question would provide clarification. However, the analysis revealed that the dominant theme to emerge was not so much the link between health promotion and nursing, but the conflict surrounding nursing and politics, as described by Salvage (1985) and Clay (1989). Salvage (1985), argues that nurses should confront the consequences of political and policy decisions as they affect them in their work. Clay (1989), while voicing similar opinions, empathises with the general reluctance nurses feel about introducing conflict. He attributes this to the fact that they think it may alter the special relationship they have with their patients:

> "They see their prime task locally, in the wards and in people's homes, as to create calm, reassurance, confidence and trust, in a way that contributes to their recovery and happiness at their most vulnerable" (Clay, 1989;2).

This was also clearly articulated in the first study, and the conflict surrounding caring and "traditional" health education was also apparent in the qualitative data in this study. The analysis of the question exploring the students reasons for thinking they should or should not be involved in politics were replicated from the first study in that the responses to this question were examined in relation to Hardy's professional reality of politics (in White; 1986). Responses were separated into two groups indicting personal and professional perceptions. Totals for these groups do not meet the total response since not all students responded to this question. Of those that did, some gave a balanced reply, providing a personal and professional rationale.

Table 18 -8 The Professional Reality of Politics

	Time 1
Private/personal	39 (31.0%)
Public/professional	87 (69.0%)
Total	126 (100%) n = 153

There were no significant differences between the schools, but again these results also differ from the those in the previous study, in that although students on the "traditional" course perceived involvement in politics from a personal perspective, and gradually changed over time, these students began their course with a predominantly "professional" perspective.

The inferences to be drawn at this stage of analysis are that these new students health beliefs reflected typical westernised lay perceptions. Their explanation of health promotion was also influenced by these beliefs in that it was generally described within a preventive framework. However, they tended to perceive health promotion as being an important and integral part of their role as nurses, although the strength of this value is not as strong as the importance they attributed to learning about it. An educational model was also identified as important, but notions of empowerment were more evident. The socio-economic and cultural factors impacting on health were widely recognised. These students also tended to be politically aware, and

although they could relate the relevance of awareness of current health issues to health promotion, it was not perceived as having a political dimension. This political element was subsumed by the political context of nursing. A certain tension was also apparent between notions of nursing and health promotion, this was a general characteristic of the data, no statistically significant variations between the schools were elicited.

The End of the Common Foundation Programme.

The results from the analysis of this second phase of the study do indeed suggest that a change had occurred.

The Students' Health Beliefs

At this time an apparent maturity was observed in that the students were expressing more multidimensional reasons for being healthy. These results are presented in table 19.

Table 19 - 8

Time 2 - Total Sample

What does "being healthy" mean to you? - Multidemensional Concepts of Health

Being Healthy Means	1st Belief	2nd Belief	3rd Belief
Not ill	31(26.1%)	0	0
Despite disease	13 (10.9%)	2 (2.9%)	0
A reserve	9 (7.6%)	2 (2.9%)	0
Living a healthy life	13 (10.9%)	8 (11.6%)	0
Physical fitness	9 (7.6%)	12 (17.4%)	1(4.8%)
Social relationships	0	2 (2.9%)	4(19.0%)
Energy and vitality	1(0.8%)	5 (7.3%)	4(19.0%)
Means to an end	10 (8.4%)	8 (11.6%)	2 (9.5%)
Well-being	30 (25.2%)	27 (43.4%)	7 (33.4%)
Missing	3(2.5)	3(25.2%)	3(14.3%)
Total	116 (100%)	66 (43.1%)	18 (11.8%)
n = 119			

Of the 116(75.8%) who responded 66(43.1%) expressed two reasons for being healthy and 18(11.8%) mentioned three. Again, the first column of figures (1st Belief), seemed to indicate the emergence of two distinct dimensions of health ranging from the biomedical perspective, to notions of "well-being". Not being ill

was mentioned less frequently 31(20.3%) than at the beginning of the course, but other negative perceptions of health became more dominant when compared with the responses at Time 1. Being healthy "despite disease" was mentioned overall by 7(3.6%) of students at the beginning of the common foundation programme, while it was mentioned by 15(13.8%) of the respondents at Time 2 (the end of the CFP). Similarly, health as "a reserve", was mentioned by only 4(2.6%) at Time 1 while at Time 2, it is mentioned by 11(10.5%). Health as a "means to an end" was mentioned by 8(5.3%) at Time 1 and at Time 2 by 20(29.5%) of respondents at Time 3. "Living a healthy life" does not feature as prominently as at Time 1, but "well-being" continued to be one of the most frequently mentioned concepts. There are also observed differences between the schools as indicated in table 20.

Table 20 - 8 Time 2

Comparison of Schools Multidimensional Concepts of Health

Being Healthy Means	1st Belief	2nd Belief	3rd Belief
Blackstone	**Blackstone**	**Blackstone**	**Blackstone**
Not ill	15(33.3%)	0	0
Despite disease	5(11.1%)	1(3.6%)	0
A reserve	6(13.3%)	1(3.6%)	0
Living a healthy life	3(6.7%)	3(10.7%)	0
Physical fitness	2(4.4%)	7(25.0%)	1(9.05%)
Social relationships	0	0	3(27.3%)
Energy & vitality	0	2(7.1%)	3(27.3%)
Means to an end	2(4.4%)	1(3.6%)	0
Well-being	12(24.6%)	12(42.9%)	3(27.3%)
Missing	1(2.2%)	1(3.5%)	1(9.05%)
Total	45(100%)	27(100%)	10(100%)
Waverly	**Waverly**	**Waverly**	**Waverly**
Not ill	0	0	0
Despite disease	4(16.0%)	0	0
A reserve	0	1(6.3%)	0
Living a healthy life	7(28.0%)	0	0
Physical fitness	7(28.0%)	2(12.5%)	0
Social relationships	0	1(6.3%)	0
Energy & vitality	1(4.0%)	2(12.5%)	0
Means to an end	0	4(25.0%)	1(25.0%)
Well-being	5(20.0%)	5(31.3%)	2(50.0%)
Missing	1(4.0%)	1(6.4%)	1(25.0%)
Total	25(100%)	16(100%)	4(100%)
Chiswell	**Chiswell**	**Chiswell**	**Chiswell**
Not ill	16(32.7%)	0	0
Despite disease	4(8.2%)	1(4.0%)	0
A reserve	3(6.1%)	0	0
Living a healthy life	3(6.1%)	5(20.0%)	0
Physical fitness	0	3(12.0%)	0
Social relationships	0	1(4.0%)	1(16.7%)
Energy & vitality	0	1(4.0%)	1(16.7%)
Means to an end	8(16.3%)	3(12.0%)	1(16.7%)
Well-being	14(28.6%)	10(40.0%)	2(33.2%)
Missing	1(2.0%)	1(4.0%)	1(16.7%)
Total	49(100%)	25(100%)	6(100%)
n =119			

Although the response rate to the instrument was only 44.2% in Waverly, compared with 75.8% in Blackstone and 92.3% in Chiswell, it appears that the Waverly students tended to have more holistic notions of health than those in the other two schools. This trend was apparent at the beginning of the course. However, although the strength of the biomedical perception in the total sample seemed to have diminished by the end of the common foundation programme, some polarity in perception was still evident, but somewhat diminished. When the recoded data was

examined the picture became much clearer, previous observations were confirmed that there was a change in the students health beliefs over time.

Table 21 - 8
Recoded Variables - Total sample -Comparison Time 1 and 2

Health Beliefs	Time 1	Time 2
Absence of disease and lifestyle	103 (67.3%)	30 (25.9%)
Lifestyle & well-being	24 (15.7%)	55 (47.4%)
Well-being	26(17.0%)	31(26.7%)
Total	153(100%) n = 153	116(100%) n= 119

The data displayed in Table 21 indicated that at Time 1 the most frequently mentioned health beliefs were founded on a medical model of health and lifestyle. At time 2 notions of lifestyle and well-being are more frequently mentioned, these changes are highly significant (Chi-squared = 53.793 at 7df). There was no significant association related to social class, age, education organisation. Thus there clearly is a real change over time, from beliefs based on a medical model of health at the beginning of the course, to those based on a holistic notions of well-being. Lifestyle however is a dominant element at both times, yet no significant variations between the schools could be detected.

The Importance of Learning About Health Promotion.

Overall, the students were consistent in maintaining that it was important, to learn about health promotion, although the results displayed in table 22 indicate that there was a decline in the strength of the value placed of learning about the subject at this point.

Table 22 - 8

How Important Do You Think It Is To Learn About Health Promotion?

Total Sample	Time 1	Time 2
1. Of no importance	0	0
2. Not very important	0	0
3. Important	30 (19.6%)	31 (26.1%)
4. Very important	123 (80. 4%)	88 (87.5%)
Total	153 (100%) n = 153	119(100%) n = 119

These results indicated that it was necessary to investigate further to find out if there were any differences in these changes in the strength of views between the schools. The data relating to the responses between the schools over time was initially analysed by the process of cross tabulation and the application of chi-square. The significance level was $p<0.05$. The results are displayed in Table 23.

Table 23 -8
How important do you think it is to learn about health promotion?
Between Schools

Time 2	Blackstone	Waverly	Chiswell
Important	13 (27.7%)	12 (50.0%)	6 (12.5%)
Very important	34 (72.3%)	12 (50.0%)	42 (87.5%)
Total	47 (100%)	24 (100%)	48 (100%)
n = 119			
Likelihood ratio	**11.63 2df** **p 0.003**		

Given the adjustment for the difference in response rates, when these results are compared with those at the beginning of the course, there was a significant difference in the value students placed on the importance of learning about health promotion according to which school they belonged. At Time 1 in Blackstone, 49 (84.5%) students thought that it was very important to learn about health promotion, this figure had dropped to 34 (72.3%) at Time 2.

Whereas in Waverly at Time 1, 14(32.6%) students reported that they thought it was important to learn about health promotion, while 29(67.4%) thought it was very

important. At Time 2 the response rate was surprisingly equal, with 12(50%) thinking it was either important or very important to learn about health promotion.

In Chiswell the results approximated to those of Blackstone at Time 1. They also changed at Time 2, when in fact more students 42(87.5%), thought it was very important to learn about health promotion at this time, than in either Blackstone or Waverly. Thus it can be seen that at the end of the common foundation programme significantly more students from Blackstone and Chiswell thought it was very important to learn about health promotion than from Waverly. There was no association in any of these changes that were attributed to age, education, or social class. It is also realistic to consider whether the results may have been different had there been no missing data. Nevertheless it had been established that the students were almost unanimous in their assertion that health promotion was an important subject. What is intriguing is the increase in the strength of the perceptions of the Chiswell students.

Were There Any Changes in the Way the Students Defined Health Promotion?

Of the total of 119 students surveyed 113(73.3%) completed this section of the questionnaire. Scrutiny of the frequency distributions (table 25), revealed that their perceptions had become more clearly defined.

Table 24 - 8
Time 2
Give reasons for your answer to question 1 - Total Sample

Reasons	1st Reason	2nd Reason	3rd Reason
Personal responsibility for health	18(15.9%)	0	1(0.7%)
Enabling maintenance of a healthy lifestyle	35 (31.0%)	3 (5.0%)	0
Coping	0	0	0
Prevention is better than cure	38 (33.6%)	15(25.0%)	0
A healthier future	2(1.8%)	6 (10.0%)	0
Providing knowledge in order to change	14 (12.4%)	16 (26.7%)	1 (11.1%)
choice	0	5 (8.3%)	1 (11.1%)
Cost	0	3 (5.0%)	2(22.2%)
Quality of life	0	2 (3.0%)	1 (11.1%)
Population perspective	6 (5.3%)	10 (17.0%)	4(44.5%)
Total n = 119	113 (100%)	60 (100%)	9 (100%)

For example, in column 1 (1st reason), "personal responsibility for health", "enabling maintenance of a healthy lifestyle", "prevention is better than cure" and "providing knowledge in order to change" were dominant, but at this point the "population" perspective, although apparent at the beginning of the programme, was more prominent, this is apparent when the students' definition of health promotion are now compared with their views at the beginning of the course (table 25).

Table 25 - 8
The students' definition of health promotion - Total Sample - Times 1 and 2

Value Label	Time 1	Time 2
1. Personal responsibility for health	8 (5.4%)	5 4.4%)
2. Enabling maintenance of a healthy lifestyle	21 (14.1%)	14 (12.3%)
3. Prevention is better than cure	49 (32.9%)	36 (31.5%)
4. Providing knowledge in order to change	71 (47.6%)	41 (36.0%)
5. Population perspective	0	18 (15.8%)
Total	149(100%) n =153	114(100%) n =119

In fact these results identify that although "providing knowledge in order to change", is not as strongly identified as an important aspect of health promotion, it retains supremacy over the preventive dimensions. However, the "population perspective has become more dominant and is placed third in order of the most frequently mentioned aspects. "Enabling maintenance of a healthy lifestyle" and "personal responsibility for health" are reduced in strength, but there is no change in order. There was also a significant difference in the perceptions between the schools at Time 2(Chi-squared = 6.997 at 2df), this lay between Waverly and Chiswell (z = -3.440 with a 2 tailed p value of 0.011), suggesting that a more preventive model of health promotion was predominant among the Chiswell students, 16(34%) mentioned prevention as an important aspect, compared with Waverly, where only 4 (18.2%) mentioned this. These results also reflect that the Waverly group adopted more holistic and less polarised health beliefs than the students in the other schools.

There was now a familiar picture relating to any similarities and differences between the students. By the end of the common foundation programme the students generally expressed more sophisticated and holistic notions of health. The strength of the value they placed on learning about health promotion had declined, but their definition of the concept appeared to be broader, in that some of them at least, were able to identify the more global aspects. There also seemed to be persistent differences between Waverly with Blackstone and Chiswell students tending to express similar views.

Changing Perceptions - The End of the Common Foundation Programme

Here the items on the scale are analysed and compared with the results at the beginning of the programme. The responses illustrated in table 26, indicate that there is a shift away from students acceptance of the power of professionals in health promotion at the end of the common foundation programme with only 14(11.9%) agreeing with the statement compared with 44(28.8%) on commencement of the

course. Although the numbers of students disagreeing or strongly disagreeing with the item were similar at the end of the programme, fewer concurred, indicating a possible change in the strength of the perception. However, the element of uncertainty remained

Table 26 - 8 Item 1

Doctors and nurses know a lot about health and illness. Therefore people should do as the professionals tell them. If they do not, and they become ill, it is their own fault.

Time	1	2
Strongly agree	5 (3.3%)	3 (1.7%)
Agree	44 (28.8%)	14 (11.9%)
Unsure	22 (14.4%)	19 (16.1%)
Disagree	71 (46.4%)	70 (59.3%)
Strongly disagree	11 (7.2%)	13 (11.0%)
Total	153 (100.0%) n = 153	119(100%) n = 119

Significant differences between the schools were also apparent at this time (Chi-squared = 2.360 at 2df). The results of the Mann Witney test indicated that there were significant differences between all three schools.

Figure 5 -8

Results of Mann Witney Test - Item 1 - Time 2

Blackstone and Waverly: z = -2.360 with 2 tailed p value of 0.048
Blackstone and Chiswell: z = -2.082 with 2 tailed p value of 0.037
Waverly and Chiswell: z = -3.526 with 2 tailed p value of 0.000

When the frequency distributions of the respective schools were examined it was seen that the highest levels of uncertainty were among Blackstone and Chiswell students with 10(17.2%) of the Blackstone group and 7(13.5%) of the Chiswell students being uncertain. In Waverly only 16 (37.2%) of the sample agreed with the statement while in Blackstone 21(41.4%) agreed, in Chiswell this figure had risen to 30(57.7%). Thus it can be concluded although that the strength of the dismissal of the "victim blaming" approach to health promotion had increased there were still levels of uncertainty, which were dominant among Blackstone and Chiswell students. Although the strength of the perception in Waverly was significantly different from the others, this could also be attributed to the low response rate by these students at that time. However, this pattern was apparent throughout the study.

With regard to item 2 (table 27), it can be seen in table 27 that by the end of the common foundation programme a strengthening in the direction of this perception occurred, with 67(56.8%) and 49(41.5%) responding positively to this item. The small element of doubt was the same. There is a general acceptance of the educational model of health promotion. However, these observed differences were insignificant.

Table 27 - 8 Item 2

Health Promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

Time	1	2
Strongly agree	52 (34.0%)	67 (56.8%)
Agree	95 (62.1%)	49 (41.5%)
Unsure	3 (2.0%)	0
Disagree	2 (1.2%)	2(1.7%)
Strongly disagree	1 (0.7%)	0
Total	153 (100%) n = 153	118(100%) n = 119

Items 3, 4 and 5 (tables 28, 29, 30) are considered collectively. At the beginning of the course the majority of students either agreed or strongly agreed with these statements, seemingly suggesting that an understanding of the socio-political and cultural context of people's lives was a general expectation of the course. It was noted that these views were stronger at this point, the level of uncertainty had almost disappeared, but these results were not statistically significant. However, it was apparent, despite the reduction in response rates, that the experience gained during this time, was having some effect on changing the students' health beliefs, broadening their conceptualisation of health promotion and as a result strengthening and reinforcing their perceptions.

Table 28 - 8 Item 3

Nurses need to know about people's different economic situations so that they can be effective health promoters.

Time	1	2
Strongly agree	68 (44.4%	61 (52.7%)
Agree	69 (45.1%)	52 (43.3%)
Unsure	7 (4.6%)	3 (2.5%)
Disagree	6 (3.9%)	2 (1.7%)
Strongly disagree	2 (1.3%)	0
No response	1(0.75)	1(0.7%)
Total	153 (100%) n =153	118(100%) n = 119

Table 29 - 8 Item 4

Nurses need to know about people's different cultural backgrounds so that they can be effective health promoters.

Time	1	2
Strongly agree	62 (40.5%)	59 (49.5%)
Agree	84 (54.6%)	56 (47.1.%)
Unsure	2 (1.3%)	2 (1.7%)
Disagree	4 (2.6%)	2 (1.7%)
Strongly disagree	1 (1.0%)	0
Total	153 (100%) n = 153	119 (100%) n = 119

Table 30 - 8 Item 5

Nurses need to know about peoples' social backgrounds so that they can be effective health promoters.

Time	1	2
Strongly agree	57 (37.3%)	56 (47.1%)
Agree	77 (50.3%)	58 (48.7%)
Unsure	8 (5.2%)	3 (2.5%)
Disagree	9 (5.9%)	2 (1.7%)
Strongly disagree	2 (1.3%)	0
Total n 153	153 (100.0%) n 153	119(100%) n =119

The previous observations are reinforced when the data from item six (table 31) is scrutinised. At the beginning of the common foundation programme 77(50.6%) of students thought that giving advice and supporting people was an essential element of health promotion. As portrayed in table 31, this rose to 84(70.6%) at the midpoint, indicating that there had indeed been some reinforcement of these views. In fact this perception of enablement and empowerment, besides being more robust at this stage,

was also stronger than the response in item 2 (table 27), relating to the educational model of health promotion. Therefore, it is concluded that although the students accepted that there was a place for the educational model of health promotion within nursing, that notions of enablement and empowerment were more valuable. There were no statistically significant differences between the schools.

Table 31- 8 Item 6

Giving advice and supporting people is an essential element of health promotion.

Time	1	2
Strongly agree	77 (50.6%)	84 (70.6%)
Agree	73 (48.0%)	33 (27.7%)
Unsure	1 (0.7%)	2 (1.7%)
Disagree	0	0
Strongly disagree	1 (0.7%	0
Total	152 (99.3%) n = 153	119(100%) n = 119

Examination of item 7 (table 32) indicates that the strength of this view increases dramatically at the mid point, with 26(21.9%) strongly disagreeing with the item at this stage compared with 12(7.8%) at the beginning.

Table 32 - 8 Item 7

Nursing is mainly concerned with giving "hands on" care. Such things as health promotion are secondary to this.

Time	1	2
Strongly agree	8 (5.2%)	3 (2.5%)
Agree	14 (9.2%)	3 (2.5%)
Unsure	22 (14.4%)	5 (4.2%)
Disagree	97 (63.4%)	82 (68.9%)
Strongly disagree	12 (7.8%)	26 (21.9%)
Total	153 (100%) n = 153	119(100%) n = 119

However, although quite substantially reduced, there still appeared to be an element of scepticism here. No significant differences were detected with regard to this item.

The responses to item 8 (table 33) indicates that this pattern of strengthening responses is continued. Elements of doubt are considerably reduced and no significant differences were identified in any of the schools.

Table 33-8 Item 8
Because they are involved in health promotion nurses should take a special interest in current affairs.

Time	1	2
Strongly agree	18 (11.8%)	24 (20.2%)
Agree	101 (66.0%)	82 (68.9%)
Unsure	23 (15.0%)	10 (8.4%)
Disagree	11 (7.2%)	3 (2.5%)
Strongly disagree	0	0
Total	153 (100.0%) n = 153	119(100%) n = 119

This trend of strengthening perceptions and reduction in scepticism continued to the last item on the scale, when it can be seen that 31(27%) of students strongly agreed that health promotion was one of the most important aspects of the nurses' role compared with 26(17.0%), at the beginning of the programme. Elements of doubt and disagreement were diminished. This was in contrast to the reduction on the value placed on the importance of learning about health promotion, however this result is consistent with the expressed views at the beginning of the course. There were no significant differences between the schools.

Table 34 -8 Item 9
Health Promotion is among the most important parts of the nurses' role.

Time	1	2
Strongly agree	26 (17.0%)	31 (27%)
Agree	99 (64.7%)	78 (64.0%)
Unsure	15 (9.8%)	10 (9.0%)
Disagree	13 (8.5%)	0
Strongly disagree	0	0
Total	153 (100.0%) n = 153	119(100%) n = 119

Table 35 - 8

Should Nurses be involved in politics?

Time	1	2
Yes	90 (67.2%)	88(75.2%)
No	44(32.8%)	29 (24.8%)
Total	134(100%) n = 153	117(100%) n = 119

The results relating to the political context of health promotion are interesting at the end of the common foundation programme in that, although the response rate is lower and the number of students responding positively remains relatively unchanged, there is a significant reduction in the number of students responding negatively (z = -2.0212 with 2 tailed p value 0.004). There were no variations in the strength of these responses related to the schools.

Table 36 - 8

The Professional Reality of Politics - Total Sample

	Time 1	Time 2
Private/personal	39 (31.0%)	34 (29.6%)
Public/professional	87 (69.0%)	81(70.4%)
Total	126(100%) n = 153	115(100%) n = 119

In comparing the results of table 35 with table 36, relating to the professional reality of politics, it was noted that these figures barely change. However, some comment is required in that, although there was a 75.2% response rate at time 2 compared with 82.4% at the beginning of the programme there were only four students declining to reply to this part of the question at the end of the common foundation programme, compared with twenty seven at the beginning. This could be an indication that there was a growing political awareness, albeit remaining biased, towards the political nature of nursing as opposed to health promotion. The frequency distributions displayed in table 37 indicate very little difference in the overall perception of students, no statistically significant variations between the schools were detected.

Table 37 - 8

Professional Reality of Politics - Differences Between Schools

	Blackstone	Waverly	Chiswell
Private/personal	14(31.8%)	7(29.2%)	13(27.7%)
Public/professional	30(68.2%)	17(70.8%)	33(72.3%)
Total n = 119	44(100%)	24(100%)	46(100%)

To summarise so far, these results indicate that on completion of this part of the course, there had been an alteration in the students' health beliefs, their conceptualisation of health had matured. Their explanation of the role of the nurse remained grounded in perceptions related to enablement, although the value placed on learning about health promotion has diminished. This definition is supported by the findings from the scale, where a significant strengthening in perceptions was identified. Areas of confusion also diminished. Despite the decline in the value placed on learning about the subject it was still perceived to be one of the most important aspects of nursing.

The Final Results

The third and final survey was conducted during the last week of the adult branch programme. The lower response rates were not directly attributed to attrition, but the result of attendance for interviews and the complexity of collecting data from students on different sites. These results are presented and compared with those from the previous two surveys. Significant changes over time are measured using the Friedman test for several unrelated samples (significance = $p<0.05$).

Health Beliefs of the "New Nurses".

When the responses in the column relating to first beliefs were examined, it was observed that at the end of the course, "not being ill," being healthy "despite disease" and health as "a reserve" and a "means to an end," accounted for 48(46.7%) of the most frequently mentioned responses, while "living a healthy life" and "well-being"

accounted for 40(32.7%). Although multidimensional concepts continued to be more apparent than they were at the beginning of the programme, this trend is not as strong as at the mid-way point.

Table 38 - 8 Time 3 - Total Sample

What does "being healthy" mean to you?

Being Healthy Means	1st Belief	2nd Belief	3rd Belief
Not ill	16 (16.3%)	0	0
Despite disease	7 (7.1%)	1 (2.2%)	1 (5.9%)
A reserve	2 (2.0%)	0	0
Living a Healthy Life	19 (19.4%)	1 (2.2%)	0
Physical fitness	2 (2.0%)	11 (24.4%)	0
Energy and vitality	6 (6.1%)	6 (13.3%)	0
Social Relationships	0	2 (4.4%)	0
Means to an end	15 (15.5%)	5 (11.1%)	2 (11.8%)
Well-being	31 (31.6%)	19 (42.4%)	14 (82.3%)
Total	98 (100%)	45 (100%)	17 (100%)
n = 102			

Comparison of the distributions of the recoded variables (table 39) indicated that the significant change in the students' beliefs observed at the end of the common foundation course was still evident at the end of the branch programme (Chi-squared = 10.111 at 3df). There were no significant variations between the schools or any associations related to age, education or social class. Thus it was concluded that there was indeed a significant change in the students' health beliefs over time from those based on a medical model of health and lifestyle to more holistic notions of well-being. Lifestyle remained a dominant element.

Table 39 - 8

Subsequent Recoded Variables - Total sample - Times 1, 2 and 3

Health Beliefs	Time 1	Time 2	Time 3
Absence of disease and lifestyle	103 (67.3%)	30 (25.9%)	27 (27.3%)
Lifestyle & well-being	24 (15.7%)	55 (47.4%)	35 (35.4%)
Well-being	26(17.0%)	31(26.7%)	37(37.4%)
Total	153(100%) n =153	116(100%) n = 119	99(100%) n = 102

The Importance of Learning About Health Promotion.

The reduction in the strength of the value placed on the importance of learning about health promotion was noted at the end of the common foundation programme, a further decline was evident at the end of the course. However, this was of no significant importance

Table 40 - 8

How Important Do You Think It Is To Learn About Health Promotion?

Total Sample	Time 1	Time 2	Time 3
1. Of no importance	0	0	0
2. Not very important	0	0	2 (2.0%)
3. Important	30 (19.6%)	31 (26.1%)	24 (24.0%)
4. Very important	123 (80.4%)	88 (73.9%)	74 (74.0%)
Total	153(100%)	119(100%)	100(100%)
	n = 153	n = 119	n = 102

It was also noted that there were significant variations between the schools. At Time 1, 49 (84.5%) of the Blackstone students thought that it was very important to learn about health promotion, this figure had dropped to 34 (58.6%) at Time 2. By the end of the branch programme this figure had fallen to 24(41.4%), the percentage of students thinking that health promotion was important remained the same with two students thinking it wasn't at all important.

Table 41 - 8

How important do you think it is to learn about health promotion?
Between Schools

Time 3	Blackstone	Waverly	Chiswell
Not very important	2 (5.1%)	0	0
Important	13 (33.3%)	7 (126.9%)	4 (11.8%)
Very Important	24 (61.6%)	19 (73.1%)	31 (88.2%)
Total	39(100%)	26(100%)	35(32.7%)
n = 102			
Likelihood ratio		**9.997 4df p0.044**	

At Time 1, 14(32.6%) Waverly students reported that they thought it was important to learn about health promotion, while 29(67.4%) thought it was very important. At Time 2 the response rate was surprisingly equal, with 12(50%) thinking it was either

an important or very important subject. However, they had reversed their opinion at Time 3 with 19(73.1%) of the group thinking it was very important to learn about health promotion.

The views of the Chiswell students were very similar to those in Blackstone at Time 1. They also changed at Time 2, when in fact more of these students 42(87.5%), thought it was very important to learn about health promotion, than Blackstone and Waverly students. However, this figure had also fallen at Time 3, although it was still higher among the Blackstone and Waverly groups.

What is important with regard to these results is that by the end of the course the Blackstone students did not value learning about health promotion as highly as the students in the other two schools, as is indicated in figure 6.

Figure 6 - 8

How important do you think it is to learn about health promotion?

Results of Mann Witney Test - Time 3

Blackstone and Chiswell:	z = -2.686 with 2 tailed p value 0.007
Blackstone and Waverly:	z = -1.062 with 2 tailed p value 0.288
Waverly and Chiswell:	z = -1.544 with 2 tailed p value 0.123

There was no association in these changes that were related to age, education, or social class.

Nevertheless it had been established that the students were almost unanimous in their assertion that it was important to learn about health promotion. There were also significant differences in the strength of these perceptions between the schools, but the most significant point at which this change seems to have occurred is at the end of the common foundation programme. What is encouraging is, that despite the decline in strength at the end of the course compared with that at the end of the common foundation programme, the change in perception is sustained over three years.

Further changing definitions of health promotion.

The provision of knowledge and the prevention of disease appear to be key elements of health promotion for these students. The hierarchical position of these items had not changed at the end of the common foundation programme but by the end of the course "Prevention is better than cure" superseded "Providing knowledge in order to change" (table 42). The broader perspective relating to population and society also remained, but were diminished in strength by almost 50% at this point. However these results were not statistically significant at this point, and there were no differences between the schools.

Table 42-8

The students definition of health promotion -Total sample

Value Label	Time 1	Time 2	Time 3
1. Personal responsibility for health	8 (5.4%)	5 (4.4%)	5 (5.4%)
2. Enabling maintenance of a healthy lifestyle	21 (14.1%)	14 (12.3%)	10 (10.9%)
3. Prevention is better than cure	49 (32.9%)	36 (31.5%)	40 (43.5%)
4. Providing knowledge in order to change	71 (47.6%)	41 (36.0%)	28 (30.4%)
5. Population perspective	0	18 (15.8%)	9 (9.8%)
Total	149(100%)	114(100%)	92(100%)
Missing	n = 153	n = 119	n = 1021

The Finalists' Perceptions of Health Promotion

No radical alteration in the direction of perceptions were detected at the end of the common foundation programme. It was deduced that there had been more of a clarification of the values the students placed on each of the constructs on the scale. Items pertaining to the knowledge required in order to be effective health promoters had not changed at all. This final stage of the analysis was exciting, however in that it was observed that this shift in perception is sustained over time.

By the end of the course the overwhelming majority of students still rejected the "victim blaming" approach to health promotion with 55(35.9%) disagreeing and 21(13.7%) strongly disagreeing with the statement. However, the element of doubt was apparent in some instances since 11(7.2%) were still unsure. These observed changes over time were in fact significant (Chi-squared =11.826 at 2df).

Table 43 - 8 Item 1

Doctors and nurses know a lot about health and illness. Therefore people should do as the professionals tell them. If they do not, and they become ill, it is their own fault.

Time	1	2	3
Strongly agree	5 (3.3%)	3 (1.7%)	0
Agree	44 (28.8%)	14 (11.9%)	15 (14.7%)
Unsure	22 (14.4%)	19 (16.1%)	11 (10.8%)
Disagree	71 (46.3%)	70 (59.3%)	55 (53.9.%)
Strongly disagree	11 (7.2%)	13 (11.0%)	21 (20.6%)
Total	153 (100.0%) n = 153	119(100%) n = 119	102(66.7%) n = 102

No significant differences in these perceptions, could be attributed to the educational establishment, age education or social class.

There was little observed change related to the students' acceptance of the educational model of health promotion at this stage compared with the change at the end of the common foundation programme, and the consistently small element of doubt is all but eradicated. However the overall change in view is significant (Chi-squared = 76.204 at 2df). No differences between the schools were detected.

Table 44 - 8 Item 2

Health Promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

Time	1	2	3
Strongly agree	52 (34.0%)	67 (56.8%)	60 (58.8%)
Agree	95 (62.1%)	50(41.5%)	41 (80.2%)
Unsure	3 (2.0%)	2 (1.7%)	1 (1.0%)
Disagree	2 (1.2%)	0	0
Strongly disagree	1 (0.7%)	0	0
Total	153 (100%) n = 153	118(100%) n = 119	102(100%) n = 102

Table 45-8 Item 3

Nurses need to know about people's different economic situations so that they can be effective health promoters.

Time	1	2	3
Strongly agree	68 (44.4%)	61 (52.7%)	52 (51.0%)
Agree	69 (45.1%)	52 (43.3%)	39 (38.2%)
Unsure	7 (5.3%)	3 (2.5%)	3 (2.9%)
Disagree	3 (3.9%)	2 (1.7%)	7 (6.9%)
Strongly disagree	2 (1.3%)	0	1 (1.0%)
Total	152(1003%)	118(100%)	102(100%)
	n = 153	n = 119	n = 102

The theoretical foundations for health promotion (tables 45 and 46), revealed no significant changes over time. Neither were there any significant variations between the schools.

Table 46 - 8 Item 4

Nurses need to know about people's different cultural backgrounds so that they can be effective health promoters.

Time	1	2	3
Strongly agree	62 (40.5%)	59 (49.5%)	47 (46.1%)
Agree	84 (54.9%)	56 (47.1%)	51 (50.0%)
Unsure	2 (1.3%)	2 (1.7%)	1 (1.0%)
Disagree	4 (2.6%)	2 (1.7%)	3 (2.9%)
Strongly disagree	1 (0.7%)	0	0
Total	153 (100%) n = 153	119(100%) n = 119	102(100%) n = 102

Table 47 -8

Item 5

Nurses need to know about peoples' social backgrounds so that they can be effective health promoters.

Time	1	2	3
Strongly agree	57 (37.3%)	56 (47.1%)	49 (48.0%)
Agree	77 (50.3%)	58 (48.7%)	48 (48.0%)
Unsure	8 (5.2%)	3(2.5%)	0
Disagree	9 (5.9%)	2 (1.7%)	3 (3.0%)
Strongly disagree	2 (1.3%)	0	1 (1.0%)
Total	153 (100.0%) n = 153	119 (100%) n = 119	102 (10%) n = 102

However, with regard to the responses to the statement alluding to knowledge of people's social status being an important aspect of the knowledge required to be an

effective health promoter (table 48), although significant change was not apparent at the end of the common foundation programme, it was at the end of the branch programme (Chi-squared = 7.7912 at 2df), although there were no significant associations related to age education and social class, neither were there any differences between the schools. The conclusion here being that the clinical focus at this stage may have had a direct influence on these perceptions.

Table 48 - 8

Item 6

Giving advice and supporting people is an essential element of health promotion.

Time	1	2	3
Strongly agree	77 (50.6%)	84 (70.6%)	66 (66.0%)
Agree	73 (48.0%)	33 (27.7%)	36 (34.0%)
Unsure	1 (0.7%)	2 (1.7%)	0
Disagree	0	0	0
Strongly disagree	1 (0.7%	0	0
Total	152(100%) n = 153	119(100%) n = 119	102(100%) n = 102

The previous observations are reinforced when the data from item six is scrutinised. At the beginning of the course 77(50.6%) students thought that giving advice and supporting people was an essential element of health promotion. This rose to 84(70.6%) at the midpoint. This trend is still apparent at the end of the programme, and the change over time is significant(Chi-squared = 15.593 at 2df).

Table 49- 8 Item 7

Nursing is mainly concerned with giving "hands on" care. Such things as health promotion are secondary to this.

Time	1	2	3
Strongly agree	8 (5.2%)	3 (2.5%)	1 (1.0%)
Agree	14 (9.2%)	3 (2.5%)	10 (9.8%)
Unsure	22 (14.4%)	5 (4.2%)	7 (6.9%)
Disagree	97 (63.4%)	82 (68.9%)	66 (64.7%)
Strongly disagree	12 (7.8%)	26 (21.9%)	18 (17.6%)
Total	153 (100.0%) n = 153	119(100%) n = 119	102(100%) n = 102

The results displayed in table 49 are interesting in that it can be seen that the increase in the belief that health promotion was not secondary to the purely practical aspects of nursing, is sustained and are significant (Chi-squared = 12.587 at 2df). What is also worthy of note, is that the proportion of students who are unsure remains small.

Table 50 - 8 Item 8
Because they are involved in health promotion nurses should take a special interest in current affairs.

Time	1	2	3
Strongly agree	18 (11.8%)	24 (20.2%)	15 (14.6%)
Agree	101 (66.0%)	82 (68.9%)	77 (74.8%)
Unsure	23 (15.0%)	10 (8.4%)	4 (4.9%)
Disagree	11 (7.2%)	3 (2.5%)	6 (5.8%)
Strongly disagree	0	0	0
Total	153 (100.0%) n = 153	119(100%) n = 119	102(100%) n = 102

The ability to detect the context of health promotion and link it to their role as nurses was very apparent at the beginning and end of the CFP (Table 50). Again, this decline in unsurety over time is significantly important (Chi-squared = 6.555 at 2df).

Table 51 -8 Item 9
Health Promotion is among the most important parts of the nurses' role.

Time	1	2	3
Strongly agree	26 (17.0%)	31 (27.0%)	16 (16.3%)
Agree	99 (64.7%)	78 (64.0%)	69 (67.3%)
Unsure	15 (9.8%)	10 (9.0%)	13 (12.6%)
Disagree	13 (8.5%)	0	4 (3.8%)
Strongly disagree	0	0	0
Total	153 (100.0%) n = 153	119(100%) n = 119	102(100%) n = 102

The view that health promotion is one of the most important dimensions of nursing was also apparent at the end of the course. However, although this view was stronger at the end of the common foundation programme, the pattern of responses at the end of the branch programme were similar to those at the beginning. There was no significant change over time.

It was concluded therefore that, health promotion was assumed to be an integral component of nursing, this was also supported by the results relating to the reduction in the value that the students placed on learning about this subject.

The Political Nature of Health Promotion

When the responses of this part of the final survey are compared with the previous results no significant change over time was identified, although the number of students responding negatively was reduced.

Table 52 - 8

Should Nurses be involved in politics?

Time	1	2	3
Yes	90 (67.2%)	88(75.2%)	79(79.8%)
No	44(32.8%)	29 (24.8%)	20(20.2%)
Total	134(100%)	117(100%)	99(100%)
	n = 153	n = 119	n = 102

However, these final results also confirm the previous observations that these students were more politically aware, compared with those in the first study.

Table 53 - 8

The Professional Reality of Politics

	Time 1	Time 2	Time 3
Private/personal	39 (31.0%)	34 (22.2%)	19 (12.4%)
Public/professional	87 (69.0%)	81(53.0%)	72 (46.5%)
Total	126(100%) n = 153	115(75.2%) n = 119	91(58.9%) n = 102

These results are also very different to those of the students in the first study, in that although at first tended to balance their views between the personal and the professional perspectives and gradually changed, these students were constantly politically aware. No significant relationships between age, education or social class were identified. Although there was a reduction in the number of students expressing personal reasons for political involvement.

The inferences to be drawn from this level of analysis are that these students perceived health promotion as an important and integral part of their role as nurses, however this perception does change over time. At the beginning of the course, this view is very strong, but it diminishes as the course progresses. An explanation for this is difficult to ascertain, but may well be associated with the negative impact of the common foundation programme, which is also has been identified in other studies (ENB 1995). This is also validated by students' anecdotal comments related during the course of the research. They appear to be exemplar of their frustration with the theoretical focus of the course and paucity of clinical work at this stage.

The analysis of the student's definition of health promotion is interesting in that this also changes in that the main constructs alter significantly in order of the value placed on them change as the course progresses. The students entered nursing expressing lay perspectives, with the key emphasis on personal responsibility for health and lifestyles. By the end of their courses their perceptions had changed with their role becoming more clearly defined. The preventive aspects of health promotion were prominent at the end of the programme. Providing knowledge in order to change behaviour with a strong focus on lifestyle was still dominant at the end of the programme regardless of which course they were following.

When the student's definition of health promotion is compared with the items representing the theoretical constructs of health promotion, it appears that there is some congruence. In the item by item analysis it emerged that students entered nursing appreciating the contribution of the social and behavioural sciences in underpinning their knowledge of health promotion, and this view remains constant. Although they tended to disagree with the statement representing the medical model of health promotion, the strength of this disagreement with the "victim blaming " approach to health promotion increases, with the most significant change occurring at the end of the common foundation programme. Giving information and advice is also

perceived as being important at the beginning of the programme and the strength of this view increases significantly over time, as does their perception in supporting and advising people. What is very interesting is the response relating to the role of health promotion within nursing. Although there is a highly significant change in the strength of the view that health promotion is not secondary to the practical clinical skills in nursing, when these results are compared with those of the item relating to health promotion being an essential elements of nursing, these results are similar in that there was a strongly held view throughout the course that this was so. However when these two results are compared with the value statement relating to the importance of learning about health promotion, some inconsistency is identified, since there was a significant decline in the strength of this value students placed on the end of their course.

Inconsistency also appears when the data attempting to identify students perceptions of the more radical approach to health promotion is examined. While they appreciated the importance of being aware of the context in which health promotion took place and were politically aware from a professional perspective, this could not be interpreted as demonstrating an understanding of the political nature of health promotion. This is supported by the responses made to the qualitative data collected in relation to the question relating to this political dimension.

It could be concluded from this interpretation of the data that students perceive health promotion on entering nursing within an individualistic framework that focuses on personal responsibility for health and lifestyle, this approximates to lay perceptions in the literature relating to health beliefs and lifestyle. As a result of their educational programme this perception changes and the prevention of disease and behaviour change in relation to changing lifestyles, being significant aspects of the role of the nurse by the end of the course. This view is also supported by the analysis of the

item scale which identified giving advice, information and support in order to change as being an essential element of health promotion.

What Are the Salient Factors that Underlie Students' Perceptions of Health Promotion?

However, a more rigorous approach to the analysis was required, before firm conclusions could be drawn. The key objective was to investigate the possibility that there may be an underlying structure to health promotion in nursing through multivariate analysis of data from the scale. The longitudinal design of the study also made it possible to study the latent structure of the scale over time. The scale was not originally developed for its psychometric properties per se, but to determine what factors students thought were important at a particular time in their programme. However, because no previous work had been conducted in this area, it was deemed necessary to carry out this type of analysis in order make a more rigorous comparison with the overall data. The data from the 9 item scale was analysed by exploratory factor analysis. The decision to use this method was based on the results of the computation of an initial correlation matrix of the total sample, in conjunction with a 1 tailed t test (Bryman and Cramer 1997). These results are displayed in tables 54, 55 and 56.

Overall most of the variables were moderately correlated with no very high correlations. All except item 9 indicated some statistical significance at each time Significant correlations were increased at time 2 and were sustained at Time 3. It is also interesting to note that item 1 relating to the knowledge and power of professionals is positively correlated at Time 1, but negatively correlated at times 2 and 3 and is only significantly negatively correlated with item 7 at Time 3. This adds further support to the previous conclusion that there was change in students perceptions of the professional dominance of health promotion.

Table 54 - 8

Correlation Matrix - Time 1 Total Sample.

1	**1.000**								
2	**.145**	**1.000**							
3	.064	**.191**	**1.000**						
4	.094	**.219**	**.141**	**1.000**					
5	.010	.122	.103	**.686**	**1.000**				
6	.077	**.454**	**.153**	**.422**	**. 357**	**1.000**			
7	.025	.044	-.019	**-.108**	**.192**	.099	**1.000**		
8	.113	**.164**	.042	.035	.088	**.185**	**-.0182**	**1.000**	
9	.050	.082	.006	.010	.043	.046	-.089	0.43	**1.000**

1 tailed t test.

1	**.**							
2	**.036**	**.**						
3	.216	**.009**	**.**					
4	.123	**.003**	.041	**.**				
5	.452	**.067**	.102	**.000**	**.**			
6	171	**.000**	**.030**	**.000**	**.000**	**.**		
7	.379	.296	.410	.091	**.009**	.113	**.**	
8	.083	.022	.302	.336	.141	**.01**	**.012**	**.**
9	. 271	.556	.486	.452	.297	.285	.138	.301	**.**

NB. Significant correlations at the level of $p < 0.05$ are shown in bold.

Table 55 - 8

Correlation Matrix - Time 2 Total Sample

1	**1.000**								
2	.043	**1.000**							
3	**-.201**	.049	**1.000**						
4	**-.118**	**.121**	**.741**	**1.000**					
5	**-.233**	.145	**.641**	**.741**	**1.000**				
6	-.081	**.247**	**.208**	**.345**	**.309**	**1.000**			
7	.042		**.260**	**.201**	**.201**	-.097	**-.251**	**1.000**	
8	-.088	.063	**.288**		**.340**	**.275**	**.207**	.064	**1.000**
9	.050	.110	.381	- .120		.381	.163	.089	.99 **1.000**

1 tailed t test.

1	**.**								
2	.323	**.**							
3	**.014**	.299	**.**						
4	.101	**.905**	**.000**	**.**					
5	**.006**	.058	**.000**	**.000**	**.**				
6	.193	**.003**	**.012**	**.000**	**.000**	**.**			
7	.324	**.011**	**.002**	**.014**	.148	**.003**	**.**		
8	.171	.249	**.001**	**.000**	**.000**	**.012**	.245	**.**	
9	.301	.125	.381	.105	381	.044	.176	.149	**.**

NB. All significant correlations at the level of $p < 0.05$ are shown in bold

Table 56 - 8

Correlation matrix - Time 3 Total Sample

1	**1.000**								
2	-.084	**1.000**							
3	-.027	.075	**1.000**						
4	-.126	.169	**.671**	**1.000**					
5	-.070	.055	**.681**	**.659**	**1.000**				
6	-.136	**.258**	**.345**	**.367**	**.323**	**1.000**			
7	**-.296**	-.186	-.412	**.383**	**-.250**	-.193	**1.000**		
8	-.074	.058	.244	**.290**	**.200**	.104	**.208**	**1.000**	
9	.036	.013	.182	.191	.296	**.226**	.058	.181	**1.000**

1 tailed t test.

1	.								
2	.403	.							
3	.789	.451	.						
4	.209	.451	**.000**	.					
5	.484	.583	**.000**	**.000**	.				
6	.172	**.009**	**.000**	**.000**	**.001**	.			
7	**.003**	.061	**.000**	**.000**	**.011**	.052	.		
8	.459	.563	**.014**	**.000**	**.044**	.297	**.036**	.	
9	.726	.896	.079	.057	**.003**	**.024**	.565	.072	.

NB. All correlations significant at the level of $p < 0.05$ value are shown in bold.

Exploratory Factor Analysis

Since there were some significant correlation between these variables, the decision was made to continue with exploratory factor analysis (Bryman and Cramer 1997). The method used was principle component analysis (PCA) followed by oblique rotation using varimax. Factor analysis reduces multivariate data to fewer underlying dimensions (Hair et al (1997), or factors, which explain the shared variance in the

data (Dillon and Goldstein 1984). Principle component analysis enables as much of the total variation in the data to be explained in as few factors as possible, and also provides a rationale for selecting the number of latent factors present. The number of factors extracted at each point in time was decided upon using the scree slope method of analysis (Child 1990) as opposed to the Eigenvalues greater than one rule which can overestimate the number of factors (Cliff 1998). In order to characterise factors a rotational factor is necessary which maximises the loading (correlation) of items with their putative factors (Kline 1994). In relation to the selection of these putative factors, the convention was followed that is suggested by Child (1990), where only items with loadings greater than 0.40 are selected. Putative factors were further analysed for internal consistency using Cronbach's alpha (Polit and Hungler 1995).

Number of Factors

Both the unrotated and rotated components of the total sample are presented below. For purposes of clarity decimal points have been omitted. Some of these results are written in scientific notation but in terms of being significant in relation to factor extraction are unimportant. Items on the rotated principal table with loadings greater than 0.04 are highlighted in bold.

Table 57- 8

Principal Component Analysis - Unrotated - All Schools

	Factor 1			Factor 2			Factor 3			Factor 4
	T1	**T2**	**T1**	**T3**	**T2**	**T3**	**T1**	**T2**	**T3**	**T1**
1	216	-415	-224	480	194	697	-125	925		126
2	549	314	266	573	548	-486	105	174		4923 E-02
3	325	804	823	300	-304	177	183	4764 E-02		-289 E-02
4	782	863	841	-343	-257	6184 E-02	246	218		-232 E-02
5	736	805	793	488	-178	288	109	7614 E-02		-120 E-02
6	748	511	583	158	480	-862 E-02	3833 E-02	-787 E-02		-399 E-02
7	-242	468	569	377	-264	463	710	177		-889 E-02
8	-298	468	437	269	109	3131 E-02	-678	-151		-362
9	105	5378 E-02	369	4671 E-02	687	431	-169	-131		934

Prinincipal Components Analysis - All schools - Rotated

	Factor 1			Factor 2			Factor 3			Factor 4
	T1	**T2**	**T3**	**T1**	**T2**	**T3**	**T1**	**T2**	**T3**	**T1**
1	-121	-566 E-02	3594 E-02	**506**	2726 E-02	**731**	131	**954**		142
2	151	116	7783 E-02	**787**	**605**	**-584**	9843 E-02	222		3763 E-02
3	140	**856**	**833**	**445**	2290 E-02	-125	-961 E-02	-881 E-02		-569 E-02
4	**874**	**920**	**809**	161	7127 E-02	-239	-227 E-02	7993 E-02		-147 E-02
5	**884**	**815**	**844**	7486 E-02	136	-992 E-02	9785 E-02	-405 E-02		2568 E-02
6	**524**	282	**515**	**538**	**644**	-286	153	580 E-02		-105 E-02
7	-233	-328	369	260	**-449**	**634**	**-725**	-186		-215
8	-599 E-02	382	**420**	303	301	-125	**782**	-184		-215
9	1268 E-02	-222	**497**	9779 E-02	**665**	273	-606 E-03	-277 E-02		**951**

Table 58 - 8

Cronbach's alpha - rotated components - total sample

Factor 1			Factor 2			Factor 3		
T1	T2	T3	T1	T2	T3	T1	T2	T3
0.7384	0.8783	0.7576	0.3226	0.1338	0.1475	0.4259		

As can be seen from the results of the rotated component analysis in table 57, principal components analysis did in fact elicit rudiments of a four factor structure, at the beginning of the course. The percentage of variance explained by the first

unrotated principal at times 1,2 and 3 was respectively, 25.8, 32.2 and 34.7. Therefore, although separable dimensions are implied in the results, the majority of individual differences in perceptions of health promotion in this population may be accounted for in a generic factor common to almost all items. Two factors are evident however, at all times, but despite the size of the total sample at Time 1, only one factor with acceptable loadings was extracted. These two factors and the change in loadings are presented in table 59 below.

Table 59 - 8

Derived Varimax Factor Solution

Model 1		Time 1		Model 2		Time 2		Model 3		Time 3	
Factor 1		**Factor 2**		**Factor 1**		**Factor 2**		**Factor 1**		**Factor 2**	
4	874	1	506	3	856	2	605	3	833	1	731
5	884	2	787	4	920	6	644	4	809	2	-584
6	524	3	445	5	815	7	-449	5	844	3	634
		6	538			9	665	6	515		
								8	420		
								9	497		

This analysis also supports the evidence from the item analysis, in that significant changes occur at the end of the common foundation programme. The underlying constructs in the first factor are associated with the importance of having knowledge of people's cultural and socio-economic status of the of the context of peoples' lives in order to become effective health promoters. The items loading on the second factor at this time are the constructs of health promotion through giving information and supporting people in order that they can make choices and, health promotion as an important element of nursing in conjunction with the belief that it is not an adjunct to "hands on" care. However this last item is negatively correlated at this point, therefore, it is construed that health promotion is not endorsed as an integral component of nursing.

At Time 3 the loadings onto factor 1 are increased to include the enabling elements of health promotion, through advising and supporting people so that they can make choices, knowledge of current affairs and health promotion as being an important part

of nursing are also included. Factor 2 at this time includes the item negating the "victim blaming approach to health promotion, the educational model depicted as giving advice and information about lifestyle, is still apparent as is the item relating to the health promotion not being secondary to "hands on" care, at this time, however, there is a positive correlation,

These results clearly demonstrate a change a change in perception over time. The analysis also reveals a two factor model: factor 1 being associated with the theoretical underpinnings of health promotion, factor 2 attempts to define health promotion in nursing. However, given the low level of internal consistency on the second factor further work is required with regard to refining, testing and improving the scale. Gorsuch (1983) suggests that in order to improve the reliability of emerging factors there should be an absolute minimum of five subjects per variable. Further utilisation of the constructs identified in the qualitative data defining elements of health promotion could be one resolution to the problem.

Conclusion

Our statistical analysis suggests that there were significant changes in students perceptions of health promotion over time. Exploratory factor analysis has provided powerful evidence to support these conclusions. What has emerged is that while core variables relating to the theory underpinning health promotion and nursing remain constant at all points, other dimensions become more clearly defined. Some polarity between the biomedical and more holistic notions of health were initially observed but by the end of the course a more enabling and empowering conceptualisation of health promotion is apparent. However, an educational model is also evident on completion. While health promotion was not perceived as an integral aspect of nursing at the end of the common foundation programme, this aspect of nursing can be construed as being embedded in the role of nursing at the end of the course. There

is some evidence to suggest that the clinical emphasis in the branch programme has had an effect in this change.

The critical point where significant change occurs is at the end of the common foundation programme, the period of maximal theoretical input. There is an overall decline in the strength of perception by the end of the third year, but not to the same levels as those at the beginning of the course. There were also some differences in perceptions between the schools, with Waverly students, expressing more holistic notions of health and health promotion at the beginning and end of the common foundation programme. However, these differences were no longer apparent at the end of the third year. We now turn to an exploration of the reasons for these findings.

CHAPTER 9

ORGANISATIONAL CULTURE AND CONCEPTS OF HEALTH PROMOTION

We now turn to examine why these differences between the schools occur. Since there were no changes relating to age education and social class, something else seems to have influenced this change, and the difference between Waverly and the other schools. The focus of the analysis is on the culture of each school, on teachers' perceptions, and on the structure and content of the curriculum.

The Culture of the Organisations.

There is a wide literature on the culture of educational organisations (Lawton1975; Lee and Zeldin 1985). Deal and Nolan (1987) argue that ideologies reflect the intellectual development of any culture or movement. Ideologies influence people's behaviour, their relationships and their expectations. They are transmitted through the media, word of mouth and through music and literature. Ideologies are also reflected in institutions, affecting their goals and norms and defining structural patterns within organisations. Schools, they argue, like any organisation, are buffeted and defined by ideologies.

In their development of the work of Kohlberg and Meyer (1972), they identified four educational ideologies expressed by educational organisations. These ideologies, they say, influence the pattern of thinking which in turn influences teaching methods, student teacher-interaction, curriculum content and organisational structure.

The first of these ideologies, Deal and Nolan (1987) describe as representing the more traditional pattern of educational philosophy, they call this *"the school as filling station"*, where students are treated as empty vessels, "to be filled by the wisdom of

ages". The other three represent views which have influenced the development of progressive educational theories, notably;

The *"school as greenhouse"* ideology representing the liberal ideas and values of the 1960s. Students are perceived as flowers, who will blossom without too much interference. The second ideological stance is the theme of the "*school as a tool*", which emphasises the role of the school as an instrument in realising social change; the students are viewed as change agents.

The third ideological viewpoint is that of the *"school as a marketplace"*. This has it's roots in the progressive movement in the 1930s. In reality this ideology has many facets of the ideologies of the "*school as filling station*", and "*school as greenhouse*", but schools are viewed as market places where students are continuously involved in a transaction with social beliefs, values and information. In reality, they say that rarely are these ideologies found in a pure form. They are combined in diverse ways providing an eclectic approach to education.

Docking, (1987), suggests that traditionally all colleges of nursing are bureaucratic in administration and hierarchical with regard to the distribution of power, methods of formal communication and the standardisation of work procedure. Teachers, she argues are a product of this bureaucratic model through their own education and clinical practice. This bureaucratic model could be likened to Deal and Nolan's (1987) conception of "*the school as filling station*". Docking also refers to the professional model of the organisation, which is characterised by authority based on expertise, rather than hierarchy, encouraging creativity and collaboration between colleges, and where decision making is decentralised and autonomy is practised, and representing the ideology of "*the school as marketplace*".

Although, specifically addressing issues of curriculum change and innovation, Docking (1987) is aware of the contextual problems associated with creating change

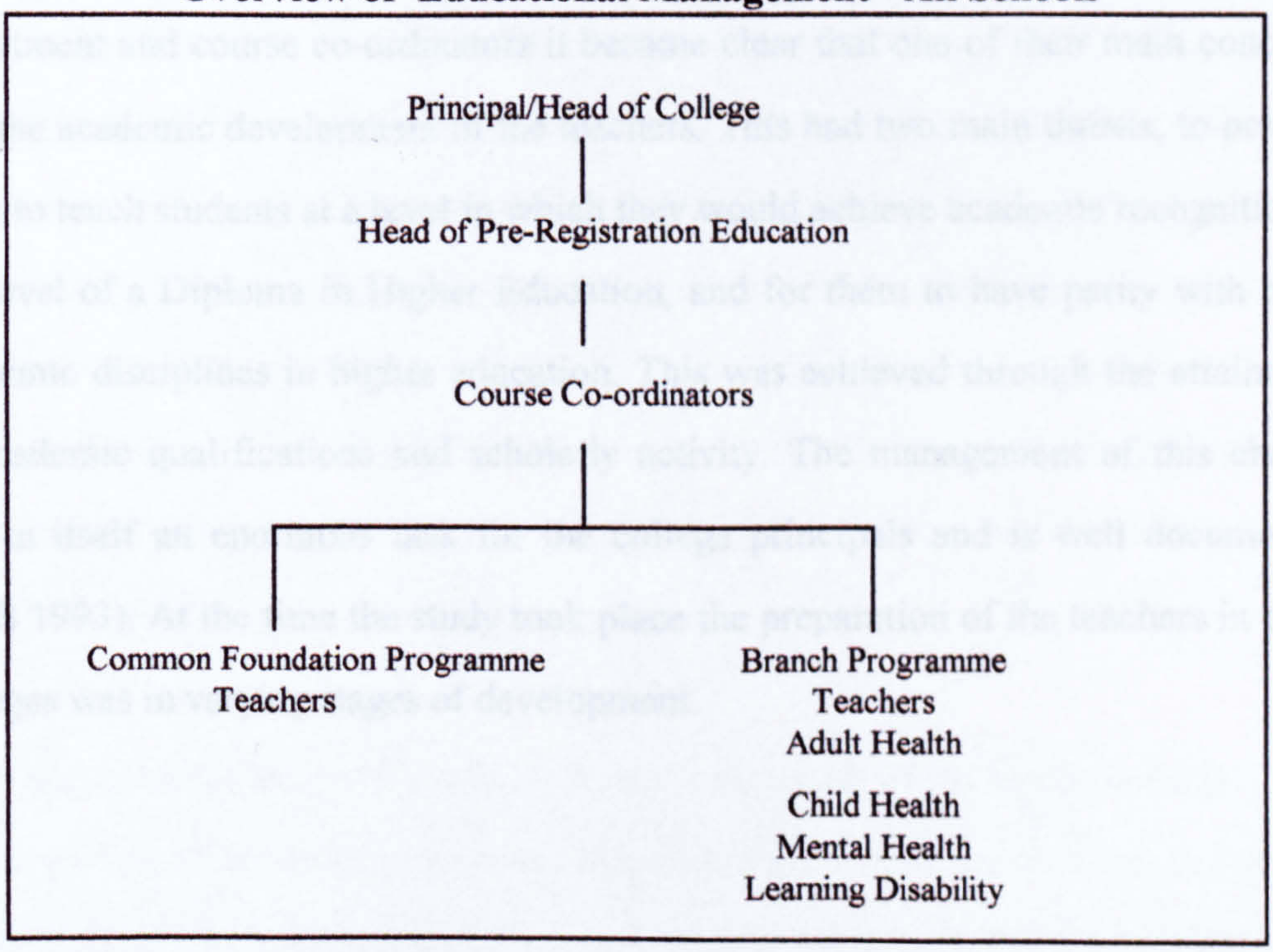
in organisations confined within a bureaucratic NHS. This study took place when nursing education was in the throes of being removed from the NHS and into higher education. Although leaving the confines of the NHS, it was also having to learn to assume, or adjust to, the educational ideologies of a variety of higher education establishments. Therefore it is within Deal and Nolan's(1987) framework of educational ideologies that the culture of the organisations has been analysed.

The Similarities Between the Schools

Docking (1987) describes the bleakness of hierarchical management structures suggesting that there are few opportunities for professional development, lack of regular meetings, and little innovation in the curriculum. Hearn (1995), in a study she conducted in Blackstone, disputes this stating that although the management structure in this school was hierarchical, this description was not wholly true. Docking's view, while having an element of truth is in itself rigid. Certainly the management structure in all three schools was similar as outlined in figure 1.

Figure 1 - 9

Overview of Educational Management - All Schools



All members of staff were directly accountable to the principal. The course co-ordinators were responsible for the delivery of the educational programmes. In addition senior nurse educationalists, responsible for assessment and curriculum development were directly responsible to the head of pre-registration education. The teachers, regardless of which branch of nursing they specialised in taught on the common foundation programme, teaching the specialist elements in their branch programmes.

However, all three schools were implementing the most progressive curriculum development in nursing education for many years. By the nature of curriculum development in professional organisations this cannot be accomplished successfully in isolation. In all schools regular meetings with education management and staff took place and opportunities for professional development were available.

The Effects of the Transfer of the Colleges into Higher Education on the Culture of the Organisations.

During the course of informal discussions with the college principals, heads of department and course co-ordinators it became clear that one of their main concerns was the academic development of the teachers. This had two main thrusts; to prepare them to teach students at a level in which they would achieve academic recognition at the level of a Diploma in Higher Education, and for them to have parity with other academic disciplines in higher education. This was achieved through the attainment of academic qualifications and scholarly activity. The management of this change was in itself an enormous task for the college principals and is well documented (ENB 1993). At the time the study took place the preparation of the teachers in these colleges was in varying stages of development.

Professional Development of the Teachers

Evidence of this professional development began with examination of the curriculum documents for the course in each school. All of these courses had been validated between 1991 and 1992. The documents contain detailed information relating to the resourcing of courses. This, in fact while an interesting pursuit was not, as informative as expected. There was no problem in accessing this information from Blackstone and Chiswell, but Waverly would only provide a curriculum working document lacking information relating to the resourcing of the course. However the comparison of the information between Blackstone and Chiswell was very illuminating.

The information provided by Blackstone was comprehensive. A list of all the teachers and senior managers in the school was presented. In 1992 ninety four teachers were employed in the college, this included the principal and three vice-principals, who were individually responsible for pre-registration, post-registration and midwifery education. There were also twelve course directors, some had wide-ranging responsibility for areas such as curriculum development, assessment, the clinical learning environment, mental health nursing, general nursing and midwifery, others led teams of specialist teachers on a variety of post-registration programmes such as acute care, elderly health or community nursing. This list, represented the total number of teachers, who were potentially available to teach the pre-registration course, there was no description of the roles or responsibilities of any of these teachers. Some, specialising in critical care or nursing management, were involved to some extent with pre-registration nursing education, but others had no involvement at all with the course.

With regard to the teachers' academic qualifications, all of the senior managers were in possession of formally recognised teaching qualifications and seven had higher degrees, four had been educated to first degree level and five had diplomas in

education. With regard to the teachers, sixteen had no formally recognised teaching or academic qualification, the remainder were qualified teachers, twenty six of these had first degrees and nineteen had been educated to masters level. There was no indication in the document of continuing professional development for the twenty two teachers who did not report having first degrees. Degree subjects were not recorded in the document.

The Blackstone annual report for 1993-4 was more informative in eliciting the subject areas of these degrees, although reporting was inconsistent, thus it was still not possible to obtain a totally accurate picture of the teachers specialist knowledge. However, of the seventy six teachers in the college at that time, fifty had first degrees and twenty one had been educated to masters level (table 1). Fifteen teachers held degrees in nursing, six in health studies and four in sociology. The range of subject areas for the teachers with masters degrees was diverse ranging from studies in gender, human rights, economics, medical law and ethics. Three of the senior managers had MAs in education and three of the teachers had achieved higher degrees in nursing studies. Interestingly, two teachers had MAs in health education and one an MSc in health promotion.

Table 1-9
Academic Qualifications - BlackstoneTeachers

Blackstone	1991	1993
BA/BSc	26 (42.6%)	50 (64.5%)
MA/MSc	19 (31.1%)	21 (28.9%)
None	16(26.3%)	5(6.6%)
Total	45 (100%)	71 (100%)
n	94	76

In contrast, the Chiswell document listed only those teachers who had responsibility for the course. There were a total of thirty five teachers in all. These included the Head of the college, the head of studies and planning, the co-ordinator for the Common foundation Programme and co-ordinators for the branch programmes for adult nursing, children's nursing and mental health nursing. However, at that time

none of the Chiswell teachers were educated to the same level as those from Blackstone. Of the senior managers, three had been educated to first degree level and three were studying for masters degrees. The Head of the college had not published her academic or professional qualifications. There was little evidence of the diversity of subjects exhibited by the Blackstone teachers. Of the eleven teachers studying for first degrees, nine were in nursing, of the teachers studying for higher degrees, five were in education and six were in ethics and healthcare. This may well have been because the college was already affiliated to, and located within a college of higher education offering those subjects at masters level.

Table 2-9

Academic Qualifications - Chiswell Teachers

1991	
BA/Bsc	12(34.3%)
Studying for in 1991	11(31.4%)
MA/MSc	1(2.9%)
Studying for in 1991	11(31.4%)
Total n	35(100%) 35

Considering, the inability to access information from Waverly, the results of the teacher's survey, carried out in 1996, where the teachers reported their academic qualifications enabled some comparison. As can be seen in table 2 these teachers were all academically credible in that apart from two (14.2%) in Chiswell, they all had first degrees and masters degrees. However, only two teachers in Blackstone had higher degrees compared with five in Waverly and six in Chiswell.

Table 3 - 9

Academic Qualifications of Teachers - All Schools 1996

	Blackstone	Waverly	Chiswell
BA/BSc	6 (75%)	8 (61.5%)	6 (42.9%)
MA/MSc	2 (25%)	5 (38.5%)	6 (42.9%)
None	0	0	2(14.2%)
Total n	8 (100%) 8	13 (100%) 13	14(100%) 14

One interesting observation was, the similarity between the Blackstone and Chiswell teachers degree subjects. In Blackstone, three teachers had first degrees in nursing

and the two with higher degrees were also in nursing. The remaining five teachers had degrees in health studies and sociology. In Chiswell, of the six who had first degrees two were in nursing, two in health studies, one in education and one in sociology. Two teachers had masters degrees in nursing with the other three in healthcare ethics, social anthropology and education. It appeared then that the teachers' academic qualifications had not only reached a similar level in 1996, but there was parity between their subjects.

In Waverly this profile is different. Although the level of academic achievement was comparable with Blackstone and Chiswell, of the teachers with first degrees, two were in nursing, four were in social sciences, two were in psychology, one was in life sciences and the last in health studies. Of the four teachers with higher degrees, these were in nursing, education, health psychology and health promotion. Whether this was representative of the teacher population in the school, or an indication of the interest that these particular teachers had in health promotion is debatable.

In comparing the numbers of teachers in this sample with the totals in tables 1 and 2, the numbers do not in any way approximate a representative sample of the teachers in the colleges, a true comparison is difficult. However, all of these teachers reported that they taught the students participating in the study, therefore their perceptions of health promotion were important, and were potentially influential in shaping the students perceptions. Sampling methodologies for the teachers survey are discussed at a later stage.

Scholarly Activity

With regard to scholarly activity, this was being fostered in various ways and was at varying levels of development in each the colleges. Activities ranged from encouragement to participate in research, to the development of innovative teaching methods.

In Blackstone, at the commencement of the study, the Principal of the college, who had previously worked in higher education institutions, was negotiating for integration of the college with a Colleges of London University. She was proactive in encouraging teachers, not only to register for higher research degrees and increase their publication records, but had formed a research strategy group, which liaised closely with the nursing research group within the main purchasing hospital. In addition to this teachers, had formed special interest groups in social science and health promotion, where they developed teaching methods and disseminated information either through debate or presentations at formal college meetings. Guest speakers were also invited to conduct seminars at these meetings.

With regard to Waverly, teachers were, actively encouraged to study for research degrees and the course co-ordinator for the CFP was registered for an MPhil/PhD in education. Her personal views on scholarly activity was through the development of innovative teaching and learning strategies and her philosophy of education was similar to that of the principal, who was a man whose professional and educational background was in mental health nursing. His views on education were progressive and focused very much on Knowles (1978) theories of adult learning, and more closely representing the ideology of *"the school as a greenhouse"*.

Chiswell also did not appear as advanced as Blackstone, in terms of enabling teachers attain academic credibility that thrust was there, and the development of scholarly activity was valued. The Principal and Head of Programmes and planning, stated that they wished to foster a research culture within the college. The investigator was invited to present her own work to the staff.

Thus, it would seem that all these colleges were moving away from the traditional notion of the bureaucratic college of nursing, although this was to some extent, being driven by external forces, rather than by in-house commitment. This judgement

requires further justification, provided by evidence derived from informal observation during the study. The transfer of the colleges into higher education was an overriding factor, having a powerful effect on the culture of these organisations.

In all of the colleges, while the principals had the remit for this transfer into higher education, they were extremely busy people, working hard to achieve this. They saw their deputies as the key people in managing this change. As one reported, " I see the principal lecturers as the catalysts in implementing this transfer in the college. I'm too busy fighting the men in suits. The teachers don't know whats' in store for them. I've tried the "soft" approach to their professional development, but just have to be "hard nosed" about it now" (Head of college, Chiswell).

This view was also apparent in Blackstone, where the vice-principal responsible for pre-registration was the key person. While, she ran the department in what appeared to be an open and democratic management style, this was not always perceived as such by the staff. Certainly she was accessible, and ran what she called an "open door" policy of communication between herself and her staff, but elements of a hierarchical management style were evident. An example of such was a tradition in the school of the daily meeting at 8.30 every morning, ostensibly to disseminate and exchange information. However, many of the teachers perceived this as a form of control over their whereabouts. Senior teachers also commented on their lack of autonomy in relation to course management. Comments such as;

> "You think once you are promoted that you will have some authority, but you don't, she knows what she wants and you have no control".

They also commented on the seating arrangement in the staff common room, where the senior members of staff sat at one end of the room and teachers and support staff at the other.

In Waverly, evidence of this bureaucratic management style was not superficially apparent. This may well have been due to the geographical location of the college, classroom teaching took place on two separate sites twenty miles apart. Teachers were constantly moving between sites and although quarterly school meetings and monthly team meetings were scheduled, there were no focused points of daily contact. Teachers appeared more autonomous, enthusiastic and innovative. They were encouraged to experiment with the introduction of new material or teaching methods. For example the Co-ordinator for the common foundation programme was working with the social science teachers to devlelop material based on Foucault's (1979) analysis of medicalisation, power and control. The head of the school was a proponent of experiential learning (Kolb, 1984), not believing that students should be taught "purely from books".

To conclude, there were both similarities and differences in the culture of these organisations. The structure of all three of these organisations was hierarchical, but more apparent in Blackstone and Chiswell. The influence of the principals and their deputies appeared to play an important part in shaping this culture. The differences may have been influenced by gender, professional orientation as well as educational ideology. The principals of Blackstone and Chiswell were registered general nurses who were women, they held more traditional views of nursing than the principal of Waverly a man who's professional experience was in mental health nursing. To some extent this observation is supported by the subject areas of the teachers educational qualifications which were more diverse in Waverly. However, the culture in all the schools was more comparable with a professional model, in Blackstone and Chiswell this appeared to reflect the "*market place*" ideology, while in Waverly, elements of the *"greenhouse"* ideology were apparent.

The Effects of the transfer into Higher Education on Sampling Methodologies.

A rudimentary picture has been presented earlier in terms of the teachers academic achievements. We now turn to a more detailed profile. It is admittedly based on small scale data, but it provides at least an insight into teacher's perceptions of health promotion, and is worthy of comment in that the low level of participation in the study reflects a general lack of interest in this subject. In offering an account of the problems encountered in trying to obtain a representative sample of teachers, the context of change that was occurring in these institutions at that time is discussed. The effects that it had on one of these organisations was profound.

When the study commenced negotiations were proceeding for the transfer of Blackstone College to a department within a college of London University. However, in November 1993 the regional Health Authority recommended that no further pre-registration nursing students would be admitted to the college, and that these contracts should be transferred to other organisations. The effect of this recommendation was to close the college (Pattison 1993). In fact, the cohort of students in the study were the last group of students to complete their education in this organisation. Needless to say this had a drastic effect on staff. In 1995, two years after the original closure announcement there were only 40 permanent and temporary teaching staff within the college (Hearn 1995), twenty five of whom were involved directly with teaching pre-registration students. These numbers were constantly reducing as students completed courses and teachers became redundant. The twenty five teachers who were directly involved with the teaching the course who were invited to participate in the study. Of the eight who did, these were the eight (12.5%) who continued to work in the college until it's final closure in 1997.

Integration into higher education at Chiswell, had a negative effect for some of these teachers. This occurred in the autumn of 1994, when the study began and the then Head of Studies reported that as a result. twenty three teachers had been made

redundant across the college. She also retired in 1994. The key research contacts during the remainder of the study, were the Course Directors for the Common Foundation Programme and Adult Branch Programme, neither of whom said that they had access to complete figures for the total number of staff teaching on their programmes. In order to obtain a sample, it became necessary to identify teachers through photographic displays of staff in the college. Twenty teachers were identified and fourteen questionnaires were returned, eliciting a response rate of 71.42%.

By contrast, the transfer into higher education at Waverly appeared less traumatic. Negotiations were completed in 1996 and there were no redundancies. Gaining access to the teachers, however, was also less than satisfactory, in that figures for established numbers of teachers were not available. However the Course Directors for both the Common Foundation Programmes and the Adult Branch Programmes were responsible for small teams of teachers totalling nineteen in all, who taught the students participating in the study. It is these teachers who were invited to participate, thirteen teachers responded giving a response rate of 76.9%.

Table 4 -9

Response Rate to Teachers' Questionnaire

Blackstone	Waverly	Chiswell
8(12.5% 25(100%)	13(76.9%) 19(100%)	14(71.2) 20(100%)
n=25	n=19	n=20

Who Were the Teachers?

These details are presented in terms of the teachers' age, gender and ethnicity. Their academic achievement has previously been addressed, but is again reviewed in conjunction with their professional qualifications and the subjects that they taught.

With regard to gender and the ethnic origins of the teachers, thirty one (88.6%) reported their ethnicity as being white and British. Two (5.7%) described themselves as Irish, these were Blackstone teachers. One Waverly teacher reported his ethnicity

as Asian. There were 27 women and eight men in the sample, this ratio of 1:3.3 is higher than usual for men to women than is usual in nursing.

There was a wide variation in age ranging from thirty one to fifty nine years of age with a mean age of 41.94 across the schools. The mean ages of the teachers in the schools is reported in table 4.

Table 5 - 9

Mean Scores for Age Between Schools

School	Age Range	Mean Age	n
Blackstone	31-49	38.5	8
Waverly	31-50	41.62	13
Chiswell	35-59	44.21	14

Although the age range between Blackstone and Waverly teachers were similar, the mean age of the Chiswell teachers was higher. Whether this was statistically significant is trivial, since the sample size was small. With regard to Blackstone, the effect of the closure of the college was influencing this result since teachers were leaving and teachers over fifty were being offered voluntary retirement. However, given that there had also been redundancies in Chiswell, the mean age of the teachers is overall higher, the difference in these ages between the schools is worthy of note.

The teachers had also been asked to report the length of time they had been in education and these results are interesting when compared with their ages. In Blackstone the mean number of years that they had been teachers was 5.1 years compared with 6.5 years in Waverly and 10.2 years in Chiswell. In Blackstone one Course Director was responsible for both the Common Foundation Programme and the Adult Branch Programme, these responsibilities had been divided in Waverly, all three of these teachers were over forty years of age and had been teaching for more than ten years. In Chiswell, it was not possible to make any comparisons. Although responsibilities for the Common Foundation Programme and the Adult Branch Programme were also divided, both Course Directors in this school refrained from

participating in the study. Interestingly though, the Course Director for the Child Branch in Chiswell did, she was in her early forties and had been teaching for ten years. The main conclusions drawn from the data were that, the teaching population at that time were older and more experienced teachers overall in Chiswell than those in Blackstone and Waverly.

This does not necessarily imply that the older and more experienced teachers were more experienced clinicians, or that the range of subject areas that they taught was different. Questions had also been asked to determine the subjects that were taught. These were then compared with the teacher's professional and academic qualifications. These results are presented in full in appendix 11. What proved to be fascinating was the difference between the schools in the range of subjects the teachers said that they taught. These are displayed in table 6. The professional qualifications of the teachers are those registered and recorded by the UKCC. Academic qualifications are presented according to the subjects in which they held degrees or higher degrees. The subjects they taught are reported according to how the teachers described the subjects they taught, and the number of times they were mentioned. These subjects are also a reflection of the manner in which the curriculum was organised as discussed in Chapter 11.

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Table 6 - 9

Comparison of Professional/Academic Qualifications and Subject Teaching

School	Professional Qualifications	Academic Qualifications	CFP Subjects Taught	Branch Programme
Blackstone	RGN 8 RMN 2 RNT 8	Nursing/Ed 3 Nursing 1 Sociology 1 Soc. Sci. 1 Education 1 Health Studies 1 Counselling Psy 1	Nursing 4 Soc. Sci. 4 Ethics 1 Research 1 Women's Health 1 Sexual Health2 Mental Health 2	Adult 6 Mental health 2
Total	**n = 8**	**7 subjects**	**8 subjects**	
Waverly	RGN 9 RMN 4 RMNH 2 RSCN 1 RNT 9	Nursing 5 French/Soc. 1 Soc. Sci. 2 Life Sci. 2 Education 2 Soc. Ethics 1 Health Studies 2	Nursing 8 Sociology 4 Prof. Studies 5 Biology 1 Health 1 Health Policy 1 " Beliefs 1 " Promotion 1 Psychology 2 Ethics 1 Philosophy 1 Communication 2	Adult 7 Mental Health 4 Learning Disability 2 Child 1
Total	**n = 13**	**7 subjects**	**11 subjects**	
Chiswell	RGN 13 RMN 4 RM 2 RSCN 1 SN 1 DN 1 RNT 12	Nursing 7 Nursing/H. St.1 Education 4 Comm. Health 1 Psychology 1 Health Psych. 1 Health Studies 1 Life Sciences 1 Soc. Anth. 1	Nursing 12 Research 5 Sociology 5 Social Policy 4 Biological Sc. 1 Microbiology 1 Prof. Nursing 2 Ethics 1 Health 1 Law 1 Paediatrics 1 Comm. care 1	Adult 12 Child 1 Mental Health 1
Total	**n = 14**	**9 subjects**	**11 subjects**	

N.B. RGN Registered General Nurse
RMN Registered Mental Nurse
RNMHRegistered Nurse Mental Handicap
RM Registered Midwife
RSCN Registered Sick Children's Nurse
RNT Registerd Nurse Teacher
SN School Nurse
DN District Nurse

From an overall perspective, it can clearly be seen that the majority of the teachers were registered general nurses and registered nurse teachers. In all the schools the most commonly held academic qualification was either a first degree or higher degree in nursing. These were either combinations of nursing degrees with education in Blackstone, in Blackstone and Waverly there were more teachers with degrees in social sciences than in Chiswell. In Chiswell there appeared to be more focus on

degrees in nursing, health studies and education than in the other two schools. Two Chiswell teachers held community nursing qualifications in school nursing and district nursing.

What is more interesting is the diversity in the range of subjects taught and how they were reported. In Blackstone, the main focus of reported teaching subjects were social science and ethics. Women's health, sexual health and mental health were also reported. Clearly they were components of health promotion, but were not reported as such. In Waverly the range of subjects was interesting in that while nursing and social science were frequently reported subjects, more insight into the curriculum content was given in that professional studies were reported, although only one teacher stated what this implied, namely; nursing history, quality standards and nursing models. Interestingly, one Waverly teacher taught philosophy, and another health promotion, there also appeared to be more emphasis on teaching health studies than in Blackstone and Chiswell.

By contrast in Chiswell, although, four teachers held degrees in community health studies, health psychology and psychology, there appeared to be more emphasis on biological sciences, only one teacher reported that she taught health studies, she was one of the three non-graduate teachers in this school. Paediatric nursing and community care were identified subjects in this school. Nursing was described by some of the Chiswell teachers as either nursing theory and practice. Health promotion did not emerge as an explicitly taught subject.

From this comparison of the teacher's academic and professional qualifications with the subjects they taught there are several issues that require comment. Firstly, what seemed apparent was that the teachers in Blackstone and Chiswell appeared to be from more varied backgrounds than the Blackstone teachers. Although in all schools, and not surprisingly, the key subject taught was nursing. However, the main emphasis

in the subjects taught that complemented and underpinned both nursing theory and practice seemed to be very different in Chiswell than in the other schools. The emphasis seemed to be on the social sciences in these first two schools, while in Chiswell more teachers reported teaching biological sciences. This was surprising, given that in all schools there was an equitable distribution of teachers with academic qualifications in the social and behavioural sciences. Secondly, health promotion was addressed as a subject implicitly in Blackstone, and explicitly by one Waverly teacher (the Course Director for the Adult Branch Programme), this was not apparent at all in Chiswell. Thirdly, there was an apparent lack of diversity in the Blackstone teachers professional qualifications. While it was recognised that the teaching population was rapidly reducing, at this time, and teachers with more varied professional qualifications such as community nursing, may have left, or chosen not to participate in the study, some subject areas were not taught by these teachers. Some clarification is required in that the Common Foundation Programme was organised and taught collaboratively with the students and staff from a children's hospital in central London. Also, biological science was taught exclusively, by academics in the Department of Life Sciences in the University College that validated the course. These factors may well be influential in the presentation of this profile.

This analysis is also interesting since when the teachers were asked whether they thought it was important for student nurses to learn about health promotion, 29 (82.1%) thought it was very important and 6 (6.17%) thought it was important. This overwhelmingly positive response was also similar to that of the students, but questionable, in that it was not clearly identified as a taught curriculum subject by any of these teachers. Further exploration, was evidently necessary.

The Teachers' Perceptions of Health Promotion.

This part of the study was conducted in two phases, in the survey teachers were asked questions relating to their own health beliefs, what they thought health promotion

was, and to explain why they thought it was important for students to learn about health promotion. The intention was to both carve out "entities or properties" from the data to identify some conceptual order, also to illuminate through "insightful description" (Tesch 1995). The properties, or themes generated would be utilised as key areas for focus group discussion with the teachers.

As a starting point, the index developed by Blaxter (1990) was used to analyse the content of the text relating to the teachers' health beliefs, Since it had been demonstrated that the total sample were an educated professional group it was not surprising that they described quite sophisticated multidemensional concepts. These are presented below in the order that they were most frequently mentioned. Content analysis scores are contained in appendix 9.

Table 7 - 9

The Teacher's Health Beliefs

	Frequency 1	Frequency 2	Frequency 3
Not ill	3 (8.8%)	0	1 (16.7%)
Despite disease	1 (2.9%)	3 (15.6%)	0
A reserve	2 (5.7%)	1 (5.3%)	1 (16.7%)
Living a healthy life	3 (8.8%)	1 (5.3%)	1 (16.7%)
Physical fitness	3 (8.8%)	2 (10.5%)	0
Energy and vitality	3 (8.8%)	0	0
Social relationships	1 (2.8%)	4 (21.1%)	0
Means to an end	7 (20.9%)	4 (21.1%)	0
Well-being	11 (32.5%)	4 (21.1%)	3 (49.9%)
Total	34 (100%)	19 (100%)	6 (100%)
n	35	35	35

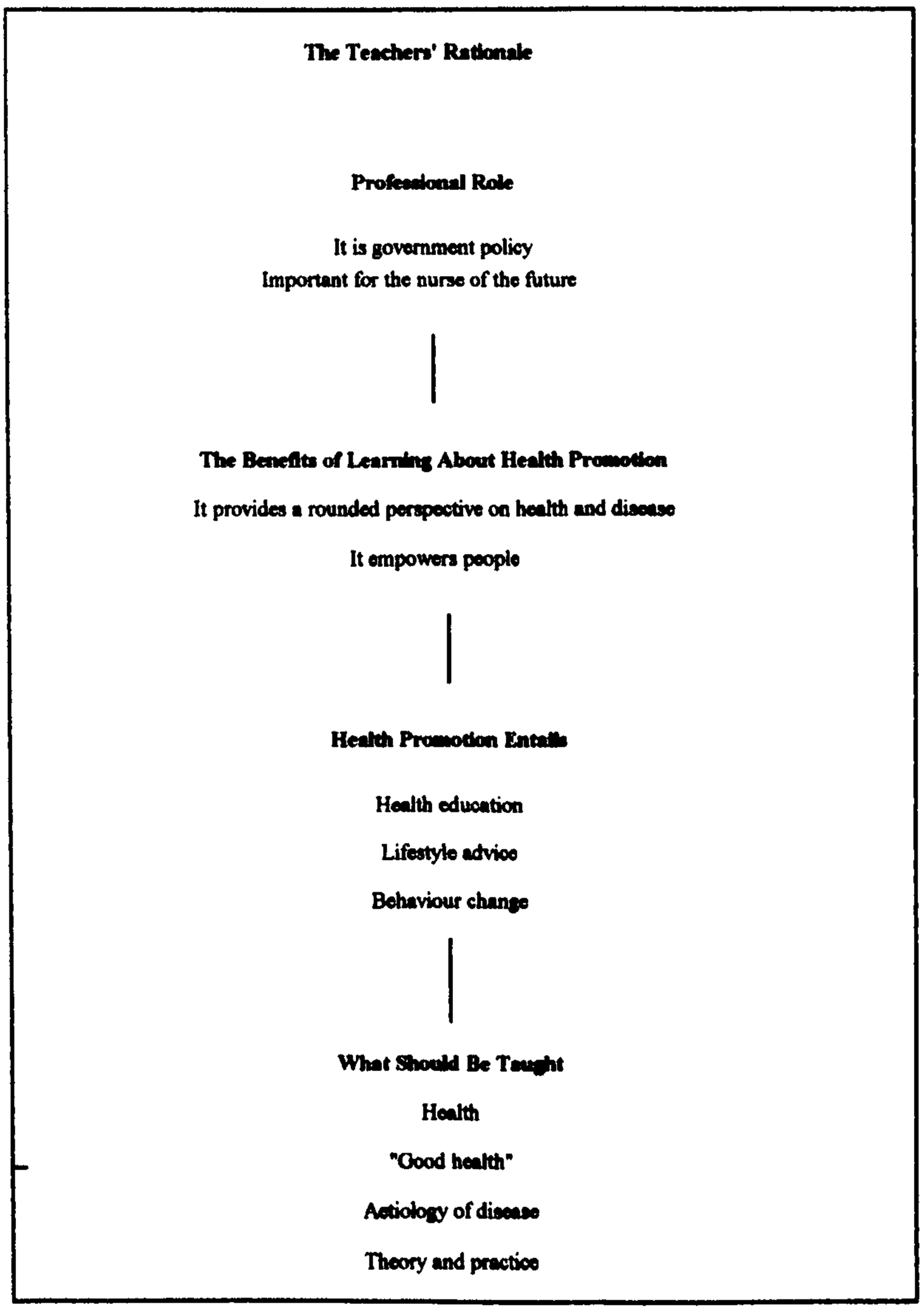
The most frequently mentioned categories were associated with well-being and "being healthy" as a means to an end. Some polarity in the data was also observed, but since the numbers involved were small, there was little point in proceeding with any further quantitative analysis.

Why Was it Important for Student Nurses to Learn About Health Promotion?

The responses to this question revealed a multiplicity of complex and interrelated reasons. Some were quite pragmatic relating to policy decisions others acknowledged

the philosophical shift from curative to preventive healthcare. Others made similar responses to the students in that they were defining health promotion, but they were more focused, in that they were also offering opinions about what should be taught in the name of health promotion. These responses were organised into themes and subsections and are outlined in figure 2. The themes generated from the data are then analysed in the context of these headings and their subtitles. These themes were submitted to independent review for construct validity (Streiner and Norman, 1995), a 100% validity score was achieved (see appendix 9).

Fig. 2 - 9
The Importance of Student Nurses Learning About Health Promotion



Professional Role

The development of nurses role through the achievement of the competencies outlined in the Nurses, Midwives and Health Visitors Rules Approval Order (1989) was mentioned, but without further clarification, by several teachers in both Waverly and Chiswell. Nurses empowering patients indirectly through vicarious learning and role modelling and directly by teachers facilitation in learning the practical elements of health promotion was mentioned by Blackstone and Waverly teachers. The essence of these notions, however, was crystallised by one Blackstone teacher;

> "Nurses of all levels are powerful and influential professionals (even though they are not often conscious of it). Exposure to health promotion both in theory and practice, helps nurses make a more effective impact on the lives of patients, colleagues and self, without health promotion nurse education would be incomplete - nurses have a right to an education which gives them scope to develop in this area".

The Nurse of the Future

The changing nature of healthcare was acknowledged in statements relating to both government policy and the professional role. This notion of nurses being educated to cope with and adapt to current and future change as well as enabling them to effect social change was addressed in this category. It was an issue that was addressed by teachers in all three schools. For example the course director in Blackstone stated;"

> It is one of the most important aspects of nursing-or should be. It is a way that nurses could affect social change".

Another comment from a Waverly teacher (a Learning Disability Nurse, with degrees in psychology and health psychology) said;

> "Change - in health service, society, disease illness patterns etc. Same policy in health service (HON) emphasises health promotion, organisational change - rise of community care, particularly in Learning Disability and Mental Health Nursing - shift to prevention and maintenance of people in the community. Reduced role for hospital, for general medicine too. Change in patterns of disease - on the whole an individual's behaviour can have an impact on mortality and morbidity rates today - in terms of coronaries, heart disease....."

A Chiswell teacher also highlighted the changing nature of healthcare in this context, depicting the future for health promotion and nursing being outside institutionalised care. She was a community nurse;

> "More students electing to practice community nursing. Rapid throughput in hospital gives nurses less opportunity to develop the necessary relationships with their patients to develop empathy and trust".

Policy Dictates that Students Should Learn About Health Promotion

The WHO Health For All 2000 and UK government Health of The Nation strategies were mentioned by two Blackstone teachers. Government policy was only mentioned by one other teacher who was the common foundation course director for Waverly. Her response was revealing in that although she clearly valued health promotion, she was also sceptical, she was calling for rationalisation and balance. She seemed to be expressing a fear that the care of severely ill people was being jeopardised as a result of this reorientation, a theme which recurred throughout both the student and teachers perspectives;

> "Health promotion is clearly important in relation to recovery from illness as well as in preventive care. It is also, currently, a high profile issue with regard to government policy. However, there may be a tendency to swing too far in this direction, to the detriment of acute care, there needs to be a balance".

The Benefits of Learning About Health Promotion

"It provides a rounded perspective on health and disease". This was one of the responses from one Blackstone teacher, and provided a useful subtitle for a range of data including the dichotomous and ubiquitous "prevention/cure" responses. These notions were expressed by teachers across all three schools, with the more eloquent explanations provided in Blackstone and Waverly. The dominant thought is exemplified in the following statements;

> "Often, in nursing the focus is on illness and disease and I think students need to explore and think about other priorities, it may encourage/promote healthy behaviour among the students! Provides a focus in nursing away from the disease model".

This was a comment from one of the two mental health nurses in Blackstone, and clarified by another from Chiswell, who was also a registered mental health nurse.

> "The healthier people are the less disrupted are their lives. Illness causes loss of earnings, social, emotional problems".

It Empowers People.

Empowerment was referred to in the context of the influence nurses can have on patients lives through the development of autonomy for the patient. This notion was mentioned more often by the Chiswell teachers, their perspective was quite pragmatic in terms of the acknowledgement of the limitations of personal freedom and choice and the necessity for support.

> "Health promotion is about enabling individuals to achieve optimum health status within the potential of their individual circumstances".

> "To empower individuals to become active participants in their healthcare and be offered the facilities to achieve this;
> e.g. occupational health department
> No smoking areas
> Well woman/ well man clinics/ screening".

> "To give the person a choice about their health and take control of their lives from an informed basis".

However, these ideas are quite individualistic, as is the content of the responses relating to their perceptions of health promotion and what it entails.

The Elements of Health Promotion

Here there was a clear focus on health education, although sometimes couched in terms of health promotion, for example;

> "Nurses are probably best placed to give advice because of nurse/patient relationship - time spent with patients on one to one basis".

> "Need to be able to educate clients on how to maintain a healthy lifestyle".

These notions were not expressed frequently, but they were expressed by teachers in all three schools. What underpinned the observation that health promotion was

perceived on the whole to be more within an individualistic framework was the focus on lifestyle and behaviour change.

Lifestyle and behaviour change

These notions were apparent across all three schools and interwoven with ideas of empowerment by giving advice and information, but also the promotion of a healthier lifestyle through knowledge of risk factors.. However, one teacher who worked with people with learning disabilities was not focused so much on lifestyle and behaviour change as on healthier living;

> "I feel that it is absolutely essential for my own branch of nursing for practising nurses to promote healthier living for our client group".

What Nurses Should be Taught

The responses here were interesting in that in general what need to be taught in the name of health promotion was not expressed at all clearly. Health and what constituted "good health" were stated, but not developed. Theory, models methods and practical skills were also mentioned but few examples of theoretical content or the skills were forthcoming. One Chiswell teacher attempted to define the theoretical content but from a biomedical perspective;

> "It is impossible for a student to understand the aetiology of an individual's illness and the advice to be given to a client without the theory/understanding of health promotion".

Although this person is separating health from illness, it seems that he/she wishes to include the theory of the determinants of ill health as well as health. It could seem that the focus for that person is on illness as opposed to wellness. Another teacher in Blackstone attempted to define the practical skills in terms, of listening, empathy and understanding, which she called "traditional nursing skills".

In this chapter the influence of educational ideology on educational organisations has been discussed. Although it is acknowledged that nursing education is beaurocratic, to some extent all educational organisations are beaurocratic. however, it has also been demonstrated that these colleges of nursing were functioning within different ideological contexts, especially Waverly. However the transition from the health service into higher education was a factor that had very wide ranging, and in one case drastic effects on these organisations. The culture of these organisations was led not by ideology, but by the transition into higher education.

The comprehensive identification of academic achievement was difficult, and could be attributed to this change. Nevertheless, it is concluded that senior managers were effecting successful change in this area. It has also been demonstrated that the teachers own health beliefs were sophisticated, tending to reflect a holistic notion of health related to well-being. They also thought that it was very important for nurses to learn about health promotion which was encouraging. However, while health promotion as a force for empowering people was recognised by some, it was not described in any way as an overriding philosophy for care. The importance of health promotion as an aspect of the professional role was acknowledged in the context of attempting to meet the changing demands of healthcare. There was no clear description of what was taught in the name of health promotion, only one teacher reported teaching the subject, this was perhaps an underlying indication of the teachers own lack of conceptual clarity, and is supported by the findings of other studies (Gott and O' Brien 1990). Conflict was also apparent in relation to this new paradigm approach to healthcare, which could possibly place the care of acutely ill people at risk.

CHAPTER 10

EXPLAINING THE TEACHER'S PERCEPTIONS

The previous chapter demonstrated that although the teachers perceived health promotion to be important, their perceptions were confused, consequently there was little clarity regarding what was taught in the name of health promotion. A deeper analysis is executed in this chapter.

Methodology

Focus group methodology was selected for this part of the study since it has been used effectively in healthcare in the examination of peoples' experiences of services (Murray et al 1994) and the attitudes of staff (Denning and Verschelden 1993). Patton (1990) describes focus group approaches as being appropriate in the following contexts:

- basic research, to contribute to fundamental theory and knowledge;
- applied research, to determine programme effectiveness;
- summative research, to determine programme effectiveness;
- formative evaluation, for programme improvement;
- action research, for problem solving.

Since the intention here was to extrapolate underlying meaning and experiences in order to contribute to knowledge this, approach was indeed appropriate.

Sampling Methodology

Purposive sampling methodology as described by Silverman (1993) was used. Recruitment to the interviews was problematic. Teachers had been invited to indicate willingness to participate when they received the original questionnaire. Responses to this initial invitation had been encouraging, in that, of the 35 teachers who participated in the study 30 responded positively. However, the reality of identifying

a mutually convenient time and location proved to be the stumbling block. The Course Directors in all three schools were helpful in co-ordinating these events. The inclusion criteria being that teachers taught students in the common foundation programme.

The overall characteristics of the groups are outlined in table 1. There were five participants in Blackstone, three in Waverly and four in Chiswell. For purposes of anonymity fictitious names were ascribed to them. Apart from three teachers (one in each school) all had participated in the initial survey. When the professional qualifications of those three teachers are examined it can be seen that Penny, in Blackstone was a Registered Sick Children's Nurse. Gerald in Chiswell taught sexual health, however, it is interesting to note that he reported this subject area in terms of HIV/Aids and sexually transmitted diseases, certainly not the language of health promotion. The academic qualifications of the participants are not included in the table, however, Barbara in Chiswell had an MSc in health promotion and while she taught the subject to the pre-registration students, was also responsible for teaching a module in health promotion on a post-registration BSc Nursing course. It was also observed in Blackstone, the Course Director for the common foundation and Adult Branch Programme was a participant as was the Course Director for the Adult Branch Programme in Waverly. While the course Director in Chiswell, was helpful in the organisation of this group, she withdrew from participation due to pressure of work.

Table 1 - 10

Characteristics of Focus Group Participants

Name	Subject s	Status	Professional Qualifications
Blackstone			
Julia	Soc. Science, Nursing	Course Director	RGN, RNT
Neil	Soc. Science, Sexual Health	Teacher	RGN, RNT
	Child Health, Nursing		
Penny		Teacher	RGN, RSCN, RNT
	Elderly Healthcare, Nursing		
Kate		Teacher	RGN, RNT
	Nursing		
Sally		Teacher	RGN, RNT
Waverly			
Sheila	Sociology, Nursing Communication	Teacher	RMN, RNT
Jenny	Health Policy, Health Beliefs, Health Promotion	Course Director Adult Branch Programme	RGN RNT
	Health Promotion	Teacher	
Barbara			RGN, RNT
Chiswell			
Dianne	Biological Science, Nursing	Teacher	RGN, RNT
	Sociology, Soc. Policy		
Trish	Community Nursing	Teacher	RGN, NDN, RNT
	Biological Science, Nursing,		
Gerald	HIV/AIDS/ STD	Teacher	RGN, RNT
	Social Policy, Nursing		
Ben		Teacher	RNMH, RNT

Although the methodological problems associated with the organisation of these groups have been addressed, some comment is necessary at this point on their size. The literature on focus group methodology recognises the problems associated with attrition (Mays and Pope 1995) and generalisability and reliability of the data. However, since the study consisted of several groups and the population was homogenous, it was anticipated that these factors would outweigh the initial concerns.

Data Collection

Data analysis from the previous survey had indeed fulfilled the intention of providing a framework of topics on which to base the interviews. As a result a guide was constructed based on two key areas, associated with process and product;

- What do we perceive the students to be doing in the name of health promotion once they are qualified nurses? This was split into areas associated with knowledge and practice.
- How is that achieved?

It was anticipated that this mode of enquiry would contribute to meeting the deficit in understanding so far.

The focus group interviews were carried out in all three schools between February and May 1997. The researcher was the key facilitator and a psychology graduate was recruited as an independent observer or "structured eavesdropper", as recommended by Powney (1988). The interviews were conducted in an unstructured manner, in all of the interviews the facilitator attempted to adopt a passive role in order to allow the discussion to be led by the groups (Butler 1996). Overall, this proved to be a successful strategy given the homogeneity of the groups. However, there were also differences, and it is appropriate to place the discussions in context, since the dynamics of each group did affect group facilitation.

The Characteristics of the Groups

These observed characteristics and impressions of each group are the result of comparisons with the researcher's field notes, those of the observer and the notes taken from the transcriptions.

Blackstone

This interview took place in February 1998. The college was closing at the end of the month. The teachers were in a reflective mood. Although there were areas in the

curriculum that they wished to change there was no way forward. What emerged was an overwhelming feeling that they were proud of their achievements, this was a loss to nursing, as was an educational organisation, where both at strategic and operational levels the dominant philosophy was a belief that health was important. Nurses, even though they were working in hospitals and nursing the sick, needed to know about health. There was also a feeling that the NHS and Community Care Act (1991) had been implemented too quickly and that the divide between health and social care was reactive in enabling nurses working in the community to work within a health promoting context. There was too much focus on tasks, care was not holistic.

Overall, however, there was a prevailing feeling of sadness. This interfered with the group dynamics. One member of the group, although agreeing to participate was almost totally silent. One explanation of this could have been that the discussion, itself was another manifestation of the hopelessness she felt regarding the situation. Discussion after the session revealed that she was the only member of the group who had found no alternative employment once the college had closed.

Straw and Smith (1995) warn that clinicians are not always the best moderators since they can become "trapped" into creating a therapeutic environment. In this instance the author had certainly fallen into that trap. On conferring with the independent observer, her notes had not identified this strong feeling of loss and bereavement. She thought the group were understandably negative, and also observed that the facilitator played a prominent role in prompting the group to lead its own discussion, by asking probing questions and summarising. Her impressions were supported by the tape recordings and the transcripts. Certainly the group were reflective, but they were also thoughtful and the discussion was lively. The group member, whose non participation had caused concern was in fact taking on the roles of clarification and support, although she was definitely not a leader (Tuckman, 1965; Satow and Evans 1995)

Waverly

The teachers were dynamic and enthusiastic, they appeared to enjoy good working relationships. They had very different views on health promotion but were willing to and seemed to relish engaging in debate. They immediately entered the performing stage of "group life" as described by Tuckman(1965).

One main concern common to all of them was that they were not sure whether they had common perceptions of health promotion. The Course Director was certain that all nurses had a role, it was not just done in the community. She had a deeply held belief that it was inextricably linked with nursing and Virginia Henderson's model of nursing. She also felt that there was too much of a focus on wellness and community. Hospital nurses would be definitely needed in the future. The teacher who taught health promotion expressed a more stucturalist view. The impression that I came away with was that she felt nursing in general had a narrow individualistic focus in terms of what was taught, namely health education and information giving. The mental health teacher was not sure how she felt about this subject as she thought she didn't teach it. As the discussion progressed the lights came on. As she described what she did she suddenly realised that she was teaching health promotion. This was very exciting and rewarding to observe. These observations were also confirmed by the independent reviewer and by the data.

Chiswell

The general impression was that this was a very thoughtful and serious group. They needed time to begin to perform as a group and this was demonstrated by long silences at the beginning of the session. They had some conflicting ideas about health promotion in the curriculum, that it was not just the role of community nurses. They would side-track, digress, they also needed to be guided with probing questions. The admitted differences between a structuralism, public health and lifestyle approach, they were unsure which was the most important for nursing. They did not seem to

articulate beliefs or philosophies. They seemed to touch on an area and the float away. The general feeling and impression was that they had an idea about application, being as important and that the subject should be explicit not implicit in the curriculum.

These overall impressions were supported by the independent observer. However, her notes revealed that she had absorbed more than the researcher, in that she described the group as pragmatic, offering practical opportunities for students to experience health promotion. It seemed that the researcher had indeed been working hard in facilitating the group dynamics in this instance, and had not heard the detail. These conclusions were also supported by the data.

Each interview lasted for approximately one hour before a point of saturation was reached. All of the interviews were tape recorded and transcribed in full.

Data Analysis

Data were analysed using the "Framework method" described by Ritchie (1994). This is a four stage iterative method. In the first stage the researcher listened to the tapes and read the transcripts in order to familiarise herself with the data. At this point notes were made which formed the basis for the second stage of identifying thematic frameworks. In addition, at this stage and in order to protect against contextual "ironies" (Garfinkel 1967), these notes were compared with the field notes taken at each interview. The transcripts and notes were then used to identify themes which emerged as a result of the use of the topic guide (apriori issues), that are introduced by the participants (emergent issues) and those which arise from recurrence or patterning in the data (analytic issues). Stages three and four involved the development of headings and subheadings and mapping and interpretation of data from the separate cases under each heading. In reality stages two, three and four overlapped as the analysis involved all three activities simultaneously. Content

validity was assessed by submitting the full transcript and the thematic framework to three independent reviewers (Appendix 12).

Quotations from the data are presented that represent a particular theme. Each quotation has an individual code which facilitates the identification of the originating transcript e.g. B = Blackstone. In all groups it was possible to identify the voices of particular individuals from the tapes, each person was assigned a specific letter code throughout the transcription. In addition each quotation was assigned a number referring it to its place within the transcript e.g BP12 = Blackstone Penny 12th quotation. However, because it was possible to identify the voices of the participants, and in order to present the dialogue in a more meaningful context the participants assumed names are used.

Results

Although the topic guide was referred to in the same sequence with all groups, the respondents typically focused on an issue they considered important and the discussion during each session tended to range backwards and forwards across the topic areas. To some extent this reflected the degree to which the issues identified were interrelated. In the presentation of the apriori themes these have been divided into the areas covered by the topic guide. This is not an indication that the participants discussed these issues separately. In reality their views about these issues tended to be complex and highly interrelated.

Eight apriori themes were identified that were directly related to the topic guides namely:

- What the students should be doing in the name of health promotion as newly qualified nurses.
- The product - Where the nurse will be working?
- Barriers
- What is health promotion?
- What the students learn.

- How the students learn
- Critiques of health promotion.
- Should health promotion be explicit or implicit within the curriculum?

All of these categories were mentioned by the participants in all three groups but, as described in the literature there was both consensus and disparity in and between the groups. This was influenced according to the nursing background and experience of the teachers, this is reflected in their examples and descriptions of practice.

1. What should students be doing in the name of health promotion as newly qualified nurses?

In all groups very wide ranging views were expressed but in Blackstone and Waverly the main contentions were that it was important to be thinking about health promotion.

Neil: "I suppose what I see students who've just finished the course doing is really...erm, start thinking about health promotion" (BN2).

Jenny: "Because I think what we try to do with the diploma courses..... is to make the students think about it...."(WJ1)

Penny, a Registered Sick Children's Nurse elaborated on this and introduced an interesting example of how and why this was important.

> " I think it's quite important for people to be aware of what's actually going on all the time, you know things like children....why parents are there (on the ward, my emphasis) - why we encourage family participation and care and discuss emotional and health issues. That they're actually thinking about what they are doing - that they actually see it as part of health promotion. Just the little things" (BP3).

Jenny, in Waverly also elaborated on the importance of teaching about the "little things" in relation to ethics:

> "I'd like to say something else..... A comparison with er .. practitioners, not recognising whether they are engaging with health promotion. One of the areas in the clinical assessment is to assess ethical issues. Practitioners have said we don't do that it's rubbish. There are plenty of ethical issues, the students recognise this....It indicates that the practitioners are thinking of things like abortion, euthanasia, turning off life support. The students aren't,

the students are thinking about what do you think about the patient who has a bed that's not available, what do you tell patients about their illness. They're thinking about all those things because that's what we talk about, and I think the same could be said about health promotion. That the practitioners think about big campaigns, leaflets etc. They don't realise that what they're engaging in can be classified as health promotion" (WJ15).

There was also a more pragmatic view expressed by other teachers in Blackstone and Chiswell. This was associated with application and adaptation as expressed by Dianne in that;

" ...depending on what setting they're working in they should be able to adapt what they've learned .....that they make the most of the opportunities they have for health promotion" (CD11).

Julia, the course Director in Blackstone, thought that the students should be focusing on the interface between home and the hospital and incorporating discharge planning into health promotion;

"When a patient's discharged I'd like them to be able to talk to the patient about that.....very basic.... laughs..... you know discharge advice, health advice is, remains the first priority" (BJ11)

Gerald in Chiswell expressed a similar view;

"I think they should be using models of health promotion and nursing and helping patients to be more compliant by giving them information they can understand in layman's terms and try hopefully to reduce readmission of that patient by health promotion and by enabling understanding of diets, treatments and so on"(CG11).

Jenny in Waverly had not focused on the setting where the nurse would be working, but seemed more philosophical in her perception in that nursing was health promotion;

"My view is that virtually everything a nurse does can be classified as health promotion, throughout the continuum of a person's life. So even at death I think a nurses action can be considers as part of health promotion" (WJ11).

Trish, who was a community nurse expressed a less individualistic idea of what the nurses should be doing;

"it's not just about helping individual clients to promote their health, but it's looking at how they can improve the health of the environment" (CT11).

These views were interesting in that they all tended to desire students to be looking thoughtfully at their practice, but in Blackstone and Chiswell elements of conflict

arose at this stage, within and across the groups regarding, whether the focus of practice was on the patient or at a more structural level. The notion of adaptation and flexibility was also present across the groups.

2. The product - where will the nurse be working?

This was not entirely clear in Blackstone the Course Director thought that in the short term there was little scope for newly qualified nurses working in any other setting than the hospital;

Julia: "the product we have with our groups is hospital staff nurses" (BJ11).

The reason she provided for this that there few employment opportunities for newly qualified staff nurses in alternative settings especially in community nursing, in that part of London. Also the nurses themselves were being recruited by, and wanting to work in hospitals;

Sally: "most of them are working in hospitals.....some, not many, are considering going into the community" (BS11)

A similar view was apparent in Waverly, but not expressed so explicitly. In Chiswell there seemed to be a caveat in the text in relation to this issue;

Trish: "we'd expect them to relate that to where they're working" (CT24)

Dianne: "I think it depends where they are..... in the hospital community or wherever"(CD25).

3. Barriers to the nurse being an effective health promoter.

There was general agreement that there were elements in both the clinical areas in hospital and community settings mitigating against students learning about health promotion. The reasons for these identified as the lack of support from qualified staff and the managers;

Neil: "I just don't think we can prepare them to go out and do it stat. There has to be...there has to be the support for them to do it..... I just don't think without the support in the work area, the places where they're going to

be employed. They're not going to have a chance of doing anything" (BN11)

Another reason was the reduction in the length of time patients were in hospital;

Barbara: "in particular hospital nurses ..erm.. to actually get any health promotion done, because I don' t think they actually do any because of the time factor with patient turn around. A lot of them just totally rely on leaflets and that's it . There's no health promotion done" (WB23).

Pressure of work was another reason for avoiding any health promotion activities, which was not necessarily confined to hospital ;

Penny: "It's easy to disassociate yourself from it because you're too busy" (BP13)

Julia; "Well, I mean, talking about the reflection that my students have done on their community experience and it's been very much that, well the nurse comes in and does the dressing, focuses on the (leg) ulcer and goes out again...laughs....which is definitely not the way they act on the wards. Definitely not" (BJ73).

The reason for explaining the perceived barriers to nurses being effective health promoters was the implementation of the NHS and Community Care Act (1991).

Sally: "It's not a question of the community nurse as such. There's a lot more sick people being cared for in the community and so the community nurses are really stretched" (BS23).

Neil: "and also social care has taken out...." (BN43).

Sally: "Exactly yes" (BS33).

Neil: "Social care is now where a lot of health promotion takes place. They're not doing the baths and dressings. Healthcare assistants do baths - it was at that sort of time that health promotion took place" (BN53).

All of these experiences were perceived as being stressful for the students in terms of them achieving their educational objectives.

Jenny: "I've always been told what happens in the classroom is all very well, but what really matters is what happens in practice. That we're not seeing this integration in other areas in practice....in the way that other practitioners or qualified practitioners think and behave. So it's really hard, unless they're very bright themselves....it's very hard for students to make these connections" (WJ33).

Sheila: "Then they begin to think there really is a theory practice gap" (WJ13).

There was also another problem associated with practitioners knowledge, in that some were unaware that they were utilising health promotion principles in their practice;

Jenny "Even those practitioners who are doing it but don't realise they're doing it.

> But because they don't realise they're doing it they can't point it out to the students" (WS43).

The focus on illness as opposed to "wellness" was another reason for this;

Dianne:"I still think when they go into hospitals the focus is on helping that patient through their illness and much less on the health promotion aspects. Even though throughout the course they are taught about the principles of health promotion. But I still think there is less done in the hospital than in the community setting" (CD33).

Interestingly Jenny was critical of current nursing theory.

> "if you take the current nursing text...not the health promotion text. I'm afraid they still promote what I think is quite a narrow view of what health is. And although the WHO's definition .....was fine and dandy when it was first produced it is still today being pushed around by nursing text and it is not enough. It doesn't incorporate enough, it's not flexible enough..... So we're battling against that, with what we're teaching and trying to get them to think much more broadly"(WJ14).

4. What is health promotion.

This area of the discussion revealed some interesting perceptions with the teachers in Waverly and Chiswell being much clearer than they were in Blackstone. At a structural level this related to the WHO (1986) definitions and strategies as well as the UK Health of the Nation strategy (1992). There was agreement that it was a multifaceted concept and grounded in the social and behavioural sciences. A broad view of health was also integral to a definition of health promotion.

Neil: "Well...well, I've been studying health and health promotion for nearly ten years now and ...and to be honest with you I still don't know what it is. And I don't think there is an "it" - I think there are several "its" (BN84).

However, Neil was clear, as was Jenny that there was an interrelationship between health promotion and nursing;

Neil: "....health promotion is nursing and nursing is....there's no direct equation, but they are the same kind of thing, there's such a lot of overlap. I think having us standing in front of a class saying this is health promotion is really good for nursing and for healthcare" (BN34).

But Jenny was aware that this conflicted with Barbara's view, whom she regarded as, and referred to, as a "specialist"

" their view of health promotion is of course very wide, very big...an activity that goes on at specialist level across communities and so on and so forth. Whereas in nursing we tend to use the term in the context of an individual client, and a lot of health promotion specialists don't like that. They say that's not health promotion that's health education, whatever that might be. So there's a lot of confusion about terms. I still don't think we can get away from the fact and I think my colleagues in health promotion would agree with this. If nurses are not trying to promote a patient's health, what the hell are they doing?" (WJ14).

The "specialist" view was also expressed and clarified in Chiswell;

Ben; "One thing I'm not sure of.....is where health promotion ends and where public health begins, and whether the two are linked and whether things to do with the environment are structural and issues related to public health become health promotion" (CB14).

Trish: "I think we do a lot of work on the factors that influence health and despite the fact that we've gone through a long and difficult time from what the individual can do to a more balanced view.. that there's more to health promotion than what individuals can do. It's about changing environments, equally as important is legislation, that broader view, which incorporates public health, which I personally feel is health promotion" (CT34).

Ben: "This idea of empowerment is useful. But to what extent do we empower students and patients? In that process...you get people to take responsibility for their own health" (CB44).

Where the difficulty appeared to be for the teachers was reconciling the focus in nursing on individualised care, with the collective principles of health promotion.

5. What do the students learn?

There was unanimous agreement in all three groups that the common foundation programme was the key part of the curriculum for teaching the theoretical principles of health promotion.

Neil: "the first eighteen months in the CFP were the foundations for health promotion. The foundations for a whole load of stuff. But I think the students starting by looking at health.... and that was the key"(BN1).

The social and behavioural sciences were seen as the key subject areas in which this "broader view of health" that they all referred to could be developed. Specific areas such as race, culture gender and class were identified as key areas in all three schools. The introduction of ethics in relation to health promotion was also agreed to be important. All the groups were very aware that these subject areas were also the theoretical foundations for nursing, and consequently were not taught as discrete areas pertaining to health promotion. The way in which they addressed the problem was as Jenny stated;

"we refer across, we have to. Also we refer in health promotion to areas like sociology and psychology - yes we very much try to make the link.....we do make that point" (WJ135).

6. How the students learned.

The development of critical thinking was perceived as being an important element. The participants in all three groups were in agreement that the integration of theory with practice was of paramount important in this process. The classroom teaching strategies utilised in this process were mainly through group discussions and debate, exploring theoretical concepts, health and health promotion policy. Reflection on clinical practice was another strategy mentioned. The prominence of health promotion in the curriculum was also perceived as being important as, articulated by Jenny;

"First of all the timetable...that it's there....that it's important enough to make a key part of the curriculum. It's also brought out in the competencies. So that's the importance"(WJ16).

There was also general agreement that health promotion had been successfully implemented and sequenced throughout the common foundation programme;

Trish: "I think we look at health promotion quite a lot and.....um...and we certainly at the beginning get them to explain what they understand by health promotion, and then we have a go at things like health education packages. They produce something for their target group,

they choose what is the topic and their target group and have a go at producing health education packages"(CT86).

Trish: ".....as we progress through the CFP they learn more about health promotion in specific groups. So when they're in their specialities.....like child health, they look at health promotion opportunities with respect to children....." (CT96).

Despite the aforementioned problems in relation to the students achieving their educational objectives, assessment was recognised as an essential element in the learning process, in that it helped the students to critically review their practice and identify for themselves what they were doing in the name of health promotion;

Julia; "I think here, we've worked really hard to integrate theory with practice.....we've worked really hard with health promotion you know, they've had that project... and there were faults with that project.....but it's very clearly a practical piece of health education, with stroke... promotion (giggles). But that with theory and research .....OK it might be health education, most of it is, but it's.....they clearly have to identify that it's that, and that there are other steps on the ladder" (BJ116).

There was general agreement that health promotion was not addressed sufficiently well in some areas of the curriculum. In Waverly and Chiswell these deficiencies were specifically identified as being in the branch programme;

Jenny: "I suspect in areas like mental health and learning disabilities they don't even know what they're doing, even though they engage in it. I think at least in the adult branch and possibly the branch programmes they know when they're engaging in it"(WJ116).

Trish: "I think there's a tendency in the adult branch to focus on disease and look at health promotion related to the disease process"(CT.146).

Should health promotion be labelled as such?

This was another area where wide discussion occurred, it was acknowledged that because it was one of the key competencies that it had to be. However, from this utilitarian notion arose a more thoughtful reason in that it should be an integral part of the professional role. The view in Blackstone was that it had been part of the

philosophy of the college for so long that it had become implicit. However the teachers in the other schools were not so complacent and thought that by making health promotion explicit it would finally become embed in their practice;

Trish: "There's a temptation to make it implicit, part of the care of the client group and then you're reminded, I need to get the health promotion side into that. and you're short of time and health promotion is forgotten"(CT21).

Dianne: "If it's done explicitly within the curriculum, then it should become implicit in what nurses do when they're out in the practice areas shouldn't it. It's part and parcel of what you do, wherever you are....it should be"(CD23).

Emerging Themes

The role of the teacher - linking theory and practice.

The limitations of the development of the role of health promotion within nursing was constantly addressed throughout the discussions in all the groups and the support needed in order for this to be achieved was referred to on many occasions. This was by acknowledging that in all clinical areas, regardless of whether it was in a hospital or community setting, they could identify areas of good or poor practice in the name of health promotion. This was identified in the apriori themes. At a structural level this was attributed to the restrictions opposed by legislation, which had contributed to an increased workload. This is supported by other studies (Caldwell, Francome and Lister, 1998). However lack, of knowledge or awareness of health promotion principles, was also identified. The teachers clearly identified a role for themselves in addressing the problem for both students and qualified staff.

Providing Educational Opportunities for Health Promotion for Pre-registration Students.

Two aspects of this role were clearly identified in all of the groups. The first emerged as being facilitative in providing the link between theory and practice. In Blackstone and Waverly, this was discussed more in relation to linking theory to practice through

theoretical discussion in the classroom and helping the students to structure and evaluate the health promotion activities in their assignments. These samples of the texts are used to illustrate the general agreement regarding these roles. In Blackstone Kate and Julia discussed how they facilitated the development of knowledge in a specific area of the curriculum.

Kate: "...um some places in the curriculum where health promotion isn't identified, it's useful, that we've been able to look at things other than the disease process for that client group. So in unit four where.... erm... where we did the elderly care module we looked at elderly people as a group. We looked at their position of power, or not, in a ward. We looked at ....um... society or how people fitted in that structure of dependence. I think that's useful as well in broadening the students' view of that particular client group. How their health is defined, how the group is defined, rather just being able to dress a wound you know" (BS18).

Julia: "You also looked at ageism, and attitudes towards dying" (BJ138).

Kate: "Yeah. Old age and different cultures and caring. Not health promotion I suppose..but you know. It would come under that umbrella"(BS28).

In Waverly, Jenny describes how they addressed social policy in relation to health promotion;

> "It's all about people and whether they can make choices. Whether people are constrained by the policies, that's the way we do it, and of course the policy about health promotion we pull to pieces. From the curriculum point of view what we are trying to do is say. Well O.K., there's the individual, but the sociology, the health and healthcare... we're trying to relate it in the broader context of society, so in terms of curriculum we're doing that, in terms of practice....perhaps, it's quite different" (WJ108).

In Blackstone, the assessment was used as an example of the teacher attempting to bridge the theory practice divide, and make the links between health promotion and nursing. Initially she alludes to the focus on research and evaluation in the student assignment on health promotion;

Kate: "I think they oversimplify health promotion, by wanting to go on to the ward and make people healthy by giving them information, but I think they come

up in their evaluation that they haven't been able to do that. Then I think that's useful" (BS28).

She then elaborates by giving the following example;

Kate: "Just recently a student was working with me and another teacher and they had to do a health promotion project with the elderly..and, er, you know she was trying to put into practice all the things we've just been talking about. But again, wasn't doing it terribly well. She had ..er... she found her project... health promotion wasn't appropriate to her client group. Rather than her being able to reflect on her own work and seeing that needed changing, she wanted to change elderly people and make them more... er... appropriate to her. She wasn't there. I think because there was this project called health promotion. She was then thinking back about stuff, attitudes, poverty and the rest of it in terms of elderly care. I was getting her to see what they'd done and apply it. She was doing it in some ways but not in others. Health promotion....there erm....needs to be linking with the nursing theme, so it's our job to make that link" (BS38).

The teachers in Chiswell tended to reflect on the practice areas and identify places and situations where opportunities for learning about health promotion could be provided;

Trish: "I think one of the problems for students is this culture which isn't used to health promotion, and it's getting that culture change isn't it? So it's about discussing with them, what are the opportunities in their practice areas and giving it the sort of emphasis that we give to all aspects of nursing" (CT238).

Diane: "Cardiac rehab is one very good example" (CD48).

Gerald: " Yes - fantastic. Asthma rehab as well. Making best use of or avoiding situations that create that asthmatic episode are being addressed more now than before. And enabling people to look at their medication and their lifestyle, to improve their lifestyle. Cardiac rehab is really more MOT than care. To enable them to lead a better life. To walk seven steps instead of one or two. I think that should be promoted as a resources as we have a high incidence of coronary thrombosis in the ....shire area, which needs to be addressed" (CG 48).

Gerald: "I think that is where we can use that time and negotiation with the family. Especially when visiting time starts, the mid afternoon. They've got access to the families, therefore it's not just the individuals they're concentrating on. And by having them in a relaxed atmosphere and possibly having the specialists around, like the asthma nurse and the rehabilitation nurse, a lot more information could be given to the relatives... erm... er... in a non-rushed atmosphere to try to enable them to help them help their ill relatives" (CG68).

Giving Support

Reasons given for the lack of support for both students and newly qualified nurses, was that health promotion wasn't sufficiently embedded in their practice. This problem, while acknowledged in Blackstone and Chiswell, was not discussed in sufficient depth to provide a solution. However, the experiences of Barbara in Waverly, who taught both post-registration and pre-registration students was particularly enlightening, in that she addressed the issue of enabling health promotion to become an integral part of practice;

> "....the courses the qualified nurses are on. They know it all really, they don't know the models and stuff, but the rest of it comes from them. They don't realise it, it's there. It's just a question of dragging it out of them, and you can see it slowly dawning on them and thinking oh yes. It's really quite nice to see that coming over their faces" (WB29).

However, she also acknowledged the difficulties associated with the work. This she attributed to nominal support from managers:

> "...on their assignment they actually have to go out and do a health promotion teaching session, and evaluate it and the whole lot and that actually gives people the power. Because they all know what area they want to do for a start, because they can actually see what is happening. But this sort of gives them....I'm doing this for my work...I've got to do it and this gets them in. They wouldn't do it otherwise, but because it's for an assignment they've got to do it and the managers say oh fine and back it up, you know because it's part of an assignment. But that's sort of the only way it is at the moment...which I think is a shame"(WB29).

Whether or not her students continued to incorporate health promotion into their practice, she thought depended on where they were working. More opportunities were available, in the community she thought, than in the hospital this she attributed to the limitations imposed by organisational structure;

"....some of them tend to drop it. But some, particularly with practice nurses.....if it's something constructive they keep it going that way. And I think out in the community more....but I think again, because of the hospital and the time factor, a lot of them can't keep it up, or they change wards, or go on nights and things, you know...so it's quite hard to keep with the flow"(BB139).

Analytical Themes

As the discussions continued and the groups became cohesive, they began to evaluate what had happened as a result of this change in nursing education. Aspects of both formative and summative evaluation were addressed and analysed. The teachers, themselves giving thoughtful insights into their personal views of the nurse, the teacher and the curriculum.

What We have Achieved - The Project 2000 nurse

There was much discussion relating to the characteristics of the Project 2000 students.

The Impact of Health Promotion on Students

One key aspect was the process of socialisation, with one Blackstone teacher voicing the opinion that the students had clearly defined concepts of health on entry to nursing;

Neil: ".. perhaps the students themselves have changed and I think their whole concept of health has changed. I see nurses that are more aware for their own health" (BN10).

Pam: "No!"

Julia: "Really?"

Neil: "But I do...I do think so. I've got no documentation for this, but whenever talk to my own personal students they're obviously involved in keeping fit, keeping well. They have a broader idea of what health is than just the biomedical model. You know, many of them will know about nutrition and know about complementary therapies that they use for themselves. the difficulty is trying to get them to put that into practice for people" (AN10)

This phenomenon was also observed in Chiswell, but discussed in terms of the impact the change in nursing education has had on public perceptions;

Dianne: "Interestingly enough though, this new group that started in March, and we do "what is nursing".. a lot of them brought up health and health promotion as part of the nurse's role. Whereas previously nurses haven't brought that up much. They've thought of looking at people who were ill as health, but this was the first group that really sort of honed in on the health issue, which I thought was interesting"(CD14).

Ben: "... maybe we really are seeing a paradigm shift. With people's lay perceptions of health promotion and fundamentals of healthcare changing. With the hospital as a garage and people coming in to get fixed"(CB16)

Dianne: "Maybe they know more nurses who've been through the P2K system. those who are coming through now are talking to them about health promotion" (CD17).

The Impact of Education on Students' Perceptions of Health Promotion

There was thorough discussion in all groups relating to the difference in the Project 2000 students in comparison to the "traditional" courses.

Julia: "I think certainly more aware of themselves....they're certainly more aware of their power and they're assertive, and more able to take on fairly large concepts, not frightened of change, not frightened of using research" (BJ7).

Neil: "... there are a lot of students in this set who are able to appreciate that somethings like the WHO targets or WHO strategy are at odds with some of the health promotion they are being asked to do...some quite directive stuff....to actually go out and be very "top down" ..um.. very directive in a lifestyles focus. They'll write about it and discuss it, they're as powerless as the rest of us to actually do something about it. They're much more sophisticated than they used to be. From what I remember, I didn't have much to do with the '86 curriculum, but from what I remember they have a greater understanding of the theory of it all" (BN8).

Julia: "I think they see themselves as part of it, whereas with the old curriculum, on the whole, someone else was involved with that - not nurses. I think they see that nurses have something to do with that..."(BJ910).

The Generic Nurse

The nature of nursing practice was thoroughly addressed. As previously recorded whether, there were better opportunities for students to learn about health promotion in the hospital, or the community was a dominant theme. These perceptions were certainly influenced by political, and organisational factors as well as by their own professional backgrounds. This perhaps is crystallised by the following comments;

Sheila: ".. there's been a lot of debate about the recent campaign by the DOH .....we were sickened by the adverts about adult nursing which portrayed nurses as sort of saving lives rather than this other issue. As nurses not as caring, but educating and health promoting....so it's quite interesting that the powers that be are actually promoting nurses, nursing and saving lives and caring in a disease focus, and actually what we're trying to do and certainly what we're trying to do on these courses is ....about health promotion"(WS11).

Trish: "I just have concerns that people see health promotion as community, it isn't, it's everything. I think if we focus on it in the community, what we're doing is telling the students that's the only place you need to know about health. It isn't, it needs to be everywhere" (CT15).

This split between the hospital and the community nurse was rejected by all three groups. With regard to the curriculum, they also seemed to be uneasy with regard to the separation of the nursing disciplines in the branch programmes feeling that it did not facilitate meaningful learning in the name of health promotion. This extract from the Waverly text exemplifies this unease;

Sheila: " ...this brings us back to the issue of "genericism versus specialism" When we did the debate.... and we all agreed that genericism was the way forward in nursing for all sorts of reasons. But maybe one of the reasons in terms of health promotion is that I as a psychiatric nurse I am very much trained to look after your mental health, your emotional problems and forget the physical problems, and I still think that happens.....erm... because we have specialisms in nursing we're not developing whole nurses and maybe if we had a generic course we would very much be able to focus on this nurse as a health promoter"(WS6).

The Characteristics of Teachers Who Teach Health Promotion

This was a very wide ranging and insightful discussion, the overall concensus being that not all teachers were interested in health promotion. Different aspects of the

characteristics of the health promotion teacher were emphasised within the groups.

The Blackstone teachers were of the opinion that all the teachers who taught this subject valued health promotion, it was the underlying philosophy of their teaching and nursing practice. They also felt that they were supported by their managers.

> Kate: "Sometimes when the students find the programme isn't consistent with what they thought they were going to learn. Say like the CFP when there's a lot about health and not much about illness... um..I think the teachers here tend not to buy into that and .... resist rubbishing the course.....When I listen to what goes on in other places, they sort of go along with that pressure and maybe make changes to the courses. Well I don't think that happens here. I believe the people managing this course .....allowed people to pursue subjects they thought were important, like you say (to Julia), we had a small nucleus of people who thought this part of the course was important" (BK9).

> Neil: "Health and health promotion has been a persistent theme in this college regardless of the fact that staff have changed" (BN17).

Teacher Development

The Waverly teachers also expended much time and energy in trying to establish their credibility in teaching health promotion. Much discussion took place regarding their suitability as role models due to their own unhealthy behaviour. This was not perceived as a barrier to effective teaching.

> Barbara: "But I would argue that...Sheila said she smoked so she can't teach health promotion. but the thing about health promotion is that general being of empowerment. .....it's not just about smoking and I do this. This is where there is the stumbling block. I could argue that I'm quite large, so how could I teach health promotion, because I should be waif-like thin, a sort of Kate Moss type figure.....But that shows that not everyone is perfect, but that you're actually striving towards it and you know. I always feel we should have some little foible. But as long as you can actually justify why you're smoking that's fine.....it's only when you say (to someone) you've' got to give up smoking...."(WB9).

The knowledge and perception of health promotion of teachers was addressed quite forcefully by Barbara, she advocated that the subject should at least be led by a

someone with specialist knowledge, this was in order to provide conceptual clarification between health education and health promotion, which she thought was a problem for nurses. To illustrate her point she described how she had unintentionally eavesdropped on a colleague;

> ".....I thought how the hell has she taught health promotion and all the books she's recommended have been health education.....it, it takes it away. And I don't really know how to tackle that subject because I have tried ....it's been totally knocked down..um... but it's those sorts of concerns, because if you've got people teaching the wrong thing, it's the wrong concept, you've got it wrong to begin with"(WB12).

What was interesting was the fact that a need was expressed for the teachers themselves to have the opportunity for discussion, to clarify their own ideas about what they should be teaching. In Blackstone, this was addressed retrospectively, in that they felt they had the opportunity and support for this. However in Waverly and Chiswell they perceived it as the process of curriculum development;

> Sheila: "I think we need to take a step back from what we teach on the curriculum and educate each other, because certainly when I came in here at first and was asked that question I thought, Oh my God, what do I know about health promotion. But as the time has gone on and you have all unpacked your concept about this wider view of health promotion, I can actually see that a lot of the work I do is about health promotion. But unless I had come into this particular interview Lesley, I would never have known that. So now I can begin to think about all the work that I do that I can call health promotion. So I think you need to educate people like me about what health promotion is. I think it's very interesting Jenny, about what you said about the mental health branch. What we tend to do is look at health promotion as therapies....we would tend to look at behaviour therapy rather than looking at it in terms of a health promotion opportunity to educate and better managed and develop other strategies for coping with life, which is very much health promotion"(WS13).

The Curriculum

Although subject areas had been identified as well as the need to integrate theory with practice there was a lot more depth to this analysis and further themes were

identified ranging from what the teachers should be teaching to the range and level of knowledge required and how this should be sequenced in the curriculum. Discussion also took place regarding whether or not health promotion should be explicitly, or implicitly addressed within the curriculum.

There was general agreement that the breadth of knowledge required was daunting and that both theory and practical experience should be more focused.

> Barbara: "... I know we've worked on it and revamped it. But.....maybe we need to look at it again and maybe cut out more and narrow it down, so then its in more depth and you have better understanding.....they'll get the basics and from there hopefully expand on it" (WB13).

There was also agreement that the sequencing of subject matter in the curriculum was important and that the move should be from the general to the specific. The Blackstone teachers reflected on how they thought that they had achieved this and felt that the structure of the assignments had been useful.

Kate, specifically mentioned the first and last assignments that the students had to do, the first being a neighbourhood study based on a needs assessment, that was intended to underpin both health potion and nursing. The last assignment was a specific health promotion project;

> "The thing about the neighbourhood study.....When you're doing the marking for the health promotion project you see the neighbourhood studies keep coming back.....I think it's good that you're trying to integrate something that we taught them right at the beginning when they did find it hard to relate, but at the end they're revisiting it in a much more direct way" (BK14).

The Chiswell teachers, while acknowledging the limitations of their curriculum, in that health promotion was not addressed particularly rigorously in the branch programme, discussed the notion of sequencing health promotion in the curriculum in terms of progression. There was a wide ranging discussion about how this progression from the general to the specific could be achieved. The emphasis here

was still on teaching health promotion in the curriculum in what they termed "community" modules.

Dianne: " In the new curriculum....the community module comes at the end. There's more community in the CFP and less in the branch, which comes at the end, and maybe in some respects this could be emphasised more"(CD13).

However, as their discussion progressed, they became more focused on health promotion. As the presentation of the previous data has indicated they were very creative in offering solutions to problems and offering suggestions for creating opportunities for learning. This appeared to have been a useful clarifying process for them to identify what they were teaching in the name of health promotion;

Ben: "I wonder sometimes if health promotion has a bad image...maybe it's part of an evolution process.....I don't know, but it seems sometimes the students think they get overloaded with health promotion and nursing can be boiled down to health promotion. And yet they want so desperately to be equipped with the skills to do nursing. I mean that's practical nursing skills.....and therefore there's this conflict and maybe somehow we need to merge those skills" (CB14).

Gerald: "They need to learn not to nurse don't they really" (CG11).

Ben: " But.....I agree with you, but how do you teach "hands off" nursing, because that's basically it. It's bringing into play other skills that we emphasise very strongly, I think within the course...communication, observation all those things are emphasised, but I don't think they're as highly valued among some of the students, as these others" (CB15).

This analysis has demonstrated that the teachers were generating their own definition of the type of health promotion that nurses on adult branch programmes should be able to engage in on registration. The key to this was the philosophical approach to their nursing practice, which they perceived as being embedded in health. The type of health promotion these nurses should be involved in should be holistic, negotiable and empowering for their clients. It contained both individualistic educational elements, as well as structural properties. It was not perceived to lie solely within the remit of community nursing.

Several problems were identified associated with the students ability to practice in this way due to the persistent conceptual confusion among staff in the clinical areas, and the increasing strain that placed on healthcare workers due to NHS (1991) reforms. Other problems were connected with how health promotion was taught. It was acknowledged that there was conflict surrounding the meaning of nursing knowledge and health promotion knowledge and as a consequence health promotion was being lost in the branch programme despite the predominant focus of health in the common foundation programme. These conclusions are supported by analysis of the student data reported in chapter 8.

The solution to this was thought to be that health promotion should be aligned to the nursing theme in the curriculum but that clearly defined and explicit boundaries should also be defined between these subjects. The timetabling of the subject was deemed important, as was the question of the development of an assessment strategy that provided continuity of the integration of knowledge throughout the course, as recommended by the ENB(1989). Teaching resources were another issue considered to be problematic. The provision of appropriate and relevant literature was considered important, as was the question of the responsibility for teaching this aspect of the curriculum. The solution to this latter problem was complex, it became apparent that in order for health promotion to be integrated into the curriculum that all subject areas should incorporate the philosophical foundations of health promotion, but that the specific subject area should be led at least by a "specialist" in health promotion.

CHAPTER 11

THE CURRICULUM AND CONCEPTS OF HEALTH PROMOTION

It has been demonstrated that the students perception of health promotion changed as they progressed through the course. The examination of the teacher's perceptions of health promotion, identified some congruence with those of the students. The previous chapter also indicated that the teachers were constantly clarifying and evaluating what they taught in the name of health promotion. Despite identifying solutions to the problem, constraints regarding the particular curriculum frameworks within which they were working were acknowledged.

The intention in this chapter is to examine that part of the student learning experience within the curriculum documents pertaining to health promotion, in order to identify any areas in the planned learning experience that influenced the students' conceptualisation.

The literature relating to curriculum development suggests that the statement of philosophy in any curriculum document should reflect the beliefs and ideas upon which the curriculum is based. The statement of philosophy purports to drive the process (Stenhouse 1975), and the "curriculum in action" is the reality, comprising the total learning experience. Ideally, it should incorporate correctly delivered and experienced curriculum intentions, but inevitably there are some distortions (Wells, 1987).

Specific curriculum content relating to health promotion for each school is examined and presented independently. Their respective philosophy statements pertaining to nursing, health, and health promotion are presented, as are the design, content and

assessment strategies for each course. These are then compared with available programme timetables and course learning materials. The complete philosophies, theoretical frameworks and relevant programme materials are contained in appendix 13, 14 and 15. Lask et al (1994), in their study designed to evaluate the extent to which the integration of a philosophy of health had been achieved in educational curricula for nurses, midwives and health visitors, identified very broad interpretations ranging from what they called "traditional medical and educational models" to "progressive socio-political models". It is their criteria that was used for this part of the analysis.

The Structure of the Courses

In common with the structure of all professional education, the curriculum for pre- and post-registration courses in nursing is controlled by the requirements of the regulating bodies. Therefore, as previously described, in terms of the competencies to be achieved and the broad educational aims and objectives, the structure of all three courses were the same. However, in order to demonstrate the rigidity of these frameworks, it is necessary to consider the regulations surrounding the course content for the pre-registration programmes.

Course Guidelines and Criteria

The document distributed by the ENB(1989), to approved training institutions, provides specific guidelines and criteria for the development of Project 2000 courses. These relate to the purpose, length, content and outcomes of the Common Foundation and Branch Programmes. For example, item1.6 in the section relating to general information states that:

> "The total length of all courses leading to admission to the Professional Register should, normally be three years full-time or the equivalent part-time period. This overall length should be divided into units of learning spanning 45 programmed weeks each year. This should comprise a total of 4,600 curricular hours....."(ENB1990).

The number of hours spent in theory and practice in common foundation and branch programmes are also determined in this section. It is also specified that common foundation and branch programmes, form a continuous educational process, and decreed that the assessment strategy is based on continuous assessment of theory and practice.

The document lists twelve learning outcomes which, "require the student to apply knowledge and skill to meet the nursing needs of individuals and groups in health and sickness, in a specified area of practice". These notions of individualism and collectivism, appear to incorporate a public health perspective, and the groups are identified as those with specific health needs, as described in the first outcome which requires the nurse to identify,

> "the social and health implications of pregnancy and childbearing, physical and mental handicap, disease, disability, or ageing for the individual, her or his friends/family and community".

However, a clearly educational model of health promotion is assumed in the outcome relating to health promotion;

> "The identification of health related learning needs of patients/clients/family/friends and to participate in health promotion"(ENB1990).

Embedded in this statement is, the focus on the individual, illness as opposed to wellness, and the assumption that this individual needs to learn rather than become empowered.

This confusion persists when the content for the course is identified. Throughout the course five key themes are identified:

1. The person - the individual
2. Society
3. Health
4. Health Care
5. Nursing

A description is given of the way each concept should be developed, and suggestions are made relating to content. This less autocratic approach is useful in that it presupposes that the educationalists in each institution have expertise in incorporating these concepts into the curriculum design and that health promotion is identified as an essential element of nursing. However, there are two major causes for concern here. At face value an examination of all the themes infers that health promotion principles should be explicit, for example the guidelines for the development of the content relating to the individual, states that a consideration of the perspective of the individual as a client, carer, or professional is required. The suggested content is given as;

- Human growth, development and function;
- The philosophical, cultural and social aspects of identity;
- Exploration of self, self within a variety of roles and affiliations;
- Consideration of the individual as part of the collective-family, community, society
- Aspects of integrity, dignity, individuality and autonomy;
- The individual as a carer/student of nursing;
- Presentation of self and self-awareness;
- Personal accountability; professional accountability;
- Interpersonal skills; between the nurse and the client or patient and the nurse and the caring team;
- The implications of being a patient or client;
- The nature and implications of client empowerment (ENB 1990).

This last item is quite a complex concept to be unravelled prior to being taught in any meaningful way. It incorporates the underlying disciplines involved in the education of any healthcare professional, and the tenets of health promotion through the development of understanding of the concept of empowerment.

The second reason for concern, is that in the introduction to this part of the document the ENB acknowledge the lack of expertise existing teachers may have in delivering a curriculum enshrined in the study of health. They state quite clearly that:

> "Training institutions may experience difficulty in identifying teachers with a background in each of the Branch Programmes to contribute to the Common Foundation Programme. However, there will be a number of practitioners working within these specialist areas who, with adequate preparation and support, should be capable of making this contribution"(ENB 1990).

Despite the rhetoric, optimism, and recognition for the need for change, it seems that at the beginning of the development of these programmes the principles of health promotion were not clearly defined within the curriculum guidelines. There was also concern that there was a lack of expertise within the resources available to teach health promotion.

Curriculum Frameworks

All three schools had adopted an eclectic approach to curriculum design based on Skilbeck's (1975) process model of school-based curriculum development, Lawton's (1975) cultural analysis approach to curriculum design, and Stenhouse's (1975) model for curriculum evaluation. These models were developed in reaction to the traditional product or outcome model of education based on behavioural objectives, (Tyler 1949). They are influenced by the work of the educationalist R.S.Peters, who argued that "areas of knowledge can be justified intrinsically", without being an end in themselves (Peters 1966). This examination of the breadth and depth of cognitive content enriches and "deepens one's views of countless other things" (Peters 1966). The principles of these particular theories of curriculum development are now considered.

Skillbeck's Concept of School Based Curriculum Development

Skillbeck (1982) argues Socratically, that the most appropriate place for designing the curriculum is "where the learner and the teacher meet". He makes a series of claims in that:

- The learning experience should be valuable for both the teacher and the learner. This experience should be negotiated between the teacher and the student, from an appraisal of the learner's needs, and learning style.

- Freedom is an essential component in that the teacher should be allowed to define objectives, set learning content evaluate the learning process.

- The school is a social institution, where educational experiences can occur naturally, but not without effort.

- Curriculum development is an intellectually demanding task which requires substantial support systems (Skillbeck 1982).

Five steps in this model of curriculum development are identified which are:

1. **Situational analysis**

   This is a review of the change situation which is in turn dependent on external and internal factors.

External factors	**Internal factors**
cultural and social	pupil needs
teachers values	teachers values
material resources	school ethos
system requirements	material resources
flow of resources	existing curriculum problems
changing nature of subject matter	
teacher support systems	

2. **Goal formulation**
   A statement of goals which encompasses teacher and student actions, but not necessarily manifest behaviour. These imply and state preferences about the direction of any educational activity.

3. **Programme building**
   This includes the design of:

   a) Teaching and learning activities, namely the content, structure scope and sequencing of the programme.
   b) Learning resources/materials.
   c) Appropriate institutional settings, (laboratories, fieldwork experience.
   d) Personnel deployment and role definition.
   e) Timetables.

4. **Interpretation and implementation**
   Identification of problems associated with implementing change, and the use of appropriate and empirically tested strategies to implement change.

5. **Monitoring, feedback, assessment, reconstruction**
   a) Design of monitoring and communication systems
   b) Preparation of assessment schedules.
   c) Problems of continuous assessment
   d) Ensuring continuity of the process.

Skilbeck (1982) states that there may well be an assumption there is a logical order through the stages of this model, but affirms that they may be planned and developed concurrently. He does not propose a means-end analysis, but offers it as an encouragement for curriculum development to see the process as an "organic whole", and to work in a "moderately systematic way". He is also aware that national policy, structures and regulations cannot be ignored, but argues strongly in defence of this model that what is required is:

> "recognition of the need to incorporate fully into the emerging national structures for curriculum development, a carefully worked-out role for the school as a creative, developmental agency" (Skilbeck 1982).

Lawton's Cultural Analysis

Lawton's approach to curriculum design is influenced by Skilbeck and based on three types of classification, namely;

1. **Cultural invariants** - major parameters of any society. He identifies eight systems:
   - Social structure
   - Economic/political
   - Communication
   - Rationality
   - Technological
   - Morality
   - Belief
   - Aesthetic
2. **Cultural variables** - aspects specific to the given society
3. **Described elements** - identifying which specific aspects of the given culture are good or bad, and which should be encouraged or discouraged.

Inherent in this classification and resulting curriculum decisions are the following considerations:

- what kind of society already exists?
- In what ways is it developing?
- How do its; members appear to want it to develop?
- On what kinds of values and decisions are these decisions based?
- What educational means are used to achieve these aims?

Stenhouse's Process Model of Curriculum Evaluation

Stenhouse (1975) developed his process model of evaluation from his government funded program on the teaching of humanities in secondary schools between 1969 and 1974. This is essentially a critical model of evaluation consisting of the "discovery of curricular happenings", in the attempt to gain an impression of what happened and how it happened, and the views the participants express about the strengths and weaknesses of the programme. Process evaluation has usually been performed by external reviewers, and involved triangulation. The main methods have been qualitative, and reporting descriptive (Stenhouse 1975; Wells, in Allen and Jolley 1987).

Blackstone

Course Philosophy

The Blackstone philosophy reflected the ENB guidelines for the course content. Specific comments were made regarding beliefs about nursing and health.

Nursing - "....all patients are unique individuals with a different genetic composition and experiences of life. This gives rise to a response from each person to health and illness which is singular and theirs' alone. Unique persons/patients require nursing interventions tailored to their individual needs. Within this context of holistic, individualised care, it is the duty and purpose of each nurse to attempt to influence those with whom she/he comes into contact to enhance the individual's ability to attain their optimum level of health. It is also the duty and purpose of nursing to care for those who are sick in order to return the individual to his/her optimum level of health. It therefore follows that the nurse may execute his/her professional skills within the institutional and non-institutional health services and, also, within the wider society, thus helping to influence those factors which promote health and prevent illness."

Health - "..in this context, is not perceived as a "static state", but as a continuum of adaptation to life events. The process of positive health promotion is thus not only concerned with avoiding illness, but also with the active enhancement of a person's entire "state of being", including the physical, psychological, social achievable by all individuals, regardless of age, and whatever his/her existing physical condition and/or psycho-social situation".

According to Lask et al (1994) this statement could be construed as being progressive. However, although the dynamic nature of health is addressed and health

promotion is mentioned, they do not appear to be embedded in the nursing philosophy. It is only when this curriculum design is re-examined that these intentions become clearer.

Curriculum Design

In this school particular emphasis was paid to Lawton's (1975) approach to curriculum design, the questions posed by Lawton (1975), were adapted for nursing and consisted of;

> "What kind of nurse, nursing and health provision already exists? and, in what ways are these developing?".

The manner in which it was felt that nurses and nursing should develop were based upon the essential roles of the nurse and nursing as identified by Peplau (1952). Lawton's model provided the framework for clarification from which both the nursing and the course philosophies were developed and essential nursing knowledge and skills identified. The curriculum was based on three premises:

1. Health is a basic human right, potentially available to all.

2. Society is composed of individuals, each with their own cultural, ethnic and healthcare needs.

3. Nurses, by their very nature and multiplicity of roles, are in a unique position to influence and assist in the reduction of inequalities and the positive promotion of "Health for All".

Finally, the philosophical foundations for health and health promotion in the curriculum were identified, but certainly not clearly sourced. However, four further criteria for an effective nurse education programme were also identified two of which made health promotion explicit in this context these were to;

- "prepare the nurse to assist the client to make the health choices which are optimal for him/her as an individual;

- enable the nurse to develop and maintain a critical, analytic and flexible approach to health promotion and care".

In short, statements about health and nursing are clearly defined within the philosophy and appear to reflect a socio-politcal model of health. However, no statement of belief is made regarding the nature of health promotion. The impression gained is that it is an adjunct and the philosophy is not grounded in the WHO philosophy of Health for all by the year 2000.

Curriculum Content

The overall content was divided into nine units of learning, four in the Common Foundation Programme and five in the branch programme, the length of each unit varied from thirteen to twenty eight weeks. They were planned sequentially, incorporating and developing from skills and knowledge achieved in previous units. Eleven aspects for professional development were identified as essential components of these units, but each having a particular focus, these were;

- Acclimatisation
- Adaptation
- Observation
- Socialisation
- Exploration
- Participation
- Identification
- Internalisation
- Dissemination
- Consolidation
- Professionalisation

For example, in Unit 1 the main developmental emphasis was on facilitating the students awareness of, and **acclimatisation** and **adaptation** to:

- The likely change from being part of a nuclear family to that of being independent within a new group situation.

- The role(s) of adult learner and student nurse, and the responsibilities this entails.

- The "culture" of nursing, the hospital, and the wider healthcare system and its members.

- The local community, its cultures and its people.

Throughout each unit, the following key themes are identified ;

- Nursing Studies
- Biological Sciences
- Behavioural Sciences
- Social Sciences

Within each theme a rationale was given for the inclusion of particular curriculum content, along with a list of indicative content. The broad concepts were initially addressed and as the course progressed became more specific.

The Common Foundation Programme

The analysis of these themes and their subsets indicates the difficulty associated with integrating the concept of health promotion into the curriculum. The nursing theme was the central discipline around which all other knowledge was organised. The biological science theme concentrated on normal physiological processes. Health promotion was incorporated within the social sciences theme

The Nursing Theme

This component was designed to introduce students to the blend of knowledge and skills constituting nursing. The focus was to assist the student to meet the specific needs of the individual in society, the study of nursing theory was intended to introduce the nursing process, together with it's application and use within the frameworks of various nursing models. The professional role of the nurse was explored together with the external political influences on nursing. The management of care was introduced at this point. Each aspects was addressed in increasing depth as the course progressed.

The students were also introduced to the concept of "community" and community care, an epidemiological approach was adopted through needs identification, with specific reference to vulnerable groups:

- The elderly

- People suffering with mental illness
- People with learning disabilities
- People with physical disabilities
- Children

Concentration on the concept of "community" was dominant in Units 1 and 2. For example in Unit 1 specific learning outcomes are expect students to;

- Examine the concept of community in relation to the practice of nursing in non-institutional settings

- Focus on a locality in .....Health Authority and develop an awareness of the use of epidemiological and demographical research data to identify community health needs and formulate community profiles.

The Social Science Theme

The social science theme was divided into subsets of social policy namely; people, policies and social perspectives, the sociology of health and illness and health promotion and education. Each unit had an overall aim and as stated above moved from general to specific content. In Unit 1 the aim of the social science theme was to:

> "introduce students to social perspectives of the nature and organisation of society with particular reference to contemporary Britain, and to examine current policy issues relevant to health workers and problems of welfare policy".

By the use of the terminology health promotion and health education as the title relating to this aspect of the theme, it appeared, that at the time this curriculum was written there was an underlying belief that the two were separate items. This is also reflected in the aim which was to;

> "initiate the student into an understanding of the concept of health, in both the personal and the public domains, and to ensure that their perception of nursing includes health promotion and health education".

This is also reflected in the learning outcomes which state that the students will be given the educational opportunities to:

- Develop an understanding of the concept of health and health models as a framework for further learning and practice in this field;

- Explore the internal and external factors which influence health and approaches to the measurement of health;

- Examine public and environmental health issues which are of current concern;

- Be introduced to the principles of health education as the basis for further learning and practice in health education;

- Examine issues relating to health within the workplace as part of study of general health promotion as well as consideration of how these issues affect the individual within professional practice.

The indicative content for unit 1 is presented below. The content for each unit is displayed in appendix 14.

Social Science Theme: Indicative Content for Health Promotion

- Concepts and models of health
- Internal and external factors affecting health
- Measuring health
- New public health issues
- Topical environmental health issues
- Principles of health education
- Self-help help groups
- Occupational health
- Health and safety at work.

Although the learning outcomes relating to the sociology of health and illness are directly linked with health promotion, in terms of what is taught in the curriculum, an educational model of health promotion appears to be intended.

The Behavioural Sciences Theme

When the behavioural sciences theme is examined, there appears to be conflict in terms of application of the subject, in that because the focus is aimed at its relevance to nursing, the relevance of this discipline to health promotion is lost. This component is organised for the study of behaviour and the interrelationship between self and others in order that the students become effective in the management of

patient care as well as caring for carers. The content is classified under three headings:

- Psychology - Basic issues
  Individual and group processes
  Social and emotional processes
  Developmental psychology
  Applied health psychology
- Interpersonal and teaching skills
- Personal health
- Organisational and teaching skills

Besides intending to introduce the students to the overall concepts of psychological processes, there was an intention that the knowledge gained would be utilised to enhance a client or patient's health and that of the individual student, to prevent and treat illness and assist in identifying health risk factors. It was also acknowledged that there was also the potential to improve the healthcare system and shape public opinion in regard to health and lifestyle.

The tenets of health promotion are not clearly stated in the aims and learning outcomes in this theme. For example, in unit 1 the intended aim is to relate the relevance of psychology to nursing, no allusion to psychology being one of the disciplines pertaining to health promotion is made. In Unit 2 the intention is to introduce the student to;

> "the concept of self, and the effects of social relationships and an altered health status, thus helping the student to understand their own and their client's responses to health and illness".

In common with the other subject areas in the curriculum the application of the theories becomes more specific, and in Unit three this is related to developmental psychology in relation to child development, and health psychology in relation to mental health issues. In unit four applied health psychology is related to the psychology of ageing. Although the links with health are clear, they certainly are not with regard to health promotion.

Further indications of the difficulties imposed on the integration of health promotion into the curriculum are reinforced when the teaching hours allocated to each subject in each unit of learning are examined.

Table 1 - 11

Hours Allocated to Each Subject Area in the Common Foundation Programme

Subject	Unit 1	Unit 2	Unit 3	Unit 4
Nursing studies	50	60	87	75
Biological sciences	100	90	30	30
Behavioural sciences	45	45	40	18
Social sciences	40	35	23	17

Clearly, the main focus of the theoretical content in units 1 and 2 are the biological sciences, with the balance changing to nursing studies in units 3 and 4. The number of hours allocated to behavioural sciences declines sharply by the end of Unit 3, while social sciences have the smallest number of hours allocated, there is an incremental decline in these hours as the course progresses.

Thus, it appeared that the health promotion content of the curriculum was fragmented due to the fact that the subjects supporting nursing knowledge were the same as those supporting health promotion knowledge. There was a possibility that health promotion could be lost altogether, or that the focus was health education.

The Assessment Strategy

The intention of the entire programme was to reduce the theory practice gap. The assessment strategy for the nursing behavioural and social sciences was designed to integrate all of these themes, and in Units 1 and 2 a longitudinal approach to the assessment was adopted. This was linked directly to the practical experience and is discussed in conjunction with a description of the practice placements.

Unit 1

The focus was on people and the environment. Students were required to develop a community profile. They were allocated to a particular locality within the health authority to discover and comment on the determinants of health and the consequent health needs of individuals and groups within that area. The framework for this study was the WHO European strategy for Health For All 2000 (1985). This study was complex involving several activities. The students had to submit a written population profile and also focused on a particular environmental issue related to one of the European Health For All goals (i.e. Target 11: Accidents). They were also required to provide a log or diary of their fieldwork. In addition they had to prepare group presentations on aspects of the environment related to the WHO European Strategy. This practical experience was grounded in social research methods in that they collected evidence through "walkabout" exercises, visited libraries and public health departments. Their teachers provided support through group discussion and structured assignments. These are presented below:

- Assignment 1 "Walkabout" Locality/neighbourhood
- Assignment 2 Collecting and making sense of data
- Assignment 3 Developing the "Log"
- Assignment 4 Arrange a visit to one or two agencies relevant to the area and target being studied
- Assignment 5 Interview/contact local people, agencies on thoughts and feelings of living in the area
- Assignment 6 Provide key references by week 9 of Unit 1
- Assignment 7 Group presentation

Unit 2

The focus was on personal health and health care needs. Practical experience consisted of a placement one day per week over six weeks in non NHS settings. These consisted of various government and non governmental agencies, such as, homeless families projects, community associations, organisations dealing with substance abuse and children's playschemes. The assessment framework was similar to Unit 1, in that three pieces of work were presented, a written assignment, a diary of

evidence and a group presentation. The difference was that the needs assessment was intended to reflect the needs of their particular client group and was identified by or negotiated with the group or project organisers. This provided the foundation for the selection of appropriate health promotion material which they presented to their peers, and reflected on its usefulness in a written assignment.

Unit 3

This unit was not summatively assessed. The practical experience aimed to encourage the students to relate theory to practice by developing their powers of observation, by comparing and contrasting their experience of working with people with learning disabilities and mental illness. They also had their first and only experience of maternity care and child health. It was at this point that the clinical experience was split between institutional and non-institutional care. It was also at this stage that the non-institutional care was organised within NHS primary care. The students spent time with health visitors studying normal child development. They were also assigned to the local obstetric unit and children's' wards.

Unit 4

At this point the students were expected to continue to develop powers of **observation** during their experience with different groups of patients/clients, and that the **socialisation** process (to nursing) would continue. However, it was also anticipated that they would have sufficient experience and knowledge to begin to explore their understanding of the key concepts of nursing and its related disciplines. This exploration was to be supported by the assessment process, which required the student to apply and analyse their knowledge.

Again the clinical placements were within institutional an non-institutional settings. The focus in the non-institutional environment was within primary care and involved an allocation to district nursing or residential nursing homes. They also supported had

an elective placement. The aim of this learning opportunity was to enable them to pursue an aspect of the course that they had found particularly interesting. They were allowed a deal of freedom in their choice of study, but three main areas were suggested, these were:

- The application of an aspect of the curriculum disciplines to health promotion and nursing care.
- Areas related to social policy, health care provision, alternative therapies.
- Areas related to social structure and health care needs.

They were supported in this endeavour by developing learning contracts and keeping reflective journals. Summative final assessment of all elements of the course was through written examination.

It appeared, therefore that despite the complexity and prescriptive nature of the curriculum, a sustained attempt was made to imbue the students with an understanding of the concept of health and health promotion.

The Branch Programme

At this point the balance between the theoretical and practice elements of the course reversed, the students spent a larger proportion of their time in clinical practice than in the classroom, as is indicated in table 2

Table 2 - 11

Hours Allocated to Theory and Practice in the Branch Programme

Subject	Unit 5	Unit 6	Unit 7	Unit 8	Unit 9
Nursing studies	64	35	47	30	10
Biological sciences	38	20	28	15	0
Behavioural sciences	10	14	20	10	10
Social sciences	12	14	34	11	19
Professional Development	0	0	10	15	50
Study	11	44	91	49	41
Practice	560	347	382	345	0

The key themes continued to spiral throughout the curriculum. In unit 7 a professional development theme was introduced however the subsets of knowledge to be acquired were not described. An examination of the aims, learning outcomes and indicative content for all five themes revealed that health promotion was not allocated to any one theme, but embedded in all four. Practical skills concentrated on patient teaching, patient education and health education.

Unit 5

The developmental foci were on the exploration of the various dimensions of nursing and participation in patient care. Practice placements were in both institutional and primary care settings. In the hospital the care focus was on high dependency care and stress management.

The non institutional experience was designed to develop previous knowledge of health promotion and primary care. Students were supposed to study secondary and tertiary aspects of care and the practical experience was intended to highlight quality of life issues and the experience of health and illness of people with chronic illness. Besides working under the supervision of district nurses, they were expected to contact other health professionals involved in these aspects of care, such as Macmillan nurses or social workers. Visits to relevant agencies or organisations, such as rehabilitation units, were arranged.

Within the nursing studies theme the theoretical components of community nursing care were categorised as, communication systems and continuity of care, the role of nurse specialists within the community and support networks, self-medication and client-held records. Professional and management issues also addressed multidisciplinary teamwork and advocacy. The aims of the behavioural science theme was to enable the student to develop deeper understanding of perceptions of life-events, in order to appreciate how these differences affect the thoughts and

behaviour of themselves and others. The social science theme intended to contextualise this, through an examination of the relevant social policy relating to disability (appendix 14).

Theory was assessed by submission of a written case study which identified the needs of people with chronic health problems. The students were also expected to focus on quality of life issues and the experience of health and illness.

Unit 6

At this stage the students lost their supernumerary status in the clinical areas, they became integral members of the nursing team, working under supervision. This practical experience was in adult and elderly healthcare and included the care of patients requiring both surgical and medical care.

In addition a further four weeks community nursing experience had been anticipated. It was thought that this experience would include placements with district nurses, in nurse-led clinics, practice nurses or occupational health departments. In reality, this never happened. None of these services were able to support the student numbers. Consequently the only community nursing experience the students gained was in unit 5.

The aim of the nursing studies theme was to enable the student to adapt to their new role as a member of the nursing team and to develop nursing skills. The specific learning outcome relating to health promotion was to;

> "have participated in the psycho social support and health education of patients/clients and their family group".

The intentions of the behavioural sciences component was to develop communication skills and explore the psychological influences affecting compliance, and the teaching strategies required to facilitate positive responses to health education and care. Students were expected to have increased proficiency in listening and responding skills, the observation and interpretation of non-verbal behaviour and questioning techniques. The psychological theories addressed were in relation to Becker's health belief model and Seligman's theory of learned helplessness in relation to self-efficacy. The social science theme also specifically addressed health promotion, in that the students were expected to develop an understanding of the roles of prevention and health education strategies in promoting disabled peoples' health.

Unit 7

At this advanced stage of the programme, the main focus was on the internalisation of professional skills. The key aim being to develop confidence in the assessment and identification of needs and implementation of nursing care. Health promotion was firmly grounded in health education within the nursing theme in that the nurse should have

> "developed greater skills in his or her role as health educator".....

The aspect of care devoted to health promotion was nutrition and this was highlighted in the aims of the biological sciences theme which sort to enable the student to dwell on;

> "aspects of nutritional balance in health, illness and recovery, and the actual and potential effects of nursing and medical interventions on patient/client physical and nutritional status".

Both the learning outcomes and the indicative content of the social sciences theme was totally focused on nutrition in that the students were to:

- have explored current issues concerning food availability and cost in Britain today, and its influence on nutritional status:

- be able to assess critically current nutritional research and the advice given to the public;

- be aware of the likely/possible future developments in the field of nutrition and nutritional policy.

This is also clearly supported in the social science teaching programme where the ethical dimensions of health promotion are also addressed which is displayed in table 1:

Figure 1 - 11

Social Science Programme - Unit 7

31.8.97	Health education: historical and present health education campaigns.
1. 9.97	Ethics and health promotion Ethical basis of traditional campaigns Social reformism and beneficence Social reformism and benign paternalism Liberalism and non-malificence Conservatism and non maleficence Informed choice and competency
8.9.97	International perspectives: Marxism Sociology of development Role of MNC's e.g. famine/drought infant nutrition
11.9.97	Ethics - global issues: Resources } Beneficence Charities } Justice UN } Honesty World banking } Non-maleficence Images }
13.9.97	Health promotion - alternative strategies Politics Values Personal ethics Structure versus agency

Unit 8

This was the penultimate phase of the programme, and the last practical placement prior to qualification. The focus was on consolidation of knowledge and the role of the nurse in terms of health promotion was perceived as being ;

> "able to function efficiently in his or her role as health educator and patient advocate".

The psychological focus was on the importance of self and self awareness in developing empathy, while the social sciences were mainly concerned with extending knowledge and were addressing gender issues in health and welfare.

The assessment, however, was focused on health promotion and not entirely targeted at individual behaviour. The students were required to plan, implement and evaluate one of the following activities:

1. A teaching session specific to the identified needs of an individual or small group patients/clients.
2. A health promotion package appropriate for the needs of a group of patients or clients who share a common health problem/need.
3. A strategy for health promotion within a clinical environment.

The rationale for this activity had to be grounded on a health needs analysis and methods for evaluation either through, self, peer or client had to be incorporated into the overall design. A reflective journal was included in this assessment as was a critical evaluation of the entire process.

Unit 9

This was a very short four week experience, it was college based and designed to enable the students to consolidate their learning and prepare them for their professional role. Health promotion was again explicit within the themes. The social science theme was very clear in that the students should have:

> "a greater understanding of the issues surrounding health promotion and the prevention of illness, and the philosophies and policies which underline them".

However, this was again clearly interpreted in the nursing theme and an educational model was identified in that the students were required to:

> "have developed further his or her teaching skills , and appreciate the importance of the teaching role in respect of both colleagues and patients/clients and their families".

Interpersonal skills and stress management were again seen as the tools to be utilised in order to do this in relation to the content of the behavioural sciences.

Waverly

The approach to the development of a course philosophy was pragmatic and grounded in the need for change associated with legislation, rather than the WHO (1985) strategy. It related directly to the philosophies of the nursing services in the health authorities where they held educational contracts. All were compatible, this approach is exemplified in the following statement in the introduction to the curriculum.

> "The health authorities are committed to enabling as many people as possible to live within the community, and to providing adequate support services to enable that to happen safely. Their objective is to make the large institutions redundant and to provide alternative, smaller community and sheltered homes as required".

This pragmatism is further reaffirmed in the opening paragraphs of the course philosophy:

> "Continuing changes in society and in the organisation of health care delivery generate an expectation that nursing in the years ahead will take place in an environment which places significantly more emphasis than previously on aspects of health, health education and health promotion.
>
> Inherent within this process of change is the concept of future nursing practice as an art and a science requiring the application of enhanced intellectual, interpersonal and reflective, problem-solving and technical skills to ensure practice management and delivery of quality of care to clients and their significant others in health and illness. This practice will take place in a multicultural context and within a healthcare scenario which places significantly more emphasis than previously on aspects of health, health education and health promotion".

Health is recognised as having contested meanings and statements are also made regarding the nature of professional education. The characteristics of the nurse graduating from this course are also clearly outlined. The model of health proposed is

clearly socio-political, however the model of health promotion is educational, although it is identified within the health and healthcare theme it is defined as health education in that:

> "the course considers the need to target health education messages appropriately at different life stages and to different client groups".

The Organisation of the Course

This course consisted of eight modules equally distributed between the two programmes. Each module commenced with a block of theoretical preparation followed by practical experience and a further theoretical component intended to consolidate learning. Seven subjects were taught throughout each of the programmes, these were:

- psychology
- sociology
- Philosophy/politics
- Research studies
- Health studies
- Biological sciences
- Nursing studies

The hours allocated to each of these subjects were evenly distributed on a weekly basis throughout the course and the balance did not change with the progression of either programmes, as is illustrated in table 3

Table 3 - 11

Distribution of Hours on a Weekly Basis in the CFP and Branch Programme

Subject	CFP	Branch
Psychology	4	2
Sociology	4	2
Philosophy/Politics	2	1
Research Studies	2	1
Health Studies	4	2
Biological Science	4	2
Nursing Studies	4	10
Study Time	11	15
Total	35	35

Four central themes were also spiralled throughout the curriculum, these were:

- The individual in society
- Health and healthcare
- Nursing and professional studies
- Research and research awareness

The subjects for each of these themes were organised as follows:

1. **The Individual and Society**

   Sociology, Psychology, Philosophy

2. **Health and Healthcare**

   Health studies was separated into three areas the first being, the sociology of health and illness and health psychology, the second, health policy. Biological science was incorporated into this theme.

3. **Nursing and Professional Studies**

   The content for this theme was developed around the various roles of the nurse. For example in module 1 the roles of the nurse as a communicator was developed as well as the role of the nurse as a learner. In the final module (module 8) such roles as the nurse as a professional, teacher/facilitator and manager were being addressed.

4. **Research and Research Awareness**

   The content for this theme was developed in a similar way and focusing on a variety of research methodologies as the course progressed.

These central themes were the vehicles by which the subject disciplines were integrated into nursing. The curriculum document also provided an illuminative example of how these themes were designed to be integrated. The example presented below was located in the design of the assessment strategy at the end of the common foundation programme:

> ".....the student will be encouraged to integrate all the themes of the common foundation programme so that he/she has a broad understanding of the role of the nurse in healthcare in the 1990's and the 21st century. An example to illustrate this may be the current health problem such as HIV/Aids which readily lends itself to examination ..... Through studying HIV/AIDS the student would have a deeper understanding of such biological principles as

spread of infection and the complex nature of the immune system. He or she would also appreciate how knowledge of sociological and psychological principles such as stigmatisation, labelling and mental defence mechanisms may enable him/her to understand attitudes and behaviours in him/herself and others. In addition, a knowledge of ethical issues and the political economy of healthcare would enable the student to appreciate how and why research into this problem and subsequent planning for health education may be influenced. Finally he/she will be able to identify the role of the nurse as a counsellor, carer and health educator in relation to people at risk from, or with HIV/AIDS".

Health promotion is not discussed or made explicit in all modules in either the common foundation or the branch programme. The skills required are described as being communication skills and in particular counselling skills, teaching, facilitative skills, problem solving, empathy and, "the specific knowledge base to inform clients and/or their families in an objective and authoritative manner". The justification for this being that the skills and knowledge required were developed from a very early stage in the common foundation programme and are alluded to at specific times in the branch programme. In reality it was difficult to find explicit reference to health promotion in any part of the curriculum. This may well have been because it was grounded in health promotion theory. The role of the nurse as a health educator was constantly alluded to.

The Common Foundation Programme

Three broad concepts were explored, these were Health, health maintenance, health impairment and dysfunctional health.

Module 1

This was entitled Health Maintenance, and acknowledged, nursing theory was imbued in knowledge developed from other disciplines. It was important therefore that students were provided with a foundation in these disciplines, in order to understand the complex nature of health and nursing in contemporary society, and also to begin to appreciate his/her role in health maintenance through the

development of critical thinking. The learning outcomes certainly showed evidence of the integrated nature of the subject and health promotion was addressed right at the very beginning of the course but through, "discussion of the concept of lifestyle and its part in health maintenance".

The content of the health and healthcare theme addressed issues such as concepts and definitions of health, the origins of the WHO, its role and function as well as The European Strategy for Health For All (1985). A consideration of role of the Health Education Authority was included.

The range of observational placements was broad and appeared to support the theoretical content but were not segregated into non governmental or primary care settings, or sequenced in any way. They went to health centres and spent time with health visitors, as well as primary schools, creches, health education departments, sports centres, diet clubs and factories.

Module 2

This module was devoted to the study of impaired health. Nursing theory was introduced through examination of Orem and Roper's models of nursing. At the pre-practice stage the health and healthcare theme concentrated on life chances and health, this included the social, political and economic factors affecting health and inequalities in health. Healthcare policy included an analysis of the development of the NHS, while the biomedical sciences addressed the respiratory, nervous and endocrine systems and were specifically applied to health. For example the effects of smoking on health were explored as were the physiology of stress and anxiety.

Practical experience was centred on developing the students understanding of multidisciplinary healthcare and experience was gained in district nursing and midwifery services, the hospital experience included observing the care of people in

general, mental health and learning disability services. These were complemented by other placements or visits to community mental health services, out patients departments, physiotherapy and rehabilitation services. The concept of social support and self-help was also addressed through contact being arranged with such organisations as Mencap, the Schizophrenic fellowship, and Alcoholics Anonymous.

The theoretical content of the health studies theme at the consolidation stage explored models of health and illness and behaviour change, such as the health belief model.

Module 3

It was at this point that the change from the general to the specific emerged. The curriculum content began to direct issues of what was called dysfunctional health in relation to specific groups of people. The rationale for this being that people should be valued for their individuality, rather than for any label they may have been given. The students were also introduced to the role of the nurse as a teacher and facilitator, specific reference was made to how this role was to be applied in health education. The Health Studies content particularly addressed planning for health education to both individuals and groups, both local and national perspectives were addressed. The contextual components of planning was also addressed in that the health policy content was directed towards an exploration of local healthcare policy and planning, in relation to housing, education and social services in the support of families and lay carers.

Module 4

In this final module students were continued to explore the organised and delivery of care to people suffering from mental and physical distress. Health education for specific health problems or diseases were addressed, in particular heart disease, cancer and mental illness. Specific groups of people were identified for study,

namely children, people from ethnic minority groups, women and minority groups such as, people with visual or hearing impairments or homosexuals. The ethics of health education was addressed at this stage. The students were required to examine such issues as, individual versus state responsibility, informed choice versus indoctrination, media presentation and government policy and health. They were also required to compare other models or systems of healthcare in western and developing countries, through case study presentation.

Assessment

A summary of the theoretical assessment of the course is contained in appendix 14. A closer examination of the description of each of the module assessments revealed that in the common foundation programme knowledge and understanding of the theory and concepts of health promotion are not assessed with any degree of rigour. In Module 1 students submitted a profile of some of the resources available in the community involved in the maintenance of the health of the population. The Module 2 assessment consisted of two assignments. The first was an essay, which focused on aspects of health, such as the role of the family in caring for a dependent relative; the effectiveness of multidisciplinary teamwork, or the effects of poverty on health. The second was a literature review, which formed the first stage of a longitudinal study on communication. The particular focus was on psychology and the final submission consisted of a care study which was to be completed following a placement entitled "Nursing clients with dysfunctional health".

The Adult Branch Programme

The focus on the nurse as a health educator continued throughout the branch programme, but for the first time health promotion is mentioned with one of the key aims of the programme being to;

> "examine health education and promotion as they relate especially to the chronically and acutely ill."

However, health education remained the preferred terminology.

Module 5 - Care of an Adult who is Chronically Ill

In the theme relating to nursing and professional studies four aspects of the nurses role are examined namely, the nurse as a practitioner, professional, communicator/counsellor and health educator. The practical experience was gained in elderly care settings in both the hospital and community. The health studies theme concentrated on the study of concepts of health for the elderly and chronically sick and the healthcare organisations concerned with this group of people.

Module 6

This aspect of care is explored further and the educational model of health promotion is continued. In the Nursing and Professional Studies theme the role of the nurse in teaching and organising learning opportunities for junior staff is addressed. The content of the Health Studies theme is related to reproductive physiology, human sexual response, the effects of drugs on sexual response and fertility control. However, it is not until the content of the post-placement theme is examined that this is related in any meaningful way, but this is placed in the context of the role of the nurse as a communicator/counsellor. Further evidence of the dispersal of health promotion theory is detected with an examination of the theme related to the Individual and Society where the content relating to philosophy and law covers quality of life issues, self harm and addiction, informed consent and ethics relating to human sexuality. The psychology component also addresses the psychological dimensions of sexuality.

Module 7 - Care of the Adult who is Acutely Ill

The knowledge and skills that students are expected to achieve at this stage in their programme is associated with the care of acutely ill and dependent patients. Health education is addressed in the nursing theme in terms of advocacy. The study of

current health education issues and global, environmental issues and healthcare is the focus of the Health Studies curriculum content. No examples are given as to what might be relevant here, while this may be useful in acknowledging the dynamism of this subject matter, it is also nebulous, and as such, is in danger of being denied.

Module 8

The content of this last module does appear to attempt to integrate the knowledge required for nurses to be effective health educators/promoters, with role modelling, communication and the promotion of positive health behaviour being seen as the essential elements of the health promotion role of nurses.

Assessment

In the branch programme there was no specific, assessment related to health promotion. As previously stated, the rationale for this was that the concept would be implicit, in that the students would identify the health education role for themselves. However, the reality is that this may well not have occurred, yet the student may well have completed the assessment successfully.

Chiswell

The structure of the entire curriculum document was direct and succinct. It adhered closely to the ENB (1989) guidelines and the competencies required in order to achieve registration were clearly referenced in relation to their "embodiment in Rule 18A Statutory Instruments 1989, 1456, Nurses Midwives and Health Visitors Rules Approval Order 1989". It was the only document that linked the nature of nursing to the WHO Declaration of Health For All by the Year 2000 (1985). A definite statement about health was made in the context of human rights in that:

> "The belief is that individuals have the right to achievement of health within any society as well as the right to have their personal values and desires

respected. The student is also made aware of the changing nature of health care in the context of differing expectations, demands and responses".

Therefore, it could be concluded that despite the fact that no direct reference was made to the context of health promotion within this philosophy, it was implicit, due to the fact that it was incorporated into the overarching philosophy.

Organisation of the course

This course also consisted of four modules in the common foundation programme and four modules in the branch programme. The key themes organised as follows.

- Nursing theory and practice
- Biological Sciences
- Social and behavioural sciences
- Professional nursing studies

The distribution of hours allocated to each subject area are demonstrated in tables 4 and 5 below.

Table 4 - 11

Hours Allocated to Theory and Practice in the Common Foundation Programme

Subject	Module 1 Contact	Study	Module 2 Contact	Study	Module 3 Contact	Study	Module 4 Contact	Study
Nursing	264	24	294	14	294	14	336	16
Biol. Sci	132	88	63	21	63	21	72	40
Behave. Sciences	132	88	63	21	63	21	72	40
Prof. Studies	66	54	42	14	42	14	48	20
Total	594	254	462	70	462	70	528	116
Duration	26 wks		16 wks		16 wks		18 wks	

Table 5 - 11

Hours Allocated to Theory and Practice in the Branch Programme

Subject	Module 5	Module 6	Module 7	Module 8
Nursing Practice	300	337.5	712.5	262.5
Nursing Theory	108	57	52	
Biol. Sci	32	28	37	
Behav. Science	32	28	37	
Prof. Studies	40	42	74	67.5
Study	40	70	100	45
Total	452	562.5	1012.5	375
Duration	16 wks	15 wks	27 wks	10 wks

The main focus in both of these programmes is on nursing theory and practice and professional nursing studies, and it is to these themes that the majority of hours are distributed. Psychology and sociology and social policy were taught as behavioural sciences. Equal weighting was given to the hours allocated to the biological and behavioural sciences. No emphasis was placed on a particular subject as the course progressed, the only changes in the distribution of hours was associated with the length of each module. The only difference in allocation of hours came in the final module which was devoted to professional development.

Health promotion was incorporated into the nursing theme and this was the only curriculum document that referred to health promotion consistently. The overall aims for the common foundation programme intended the student to "develop those attributes necessary to promote and maintain health". The aims of the branch programme were to:

"develop an informed critical approach to the promotion of adult health".

so that by the time the students completed the course they would be proficient in the promotion of adult health.

The Common Foundation Programme

This was divided into two parts.

Part 1

Consisted of one twenty six week module related to foundations for nursing titled "Health in Society". It aimed to enable students to begin to understand the relationship of nursing to health and society. Each of the four core subjects were introduced in relation to health issues and perspectives. On examining the aims and learning outcomes for the core modules no reference was made to health promotion. However, the aims of each subject were indirectly related to the development of key knowledge and skills required for health promotion. For example in the content for the subject relating to nursing theory and practice the intentions were to:

- Introduce key nursing concepts, perspectives, theories and models.
- To provide opportunities to reflect on the Activities of Living model (Roper et al 1980) as is for progression to other models of nursing.

- To explore the concept of normality.
- To develop skills of observation and description related to the assessment of individual health needs.

- To develop appropriate communication skills.
- To promote self-awareness and self-development

The content relating to the biological sciences were also health focused in that the students were required to demonstrate "An ability to appreciate critically the biological dimensions of health". The intentions of the learning outcomes for the material presented in the social and behavioural sciences was that the students would be able to begin to "relate developing knowledge to healthcare".

An examination of the programme for this module revealed that the first seventeen weeks of the module were entirely devoted to the introduction of these basic concepts (the timetables for the common foundation programme are presented in appendix15). Health promotion was introduced in weeks eighteen and twenty in conjunction with sessions on factors affecting health, and an introduction to quality.

Nursing Practice

The practical experience were for two days a week and a lifespan development approach was adopted in that observational placements were divided into three periods related to healthy children, adults and elderly people. In what was called the first neighbourhood placement a health visitor co-ordinated a selection of visits to child minders, day nurseries, playgroups, and clubs such as cubs and brownies and youth clubs. In the second placement a practice nurse facilitated a variety of visits to well women or men's clinics, family planning clinics, sports or leisure centres, Citizens Advice Bureau. Similarly in the third placement a Day Centre co-ordinator arranged a series of experiences that supported elderly people in the community.

Assessment

The assessment consisted of a neighbourhood study in which the students were expected to describe the characteristics of a defined neighbourhood and its related cultural factors. The aim of this assignment was to enable understanding of the determinants of health. The learning outcomes assessed were related to the social and behavioural sciences and professional nursing studies. With regard to the professional and nursing studies the outcomes assessed were;

- an understanding of the changing role and function of the professional nurse.
- a recognition of aspects of research relevant to his or her own studies.

The outcomes assessed in the social and behavioural sciences were related to the development of skills in basic social research methods in that the assessment tested their knowledge and skills of:

- key perspectives, theories and concepts
- basic methods of enquiry and their limitations
- critical understanding of relevant source material
- the presentation and identification of relevant evidence in argument
- an ability to relate developing knowledge to healthcare.

Part 2

Consisted of the remaining three modules of the programme and was devoted to "The Development of Nursing". Module 2 focused on normal child development and was called "The Early years". Module 3 focused on "The Middle Years" and module 4 was related to "The Late Years".

The learning outcomes for the theme relating to nursing theory and practice referred to the development and application of skills and knowledge in health promotion in that the students were required to "participate with understanding" in promoting the health of specific groups of people. The way in which health promotion was time-tabled throughout module 2 indicated that health promotion was in fact well supported at this stage of the course, as is demonstrated in table 6. However in modules 3 and 4 there is little clear referral to health promotion.

Table 6 - 11

Common foundation Programme Module 2

Week	Biol Science	Nursing	Psychology	Sociology	Research	IT	Ethics
1	Inheritance Embryology	Nutrition Child & Family	Introduction to module	Socialisation: Process & Perspectives	T	IT	Concepts of Childhood
2	Biological Development	Health Promotion: Infant, Toddler & Family	Sensory & Perceptual Development	Primary Agencies: The Family 1	T	IT	Rites of Passage
3	Biology of Development Metabolism of Nutrients	Health Promotion: Pre-school & Family	Cognitive Development 1	The Family 2	T	IT	Rites of Passage
4	Hearing Barriers to Infection	Health Promotion: Children & Family	Cognitive Development 2	Secondary Agencies: Education 1	T	IT	Child Protection
5	Maternity	Maternity	Maternity	Maternity	Maternity	Maternity	Maternity
6	Vision Respiratory Problems	Child in Hospital	Social Development 1	Secondary Agencies: Education 2	T School Nurse	IT	Child Abuse
7	Adolescence	Health Promotion: Adolescent & Family Sexual Health	Social Development 2	Labelling Deviance	T Children in Pain	IT	Adult Special Needs
8	Disability	Children and Adults with Special Needs 1	Social Development 3	Poverty	T	IT	Children Special Needs
9	Diabetes Nutritional Problems	Children and Adults with Special Needs 2	Adolescence 2	Post Welfare State	Nursing Standards	IT	
10	Disease Processes	Adult Special Needs 3&4	Consolidate	Feminist Critique	Social Service Structure		

Practical Experience

In module 2 the students practical experience took place on three days a week over nine weeks. Experience in maternity care was gained with community midwives and in the maternity units of two local hospitals. Experience in childcare was obtained on the children's wards of these hospitals. NHS community child health services, social services and voluntary organisations were also deployed.

Experience in the provision of care for children and adolescents with special need was achieved in various hospital and community locations. This included students learning to understand the health needs of children and young people with a physical disability and learning disabilities such as auditory or visual impairments.

In module 3 practical experience was focused on the medical and surgical nursing in hospital. Mental health was also an important component in this module and the students spent time in five local hospitals with facilities for the care of the mentally ill. Placements with community psychiatric services were also an integral to this experience.

Elderly health care was the prime focus of module 4 and the practical placements were within hospital departments specialising in elderly medicine, private residential homes, and community nursing services.

Assessment

Competencies were assessed through a longitudinal study, ranging across the three modules. The students made an in depth study of a health topic. They were expected to apply the various concepts covered in the core subjects in relation to nursing theory and practice. Health promotion per se, was not mentioned.

The Branch Programme

The four modules comprising the branch programme were also divide into two parts. Modules 5 and 6 were entitled the Analysis of Nursing and modules 7and 8 were named Preparation for Professional Practice. The five core subjects continued to be studied. The emphasis was on the integration of theory to practice. The aims and learning outcomes were written with the intention of the students achieving higher order objectives that were devoted to the analysis and synthesis of knowledge. The rationale for the branch programme being for the students to:

> " develop further the knowledge and understanding, skills and attitudes acquired during the Common Foundation Programme. This will enable the student to increase her/his ability to analyse critically, evaluate and manage nursing practice".

The learning outcome stated clearly that students were required to become proficient in the promotion of adult health. However, an educational model of health promotion was also identified in that the students were required to:

> "Develop an understanding of relevant educational theories and the application of appropriate teaching skills"

This preference became clearer when the learning outcomes and the assessment strategies for this part of the programme was examined. The theoretical assessment consisted of a four thousand word community project that was to be submitted at the end of module 6. It was assumed that knowledge of health promotion was being assessed, but since the assessment document was not available there was no way of confirming this. However, the practical assessment in both modules was confined to the students being able to use appropriate methods for teaching patients/clients and significant others.

Module 5 - Community Care

This sixteen week module aimed to continue to develop and apply caring skills to patients in their own homes. It was also thought that this experience would enhance the student's awareness of the roles and responsibilities of the Primary Health Care Teams, and they would become aware of the impact specialist practitioners can have in supporting people in their homes, although no examples are given. It was also anticipated that the students would develop an awareness of the services available for people who are terminally ill by observing and participating in nursing care in hospice and home environments.

Examination of the core subject content revealed that while there was a progression in focus from health to illness, health and health promotion were also apparent. The

learning outcomes relating to nursing theory and practice included a statement that the intention was for the students to be able to promote the health of adults in the community. The content for the nursing studies component was disease focused however, in that, it related to the application of nursing theory to patients with:

- Acute and chronic pain
- Communicable disease
- Chronic respiratory problems
- Chronic cardio-vascular problems
- Metabolic and endocrine problems
- Skin disorders
- Malignant disorders
- Terminal illness.

Interpersonal skills were addressed in that the students were required to practice the application of counselling techniques, as well as communicating with patients and their families. Teaching and learning were also addressed in that students were meant to practice these skills as well as studying the dynamics of the learning environment.

The biological sciences were also aimed at enabling the students to develop a critical understanding of the biological explanations of health and disease. It was only at this stage that these students were introduced to epidemiology. The Behavioural sciences continued with this focus on health and disease, in that a critical approach to the study of health and healthcare was being fostered. The content for the sociological component was related to critiques of :

- Socialisation- class, gender, race
- The family - Marxist, feminist
- The role of education in society
- Health promotion.

This continued with the content relating to social policy in that explanations for ill health were explored in relation to policies relating to income maintenance and employment.

The psychological contribution at this point was devoted to both the psychosocial and psychobiological basis of health and illness disorder, while the Professional Studies theme addressed the legislation relating to HIV/Aids through the 1984 Public Health Act.

Module 6 - The Adult with Special Needs

Students spent two thirds of this fifteen week module gaining clinical experience in hospitals. They were divided into groups and rotated through accident and emergency departments, and oncology departments.

The educational model of health promotion became even more pronounced here in that although the aim for the nursing theory and practice component intended the students to have an increased ability to "promote the health of people with long-term health problems", the learning outcomes were related to the application of principles of teaching and learning.

Conflict between what was meant by nursing and what was meant by health promotion also emerged in this module, in that the interpersonal skills component for this theme is examined students are required to apply a variety of communication skills such as those required for adults who are in pain, unconscious or have long-term health problems. Stress and stress management in continuing care settings is also addressed here, but not in the name of health promotion. It almost seemed as though it was easier to relegate health promotion to the teaching and learning strand in that more measurable objectives could be achieved through assessing the students "ability to create an environment in which to teach patients and clients". This seemed a shame in many ways since the content of both the biological science and behavioural sciences supported health promotion. For example, the biological science theme intended to develop the students understanding of the epidemiology of health and disease, with the behavioural sciences continued through social policy to

examine the concept of individual responsibility for health, while psychology introduced subjects such as the characteristics of group dynamics, role theory, and the psychological effects of the health/illness role.

Module 7 - Management and Evaluation of Nursing

At this point students were required to become proficient in health promotion, but with a caveat that it was in acute settings. This was the longest module lasting for twenty seven weeks. The students were again split into groups and rotated through three areas, one general surgical placement, one medical, and either gynaecological or orthopaedic departments. The content of the theoretical component of all the themes continued to support health promotion in that the nursing practice subject addressed the application of the principles of caring to patients with:

- Acute respiratory problems
- Acute cardiovascular problems
- Gynaecological, breast disorders and altered body image
- Acute gastro-intestinal problems
- Orthopaedic Disorders.

But again, the prescribed recipe for the organisation of the curriculum did not address health promotion in any other meaningful way other than through the preparation of the students for their teaching role.

The assessment for this module consisted of an in depth nursing care study, the clinical assessment focused on using appropriate methods to teach patients/clients and significant others.

Module 8 - Preparation for Professional Practice

This appeared to be another missed opportunity for health promotion. As an intention or learning outcome it was not mentioned at all in the curriculum document, other than that the learning outcomes were related to achieving the competencies required

to meet the statutory and common law requirements to his/her particular area of practice.

Integration of knowledge was being assumed in that the only subjects included in the curriculum content at this final stage were related to professional nursing studies. Competence in communication, management and teaching were the key themes.

Yet the clinical experience was imaginative in that the students were expected to have become autonomous, accountable practitioners. In order to prove this the practical placement was an elective, they were able to choose their own clinical area and negotiate their learning outcomes through a negotiated learning contract. The curriculum was imaginative enough to allow this to be negotiated with national and international institutions (in reality this did not happen).

Within each curriculum document a list of indicative reading material is presented (appendix 15). In terms of requirements for curriculum validation these texts are only required as exemplars and do not reflect the total course reading materials. However, what they do reflect is the dearth of health promotion literature at that time, and supports the teachers criticisms of the support for the educational model in the curriculum.

To conclude, examination of these documents provided several explanations for the results of the analysis of the student data. They also account for the teachers general lack of perceptual clarity and frustration with what should be taught in the name of health promotion.

The ENB (1990) guidelines reflect the conceptual confusion existing at an international level, as discussed in the opening chapter. In adhering so closely to these guidelines, the curricula in each of these colleges perpetuate the individualistic

focus on health education. Because both nursing and health promotion are relatively new academic disciplines and have similar theoretical foundations conflict arises surrounding the position of health promotion in the curriculum, rather than being a separate theme in itself, it is subsumed either within, nursing or the behavioural sciences, as such it becomes fragmented and almost extinguished. This was very apparent in the Waverly and Chiswell curricula, where there was little mention of, and no specific assessment relating to health promotion in their branch programmes. However, the fact that it was assessed as a separate subject in the branch programme in Blackstone had no impact on those students' perceptions, indeed it was in this school where the reduction in strength of the value of learning about health promotion was most apparent.

However, in all three schools health promotion was most clearly defined in the common foundation programme and it was at this point that significant change was observed therefore it can be concluded that as the teachers in all schools observed the key to creating change was within this part of the curriculum. These changes did not appear to be influenced by the elegance or creativity of the curriculum design, neither did it appear to be dependent on whether or not the WHO (1985) philosophy of Health For All was universally incorporated into the curriculum philosophies. While the importance of documenting such a philosophy is not denied, what does seem to be of more value is the philosophies, beliefs and skill of the teachers in interpreting the curriculum intentions. The importance of these skills was recognised by the ENB, and the preparation and recruitment of appropriately qualified teachers was also acknowledged. This need was also recognised by the teachers participating in the study.

Although health promotion and health education seemed to be terms that were used interchangeably in each curriculum, and an educational model was preferred, it can be argued that perhaps this is the most appropriate model of health promotion for

newly qualified nurses at the beginning of their careers. Further explanations and comprehensive conclusions are drawn in the concluding chapter.

CHAPTER 12

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This chapter provides a summary of the empirical findings reported earlier, it sets this in the context of recent research and conceptual development (Lask et al 1994; Seedhouse 1998; Macdonald 1998), and ends with an examination of the role of nurses in health promotion.

The research began with three key intentions. The first being to determine nursing students' health beliefs and the value they placed on health promotion on entry to nursing and the second to establish if there were any changes in their perceptions of health promotion that could be attributed to the philosophical shift from health to illness in nurse education and healthcare generally. The third was to develop an instrument that could be used to measure changes in perception as part of curriculum evaluation.

The empirical work consisted of two studies. The first examined the perceptions of nursing students on a "traditional" pre-Project 2000 course. The results from this work provided the foundation for the development and design of the main study, which focused on the perceptions of student nurses undertaking Project 2000 courses. A wealth of interesting and illuminative data was produced from different sources, employing a variety of methodologies. The longitudinal panel design of the main study and use of triangulation was powerful in eliminating bias and strengthening the overall structure. With regard to all of these aims, it can be said that this study has been successful. However, before any conclusions can be drawn, some methodological weaknesses require consideration.

Several confounding factors had to be taken into account in designing the project. The first was associated with funding, which was not available, consequently the study was limited to the researcher's financial situation. This in turn placed constraints on time, since the research was conducted in conjunction with full-time employment.

In the second and major study the aim had been to incorporate a much larger data set including students from all of the branch programmes, which would have provided useful comparisons, thereby increasing the reliability and generalisability of the findings. This intention was frustrated due to the then political climate, favouring a reduction in the recruitment of student nurses.

The problems associated with longitudinal research design have been addressed, however, opportunistic non-probability sampling methodology, and the fact that there were low attrition rates in all three cohorts, provided a large enough sample for statistically significant inferences to be made. The homogeneity of the student population was another factor that could have introduced bias. But, given the geographical location of the three colleges involved, in conjunction with the fact that the data was triangulated, it is concluded that this sample was representative of students at that time. These conclusions are supported by the results of other studies (Lask et al 1994; McBride and Moorwood 1994; Mitchinson 1995).

The stability of the educational organisations was another factor impacting on the outcome of the work. The research was conducted when health service reforms and Working Paper 10 (1989) were having a dramatic effect on the structure and organisation of nursing education. This particularly affected the sampling methodology utilised to determine the teacher's perceptions of health promotion. However, all the teachers who participated in the study taught the students in the

sample. The results of focus group discussions and the document analysis both support and illuminate the results.

Formative Conclusions

The results of the first study influenced the decision to extend the remit of the work. The aims of second were to:

- Determine student's health beliefs and the value the placed on health promotion on entry to nursing.

- To establish if there were any changes to nursing students perceptions of health promotion that could be attributed to the philosophical shift from health to illness in nurse education and healthcare generally.

- To continue with the development of an instrument that could be used to measure change these changes in perception as part of curriculum evaluation.

Instrument Development

The Student Questionnaire

In the second study significant structural alterations were made to the student questionnaire. The structure of this instrument was of concern in terms of content reliability. Pilot work revealed acceptable levels of inter rater reliability. Therefore the instrument was deemed to be worthy of analysis.

The Teachers' Questionnaire

This instrument was designed not primarily as measurement tool, but as a method of triangulation. The intention being:

- To determine how teachers conceptualised health promotion.
- To determine the importance they placed on it in the curriculum.
- To use these results to generate themes for deeper analysis through focus group discussion.

Although the sampling methodology in this phase was problematic, the results from the questionnaire in the construction of a topic guide for the focus group discussion

was successful. Further problems were encountered in the organisation of the focus groups, however sufficient data was obtained to produce a rich framework for contextual analysis.

Summative Conclusions

Due to the structural changes to the questionnaire, direct comparisons could not be made between the results of students perceptions in the first and second study. However, the findings suggest that there is a change, in that the students in the second study were moving away from an educational model of health promotion to one that was focused on enablement and empowerment, albeit with a focus on individualised care, which is one of the main tenets of nursing. This, to some extent is perceived as being at odds with health promotion. However, it is not so much the ideology of individualised care in nursing that conflicts with nursing in health promotion, but rather the ideology of individual responsibility for health which is problematic in health promotion. Rush (1997) argues that nurse educators should be aware of perpetuating this individualistic "victim blaming" focus in the nursing curriculum, yet these ideological beliefs, were not a predominant feature in the student data, suggesting that "individualism" was not the focus of the curriculum. Although the documents emphasised an educational model.

Statistical analysis of the student data in the main study enabled the production of significant inferences. Where comparisons were made between the groups any statistically significant differences need to be considered with some reservation in terms of generalisability due to the numbers in each group. However, observed differences between the schools were valuable. For example, the Waverly students' perceptions were frequently different from the Blackstone and Chiswell students. When these differences are compared with the data generated from the document analysis and from direct observation it can be seen that the culture of this organisation and the philosophical intention of the curriculum was also different.

However, these differences in perception in Waverly were observed at the end of the common foundation programme. By the end of the course, no significant differences in perception were noted. Neither the culture of the organisation nor the difference in curriculum design appeared to impact on students' overall perceptions on completion of the course. However the clinical experience suggested a positive impact.

Exploratory factor analysis enabled the extraction of salient factors constituting the students perceptions of health promotion. The change in the loading of putative factors as the course progressed supported initial conclusions that change had indeed occurred. One factor with acceptable levels of internal consistency were identified. The reason for the second identified factor producing lower levels of internal consistency could be attributed to the number of questions on the scale. The design of the entire questionnaire was influenced by Oppenheim's (1992) warning that the length of questionnaires can influence reliability, due to subject boredom. Another influential factor was the requests for brevity by the programme co-ordinators in the participating colleges. With hindsight, a larger scale may have facilitated a factor analysis producing higher levels of internal consistency. The identification of further items with acceptable levels of validity and reliability is a possible resolution to the problem.

Summary of the Students' Perceptions of Health Promotion

Health Beliefs

It has been established that the students in this study entered nursing with health beliefs that closely correlated with Blaxter's (1990) analysis. These were multidimensional and incorporated aspects of a medical model of health as well as the looser more holistic notions of well-being. Lifestyle and physical fitness were also assumed to be important factors influencing health. These beliefs do change over time with significantly more students adopting beliefs about health that were related to notions of well-being, although lifestyle was also a predominant theme. This

significant change was still apparent by the end of the programme although diminished in strength. There were no differences in these beliefs that could be associated with gender class or education.

The Importance of Health Promotion

Overall, the importance of learning about health promotion was highly valued at the beginning of the course, but there is a statistically significant decline in the strength of this value at the end of the common foundation programme. This trend is still apparent at the end of the course. This could be attributed to the fact that the students were frustrated by the theoretical rather than the clinical focus at this stage, and is supported by previous studies (Robinson 1991), as one Blackstone student commented:

" I do think it's important, but its been done to death on this course".

However, when these results are compared with the item on the scale relating to the importance of practical "hands on care" in relation to health promotion, the majority of students perceived it as being important 97 (63.4%) at the beginning of the programme and 66 (64.7%) at the end. What is interesting here is that although only 12 (7.8%) strongly agreed that health promotion was not secondary to practical care at the beginning of the course, this had changed significantly at the end of the common foundation programme, with 26(21.9%) strongly disagreeing with the item, this was sustained at the end of the course with 18(17.6%) strongly disagreeing with the item. Health promotion is consistently perceived to be one of the most important parts of the nurses role.

What is Health Promotion?

In defining health promotion several themes emerged purporting an individualistic ideology at the beginning of the programme, by the end of the common foundation programme this definition was wider and some 18 (11.8%) of the total population were expressing notions that were more collectively orientated. This perspective was

still apparent on completion. However, the students defined their role in health promotion as being associated with the prevention of disease, through the provision of knowledge in order to change behaviour and enabling maintenance of a healthy lifestyle. Notions of personal responsibility for health, although apparent were not identified as being predominant elements. The inference here being that the educational preventive model of health promotion was predominant.

The Students' Perceptions of Health Promotion

Analysis of the scale indicated that this was not entirely so. It was shown that there was movement away from the authoritarian "victim blaming" approach to health promotion through the giving of advice and information, to one that was supportive and enabling. The use of exploratory factor analysis was powerful in demonstrating this change, as well as determining the reliability of the data through the provision of acceptable levels of internal consistency. This method of analysis was also useful in establishing that the students' perceptions of the theoretical foundations of health promotion was related to knowledge derived from the social sciences, but this perception did not change over time and seems to be an expectation of the course. The second factor appeared to be addressing the students' professional role, which did not acknowledge the power of the professional. However insufficient variations were extracted to make any inferences reliable. There is a need for further refinement to the instrument.

Nevertheless, these students were, to use Seedhouse's (1986) terminology, "politically literate" in that they were aware of the importance of contexualising health promotion activity. However, political involvement was not related to health promotion, but rather to their role as nurses. This result is similar to the results in the first study, however the Project 2000 students were politically aware from the beginning of the course, their attitude did not change, whereas, the "traditional"

students' were expressing more "professional" perceptions on completion of training than at the beginning. However, no direct comparison or inferences can be made.

Illuminative Analysis

The Teachers' Views

The previous findings are supported and validated by the teachers evidence in both the questionnaire and focus group discussions. Their conceptualisation of health was unsurprisingly mature. For them, the importance of the students learning about health promotion was directly related to the development of their professional role though the acquisition of competencies as outlined in the Nurses, Midwives and Health Visitors Rules Approval Order (1989). The potential power of nurses in bring about both behaviour and social change was also mentioned. The influence of policy in defining the nurse's role in terms of the shift in focus from disease orientation to prevention was also considered to be an important reason for students to learn about health promotion. Notions of empowerment were also expressed.

The teacher's interpretation of health promotion were also varied. They were generally able to discuss the philosophical principles in terms of the WHO (1985) strategy, and identified its theoretical grounding in the social and behavioural sciences. Both structural and individual elements were acknowledged. However, some were unsure of how health promotion should be conceptualised in nursing. There were clearly expressed ideas that both nursing and health promotion were inextricably linked. There was also consensus that it was not merely the domain of community nursing.

The teachers also experienced difficulty in defining what they wanted the students to achieve in the name of health promotion. This ranged from a philosophical perspective of wanting the student to be thinking about health promotion and "health nursing". These notions were holistic, in that nursing care was considered to be

health promoting and involved the total environment wherever care was given. They also wanted the students to be flexible and adaptable and be able to create opportunities for health promotion.

What Should be Taught?

There was little evidence of a paradigm shift or focus on enablement and empowerment in the context of what should be taught, emphasis was placed on lifestyle and behaviour change and appeared to be disease orientated and consequently embedded in the medical model. Practical examples generally remained locked into a biomedical framework, in that health advice was important on discharge from hospital. The use of models of health promotion in order to encourage compliance with drug treatment and the prevention of re-admission to hospital was also mentioned. There was also some mention of working holistically with families, but in the context of disease prevention. Other examples were associated with cardiac rehabilitation and asthma rehabilitation.

Some teachers were also unaware that the subjects they taught were associated with health promotion. This may be do to with semantics, for example, the mental health teacher suddenly realising that the therapeutic interventions utilised in mental health nursing could be classified as health promotion. But also the teacher who gave a graphic account of how attitudes and values in relation to the elderly was not entirely sure that she was teaching health promotion. Whether they were teaching health promotion or health education was debated.

Teaching Health Promotion

There was a consensus that this problem could be rectified by specialist teachers being responsible for the teaching content of the curriculum. This was in order to ensure that the new paradigm principles were introduced and that appropriate text and course materials were introduced. It was acknowledged that health promotion

was a vast multifaceted concept and at the pre-registration stage, the basic principles were what needed to be taught.

There was unanimous agreement that the common foundation programme was the key area of the curriculum for teaching health promotion. The development of critical thinking was also identified as an essential element in the learning process, as was the integration of theory with practice. Classroom teaching strategies were mainly through, group discussion and debate, reflection on practice.

The sequencing of the subject in the curriculum was also considered important. It was generally agreed that health promotion should be explicit, and timetabled throughout foundation and branch programmes. An assessment strategy supporting this should be introduced. It was also acknowledged that curriculum content should move from the general to the specific. By making health promotion an explicit subject, it would finally become embedded in clinical practice.

Barriers to Health Promotion

Perceived barriers to the students being effective health promoters were mainly associated with the lack of support in clinical areas. This was perceived as the qualified staff not being receptive to health promotion. Two reasons were identified as causal concerns, the first being, lack of knowledge of health promotion principles, exacerbated by nursing theorists demonstrating little intellectual curiosity in defining health, and teachers recommending health education as opposed to health promotion literature to the students. The second was the negative impact of the NHS and Community Care Act (1991). Nurses in both the hospital and community were too busy, this was attributed to the shorter time people were spending in hospital, which in turn had impacted on the resources of nurses working in the community. All these factors created stressful situations for the students, in that they were unable to achieve their educational objectives.

The Way Forward

The teachers invested a considerable amount of thought into forming solutions to the identified problems. This is illustrated in the discussion relating to the curriculum content. Several other issues were also addressed. One encouraging view which supports the results relating to the students perceptions of the political context of their role in relation to nursing and health promotion, is that students were more assertive and questioning, and that they did not reject their role in health promotion. The observations of Blackstone and Chiswell teachers, that students were entering the profession more aware of their own health and participating in health enhancing activities was also interesting. This may well be due to the fact that health promotion has had an impact on society in general. It is difficult to ignore the focus on health in all areas of the media. Television programmes, magazines and newspapers are awash with articles relating to health and lifestyle especially. An example of the effects of this raised awareness is captured in the following examples from a small investigation relating to the extent of health issues mentioned in broadsheet newspapers. The first is an extract from an interview with a young musician:

> " Nikki Yeogh is a jazz pianist whose dynamic outlook matches her polished yet raw and earthy music. Clean living and vivacious, she exudes energy. "for too long jazz has had a seedy image. Most of my generation are into health: they're anti-smoke, anti-meat, even anti-caffeine," she says, and then laughs as she catches a glimpse of herself in a steamy cafe mirror, hunched over a cappuchino" (Scobie, 1996).

Exploration of the Daily Telegraph website from its inception in November 1994 until July 2000, revealed over 1000 references to health each month. The Guardian publishes a weekly tabloid journal related to health and society. The paper launched it's website in September1998, between then and July 2000 there were 9,290 references to health. Between January 1st 2000 and June 20th 2000 in the Times alone there were 3108 references to health and health promotion.

The teachers were also proactive in that they made suggestions for improvements.

Besides the specialist teacher having a responsibility for curriculum development, they felt that anyone who taught this subject should have a commitment to it and that health promotion should be a guiding principle in their clinical and teaching practice. They concluded that the subject should be made explicit throughout the curriculum. It was also clear that they thought that the institutions in which they worked, and senior management should be committed to health promotion. In essence they were calling for a curriculum philosophy of health promotion. Creativity was another factor to be encouraged, through the development of learning opportunities for students in the clinical environment. They also defined their own role more clearly in that they should be facilitating learning by clarifying concepts and enabling the transfer of cognitions. This was clearly related to their own professional development.

Curriculum Content

Document Analysis

Despite problems encountered in gaining access to some documents, a clear picture of the content and organisation of the curricula was obtained. The conceptual confusion at policy level in relation to health promotion was also identified as was the onerous task placed on the various educational organisations of implementing such radical change.

Although the ENB (1989) guidelines for the development of Project 2000 courses are prescriptive, some autonomy is allowed for curriculum development, their preferred concept in relation to health promotion was health education. The examination of the curriculum documents revealed beliefs about health and nursing were addressed in the course philosophies, but were not driven by WHO (1985) principles. In general there is conceptual confusion between health promotion and health education, even where the term health promotion is used consistently, it is apparent from the teachers evidence that an educational model is the reality of the teaching and learning outcomes.

The concept of health is addressed rigorously within each of the curricula in the common foundation programme, but health promotion principles are fragmented. Where attempts were made to adopt a more progressive approach through the integration of themes, as in Waverly, it is apparent that health promotion receded and contributes to the decline in the strength of the students perceptions. This is especially apparent in the branch programme curricula. This does not imply that the teachers in this school were not working hard to redress this problem. This is disclosed in the focus group discussion, and in the course document, which was evidently a working document, littered with hand-written annotations. This observation was rewarding in itself, the written curriculum is too often accused of being totally divorced from the curriculum in action, consigned to ignominity at the back of a dusty shelf (Cooke 1993).

Explaining the Problems

The study proceeded in conjunction with a plethora of research and development focusing on pre-registration nursing education. Cooke (1993) has drawn attention to the problems associated with the integration of subjects underpinning nursing theory in the curriculum. The main study related to health promotion was commissioned by the ENB, (Lask et al 1994). It is also acknowledged that there has been movement in the conceptual development of health promotion (Macdonald 1998; Seedhouse 1998). If any meaningful conclusions and recommendations are to be drawn from this work these developments require some consideration.

Boundary Work

This conceptual confusion, conflict between health promotion and nursing, and consequent inability to sustain health promotion in the curriculum is not a unique problem. It is only in the latter half of the twentieth century that both nursing and health promotion have emerged as academic disciplines, both of whom have borrowed from other areas to create their own body of knowledge.

Cooke (1993) discusses the contribution sociologists of knowledge have made in drawing attention to social construction of knowledge (Knorr-Cetina and Mulkay 1983), and the way in which the sociology of education has contributed to the educational establishments (Young 1971). Cooke (1993) investigated the social processes influencing the creation of subjects, and boundaries between subjects. She cites the work of Fisher (1991) who argues that the creation of academic subjects involves "boundary work". Boundary work, according to Fisher (1991) is involved in exercising power, by conferring legitimacy and authority on some forms of knowledge and excluding others.

Cooke (1993) argues sociology is marginalised in the nursing curriculum, because its legitimacy and authority has been rejected.

> "The discipline of nursing is now promoting its **own** claims to academic legitimacy yet these remain precarious. Students are exposed on the one hand to value systems which confer great power and prestige on the physical sciences and on the other hand to nursing's own scientific ambitions. It is small wonder that in coming to terms with conflicting cultures of different disciplines nurses often come to denigrate the worth of social sciences (Kornreich 1997; Theodore 1989 cited by Cooke 1993)".

Within nurse education sociology was seen as representing social problems, and that the subjects relegated to sociology were "strange bedfellows, whose single unifying factor were their marginal or deviant status, such as substance abuse, sexuality, AIDS, death and dying". In her survey (1991), of the content and boundaries of the sociology curriculum in nursing education she found that it had often been decided by non-sociologists. She also found that many textbooks listed in the sociology curricula of colleges were not sociology works and that few teachers were sociology graduates. In transferring these arguments to the case of health promotion in the curriculum the findings from this empirical work lead one to reason that, sociology has assumed the mantle of legitimacy and respectability, and that health promotion, has superseded it as the marginalised subject.

A Curricular Review of the Pre- and Post-registration Education Programmes for Nurses, Midwives and Health Visitors in Relation to the Integration of a Philosophy of Health: Developing a Model for Evaluation.

This project was a short evaluative study commissioned by the ENB and carried out by Lask, Smith and Masterson in 1993 and published in 1994. Illuminative evaluation was used to determine the extent to which the integration of a philosophy of health in the educational curricula for nurses midwives and health visitors had been achieved. Four case studies and a consultancy were undertaken in centres representing a geographical spread in England. The aims and research questions developed are contained in appendix 16.

Data collection was by semi-structured interviews with college staff, practitioners and students, focus group discussions and documentary analysis. Findings were organised utilising the model based on that of Parlett and Hamilton (1976). A summary of the data collected and the final recommendations are found in appendix 16.

In the four case study centres Project 2000 students participated in the research however, the report does not quantify the total sample of participating students, a total of 125 completed the questionnaire survey, but these were all common foundation students, and the stages in their programmes were not identified. The researchers identified this as problematic, in that they never seemed to be evaluating researchers identified this as problematic, in that they never seemed to be evaluating the "finished product". They also acknowledge that due to the short time-span and the breadth of the study, some of the conclusions they reach are superficial. Consequently, although there are some similarities between Lask et al's (1994) findings and this study, there are also differences, these are now discussed.

In this instance Laske et al's (1994) findings are similar but their conclusions differ. They conclude that a philosophy of health and health promotion principles have not been integrated in a manner in which the students are able to understand or apply, but they do not explore the reasons for this. This study has enabled a deeper reason to be offered in that no conceptual clarity was evident within nursing leadership at the inception of Project 2000. It was also identified that the courses were not adequately resourced in terms of teacher preparation, written learning materials and appropriate practice placements for students.

Lask et al (1994) concede that there is a heavy concentration of issues relating to health and health promotion in the common foundation programme. They describe the typical pattern was to "begin with a unit or module totally concerned with "normality" or total functioning". The students learned about society, with the second module focusing on health and health promotion (Lask et al 1994). This is similar to the findings in this study. Their conclusions that the students found it frustrating not to hear about disease or their future role at the outset of the programme, support the results of this study. It has also been demonstrated that regardless of these expressions of frustration, the most significant change in perception of the concept occurs in the common foundation programme. What is more, there is evidence to suggest that students continue to perceive health promotion as an important element of their role, on completion of the course.

Lask et al (1994) found that the lecturers in all the centres they studied reported that post-registration students were more likely to respond positively to health promotion than novices, because they appreciated its value and clinical application. They argue that new recruits yearned for hands on experience and high drama on the wards. This phenomena is not a unique property of noviciates to the new programme, and is worthy of comment only in that Project 2000 programmes were ineffectual in

diffusing this enthusiasm. However, the design of this study has facilitated an examination of the process and "the finished product", it has been shown that student nurses value health promotion and do not perceive it as being secondary to "hands on care". It is therefore concluded that on completion of the course these students valued health promotion and where aware of the importance of the clinical application.

It is argued here that there are other variables precluding the application of health promotion principles. The specialist lecturer in this study provided graphic accounts of the problems she encountered with practice nurses, in that although they were motivated to learn they were thwarted in their attempts to put theory into practice due to the conservative perceptions of their GP employers.

> " Her GP's don't believe in health promotion clinics at all, asthma clinics, diabetes clinics. She doesn't want people with the same condition in the same room.....It makes it hard then for the practice nurse to actually achieve anything because you can do a nice lot of health promotion when you've got a group in a clinic like that".

In their research Lask et al (1994), observed that health promotion was taught by general nurse teachers, consequently the curriculum content was predominantly concerned with promoting physical health. This preponderance was noticed in this study. They attribute this predominately general nursing approach to teaching in the common foundation programme as being a contributory factor in the development of distinct branch cultures which in turn mitigated against the integration of health promotion. This seems plausible, but it is also concluded from this investigation that, another reason for this problem is that teachers from other disciplines who taught in the common foundation programme experienced problems in conceptualising their speciality in terms of health promotion.

Clinical practice placements were also another area, where Lask et al (1994) noticed that students and qualified staff were "unable to conceptualise a role for nurses promoting the health of sick people. The general concerns appeared to be that health

promotion and health education were to be undertaken in the community by community nurses". Yet the definition of community nursing is unclear, students spent the majority of their clinical practice in the community nursing sick people and had very little opportunity to observe practitioners engaging in health promotion. Placements with school nurses and health visitors were allocated during the early stages of the common foundation programme, when the students were only expected to achieve lower order learning outcomes. These issues were also apparent in this study, but it was also observed that the practical experience had some positive impact on students' perceptions, which may well be associated with their experience of nursing sick people. Therefore, it is concluded that the process had some effect in reinforcing perceptions.

Lask et al (1994), are equally damning of the variety and quality of designated health promotion placements in both non-institutional and institutional settings, which were designed to expose the students to "normal" representations of society, such as "visiting families with community nurses, occupational health visits to steel works and nuclear plants." In situations like these they argue, students are likely to observe situations which undermine rather than enhance health. To some extent there is veracity in these statements. Certainly the document analysis in this study revealed that students were exposed to a very similar selection of placements although there had been some attempts at creativity, especially in Blackstone. Very determined attempts by the teachers were also made in order to facilitate learning. Yet very little difference was made to the student's perceptions of health promotion. Although Lask et al (1994) recommend more focus on exposure to community action and community development models, it must be acknowledged that these resources are not universally accessible or sufficient to support a comprehensive experience for large numbers of students.

However their calls for more creativity in the arrangement of clinical experience is important. For example, they cite the remarks of one of their key informants in one centre who questioned the value of placing students for eight hours with clients with learning disabilities and without adequate preparation. The solution proffered being to show students a trigger video, followed by shorter contact time. These teaching methods are effective. The author has experience of implementing a module addressing the health needs of people with learning disabilities which adopted a similar, but more structured approach. It was run collaboratively by the author and a service manager for people with learning disabilities. The module was generally well-evaluated and we also noticed positive changes in attitudes. Although the work was not subjected to empirical evaluation, the experience culminated in one journal article (Vernon and Muncaster 1995) and presentation of a paper at the ENB (1994) Conference in Learning Disability Nursing (appendix18). The teachers in this study were also aware of the need to create more dynamic and relevant learning opportunities. Consequently it can be argued that there may well be a need for more collaborative ventures as well as creative teaching materials in order create and sustain positive attitudes towards the integration of health promotion pinciples in nursing practice.

Lask et al (1994) also address the issue of health promoting hospitals and colleges of nursing, noting that it is impossible to teach health promotion (or any other subject), in poor environments. They also address the stressful situations that the teachers encountered due to inadequate preparation for the transfer into higher education. These issues became apparent in the course of this study. In the model they developed to evaluate the integration of health promotion into the curriculum. They identify both hindering and enhancing factors. While this model is useful, it is realistic to state that the factors hindering this integration are a reality of post modern society, and a reflection of the impact that market forces have on higher education. It is also necessary to state that the previous traditional, apprenticeship model of nurse

education was even more counterproductive than Project 2000 education. It is crucial to consider how educators can be proactive in working in the current context to achieve these aims. A review of recent conceptual development is essential in order to propose some pragmatic solutions.

The Foundations Theory of Health Promotion

This theory of health promotion is proposed by Seedhouse (1998). It is grounded in his conceptual analysis of the meaning of health (Seedhouse 1986). He also owns that it contains an element of prejudice since it is based on his own "untestable beliefs about the morality of social arrangements". This has led him to conclude that any "plausible account of health must understand the purpose of health work to be the identification and - wherever possible-removal of obstacles to worthwhile (or enhancing) human potentials". By this he means:

- Work for health is essentially enabling.
- A person's optimum state of health is equivalent to the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials.
- The actual degree of health that a person has at a particular time depends on the degrees to which these conditions are realised in practice(Seedhouse 1998).

Seedhouse presents his ideas in abstract form which he presents as series of boxes (appendix19). These boxes he describes as being either "conditions for" health, or "constituents of" health. Their importance lies in them providing a platform or stage for autonomy. Four central blocks are essential factors in achieving high levels of health. There may be others and their relative content and importance is arguable. He attributes five essential elements as being the most important namely:

1. "The basic needs of food, drink, shelter warmth and purpose in life.

2. Access to the widest possible information about all factors which have an influence on a person's life.

3. The skill and confidence to assimilate this information.

4. The recognition that an individual is never totally isolated from other people and the external world.

5. Other foundations for achievement are bound to vary between individuals dependent upon which potentials can be realistically achieved. (Seedhouse 1998, these are reproduced in full in appendix19).

Seedhouse (1998) writes beguilingly and seductively of the philosophical development of the theory from Socrates, Plato and Aristotle, Oliver Sacks and John Stuart Mill (Seedhouse 1986). However, he owes some acknowledgement to gestalt psychology and (despite his critique of humanism *per se)* humanist psychology, in particular Abraham Maslow's (1970) work in the development of a hierarchy of needs.

Seedhouse (1998) also discusses the limitations to this theory stating that it is not comprehensive, since health work cannot be totally comprehensive. He also says that the content of his "boxes" are prejudiced, but argues that all health work is essentially values driven and consequently prejudiced. He also declares that no measures of health are indicated and as such it is as vague as any other attempt to interpret health. His main aim in the development of this theory has been to produce a "backcloth" for measurement. He concurs with other theorists that health measurement is an inexact science, but does offer an explanation of how the foundations theory can begin to generate measures which transcend the individual level. These are outlined in appendix 19. Despite the acknowledged vagaries of the theory, given the problems identified in this study in particular, in enabling clarity in terms of what nursing is attempting to achieve in the name of health promotion, it has the potential to make a useful contribution to nursing education. His account of health work also aligns well

with accounts of nursing and health promotion that were revealed in the study. Consequently it is a useful vehicle for enabling students to understand health promotion principles. It is also argued that the tool developed in this study is a potentially useful adjunct to evaluating the successful teaching of the Foundations Theory.

Rethinking Health Promotion

In the opening chapters to his book Rethinking Health Promotion: A Global Approach, (Macdonald 1988) traces the historical development of health promotion and biomedicine, arguing that they have developed as separate entities, he warns of health promotion becoming an appendage of biomedicine. He also argues that it is a "eurocentric" concept, as such, he debates its validity at an international level. He considers whether or not it is ethically sound to incorporate a model based on westernised belief and value systems into the development of health promotion policy in third world countries. He uses the Cuban example to support his conclusion, that it may well be the means by which the successful policy implementation may be achieved.

MacDonald's work is particularly relevant to this study in his epistemological analysis of the application of health promotion to a variety of disciplines. He says that his classification does not intend to replace the popularly quoted taxonomy of ecology, holism, equity and social justice. He is quite clear that health education and health promotion are not the same.

> "The term health "promotion" implies an ongoing process involving both education about health as well as the elaboration of strategies which will enhance the effect of such education. It is this strategic aspect that informs us that health promotion involves a collective response (it transcends the activities and decisions of the individual) and, largely for that reason, is likely

> to seek (and find) expression through political structures and channels" (MacDonald 1998).

Modern health promotion according to Macdonald (1998) is underpinned by three major ideological and political thrusts:

- feminism
- environmentalism
- anti-authoritarianism

The central role of feminism is to address all forms of social discrimination and is of paramount importance in addressing issues of advocacy, autonomy, empowerment and intersectorality. Historically, we have always been aware of our "symbiotic" relationship with the physical environment for sustenance, however, it is only comparatively recently that we have been able to employ scientific principles to measure our impact on the environment. This realisation of our dependence on the physical environment, has led to what he calls "the popularisation of the scientifically dubious idea of "Gaia". This is:

> "simply the Greek word for our world (planet Earth, if one likes), but the correct Gaia concept goes far beyond this. It sees the planet plus it's enveloping atmosphere (including the holey ozone layer) as an organism in its own right, struggling to re-achieve a sort of homeostatic equilibrium in response to each assault made on the total interrelated environment. Most of the assaults of course are made by humans" (Macdonald (1998).

Although this concept has been adopted enthusiastically by proponents of the "New Age" culture, the most important aspect of the Gaia concept is that many have become aware of the seriousness of our environmental situation, and a collective responsibility for preserving and protecting it must be assumed. This notion of "Gaia", provides direction for health promotion. According to MacDonald (1998), it also aligns with the nurturing aspects of feminism.

"Gaia is our mother and our nurturer. Dare we kill her?"

He concedes, however, that modern notions of feminism are far removed from this idea but nevertheless this is basic to feminism.

The author refers to the third thrust of health promotion as anti-authoritarianism rather than the "buzz word" of empowerment, as has been argued by "pioneers" of the health promotion movement. Several reasons are offered for this, he proposes that in the past the media, tended to reflect the status quo, and that people tended to accept their place in the social structure without questioning authority. Attempts to date this change in attitude are difficult, but his view is that the possibility of widespread nuclear destruction since 1945, was the most influential factor in the reduction of public confidence in authority. Thus when people did seek meaning through social organisations they tended to form "special interest" groups, where needs were expressed as "rights'. The common feature of these groups being that their needs were marginalised, they were seeking legitimacy and empowerment. Thus, MacDonald argues empowerment is a derivative of anti-authoritarianism. To MacDonald (1998), empowerment refers to two distinct phenomena:

1 "Telling people what is good for them and then assessing the degree to which the information is acted upon in terms of the fidelity of their compliance. This is frequently seen in health education contexts.

2 Creating a situation in which either a community or an individual is encouraged to acknowledge their own self-esteem and the legitimacy of their own autonomy, and on that basis to form their own health agenda and to organise themselves to bring it to fruition. This often requires community action and the health promoter accordingly finds himself/herself advising on educational, political or legal aspects. It can be a basis for neighbourhood advocacy" (MacDonald 1998).

He suggests that the way through this semantic dilemma is to use the word *impowerment* for the first of these phenomena and *empowerment* for the second. *Impowerment* therefore assumes involvement from "outside oneself". This includes giving advice and information. *Empowerment* on the other hand can only derive from

the individual or the community, this can occur only when the person or people concerned have a sufficient sense of self-esteem to recognise the worth or legitimacy of their aspirations. Empowerment cannot be an input, although it may be a consequence of that input if other information or counselling has led to an improvement in self-esteem (MacDonald 1998).

This deconstruction of one of the central tenets of health promotion, is important in relation to this study. As previously stated nursing is a pluralist profession and because of this and the multifaceted nature of health promotion it is unsurprising that the participants in this study, and in others, have found it so difficult to articulate what exactly they were doing in the name of health promotion.

One further, area in which MacDonald (1998), is able to provide clarification is in establishing an evaluation framework. In this competitive age evaluation of health promotion has to be seriously addressed, in that evidence of its worth must be portrayed to purchasers of services and project fundholders. As he says there are two persistent problems associated in assessing health promotion, the number of definitions and the fact that since health promotion involves empowerment, it is a dynamic rather than a fixed process. Consequently assessment is dependent upon whether one is evaluating:

- "the process on its way to outcome;
- the outcome (or one of the outcomes) as an end-point;
- the outcome (or one of the outcomes) as a process enhancing a person's life" (MacDonald 1998).

A solution he offers is based on work by Rokeach (1983) which involves separating the initiatives of any health promotion objective into the following categories:

- Instrumental objectives: short-term objectives;

- Terminal goals: long-term goals.

Long-term and short-term objectives and programme evaluation strategies need to be built into any programme, but essentially it is necessary to be clear about which definition of health promotion they are using. Once this has been determined, the definition must be deconstructed in order for it to:

> "objectively and empirically recognise and measure the extent to which separate criteria, of the definition used are being satisfied by the manner in which the initiative is being mediated" (Potvin and Macdonald 1995; Rootman and Raeburn 1994; Springett et al 1995: in MacDonald 1998).

MacDonald et al (1998), in conjunction with Goodstadt et al (1987), have produced a set of definitions (appendix 20) which can be deconstructed using the following criteria:

- terminal goals;
- instrumental objectives;
- instrumental processes;
- instrumental action.

These can be used to assess health promotion interventions at individual and community levels (Macdonald 1998). They also have implications for use in evaluating process and outcome in health promotion in nursing education. This framework could be valuable in terms of educational evaluation and it is considered that the tool developed in this study would be a useful measure should this framework be adopted for curriculum evaluation of health promotion.

Implications for the Development of Health Promotion in the Curriculum

In turning to conclude whether or not nurses are health promoters, we reconsider the four levels of analysis espoused in chapter 1. An examination of the social history of the concept has traced its evolution from health education, which is rooted in ancient Greek philosophy. This has provided clarification, in that if health promoters are to

accept the modern philosophy, and definition proposed by the World Health Organisation (1986), then they must be aware of the underlying manipulative, coercive and controlling ideology implied in poor understanding of the terms enablement, empowerment and social justice.

Nursing is relatively new to academia, as is health promotion. In order to provide legitimacy and gravitas to the disciplines they "borrow" from the more established social and behavioural sciences. Nursing, especially in the United States has been proactive in the development of nursing theory, and it has been demonstrated that the boundaries between health promotion and nursing have been relaxed in some instances through theory development based on health promotion principles (Neuman 1982; Pender, 1996).

Theoretical development in nursing in relation to health promotion in the United Kingdom is not as advanced. While nursing has entered the debate between health education and health promotion we remain at the level of conceptual clarification. Current academic thought in nursing places health education on the boundaries, as a pre-requisite for health promotion, with information giving, advice and skills training as essential elements for this role (Maben and Macleod Clark, 1995). This view is similar to MacDonald (1998) who regards health education as separate, static and "impowering" with health promotion being dynamic and "empowering". These views are useful, but if nursing and health promotion are to exist synergistically and both disciplines are to continue to evolve, this conceptual separation is counterproductive. One wonders if the implication is that nurses are incapable of being, rather than becoming, health promoters. The results of this empirical work indicates that at the outset of their course, the model of health promotion that these nurses perceptions were leaned towards MacDonald's notion of "impowerment", rather than "empowerment", at the end and the beginning of their career, it has moved towards an empowerment model, but still within a preventive context. This implies that as

they mature, progress through their careers and undertake further professional development that their practice and conconceptualisation has the potential to develop. The requirement of both educationalists and nursing leaders is to facilitate this conceptual and clinical development. This leads the author to conclude that although MacDonald's conceptualisation is helpful in determining clarification, the most useful conceptualisations for nursing are those placing health education at the heart of health promotion such as Downie et al. (1991), thus enabling evolution and progression.

This challenge to current academic thought in the United Kingdom is now considered in relation to the conclusions drawn from the empirical work.

The Students

The students entered nursing with the same complex set of health beliefs as other members of westernised society. These in turn are influenced by the notions of health and lifestyle, which have become embedded in western culture. At the beginning of the course these ideas of health promotion are driven by biomedical perceptions of the concept, which are also culturally determined (Blaxter 1990). However, these perceptions of health and health promotion change as they become socialised into their role. The most significant change is at the end of the common foundation programme. Although the strength of these perceptions are diminished at the end of the course they remain statistically significant.

Two explanations are offered for the decline in strength at the end of the programme. It was noticed that these students were more assertive, questioning and politically aware than the students on the traditional course, this is supported by other studies. Therefore it can be argued that the students themselves were more autonomous and empowered, as a consequence health promotion has become conceptually embedded in their practice, the second being that some relevance has been lost because health

promotion was not a prominent aspect of the branch programme. The range of knowledge and competencies required at registration must also be acknowledged. In reality, it appears that both explanations have some veracity, but on balance it is more likely that the second explanation is probable.

The Influence of the Curriculum

Support for these conclusions are provided in the documentary analysis. Conceptual confusion at international level (WHO 1986), was reflected in the ENB (1990) guidelines for curriculum development, which it is argued is also influenced by academic thought in the United Kingdom. Not surprisingly this is evident in the curriculum documents for each organisation. While a socio-political model of health is apparent in the course philosophies, in only two of the schools were references made to the WHO strategy of Health For All. The underlying organisational culture had some impact on curriculum development, the school that was perhaps more progressive in its approach to education, attempting to integrate themes to a greater degree than in the other two schools. It was in this school that the health promotion content had less impact on the students' cognitions than in the other two.

In two of the schools the terms health education and health promotion were used interchangeably throughout the curriculum, even where health promotion was the term consistently used, it became apparent that what was inferred was health education. Health promotion was also subsumed within different themes within the curriculum, either in social science or nursing. There appeared to be an underlying conflict or tension between health promotion and nursing throughout each of the curricula. The main conclusion to be drawn from this is that because the academic disciplines underpinning both health promotion and nursing are the same, there is a degree of academic rivalry in the construction of knowledge Cook (1993).

Another rationalisation is that Project 2000 students are required to be competent to "participate in health promotion" through the identification of health related learning needs of patients, families and friends (UKCC 1986). This may well be an educational model, but curriculum planners have some degree of autonomy in decision making regarding the curriculum content. It has been demonstrated that the students' perceptions had changed from a biomedical model of health and health promotion to more holistic and enabling perceptions, albeit representing a preventive, model, but given that the major part of their clinical experience as students was nursing sick people, (and that initially, they would continue to nurse sick people in hospital as qualified nurses), it is argued that this is an appropriate model for nurses at the beginning of their career.

The Influence of the Teachers

In essence it could be concluded that the student's perceptions changed in spite of the curriculum design. However, the contribution of the teachers cannot be denied. Their perceptions of health were holistic. The overwhelming majority who taught on the common foundation programme were hospital nurses. Not surprisingly, they generally tended to view health promotion within a biomedical educational framework, what they appeared to be teaching was essentially health education. Not all of them recognised when they were teaching health promotion. One in particular however, expressed salutogenic (Antonovsky, 1977) notions of health promotion and nursing, in that she had no problem with the notion of individualised care, or that in the delivery of this care she was promoting the health and well-being of her patient/client, regardless of whether he/she was sick or well. In fact what the teachers were achieving was a definition of their contribution to health promotion, and constructing their reality of health promotion in the process. Thus curricula were dynamic and conceptual clarification was evolving.

The teachers also made pragmatic and thoughtful recommendations about how and what should be taught in the name of health promotion, and of how it should be delivered in the curriculum. It is with these teachers in mind and in conjunction with the reports of concurrent empirical work and recent theoretical and conceptual development that the ensuing recommendations are made.

It must also be added that nursing is now firmly seated in higher education, the cacophony surrounding this transfer has subsided. All curricula are modularised and the Quality Assurance Agency plays a major role in total quality evaluation. The incumbent government has introduced legislation and policies for strategic development that acknowledge the contribution of nursing to health improvement. Project 2000 has been evaluated by the ENB and new curriculum guidelines have been proposed, which reflect this change (UKCC 1999). Pilot programmes will shortly be in place. Recruitment to and retention of nurses is actively encouraged. Larger culturally, educationally and socially diverse cohorts of students are being recruited, with the associated organisational and logistical problems being incurred in the implementation of programmes. Therefore it is suggested that the recommendations made by Lask et al (1994) and the model for evaluation of the integration of a philosophy of health into the curriculum must be reconsidered. These issues are taken into account in the following recommendations.

A Philosophy of Health Promotion

As it claims its place in higher education, nursing education is either flourishing or languishing in diverse contexts, either as separate autonomous faculties or larger schools of health, environmental or medical studies. Consequently, it is having to compete with a multiplicity of, and sometimes conflicting educational and professional ideologies. Regardless of orientation, it is recommended an all embracing philosophy of health promotion should be adopted that permeates all areas

of learning, from the built environment, curriculum design, through to the selection and recruitment of both staff and students; in short a health promoting institution.

However, if such a recommendation is to be feasible and effective, there has to be clear debate about which definition of health is being espoused Macdonald (1998), and how nursing is perceived. This must involve consultation, debate and collaboration with all stakeholders involved in the organisation, from senior management, academic and non academic staff, students and purchasers of education and providers of clinical experience.

Teaching Health Promotion Effectively

Since the inception of Project 2000 progress has been made in the academic development of teachers, there has also been an increase in the publication of learning resources (Rush 1998). However, the research has indicated that further work is required in considering what is taught in the name of health promotion and how the teaching is organised. The professional development of teachers is of paramount importance in enabling them to consider their contribution to the education of nurses in the context of health promotion. This may be in the form of "in-house" seminar and discussion, or encouraging scholarly activity through research and publication. Recommendations for the organisation of teaching are concerned with the pre-registration curriculum

The Pre-registration Curriculum

The key areas identified in the study that contributed to problems addressing successful integration of health promotion into the pre-registration curriculum were the lack of a clear philosophy of health and health promotion in the curriculum design, and addressing what should be taught in the name of health promotion. If the previous recommendations regarding the organisational philosophy are feasible, this should in turn shape the design of individual course philosophy.

Both health promotion and nursing should be separate subject areas. The biological behavioural and social sciences must constitute core theoretical modules that are pre-requisites for health promotion and nursing. This, it is anticipated will reduce the fragmentation of the subject in the curriculum.

It is also suggested that because of the multifaceted nature of health promotion that it is "the basics" that are taught at this stage. If the competence to "participate in health promotion", is to be achieved a preventive model is the more realistic approach at this initial stage. The reason for this being that it reflects the environment in which nurses are employed on qualification. The theoretical framework for this should be based on Seedhouse (1998). This not to say that these are the only models or theories used and critical thinking discouraged, but that it should be applied as an initial foundation, in order to provide conceptual clarity, and a "stepping stone" for further exploration at post-registration or post-graduate level.

The Common Foundation Programme

Teaching Strategies

Teaching on this programme should be more generic, health should be addressed from different perspectives by lecturers from various disciplines in nursing. Observational placements supporting and reflecting these theories should be organised. Further clarification could generated by students dispersing into seminar groups reflecting the branches of nursing to which they aspire, and led by the appropriate key lecturers.

Health Promotion

It is recommended that this subject is led by a "specialist" in health promotion and consists of a multidisciplinary team of lecturers with either qualifications in health promotion or a special interest in the subject (these may well be the same lectures

who teach health). A similar programme of observational visits/placements could be organised to reflect a variety of models of health promotion. Consolidation seminars would also follow a similar format.

Branch programmes

The health promotion content needs to be branch specific, relating to whichever discipline the student follows. However, it must continue to be explicit. Therefore it is recommended that a core module in health promotion is introduced addressing a variety of theories, therapies, or interventions that could be applied to whichever clinical placement the students were working. Responsibility for this module would be again with a "specialist teacher" and his/her team. Responsibility for the integration of health promotion in nursing modules related to different areas of practice would be the responsibility of the health promotion teacher in the nursing team. This would enable the spiralling of the subject throughout the curriculum.

Assessment strategy

Two key areas of assessment would obviously be in the two main health promotion modules. Assessment of specific knowledge and skills would be part of the nursing modules. It is argued that Seedhouse's foundations theory framework would be ideally suitable for adaptation to either the theoretical or practical components for these modules.

Evaluation

Macdonald's (1998) model of evaluation is potentially a useful asset to be incorporated into this strategy. It is in this important area that the questionnaire, or inventory developed in this study, has the potential to make a significant contribution. Despite the acknowledged limitations, it has been demonstrated to be a reliable tool, as such it has a place as a part of both summative and formative evaluation.

The research undertaken in this study has investigated nursing students' perceptions of health promotion more rigorously than previous empirical work in this area. The design of the study and the utilisation of a multimethod approach has enabled achievement of intentions. Triangulation has reduced bias and, as such, enhanced the reliability and validity of the data. The veracity of the results is also supported by the congruence of some of these findings with similar studies. However the longitudinal design has also provided further legitimacy to the findings. Therefore it can be concluded that this study has clarified and contributed to the question of the meaning of health promotion for nursing.

Since it is recognised that conceptual clarification has continued to evolve during the course of the study, the first half of the chapter was devoted to discussion of these issues. This in turn has contributed to the interpretation of the results and provided robust theoretical frameworks on which to base conclusions and recommendations.

The study commenced with the idea that the inventory could make a formidable contribution to illuminative evaluation. As the study progressed, and as nursing education has evolved and matured this opinion is revised. An instrument is required that can contribute to the effective evaluation of change in large groups of students, while meeting the stringent requirements of quality assurance, in demonstrating effective outcome measures. Further refinement and analysis is required in the development of psychometric properties which could be an effective measure of achieving competence in this important area. It is in this context that it is offered as a contribution to the development of health promotion in nursing.

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APPENDIX 1

Bernstein, B (1971) *Class codes and control. Vol 3: towards a theory of educational transmissions.* London: Routledge and Kegan Paul.

In his paper " On the classification and framing of educational knowledge", Bernstein (1971), outlines the following concepts:

1. Classification here does not refer to what is classified but to the relationship between contents. Where classification is strong, contents are well insulated from each other by strong boundaries. Where classification is weak, there is reduced insulation between contents for the boundaries between the contents are blurred. Classification refers to the degree of boundary maintenance, between contents.

2. Frame refers to the range of options available in the control of what is transmitted and received in the context of the pedagocical relationship. Strong framing entails reduced options, weak framing entails a range of options. this frame refers to the degree of control teacher and pupil possess over the selection, organisation and pacing of knowledge transmitted and received in the pedagogical relationship.

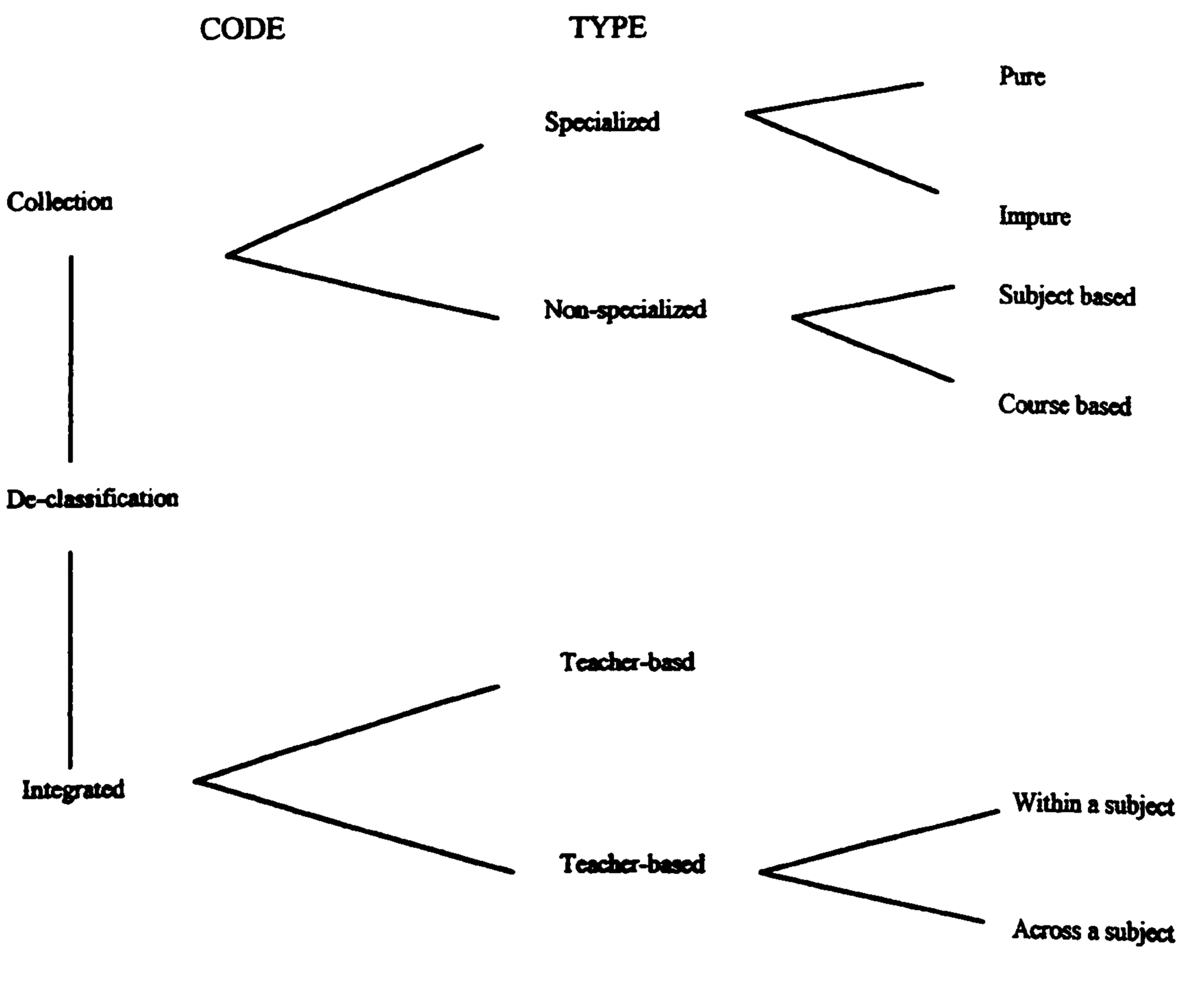
Although there is not a necessary relationship between education and framing, Bernstein suggests that such a relationship will tend to exist. His analysis involves an "identity" classification and a "power" component "frame", he suggests that the one will imply for the other for:

> " where classification is strong the boundaries between the different contents are sharply drawn. If this is the case, then it presupposes strong boundary maintainers. Strong classification also creates a strong sense of membership in a particular class and so a specific identity. Strong frames reduce the power of the pupil over what, when and how he receives knowledge and increases the teacher's power in the pedagogical relationship. However, strong classification reduces the power of the teacher over what he transmits as he may not overstep the boundary between contents, and strong classification reduces the power of the teacher vis a vis the boundary maintainers.

Types of Code.

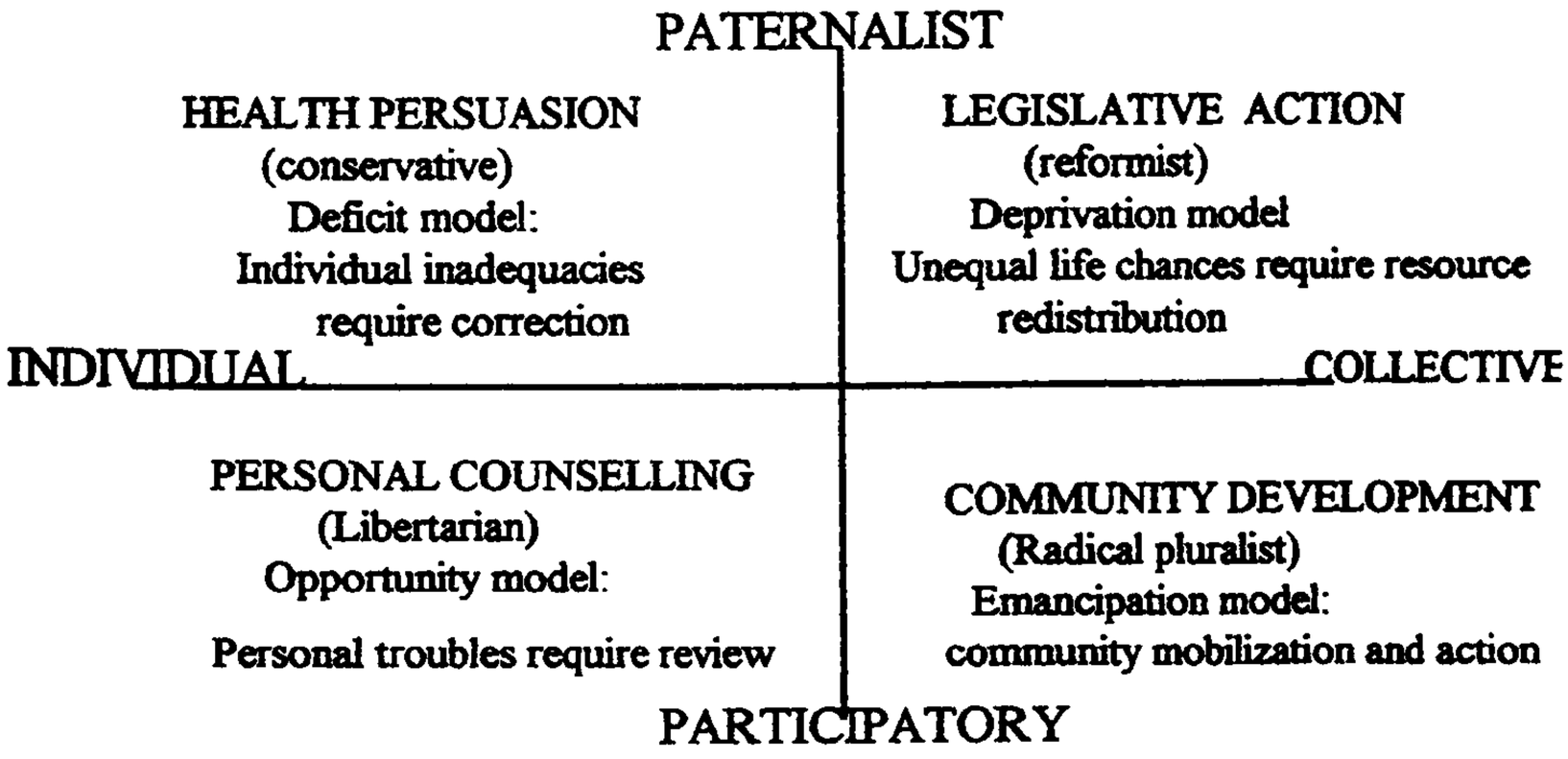
Bernstein suggests a distinction between two types of "educational knowledge" code: "collection" codes involve strong classification, "integrated " codes involve weak classification. Although there will be variations in the strength of classification and frame for both collection codes, Bernstein suggests that collection codes will normally involve both strong classification and frame, while integrated codes will involve weak classification and frame. He suggests a typology of educational knowledge.

Bernstein's (1971) Typology of Educational Knowledge.



(Source: Cook, 1993)

Conflicting political philosophies in health promotion (adapted from Beattie et al., 1992)



The bipolar dimensions: mode of intervention (vertical) and focus of intervention **(horizontal)** according to Beattie et al (1992)

APPENDIX 2

CONFERENCES AND WORKSOPS ORGANISED BY THE HEALTH EDUCATION COUNCIL.

1974 Seminar; Health Visitor Tutors' Conference Report on Health Education and Primary Care. Leeds Polytechnic.

1975. Leicester Conference on Health Education for Nursing Officers in Relation to Primary Care.

1976} Conferences for District Nursing Officers in Regional
1978} Groups.

1978 Sheffield workshop for nominated nurses from 15 health districts.

1979 Workshops for District Nursing Officers, Directors of Nurse Education and Health Education Officers.

1981 Publication of survey into health education in nurse training.

1982 Leamington Spa workshop for nurse tutors, nurse tutor students and health education representatives.

1983 Publication of outcomes from 1982 workshop.

1983 Leamington Spa seminars for lecturers and tutors from the 1982 workshops and teams from health authorities (Birmingham, Coventry, South Manchester and Tower Hamlets.)

1983 Report on the proceedings of the 1983 seminar.

1984 Setting up of a core planning group for 1985 International Conference on Health Education in Nursing, Midwifery and Health Visiting.

1984 First announcement of the 1st. International Conference on Health Education in Nursing, Midwifery and Health Visiting sponsored by the H.E.C. 21st-24th May 1985 at Harrogate.

APPENDIX 3

(COMPETENCIES - P2000 PROGRAMME)

1989 NO. 1456

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors (Registered Fever Nurses Amendment Rules and Training Amendment Rules) Approval Order 1989

Preparation for entry to Parts 12, 13, 14 and 15 of the Register.

18a. 1. The content of the Common Foundation Programme and the Branch Programme shall be such as the Council may from time to time require.

2. The Common Foundation Programme and the Branch Programme shall be designed to prepare the student to assume the responsibilities and accountability that registration confers and to prepare the nursing student to apply knowledge and skills to meet the nursing needs of individuals and of groups in health and in sickness in the area of practice of the branch Programme and shall include enabling the student to achieve the following outcomes:-

a. the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability, or ageing for the individual her or his friends, family and community.

b. the recognition of common factors which contribute to and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action.

c. the use of relevant literature and research to inform the practice of nursing.

d. the application of the influence of social, political and cultural factors in relation to health care.

e. an understanding of the requirements of legislation relevant to the practice of nursing.

f. the use of appropriate communication skills to enable the development of helpful caring relationshipS with patients and clients and their families and friends, and to initiate and conduct therapeutic relationships with patients and clients.

g. the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion.

h. an understanding of the ethics of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice.

i. the identification of the needs of patients and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death.

j. the identification of physical, psychological, social and spiritual needs of the patient or client; an awareness of values and concepts of individual care; the ability to devise a plan of care contribute to its implementation and evaluation; and the demonstration of the application of the principles of a problem-solving approach to the practice of nursing.

k. the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients.

l. the use of appropriate channel of referral for matters not within her sphere of competence.

m. the assignment of appropriate duties to others and the supervision, teaching and monitoring of assigned duties.

APPENDIX 4

FIRST YEAR

← UNIT 1 ——— ADULT HEALTH CARE NEEDS - COMMUNITY AND HOSPITAL ———→

COMMUNITY (7 weeks)	MODULE 1 BASIC CLINICAL CARE (MEDICINE) (8 weeks)	MODULE 2 ADULT CLINICAL CARE (SURGERY) (8 weeks)	MODULE 3 MENTAL HEALTH CARE (9 weeks)	MODULE 4 CARE OF ELDERLY HEALTH (9 weeks)

SECOND YEAR

← UNIT 2 LIFE SPAN AND SPECIALISED HEALTH CARE NEEDS - COMMUNITY AND HOSPITAL ———→

MODULE 6 THEATRE	MODULE 5 MATERNITY	MODULE 7	MODULE 8	MODULE 9
MODULE 5 MATERNITY HEALTH CARE	MODULE 6 THEATRE	CARE OF CHILD HEALTH (9 weeks)	HIGH DEPENDENCY ACUTE CARE (9 weeks)	ADULT CARE SPECIALISED SURGERY (9 weeks)

THIRD YEAR

← UNIT 3 ——— ADULT HEALTH CARE CONSOLIDATION AND MANAGEMENT ———→

MODULE 10 ADULT NURSING CARE (MEDICINE) (17 weeks)	MODULE 11 ADULT NURSING CARE (SURGERY) (17 weeks)	MODULE 12

FOURTH YEAR

→

MODULE 12

MANAGEMENT OF ADULT NURSING CARE (15 weeks)

KEY

= SCHOOL BASED (39 WEEKS)

= ANNUAL LEAVE (19 WEEKS)

RGN COURSE,
OUTLINE OF LINKED COMMUNITY EXPERIENCE.
WEEKS 2-7 OF FOUNDATION COURSE.

WEEK 2.

THEME; Health and a healthy lifestyle.

CONTENT; Concepts of health, aspects of health, promotion of health, health education and teaching, self-heal;, stress.
Monitoring of health -vital statistics.
Introduction to the health project.

VISITS; To include a selection from; -
Health Education Council, Well-woman clinic, Health Centre (holistic approach to health), stastical sources within health and local authority.
Volountary groups eg. Relaxation for living, women's health information centr.
Local community and ethnic minority projects.

WEEK 3.

THEME; Factors affecting health - Theory.

CONTENT; Socialisation and health beliefs, attitude formation, human life-cycle events.
Population changes - age-sex distribution.
Environmental factors, employment, unemployment, housing, education, social class, culture. Hazards - social, biological, psychological.
Black Report - Inequalities in health.

WEEK 4.

THEME; Factors affecting health - Practical experience.

VISITS; To include a selection from; - exploration of local area to observe specific situations that could be detrimental to good health eg. Transport, housing, health facilities, play space. Employment office/job centre, environmental health department, occupationl health department, Wellcome Museum, Great Chapel Street Medical Centr, West London Day Centr for the Homeless and Rootless.
Neighbourhood centres. Housing associations.

WEEK 5.

THEME; Historical and political factors influencing the formation and structure of the NHS.

CONTENT; Development of NHS., structure, past/present.
NHS and politics.
Financial organisation, R.A.W.P., N.H.S.V.,
Independent medicine.
Primary health care teams.
Student nurses and the NHS.

VISITS; To include a selection from;-
Community Health Council (meeting if possible),
District Health Authority meeting.
Finance department.
Health centre.

WEEK 6.

THEME; National and local policies for provision of health care facilities.

CONTENT; National - examination of current policy statements.
Green/white papers.
Local - Strategic/operational plans.
Analysis of provisions, areas of shortfall.
The health authority as a functional unit.
Speaker - District manager.

WEEK 7. Utilisation of stastical data to determine major health trends.

CONTENT; Presentation of health projects.

KEY OBJECTIVES - MODULE 10 (ADULT MEDICAL NURSING).

To deepen the student's knowledge and skills in caring for patients in a medical environment, based on individualised care by:-

a. Communicating effectively with patients, relatives, visitors, colleagues and other relevant personnel.

b. Developing skills in giving individualised patient care based on a model of nursing and demonstrating a satisfactory standard of patient care within this framework.

c. Developing and practising under supervision, competencies a-h as stated in Rule 18 (i) of the Nurses, Midwives and Heal Visitors Rules.

d. Becoming competent in, and deepening knowledge and skill necessary forsafe control and administration of medications; and demonstrating a satisfactory standard of skill in drug administration procedures.

e. Practicing skills of health promotion, education and rehabilitation related to the patient and his relatives.

JM/TJ/10/85

RGN COURSE.

AIM OF COMMUNITY EXPERIENCE IN ELDERLY HEALTH CARE MODULE 4.

The aim is to assist the student to gain more insiight into the total health needs of the elderly in the community in relation to the individual and the family in society today.

The one week experience should provide opportunity for the student to:-

1. Observe healthy elderly people.

2. Be involved in health education.

3. Observe the work of people helping the elderly, including community nurses, health visitors or geriatric visitors.

4. Gain some understanding of the role and difficulties of carers and support services.

5. See a range of facilities offered by statutory and volountary organisations for those coping with increasing dependence, eg. day centres, sheltered housing and residential accommodation.

6. Understand the methods by which safe and efficient transfer of care may be accomplished.

7. Become more aware of the needs of the single homeless, handicapped, those of no fixed abode and ethnic minority groups.

AIM OF COMMUNITY EXPERIENCE IN CHILD HEALTHCARE MODULE 7.

To place the student in a variety of situations in the community to enable hi/her to work with and observe the development and behaviour of well children.

Students will spend five days gaining community experience during their clinical allocation to provide opportunity:-

1. For students to observe healthy children in their normal environment.

2. to see first hand, the role of the school nurse, health visitor and preventive work in action.

3. To provide opportunity for students to observe council estates poor housing, overcrowding, or the social problems that the health visitor is dealing with, and thus gain essential knowledge of the environment that children may be returning to from hospital.

4. To see provision of schooling within the area, by attending schools which provide for children under five years of age and those who are handicapped.

5. To observe minority groups in their own homes and to discuss potential health problems with health visitors eg. Bengali mothers with lasnguage problems.

6. First hand opportunity to see social family problems eg. single parent and lack of experience as part of a nuclear family.

7. To increase the students' awareness and understanding of their role in health education.

8. To facilitate students' professional career development.

APPENDIX 5

PILOT QUESTIONAIRE FOR STUDENT NURSES.

At which stage of your training are you? Tick appropriate box.

New entrant. ☐

First year. ☐

Second year. ☐

Third year. ☐

1. In the space below describe why you think you are healthy.

2. Do you think you are unhealthy?

   Tick box below.

   YES ☐ NO ☐

   If your answer was NO give your reasons.

3. As a future registered nurse do you think you should learn about health promotion?

YES ☐ No ☐

If you answered Yes give your reasons.

4. In reply to the following statements tick the box which is closest to your own view.

A) Doctors and nurses know a lot about health and illness. Therefore people should do as the professionals tell them. If they don't, and they become ill, it is their own fault.

Stronly agree. ☐

Agree. ☐

Don't know. ☐

Disagree. ☐

Strongly disagree. ☐

B) Health promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

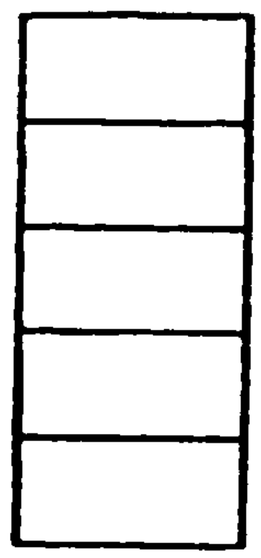
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



C) Nurses need to understand about people's different economic, social and cultural backgrounds so that they can be effective health promoters.

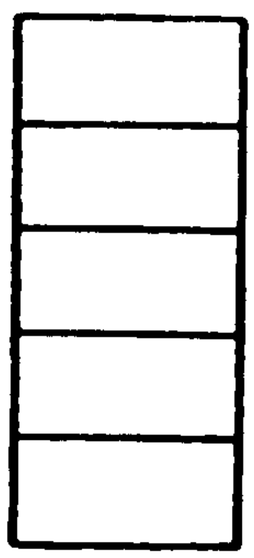
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



D) Giving advice and supporting people, so that they can make choices about their lifestyle is "commonsense."

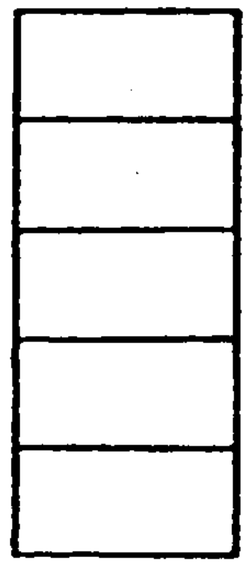
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



E) Nursing is mainly concerned with giving "hands on" care.

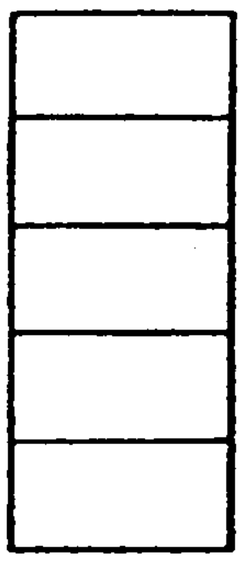
Strongly agree

Agree.

Don't know.

Disagree.

Strongly disagree.



F) Because they are involved in health promotion nurses should take an interest in current affairs?

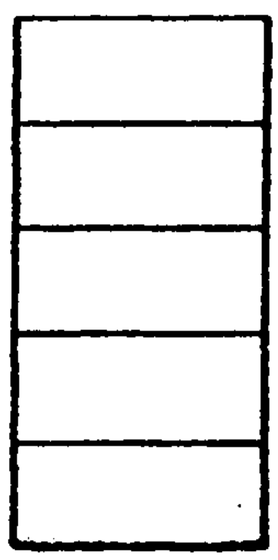
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



6. Do you think nurses should be involved in politics?

   Give your reasons.

7. What educational qualifications do you hold?

8. Have you taken the UKCC DC test? Tick box.

   YES ☐ NO ☐

9. How old are you?

10. Are you? MALE ☐ FEMALE ☐

11. What previous work experience have you had?

12. What are the occupations of your parents/guardians?

    FATHER MOTHER.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE FOR ME.

REVISED QUESTIONNAIRE.

At which stage of your training are you? Tick appropriate box.

New entrant. ☐

First year. ☐

Second year. ☐

Third Year. ☐

1. In the space below describe why you think you are healthy.

2. Do you think you are unhealthy?

Tick box below.

YES ☐ **NO** ☐

If your answer was NO give your reasons.

3. As a future registered nurse, do you think you should learn about health promotion?

YES ☐ NO ☐

If you answered YES give your reasons.

In reply to the following statements, tick the box which is closest to your own view.

A) Doctors and nurses know a lot about health and illness.
Therefore people should do as the professionals tell them.
If they don't and they become ill, it is their own fault.

Strongly agree. ☐
Agree. ☐
Don't know. ☐
Disagree. ☐
Strongly disagree. ☐

B) Health promotion is about advising and giving people information so that they can make up their own minds whether or not to lead healthy lives.

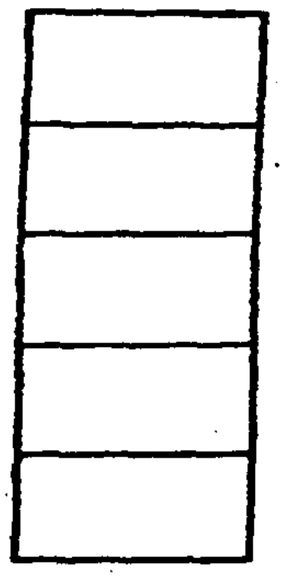
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



C) Nurses need to understand about people's different economic, social and cultural backgrounds so that they Can be effective health promoters.

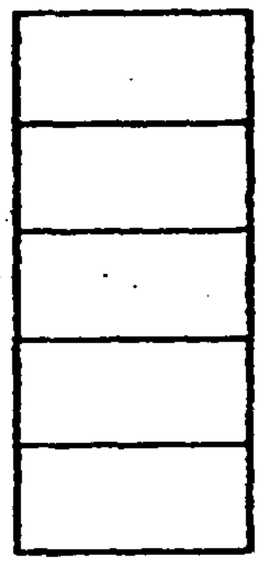
Strongly agree'

Agree.

Don't know.

Disagree.

Strongly disagree.



D) Giving advice and supporting people so that they can make choices about their lifestyle is "commonsense."

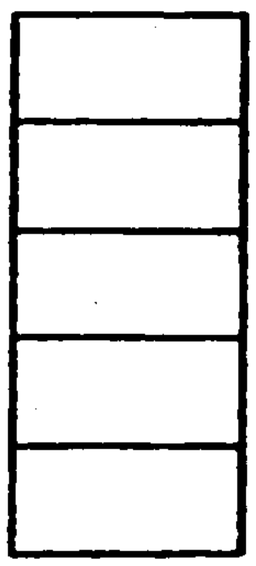
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



E) Nursing is mainly concerned with giving "hands on" care.

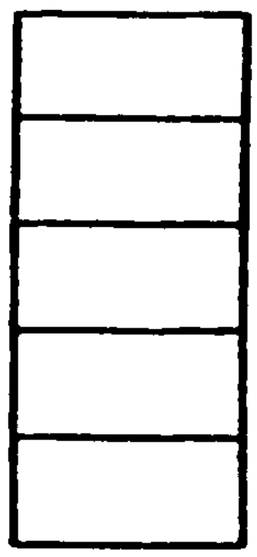
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



F) Because they are involved in health promotion, nurses should take an interest in current affairs.

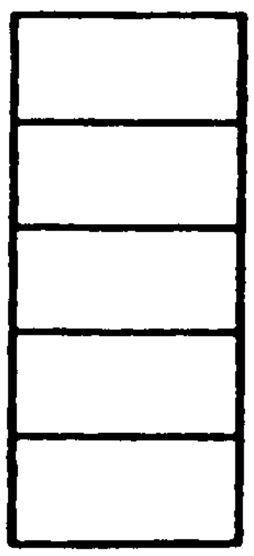
Strongly agree.

Agree.

Don't know.

Disagree.

Strongly disagree.



6. Do you think nurses should be involved in politics?
   Give your reasons.

7. What educational qualifications do you hold?

8. Have you taken the UKCC DC test?

   YES ☐ NO ☐

9. How old are you?

10. Are you? MALE ☐ FEMALE ☐

11. What previous work experience have you had?

12. What are the occupations of your parents/guardians?
    If either parent is retired state occupation before
    retirement.

    FATHER MOTHER

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE FOR ME.

APPENDIX 6

Blaxter, M. (1990) Definitions of Health.

DEFINITION	SAMPLE STATEMENT
Not ill	When you don't hurt anywhere and you're not aware of any part of your body.
Despite Disease	I am very healthy, although I do have diabetes.
A reserve	Both his parents are alive at ninety so he belongs to healthy stock.
Living a healthy life	I call her healthy because she goes jogging and she doesn't eat fried food. She walks a lot and doesn't drink alcohol.
Physical fitness	There's a tone to my body, I feel fit.
Energy and vitality	Health is having loads of whumph. You feel good, nothing really bothers you, everything in life is wonderful, you seem to feel like doing more.
Social relationships	You feel as though everyone is your friend, I enjoy life more and can work, and help other people.
A means to an end	Health is being able to walk round better and doing ,more work in the house when my knees let me.
Well-being	Emotionally you are stable, energetic, happier, more contented and things don't bother you.

APPENDIX 7

STUDENT NURSES' QUESTIONAIRE

COHORT NO.
COLLEGE NO.

PLEASE COMPLETE THIS QUESTIONAIRE AS FULLY AS POSSIBLE.
SOME QUESTIONS MERELY REQUIRE A TICK IN THE APPROPRIATE BOX.
OTHER QUESTIONS REQUIRE WRITTEN COMMENT.
PLEASE RESPOND IN THE SPACES PROVIDED.
THANK YOU FOR YOUR COOPERATION.

---

1) How important do you think it is to learn about health promotion?

1] Of no importance. ☐

2] Not very important. ☐

3] Important. ☐

4] Very important. ☐

2) Give your reasons for your answer to question 1.

3) What does "being healthy" mean to you?

4) In reply to the following statements, tick the box which is closest to your own view.

(A) Doctors and nurses know a lot about health and illness. Therefore people should do as the professionals tell them. If they don't and become ill,it is their own fault.

1) Strongly agree. ☐

2) Agree. ☐

3) Don't know. ☐

4) Disagree. ☐

5) Strongly disagree. ☐

(B) Health promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(C) Nurses need to understand about peoples' different economic situations so that they can be effective health promoters.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(D) Nurses need to understand about peoples' different cultural backgrounds in order to be effective health promoters.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(E) Nurses need to know about peoples' social backgrounds so that they can be effective health promoters.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(F) Giving advice and supporting people so that they can make choices is an essential element of health promotion.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(G) Nursing is mainly concerned with giving 'hands on' care. Such things as health promotion are secondary to this.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(H) Because they are involved in health promotion nurses should take a special interest in current affairs.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

(I) Health promotion is among the most important parts of the nurse's role.

1) Strongly agree. ☐
2) Agree. ☐
3) Don't know. ☐
4) Disagree. ☐
5) Strongly disagree. ☐

5) Do you think that nurses should be involved in politics?

YES ☐

NO ☐

Please give reasons for your answer.

IN ORDER TO HELP CLASSIFY YOUR ANSWERS AND MAKE STATISTICAL COMPARISONS, WOULD YOU MIND TELLING ME THE FOLLOWING:

6) Your age. ☐

7) Education. Indicate number of subjects in boxes.

CSE ☐

GCE/GCSE ☐

A level. Please indicate subjects taken:

Degree: Subject

8) Have you taken the UKCC DC test?

YES ☐

NO ☐

9) Which branch program do you intend to follow?

a) Adult ☐

b) Child ☐

c) Mental health ☐

d) Learning disability ☐

10) Are you....

MALE? ☐

FEMALE? ☐

11) In which country were you born?

12) How would you describe your ethnic origins?

13) What previous work experience have you had?

14) What are/were (if retired or deceased) the occupations of your parents/guardians?

MOTHER FATHER

THIS INFORMATION WILL NOT BE RETAINED OR USED FOR ANY OTHER PURPOSE.
THANK YOU FOR COMPLETING THIS QUESTIONAIRE FOR ME.

Pilot Study - Student Questionnaire

Coding Guide

Question:

1 How important do you think it is to learn about health promotion?

Of no importance.	Not very important	Important	Very Important
1	2	3	4

2 Give your reasons for your answer to question 1.

1 To prevent illness
2 To teach, educate
3 To help individuals adopt healthy lifestyles
4 Reduce strain on the NHS

3 What does being healthy mean to you?

1 Not ill
2 Despite disease
3 A reserve
4 Living a healthy life
5 Physical fitness
6 Energy and vitality
7 Social relationships
8 A means-to-an end
9 Well-being

4

a Doctors and nurses know a lot about health and ill ness. Therefore people should do as the professionals tell them. If the don't and they become ill, it is their own fault.

Strongly agree	Agree	Unsure	Disagree	Strongly disagree
1	2	3	4	5

b Health promotion is about advising people and giving information so that they can make up their own minds whether or not to lead healthy lives.

Strongly agree	Agree	Unsure	Disagree	Strongly disagree
1	2	3	4	5

Teacher's Questionnaire

Coding scores

Teacher no:

Q1	1	2	3	4			
Q2	1	2	3	4			
Q3	1	2	3	4			
Q4	1	2	3				
Q5	1	2					
Q6	1	2	3	4	5	6	7	8
Q7	1	2	3	4	5	6		
Q8	1	2	3	4				
Q9	1	2						
Q10	1	2	3					
Q11	1	2	3	4				

Summary of inter rater reliability scores - Teacher pilot study

Question	Consensus	Discussion
1	18	0
2	18	0
3	18	0
4	18	0
5	18	0
6	18	0
7	18	0
8	18	0
9	18	0
10	18	0
11	18	0

APPENDIX 9

Student Questionnaire

Content Validity assessment Criteria

Objective:

To assess the content validity of the instrument designed to measure nursing students' perceptions of the concept of health promotion.

Objective Attainment:

Please consider the following questions using the four point scale below.

1. How did each question reflect the intention f the research proposal?

2. How well did the questions relating to the construct of health promotion represent the concept?

Scale:

1. Questions relevant to stated objectives.
2. Questions mostly relevant.
3. Questions partly relevant.
4. Questions are not relevant.

Question Omission

What additional questions could be included to improve the quality of the data?

Question Improvement

What improvements could be made to existing questions?

Student Questionnaire

Results of Content Validity Ratings

Key: 1 - Questions relevant to stated objectives.
2 - Questions mostly relevant.
3 - Questions partly relevant.
4 - Questions are not relevant.
0 - Response not required.

Question	Rater 1	Rater2	Rater 3
1	11	11	11
2	11	11	11
3	11	11	11
4a	11	11	11
4b	11	11	11
4c	11	11	11
4d	11	11	11
4e	11	11	11
4f	11	11	11
4g	11	11	11
4h	12	11	11
4i	11	11	11
5	23	11	11
6	11	11	11
7	11	11	11
8	11	11	11
9	11	11	11
10	11	11	11
11	11	11	11
12	11	11	11
13	11	11	11
14	11	11	11

Construct Validity Assessment Criteria

Objective: To assess the validity of the identified constructs in the text, relating to the responses to the question asking students to give reasons for the value they placed on learning about health promotion.

Objective Attainment:

Please consider the identified items listed below and rate their validity using the four point scale.

1. Personal responsibility for health.
2. Enabling maintenance of a healthy lifestyle.
3. Prevention is better than cure.
4. Providing knowledge in order to change behaviour.
5. Choice.
6. Cost to the NHS.
7. Quality of life.
8. Population perspective.

Scale: 1. These items reflect the constructs identified in the text.
2. These items mostly reflect the constructs identified in the text.
3. These items partly reflect the constructs identified in the text.
4. These items are irrelevant.

Omissions

What additional items did you identify?

Improvements

What improvements could be made to these descriptors?

Student Questionnaire

Results of Construct Validity Ratings

Question 2: Response to question 1 requesting reasons for response to the value rating scale on the importance of learning about health promotion.

Dimensions of HP	Rater 1	Rater 2	Rater 3
1. Personal responsibility for health.	1	1	1
2.Enabling maintenance of a healthy lifestyle.	1	1	1
.3. Prevention /cure.	1	1	1
4. A healthier future.	1	1	1
5. Providing knowledge to change.	1	1	1
6. Choice.	1	1	1
7. Cost to the NHS.	1	1	1
8. Quality of life.	1	1	1
9. Population perspective	1	1	1

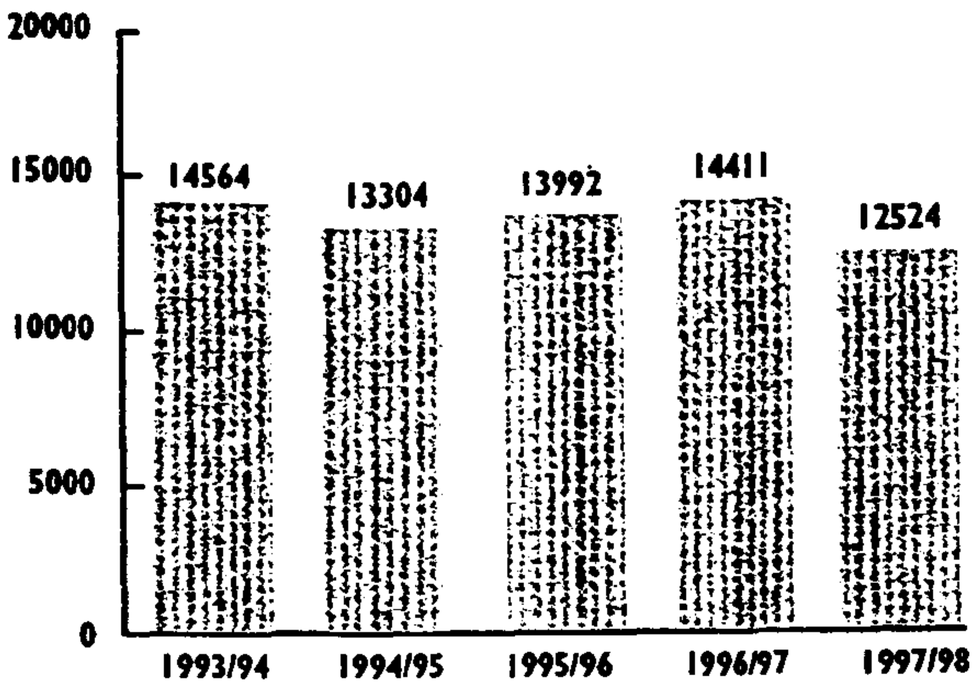
APPENDIX 10

Pre-Registration Nursing

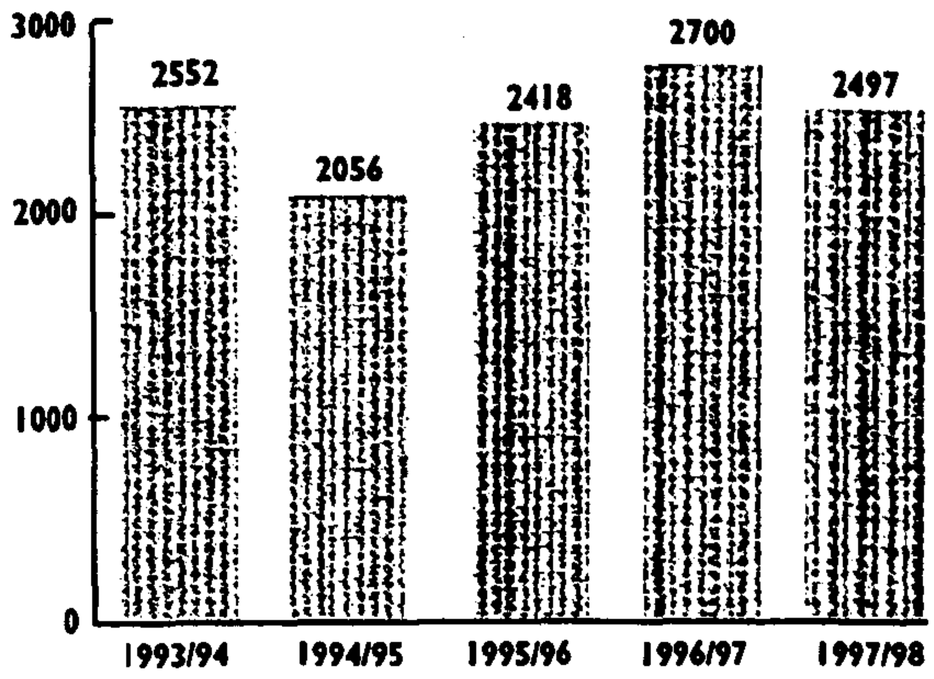
Initial Entries,Re-Entries and Post-Registration Entries by Speciality 1993-1998

The bar charts following show the information from Table 15 in graphic form

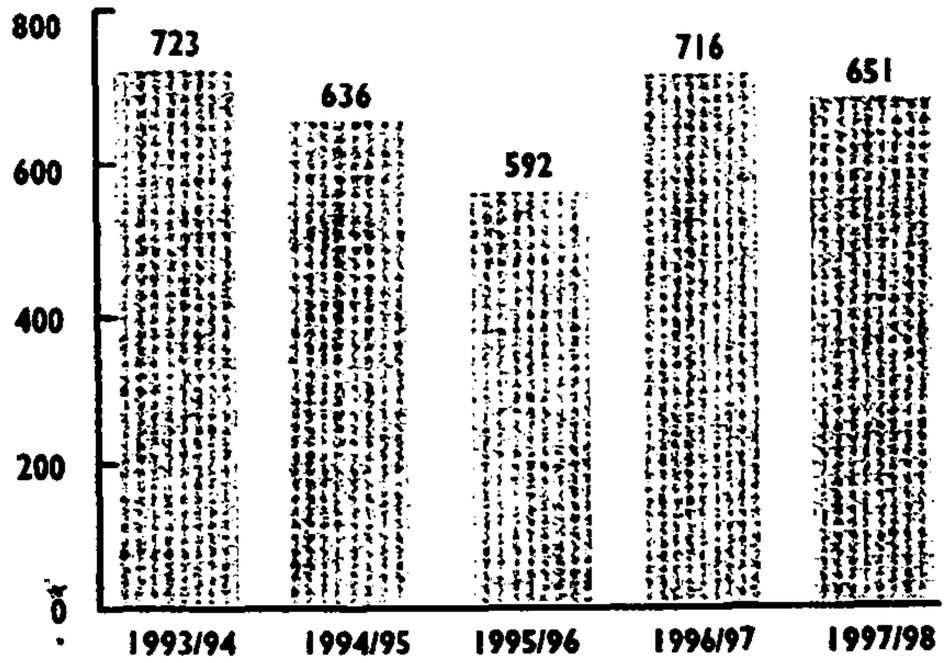
General / Adult



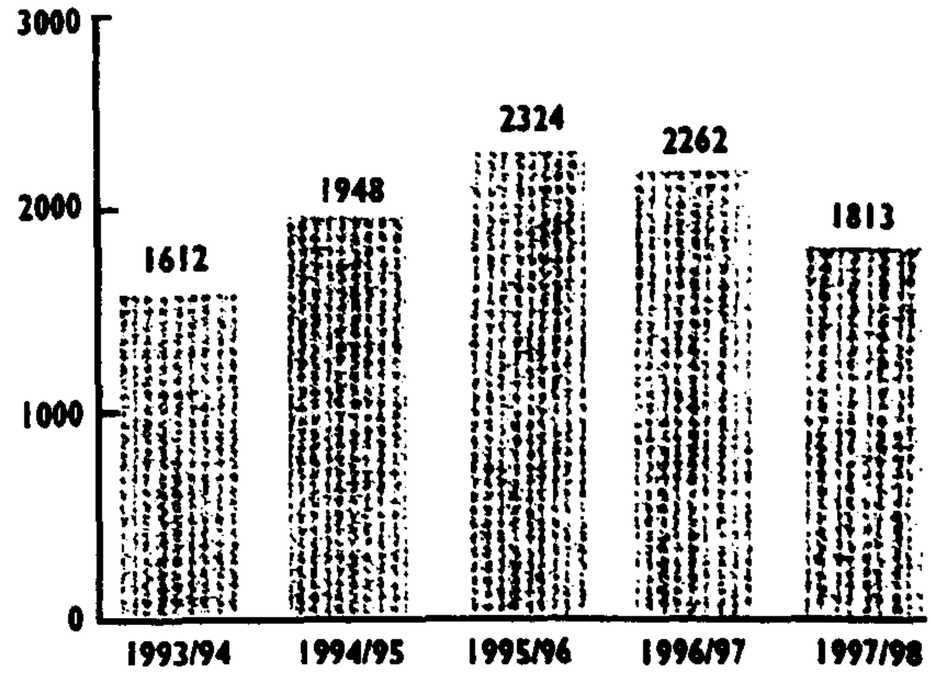
Mental Health



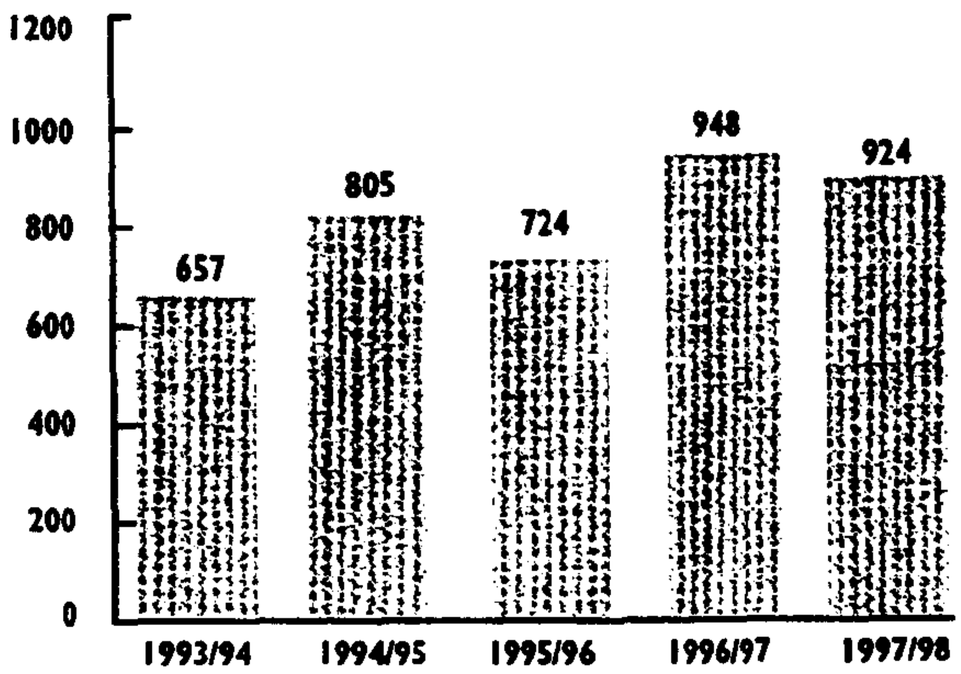
Mental Handicap / Learning Disability



Children's



Common Foundation Programme



Appendix 3

16 Pre-Registration Nursing Programmes

Initial Entries and Re-entries in 1997/1998 by Ethnicity, Age and Gender

National Summary

Diploma Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	5	26	1	13	**45**	4	2	8	9	**23**	2	1	0	0	**3**	0	1	0	1	**2**	0	6	0	4	**10**
BANGLADESHI	0	1	0	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	1	0	0	**1**
BLACK AFRICAN	4	41	9	69	**123**	17	27	33	32	**109**	4	3	2	4	**13**	1	3	1	5	**10**	0	7	5	17	**29**
BLACK CARIBBEAN	2	24	3	26	**55**	4	5	3	9	**21**	0	0	0	2	**2**	0	2	1	1	**4**	0	1	1	3	**5**
BLACK OTHER	1	7	1	11	**20**	1	2	0	2	**5**	0	0	0	1	**1**	0	1	0	0	**1**	0	1	0	1	**2**
CHINESE	0	3	1	2	**6**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	2	0	0	**2**
INDIAN	2	18	6	6	**32**	4	5	4	4	**17**	0	1	0	0	**1**	0	4	0	0	**4**	1	4	0	0	**5**
IRISH	14	119	4	10	**147**	0	4	5	1	**10**	0	3	0	0	**3**	0	8	0	1	**9**	2	25	1	2	**30**
NOT SPECIFIED	290	2,156	233	1,302	**3,981**	170	343	233	341	**1,087**	34	146	38	99	**317**	15	275	9	68	**367**	36	249	31	165	**481**
PAKISTANI	0	14	1	1	**16**	1	1	0	1	**3**	0	0	0	0	**0**	0	3	0	0	**3**	0	1	0	0	**1**
WHITE	237	2,226	157	859	**3,479**	73	255	99	145	**572**	10	87	13	30	**140**	30	519	9	80	**638**	17	176	13	24	**230**
TOTAL	**555**	**4,635**	**416**	**2,299**	**7,905**	**274**	**644**	**385**	**544**	**1,847**	**50**	**241**	**53**	**136**	**480**	**46**	**817**	**20**	**156**	**1,039**	**56**	**473**	**51**	**216**	**796**

Degree Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	0	0	0	**0**
BANGLADESHI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK AFRICAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK CARIBBEAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK OTHER	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
CHINESE	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
INDIAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
IRISH	0	0	0	0	**0**	0	0	0	0	**0**	0	0	1	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**
NOT SPECIFIED	35	396	11	54	**496**	6	50	7	21	**84**	2	16	3	21	**42**	2	93	0	16	**111**	5	106	1	10	**122**
PAKISTANI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
WHITE	3	57	2	7	**69**	2	4	0	7	**13**	0	7	1	4	**12**	0	14	0	3	**17**	0	5	0	1	**6**
TOTAL	**38**	**453**	**13**	**61**	**565**	**8**	**54**	**7**	**28**	**97**	**2**	**23**	**5**	**27**	**57**	**2**	**108**	**0**	**19**	**129**	**5**	**111**	**1**	**11**	**128**

Total: Diploma and Degree Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	5	26	1	13	**45**	4	2	8	9	**23**	2	1	0	0	**3**	0	2	0	1	**3**	0	6	0	4	**10**
BANGLADESHI	0	1	0	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	1	0	0	**1**
BLACK AFRICAN	4	41	9	69	**123**	17	27	33	32	**109**	4	3	2	5	**14**	1	3	1	5	**10**	0	7	5	17	**29**
BLACK CARIBBEAN	2	24	3	26	**55**	4	5	3	9	**21**	0	0	0	3	**3**	0	2	1	1	**4**	0	1	1	3	**5**
BLACK OTHER	1	7	1	11	**20**	1	2	0	2	**5**	0	0	0	1	**1**	0	1	0	0	**1**	0	1	0	1	**2**
CHINESE	0	3	1	2	**6**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	2	0	0	**2**
INDIAN	2	18	6	6	**32**	4	5	4	4	**17**	0	1	0	0	**1**	0	4	0	0	**4**	1	4	0	0	**5**
IRISH	14	119	4	10	**147**	0	4	5	1	**10**	0	3	1	0	**4**	0	8	0	1	**9**	2	25	1	2	**30**
NOT SPECIFIED	325	2,552	244	1,356	**4,477**	176	393	240	362	**1,171**	36	162	41	120	**359**	17	368	9	84	**478**	41	355	32	175	**603**
PAKISTANI	0	14	1	1	**16**	1	1	0	1	**3**	0	0	0	0	**0**	0	3	0	0	**3**	0	1	0	0	**1**
WHITE	240	2,283	159	866	**3,548**	75	259	99	152	**585**	10	94	14	34	**152**	30	533	9	83	**655**	17	181	13	25	**236**
TOTAL	**593**	**5,088**	**429**	**2,360**	**8,470**	**282**	**698**	**392**	**572**	**1,944**	**52**	**264**	**58**	**163**	**537**	**48**	**925**	**20**	**175**	**1,168**	**61**	**584**	**52**	**227**	**924**

Nursing programmes are at three levels: Certificate, Dip HE and degree. There are no Initial Entries at Certificate level and no Post-Registration entries at Degree level for the current year.

Certificate Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	1	0	1	15	17	0	0	0	4	4	0	0	1	1	2	0	0	0	1	1	0	0	0	0	0
BANGLADESHI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK AFRICAN	0	0	1	5	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK CARIBBEAN	0	0	0	24	24	0	0	0	0	0	0	0	0	1	1	0	0	0	2	2	0	0	0	0	0
BLACK OTHER	0	0	1	5	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CHINESE	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	0	0	0
INDIAN	0	0	0	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4	0	0	0	0	0
IRISH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NOT SPECIFIED	1	10	79	3,239	3,329	1	0	73	272	346	0	0	17	67	84	0	14	11	231	256	0	0	0	0	0
PAKISTANI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHITE	0	15	22	572	609	1	0	13	50	64	0	0	3	9	12	1	16	8	56	81	0	0	0	0	0
TOTAL	2	25	104	3,872	4,003	2	0	86	326	414	0	0	21	79	100	1	30	19	295	345	0	0	0	0	0

Diploma Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	0	0	0	0	0	0	0	1	0	1	0	0	0	1	1	0	0	0	1	1	0	0	0	0	0
BANGLADESHI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK AFRICAN	0	0	0	0	0	0	0	1	2	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK CARIBBEAN	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
BLACK OTHER	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CHINESE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INDIAN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3	0	0	0	0	0
IRISH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NOT SPECIFIED	0	1	0	45	46	0	6	14	56	76	0	0	1	5	6	0	22	8	117	147	0	0	0	0	0
PAKISTANI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0
WHITE	0	0	0	5	5	1	8	15	35	59	0	2	1	3	6	2	47	6	93	148	0	0	0	0	0
TOTAL	0	1	0	50	51	1	14	31	93	139	0	2	2	10	14	2	69	14	215	300	0	0	0	0	0

Total: Certificate and Diploma Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	1	0	1	15	17	0	0	1	4	5	0	0	1	2	3	0	0	0	2	2	0	0	0	0	0
BANGLADESHI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK AFRICAN	0	0	1	5	6	0	0	1	2	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BLACK CARIBBEAN	0	0	0	24	24	0	0	0	0	0	0	0	0	2	2	0	0	0	2	2	0	0	0	0	0
BLACK OTHER	0	0	1	5	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CHINESE	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	0	0	0
INDIAN	0	0	0	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7	0	0	0	0	0
IRISH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NOT SPECIFIED	1	11	79	3,284	3,375	1	6	87	328	422	0	0	18	72	90	0	36	19	348	403	0	0	0	0	0
PAKISTANI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0
WHITE	0	15	22	577	614	2	8	28	85	123	0	2	4	12	18	3	63	14	149	229	0	0	0	0	0
TOTAL	2	26	104	3,922	4,054	3	14	117	419	553	0	2	23	89	114	3	99	33	510	645	0	0	0	0	0

Nursing programmes are at three levels: Certificate, Dip HE and degree. There are no Initial Entries at Certificate Level and no Post-Registration Entries at Degree level for the current year.

Appendix 3

18 Pre-Registration Nursing Programmes

Initial Entries, Re-entries and Post-Registration Entries in 1997/1998 by Ethnicity, Age and Gender

Certificate Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	1	0	1	15	**17**	0	0	0	4	**4**	0	0	1	1	**2**	0	0	0	1	**1**	0	0	0	0	**0**
BANGLADESHI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK AFRICAN	0	0	1	5	**6**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK CARIBBEAN	0	0	0	24	**24**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	2	**2**	0	0	0	0	**0**
BLACK OTHER	0	0	1	5	**6**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
CHINESE	0	0	0	1	**1**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	1	**1**	0	0	0	0	**0**
INDIAN	0	0	0	11	**11**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	4	**4**	0	0	0	0	**0**
IRISH	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
NOT SPECIFIED	1	10	79	3,239	**3,239**	1	0	73	272	**346**	0	0	17	67	**84**	0	14	11	231	**256**	0	0	0	0	**0**
PAKISTANI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
WHITE	0	15	22	572	**609**	1	0	13	50	**64**	0	0	3	9	**12**	1	16	8	56	**81**	0	0	0	0	**0**
TOTAL	**2**	**25**	**104**	**3,872**	**4,003**	**2**	**0**	**86**	**326**	**414**	**0**	**0**	**21**	**79**	**100**	**1**	**30**	**19**	**295**	**345**	**0**	**0**	**0**	**0**	**0**

Diploma Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	5	26	1	13	**45**	4	2	9	9	**24**	2	1	0	1	**4**	0	1	0	2	**3**	0	6	0	4	**10**
BANGLADESHI	0	1	0	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	1	0	0	**1**
BLACK AFRICAN	4	41	9	69	**123**	17	27	34	34	**112**	4	3	2	4	**13**	1	3	1	5	**10**	0	7	5	17	**29**
BLACK CARIBBEAN	2	24	3	26	**55**	4	5	3	9	**21**	0	0	0	3	**3**	0	2	1	1	**4**	0	1	1	3	**5**
BLACK OTHER	1	7	1	11	**20**	1	2	0	2	**5**	0	0	0	1	**1**	0	1	0	0	**1**	0	1	0	1	**2**
CHINESE	0	3	1	2	**6**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	2	0	0	**2**
INDIAN	2	18	6	6	**32**	4	5	4	4	**17**	0	1	0	0	**1**	0	4	0	3	**7**	1	4	0	0	**5**
IRISH	14	119	4	10	**147**	0	4	5	1	**10**	0	3	0	0	**3**	0	8	0	1	**9**	2	25	1	2	**30**
NOT SPECIFIED	290	2,157	233	1,347	**4,027**	170	349	247	397	**1,163**	34	146	39	104	**323**	15	297	17	185	**514**	36	249	31	165	**481**
PAKISTANI	0	14	1	1	**16**	1	1	0	1	**3**	0	0	0	0	**0**	0	3	0	1	**4**	0	1	0	0	**1**
WHITE	237	2,226	157	864	**3,484**	74	263	114	180	**631**	10	89	14	33	**146**	32	566	15	173	**786**	17	176	13	24	**230**
TOTAL	**555**	**4,636**	**416**	**2,349**	**7,956**	**275**	**658**	**416**	**637**	**1,986**	**50**	**243**	**55**	**146**	**494**	**48**	**886**	**34**	**371**	**1,339**	**56**	**473**	**51**	**216**	**796**

Degree Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	0	0	0	**0**
BANGLADESHI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK AFRICAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK CARIBBEAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	0	**0**	0	0	0	0	**0**
BLACK OTHER	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
CHINESE	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
INDIAN	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
IRISH	0	0	0	0	**0**	0	0	0	0	**0**	0	0	1	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**
NOT SPECIFIED	35	396	11	54	**496**	6	50	7	21	**84**	2	16	3	21	**42**	2	93	0	16	**111**	5	106	1	10	**122**
PAKISTANI	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**	0	0	0	0	**0**
WHITE	3	57	2	7	**69**	2	4	0	7	**13**	0	7	1	4	**12**	0	14	0	3	**17**	0	5	0	1	**6**
TOTAL	**38**	**453**	**13**	**61**	**565**	**8**	**54**	**7**	**28**	**97**	**2**	**23**	**5**	**27**	**57**	**2**	**108**	**0**	**19**	**129**	**5**	**111**	**1**	**11**	**128**

Nursing programmes are at three levels: Certificate, Dip HE and Degree. There are no Initial Entries at Certificate Level and no Post-Registration Entries at Degree level for the current year.

Pre-registration Nursing Programmes

Initial Entries, Re-entries and Post-Registration Entries

Appendix 3

National Summary

in 1997/1998 by Ethnicity, Age and Gender

Total: Cert., Diploma & Degree Programmes	ADULT / GENERAL					MENTAL HEALTH					LEARNING DISABILITY					CHILDREN'S					COMMON FOUNDATION PROG.				
	Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over			Under 26		26 and over		
	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL	M	F	M	F	TOTAL
ANY OTHER ETHNIC GROUP	6	26	2	28	**62**	4	2	9	13	**28**	2	1	1	2	**6**	0	2	0	3	**5**	0	6	0	4	**10**
BANGLADESHI	0	1	0	0	**1**	0	0	0	0	**0**	0	0	0	0	**0**	0	1	0	0	**1**	0	1	0	0	**1**
BLACK AFRICAN	4	41	10	74	**129**	17	27	34	34	**112**	4	3	2	5	**14**	1	3	1	5	**10**	0	7	5	17	**29**
BLACK CARIBBEAN	2	24	3	50	**79**	4	5	3	9	**21**	0	0	0	5	**5**	0	2	1	3	**6**	0	1	1	3	**5**
BLACK OTHER	1	7	2	16	**26**	1	2	0	2	**5**	0	0	0	1	**1**	0	1	0	0	**1**	0	1	0	1	**2**
CHINESE	0	3	1	3	**7**	0	0	0	0	**0**	0	0	0	1	**1**	0	0	0	1	**1**	0	2	0	0	**2**
INDIAN	2	18	6	17	**43**	4	5	4	4	**17**	0	1	0	0	**1**	0	4	0	7	**11**	1	4	0	0	**5**
IRISH	14	119	4	10	**147**	0	4	5	1	**10**	0	3	1	0	**4**	0	8	0	1	**9**	2	25	1	2	**30**
NOT SPECIFIED	326	2,563	323	4,640	**7,852**	177	399	327	690	**1,593**	36	162	59	192	**449**	17	404	28	432	**881**	41	355	32	175	**603**
PAKISTANI	0	14	1	1	**16**	1	1	0	1	**3**	0	0	0	0	**0**	0	3	0	1	**4**	0	1	0	0	**1**
WHITE	240	2,298	181	1,443	**4,162**	77	267	127	237	**708**	10	96	18	46	**170**	33	596	23	232	**884**	17	181	13	25	**236**
TOTAL	**595**	**5,114**	**533**	**6,282**	**12,524**	**285**	**712**	**509**	**991**	**2,497**	**52**	**266**	**81**	**252**	**651**	**51**	**1,024**	**53**	**685**	**1,813**	**61**	**584**	**52**	**227**	**924**

Nursing programmes are at three levels: Certificate, Dip HE and Degree. There are no Initial Entries at Certificate Level and no Post-Registration entries at Degree level for the current year.

APPENDIX 11

Inter -Rater Reliability Scores: Student Questionnaire
Qualitative Data Time 1

Reasons HP Important	Researcher	Reviewer	Agreed Rating
Blackstone			
1	2	2	2
2	16	16	16
3	2	2	2
4	4	4	4
5	2	2	2
6	4	4	4
7	9	9	9
8	3	3	3
9	356	346	356
10	8	8	8
11	4	4	4
12	4	4	4
13	1047	1047	1047
14	6	6	6
15	4	4	4
16	1	1	1
17	8	8	8
18	67	68	67
19	66	65	66
20	16	16	16
21	2	2	2
22	2	2	2
23	2	2	2
24	6	6	6
25	2	1	1
26	4	4	4
27	2	2	2
28	37	37	37
29	5	5	5
30	2	2	2
31	46	46	46
32	2	2	2
33	26	26	26
34	1	1	1
35	169	169	169
36	26	26	26
37	7	7	7
38	7	7	7
39	5	5	5
40	2	2	2
41	1	1	1
42	1	1	1
43	4	4	4
44	4	4	4
45	39	49	49
46	1	1	1
47	2	2	2
48	6	6	6
49	4	4	4
50	99	9	9
51	0	0	0
52	4	4	4
53	36	36	36
54	2	2	2
55	2	2	2
56	2	2	2
57	46	46	46
58	47	47	47

Inter -Rater Reliability Scores: Student Questionnaire
Qualitative Data Time 1

Reasons Hp Important	Researcher	Reviewer	Agreed Rating
Waverly			
1	5 10	5 10	5 10
2	2 6 8	2 6 8	2 6 8
3	1 4	1 4	1 4
4	2 4	1 4	1 4
5	6	6	6
6	4 6	4 6	4 6
7	2 10	2 10	2 10
8	2 6	2 5	2 6
9	6 7	6 7	6 7
10	4	4	4
11	4	4	4
12	4	4	4
13	5 10	5 10	5 10
14	0	0	0
15	1	1	1
16	5	5	5
17	4	4	4
18	2	2	2
19	6 7	6 7	6 7
20	6	6	6
21	1 6	1 6	1 6
22	6	6	6
23	8 9	8 9	8 9
24	1 4 6	1 4 6	1 4 6
25	4 9	4 9	4 9
26	2 9	2 9	2 9
27	4 5	4 5	4 5
28	5	5	5
29	1 6	1 6	1
30	4 8	4 8	6
31	17	1 7	1 7
32	6	6	6
33	4 8	4 8	4 8
34	1 4 6	1 4 6	1 4 6
35	6 7	6 7	6 7
36	4	4	4
37	5 6 10	5 6	5 6
38	4	4	4
39	2	2	2
40	6 1	61	6 1
41	6	6	6
42	1	1	1
43	4	4	4

Inter -Rater Reliability Scores: Student Questionnaire
Qualitative Data Time 1

Reasons HP Important	Researcher	Reviewer	Agreed Rating
Chiswell			
1	10	10	10
2	4	4	4
3	8	7	7
4	6 10	6 8	6 10
5	2 8	2 8	2 8
6	2 4 6	2 4 6	2 4 6
7	6	6	6
8	4 6	4 6	4 6
9	6	6	6
10	4 6	4 6	4 6
11	4	4	4
12	2 6 8	2 6 8	2 6 8
13	4	4	4
14	4 8	4 8	4 8
15	2	2	2
16.	5 6	5 6	5 6
17	5 6 10	5 6 10	5 6 10
18	4	4	4
19	1 2 4	2 3 4	2 3 4
20	1 2 4	1 2 4	1 2 4
21	4 6	4 6	4 6
22	1 4	1 4	1 4
23	1 6	1 6	1 6
24	6	6	6
25	2 6	2 6	2 6
26	2 6	2 6	2 6
27	1 2	1 2	12
28	4	4	4
29	1 6	1 6	1 6
30	4	4	4
31	16	1 6	1 6
32	0	0	0
33	1 6 9	1 6 9	1 6 9
34	2 4 6	2 4 6	2 4 6
35	0	0	0
36	1 6 8	1 6 8	1 6
37	2 4	2 4 6	2 4 6
38	1 4 6	1 4 6	1 4 6
39	4	4	4
40	6	6	6
41	6	6	6
42	4 6	4 6	4 6
43	6	6	6
44	1	1	1
45	6	6	6
46	2 4	2 4	2 4
47	1 6	1 6	1 6
48	9	9	9
49	4	4	4
50	6 8	6 8	6 8
51	4	4	4
52	6	6	6

Inter-Rater Reliability Scores: Student Questionnaire
Qualitative Data - Time 2

Reasons HP Important Blackstone	Researcher	Reviewer	Agreed Rating
1	0	0	0
2	0	0	0
3	2 8	2 8	2 8
4	2	2	2
5	4	4	4
6	4	4	4
7	4	4	4
8	2 6	2 6	2 6
9	1 3 6	1 2 6	1 2 6
10	6	6	6
11	0	0	0
12	0	0	0
13	4 8 10	4 10	4 8 10
14	4 5	4 5	4 5
15	0	0	0
16	1 7	1 7	17
17	2 6	2 6	2 6
18	1 2 7	1 2 7	1 2 7
19	0	0	0
20	0	0	0
21	2 4	2 4	2 4
22	4	4	4
23	6	6	6
24	2	2	2
25	4 5 8	4 5 8	4 5 8
26	4	4	4
27	0	0	0
28	2 10	2 10	2 10
29	1	1	1
30	4	4	4
31	2 4	2 4	2 4
32	0	0	0
33	4 9	4 9	4 9
34	1 4 10	1 4	1 4 10
35	0	10	0
36	6 7	67	67
37	1 6	1 6	1 6
38	2 9	2 9	2 9
39	4 10	4 10	4 10
40	2	2	2
41	4	4	4
42	0	0	0
43	1 4	1 4	14
44	1 4	1 4	14
45	12	1 4	14
46	4 6	4 6	4 6
47	1 4	1 4	1 4
48	4	4	4
49	10	10	10
50	1 2	1 2	12
51	0	0	0
52	0	0	0
53	0	0	0
54	4	4	4
55	1 6	1 6	1 6
56	4 6	4 6	4 6
57	4 10	4 10	4 10
58	2 5 8	2 5 8	2 5 8

Inter-Rater Reliability Scores: Student Questionnaire
Qualitative Data - Time 2

Reasons HP Important	Researcher	Reviewer	Agreed Rating
Waverly			
1	0	0	0
2	6	6	6
3	16	16	16
4	0	0	0
5	0	0	0
6	0	0	0
7	0	0	0
8	0	0	0
9	0	0	0
10	10	10	10
11	0	0	0
12	0	0	0
13	1	1	1
14	6	6	6
15	0	0	0
16	24	23	24
17	0	0	0
18	0	0	0
19	0	0	0
20	4	0	0
21	15	125	125
22	6	6	6
23	0	0	0
24	14	24	24
25	6	6	6
26	0	0	0
27	0	0	0
28	27	27	27
29	2	2	2
30	0	0	0
31	0	0	0
32	45	45	45
33	6	6	6
34	6	48	48
35	49	46	46
36	5 10	5 10	5 10
37	10	10	10
38	10	10	10
39	24	14	14
40	6	6	6
41	0	0	0
42	46	46	46
43	6	6	6

Inter-Rater Reliability Scores: Student Questionnaire
Qualitative Data - Time 2

Reasons HP Important	Researcher	Reviewer	Agreed Rating
Chiswell			
1	4 6	3 6	4 6
2	6	6	6
3	24	2 4	2 4
4	4	3	3
5	0	0	0
6	4 10	4 10	4 10
7	1	1	1
8	6	6	6
9	4	4	4
10	2	2	2
11	10	10	10
12	1 4	1 4	1 4
13	4	4	4
14	2 10	2 9	2 10
15	2	2	2
16	3 6	4 6	4 6
17	6	6	6
18	2 4	2 4	2 4
19	2 10	2 10	2 10
20	2	2	2
21	0	0	0
22	6	6	6
23	2	2	2
24	0	0	0
25	2	2	2
26	4	4	4
27	2	4	4
28	4 5	2	2
29	0	4	4
30	5	2	2
31	2 6	4 5	4 5
32	0	0	0
33	4	5	4
34	2 7	26	2 7
35	2 6	26	2 6
36	1 4	1 4	1 4
37	4	4	4
38	4 6	4 6	4 6
39	6 7	6 7	6 7
40	1 0	10	10
41	4	4	4
42	4	4	4
43	2 10	2 10	2 10
44	4	4	4
45	2 4	2 4	2 4
46	2	2	2
47	2 6	26	2 6
48	2 10	2 10	2 10
49	4 10	4 10	4 10
50	1 6	1 6	1 6
51	4	4	4
52	4 6	4 6	4 6

Inter-Rater Reliability Scores: Student Qustionnaire
Qualitative Data - Time 3

Reasons HP Imporant	Researcher	Reviewer	Agreed Rating
Blackstone			
1	0	0	0
2	4 7	4 7	4 7
3	1	1	1
4	0	0	0
5	4 6	4 6	4 6
6	1 4	1 4	1 4
7	4	4	4
8	0	0	0
9	1 4	1 4	1 4
10	0	0	0
11	4 8	4 8 9	4 8 9
12	4	4	4
13	4 10	4 10	4 10
14	4	4	4
15	0	0	0
16	0	0	0
17	5 10	5 10	5 10
18	0	0	0
19	1 4 7	1 4 7	1 4 7
20	0	0	0
21	2 4	2 4	2 4
22	0	0	0
23	0	0	0
24	1	1	1
25	10	10	10
26	5 10	5 10	5 10
27	4 6	4 6	4 6
28	8	8	8
29	0	0	0
30	4	4	4
31	5	5	5
32	4	4	4
33	1	1	1
34	0	0	0
35	0	0	0
36	1	1	1
37	1	1	1
38	6	6	6
39	0	0	0
40	1 4 8	1 4 8	1 4 8
41	1 6	1 6	1 6
42	0	0	0
43	3	10	10
44	0	0	0
45	0	0	0
46	0	0	0
47	0	0	0
48	0	0	0
49	0	0	0
50	0	0	0
51	4 6 7	4 6 7	4 6 7
52	0	0	0
53	0	0	0
54	4 6 10	4 6 10	4 6 10
55	1 4	1 4	1 4
56	0	0	0
57	6 10	6 10	6 10

Inter-Rater Reliability Scores: Student Qustionnaire
Qualitative Data - Time 3

Reasons HP Important	Researcher	Reviewer	Agreed Rating
Waverly			
1	0	0	0
2	16	16	16
3	6	6	6
4	23	23	23
5	26	26	26
6	4	4	4
7	14	14	14
8	0	0	0
9	12	132	12
10	0	0	0
11	4 10	410	410
12	2	2	2
13	0	0	0
14	0	0	0
15	0	0	0
16	0	0	0
17	0	0	0
18	46	46	46
19	57	57	57
20	48	48	48
21	4	4	4
22	18	18	18
23	1	1	1
24	15	15	15
25	124	124	124
26	0	0	0
27	24	24	24
28	14	14	14
29	4	4	4
30	0	0	0
31	0	0	0
32	0	0	0
33	0	0	0
34	46	4	4
35	6	6	6
36	0	0	0
37	0	0	0
38	4	4	4
39	0	0	0
40	0	0	0
41	12	12	12
42	0	0	0
43	0	0	0

Inter-Rater Reliability Scores: Student Qustionnaire
Qualitative Data - Time 3

Reasons HP Important	researcher	Reviewer	Agreed Score
Chiswell			
1	0	0	0
2	26	26	26
3	248	248	248
4	0	0	0
5	0	0	0
6	6	6	6
7	0	0	0
8	0	0	0
9	23	23	23
10	27	27	27
11	14	14	14
12	4	4	4
13	0	0	0
14	0	0	0
15	2	2	2
16	6	6	6
17	6	66	6
18	4	4	4
19	129	129	129
20	24	24	24
21	23	24	24
22	2	2	2
23	0	0	0
24	2	2	2
25	6	6	6
26	2	2	2
27	26	26	26
29	0	0	0
30	26	26	26
31	0	0	0
32	4	4	4
33	77	76	76
34	267	267	267
35	2	2	2
36	0	0	0
37	24	24	24
38	0	0	0
39	24	24	24
40	256	256	256
41	6	6	0
42	0	0	0
43	0	0	26
44	26	26	6
45	6	6	2 10
46	2 10	2 10	6
47	6	6	167
48	167	167	26
49	26	26	0
50	0	0	0
51	0	0	67
52	67 2410	67 2410	2410

APPENDIX 12

Teachers' Questionnaire

Construct Validity Assessment Criteria

Objective: To assess the validity of the identified constructs in the text, relating to the responses to the question asking teachers to give reasons for the value they placed on students learning about health promotion.

Objective Attainment:

Please consider the identified items listed below and rate their validity using the four point scale.

1. The professional role.
   Government policy dictates this.
   It is important for the nurse of the future.

1. The benefits of learning about health promotion.
   It provides a rounded perspective on learning about health and disease.
   It empowers people.

2. Health promotion entails?
   Health education.
   Lifestyle advice.

3. What should be taught?
   Health.
   "Good Health".
   Aetiology of disease.
   Theory and practice.

Scale:
1. These items reflect the constructs identified in the text.
2. These items mostly reflect the constructs identified in the text.
3. These items partly reflect the constructs identified in the text.
4. These items are irrelevant.

Omissions

What additional items did you identify?

Improvements

What improvements could be made to these descriptors?

Teacher's Questionnaire

Results of Construct Validity Ratings

Question 2: Response to question 1 requesting reasons for response to the value rating scale on the importance of students' learning about health promotion.

Dimensions of HP	Rater 1	Rater 2	Rater 3
1. Professional role	1	1	1
a It is government policy	1	1	1
b. It is important for the nurse of the future.	1	1	1
2Benefits of learning about health promotion			
a. Provides a rounded perspective on health & disease.	1	1	1
b. It empowers people.	1	1	1
2Health promotion entails learning about...	1	1	1
a. Health education.	1	1	1
b. Lifestyle advice.	1	1	1
4. What should be taught.....	1	1	1
a. Health.	1	1	1
b." Good health".	1	1	1
c. Aetiology of disease.	1	1	1
d. Theory & practice.	1	1	1

Focus Group Transcripts

Content Reliability Scores

Apriori Themes

Themes	Rater 1	Rater 2	Rater 3
1 The practice of health promotion	1	1	1
2 Barriers to practice	1	1	1
3 Defining health promotion	1	1	1
4 What the students learn	1	1	1
5 How the students learn	1	1	1
6 Should health promtion be explicit/implicit in the curriculum	1	1	1

Emerging Themes

The Teacher's Role	Rater 1	Rater 2	Rater 3
1 Linking thoery to practice	1	2	1
2 Providing educational opportunities	1	2	1
3 Supporting learning	1	2	1

NB. The second reviewer commented that this was perhaps one theme that could be labelled as facilitation of learning. Similar comments were not made by other reviewers and the researcher thought that these were discrete elements of facilitation. These themes remained unchanged.

Analytical Themes

Themes	Rater 1	Rater 2	Rater 3
1 Characteristics of P2K students	1	1	1
2 Socialisation	1	1	1
3 Characteristics of teachers	1	1	1
4 Impact of education on perceptions of health promotion	1	1	1
5 Characteristics of the teachers	1	1	1
6 Teacher development	1	1	1
7 The curriculum	2	2	1

NB: Although all these themes were scored as being relevant to the interpretation of the text. There was some discussion regarding item 7. Consideration was given to wheter this item was related to curriculum content, by two raters. However, stuctural issues relating to design and resources were also apparent in the text. The decision was made to leave this item unchanged.

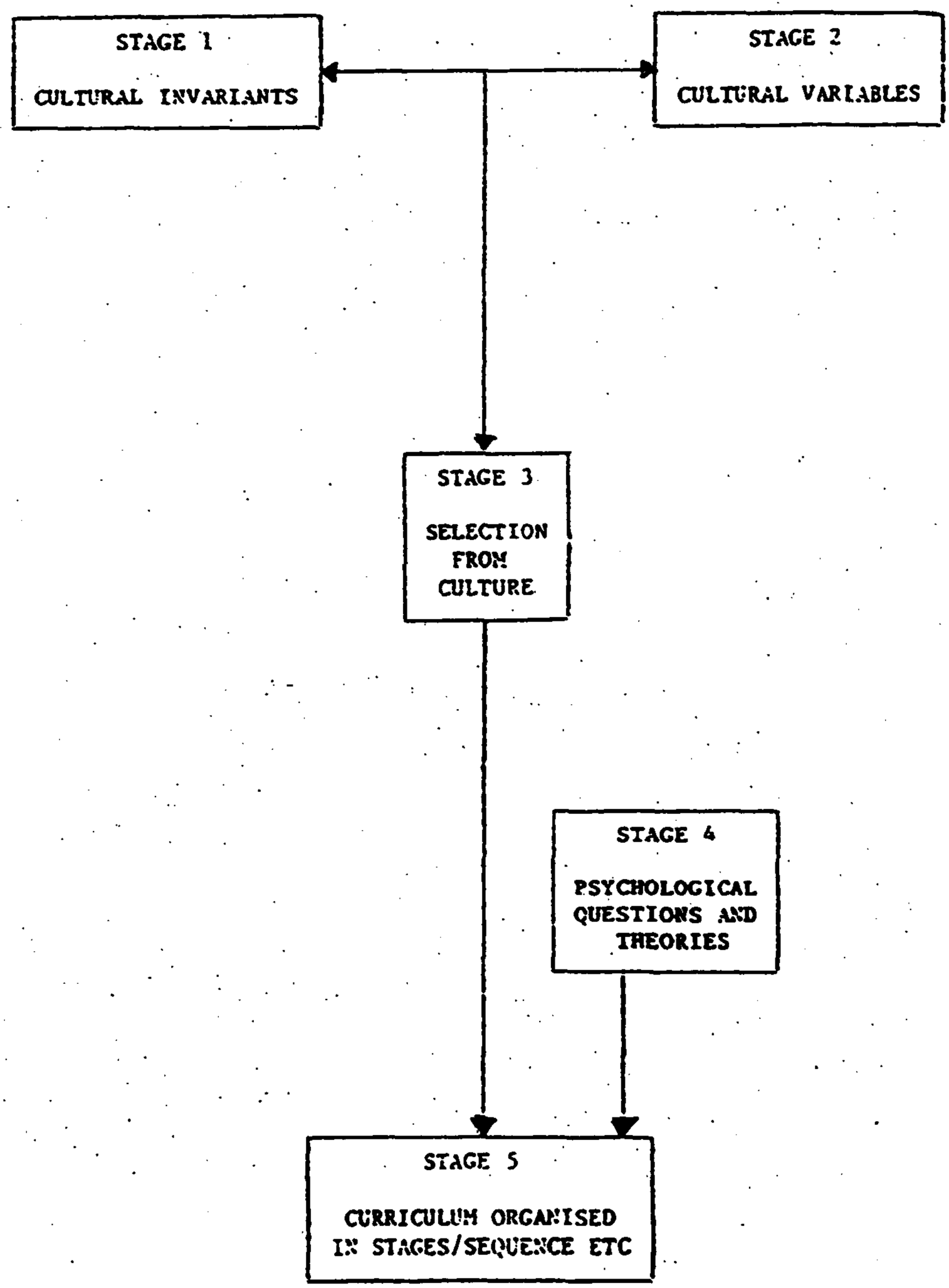
APPENDIX 13

BLACKSTONE

Fig. 3

CURRICULUM DEVELOPMENT MODEL

BASED ON A CULTURAL ANALYSIS APPROACH



LAWTON (1983)

FIG. 4

THE CURRICULUM CONCEPT

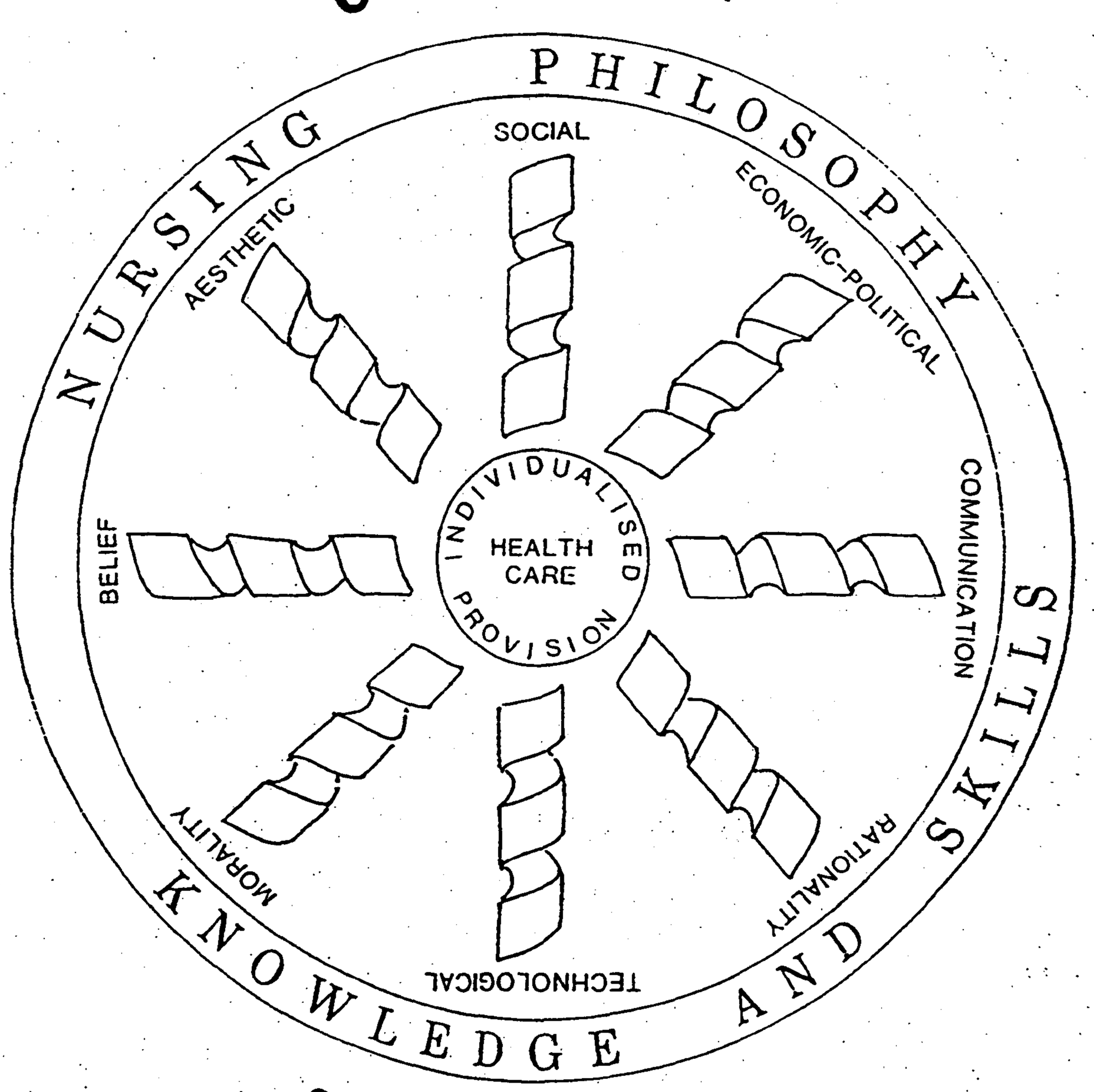
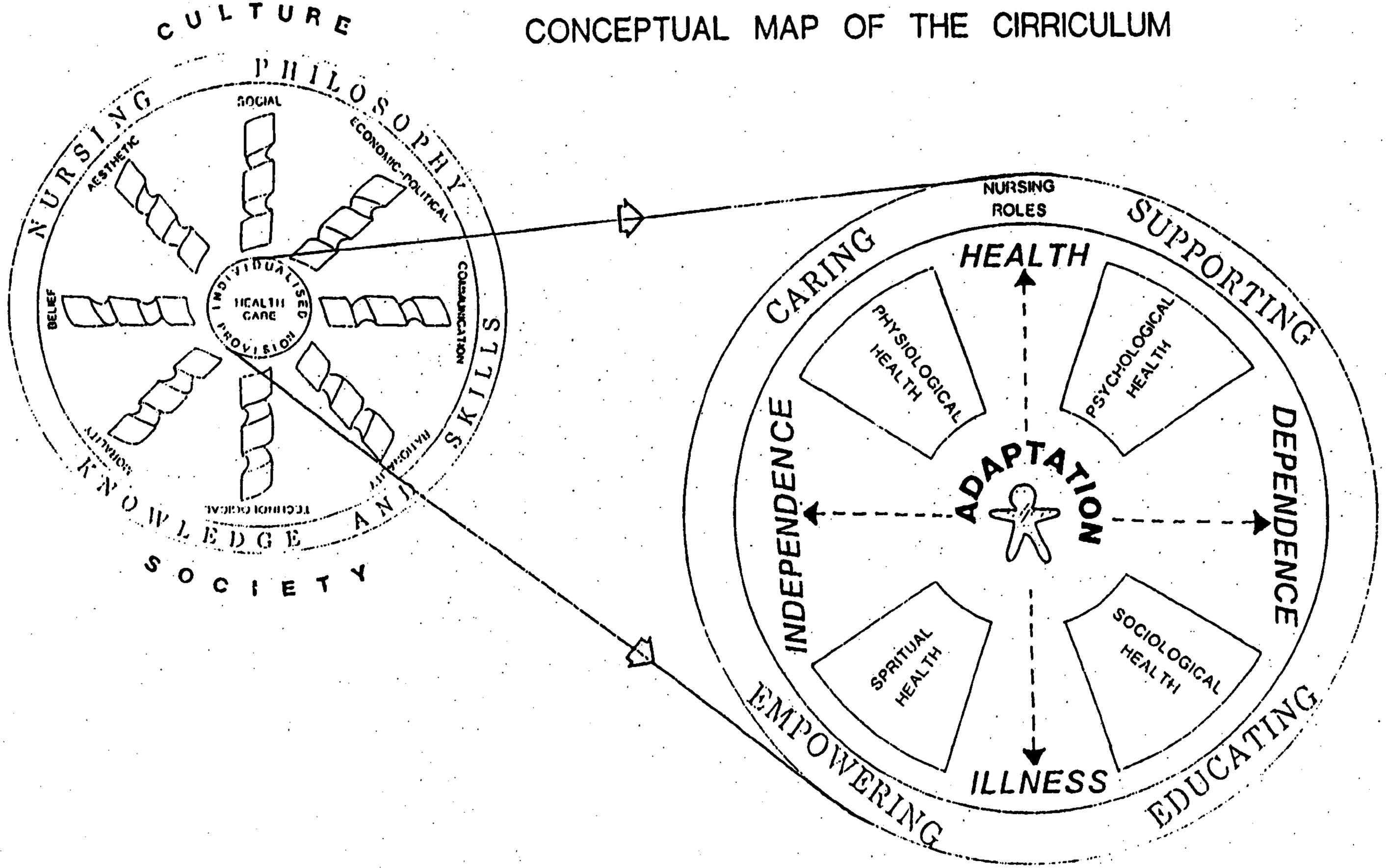


FIG. 5

CONCEPTUAL MAP OF THE CIRRICULUM



WAVERLY

COURSE PHILOSOPHY

Continuing changes in society and in the organisation of health care delivery generate an expectation that nursing in the years ahead will take place in an environment significantly different from that to date.

Inherent within this process of change is the concept of future nursing practice as an art and science requiring the application of enhanced intellectual, interpersonal, reflective, problem-solving and technical skills to ensure practice management and delivery of quality of care to clients and their significant others in health and in illness. This practice will take place in a multicultural context and within a healthcare scenario which places significantly more emphasis than previously on aspects of health, health education and health promotion.

The concept of health presents a problem of meaning. It defies universal definition, since "health" has political, economic, sociocultural and environmental dimensions in addition to physical and psychological ones and is variously interpreted by individuals and groups within society. It is, therefore, important for the future practitioner to understand the complexities of this problem in order to offer flexible, individualistic approaches to care and to adopt a role which will increase both personal and client awareness of the choices available for achieving full potential, whilst at the same time helping to remove the obstacles to that achievement.

Professional education aims to improve practice and is thus a vital medium through which practitioners may influence and change the image and practice of nursing in a positive way to meet the above requirements. Preparation for such practice therefore, demands a course which is educationally dynamic and substantive, enabling students to develop the ability to deal with complex nursing situations; to use skills derived from research, knowledge and experience; to promote and respond effectively to required change and to gain the necessary skills for facilitating continuing personal and professional development beyond initial qualification.

To this end the course will be based on sound nursing theory and practice, underpinned by the supporting disciplines of psychology, sociology, philosophy and biological sciences. Teaching and learning will take place in a supportive, facilitative atmosphere which fosters the development of tutors, students and clinical

supervisors as co-learners, and in which students are seen as individual adults.

The outcome will be a diplomate and competent practitioner differing from nurses completing traditional pre-registration courses. The P2000 practitioner will possess greater skills of critical analysis, and rational objective argument, together with increased research awareness, a broader deeper knowledge base and more awareness of the moral and political issues involved in nursing. He/she will be able to respond more flexibly to the options available in meeting healthcare needs and will, therefore, have the potential to enhance the quality of client care in a wide variety of settings; to contribute to the body of professional nursing knowledge; and to progress beyond initial competence towards genuinely reflective practice, expertise in the chosen branch of nursing and equal partnership in professional healthcare.

This philosophy is reflected in all aspects of the course. For example the selection procedure utilises the group discussion to elicit candidates' potential flexibility of thinking and attitudes: The Health and Health Care theme of module 3 of the course considers the need to target health education messages appropriately at different life stages and to different client groups; the acquisition of reflective communication skills in nursing is facilitated through the use of experiential learning methods.

COURSE CURRICULUM

Philosophies for the nursing care of patients and clients within Aylesbury Vale and Wycombe Health Authorities are compatible with the Course Philosophy. All three emphasize the individuality of patients and clients and their objectives are to provide the highest possible standard of care.

i. [redacted]

PHILOSOPHY OF THE NURSING SERVICE

[redacted] Authority aims to provide the best possible health service for the people it serves. When engaging in the delivery of care, each nurse will have due regard to ethical and professional research-based practice. Nursing is a major contributor to the provision of services within the health care system of [redacted] Authority. Nursing supports the principle and belief that quality of health care includes those requirements which promote the physical, mental, psychological, social and spiritual well-being of individuals.

This holistic care should ensure continuity, taking into account the individual needs of the patient, the family and significant others, enabling them all to grow within an empathetic framework which promotes confidence, support and education.

In the pursuance of this care, nursing shares its professional knowledge and expertise with other disciplines and agencies.

ii. [redacted] **HEALTH AUTHORITY**

PHILOSOPHY FOR THE NURSING SERVICE

The Nursing Service of [redacted] health Authority believes in he individuality of the client and will provide appropriate nursing care in partnership with the client within the context of the multi-disciplinary practice.

Principles on which the Nursing Service shall be provided are:

1. Clients' rights to privacy, independence, confidentiality and dignity should be maintained at all times.

2. Clients and where appropriate their advocates will be involved in and able to have informed choices about their treatment and care.

3. The service provided should be commensurate with the needs of the individual.

4. The nursing staff should be valued and their work recognised.

5. Standards for nursing care shall be clearly defined and attainable in practice facilitating objectives, monitoring and evaluation of the service.

6. Standards for nursing care will reflect development in nursing knowledge and research based practice.

The Health Authorities are committed to enabling as many people as possible to live within the community, and to providing adequate support services to enable that to happen safely. Their objective is to make the large institutions redundant and to provide alternative, smaller community and sheltered homes as required.

CURRICULUM FRAMEWORK/MODEL

The course is based on an eclectic approach to curriculum planning. This is evidenced by the adoption of elements of both process and product models, subject based aspects and by using a portfolio of meaningful experiences. Progression through the course will involve the student in the examination and analysis of the core themes on a recurring basis, so that key concepts of nursing can be explored in greater breadth and depth in a spiral fashion.

The curriculum framework reflects the College Philosophy in the approach to students fostering collegial relationships between tutors and students, allowing a two-way interchange in the educational process. Students will be encouraged to identify their learning needs and become increasingly responsible for their own personal and professional development.

CHISWELL

13.0. NURSING PHILOSOPHY

We hold that, although the branches of nursing have inherent differences, there is a unity of belief amongst the nurses participating in this course about the nature of the patient (client) and the nature of nursing, and the nature of health. It is our intention to reflect these beliefs within the curriculum plan and in its implementation, enabling students to understand and internalise the values inherent in the course philosophy.

It is our philosophy of nursing that all patients are unique individuals with a different genetic composition and experiences of life. This gives rise to a response from each person to health and illness which is singular and their's alone. Unique persons/patients require nursing interventions tailored to their individual needs. Within this context of holistic, individualised care, it is the duty and purpose of each nurse to attempt to influence those with whom she/he comes into contact to enhance the individual's ability to attain their optimum level of health. It is also the duty and purpose of nursing to care for those who are sick in order to return the individual to his/her optimum level of health. It therefore follows that the nurse may execute his/ her professional skills within the institutional and non-institutional health services and, also, within the wider society, thus helping to influence those factors which promote health and prevent illness.

The practice of nursing has in common certain knowledge, interpersonal and psychomotor skills, and attitudes which together support the nurse in her/his varied roles. This commonality extends through all the branches of nursing. Common to all is the expectation that the nurse will behave in a professional and moral way, acting as the patient's/client's advocate, teacher, supporter and counsellor, as a coordinator of the patient's care, and as a resource interpreting and explaining the patient's past, present and future experiences of health and sickness.

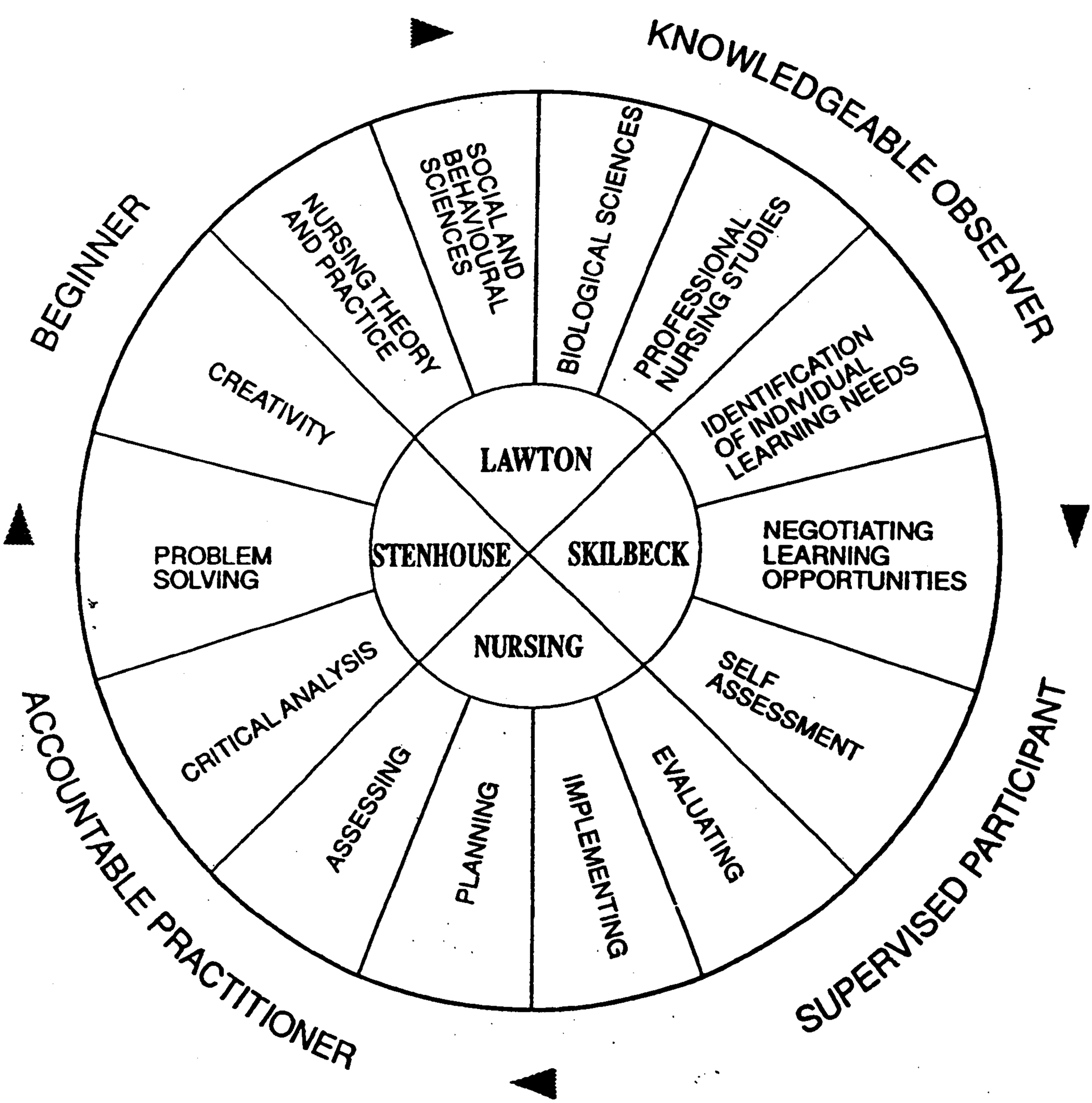
Health, in this context, is not perceived as a 'static state', but as a continuum of adaptation to life events. The process of positive health promotion is thus not only concerned with avoiding illness, but also with the active enhancement of a person's entire 'state of being',

including the physical, psychological, social and spiritual qualities of life. Optimum 'health' is therefore considered potentially achievable by all individuals, regardless of age, and whatever his/her existing physical condition and/or psycho-social situation.

All nurses exercise nursing skills within the framework of the assessment, planning, implementation and evaluation of care, thus responding to the patient's unique constellation of needs.

We also conceive of practice, management, education and research in nursing as interdependent factors essential for the advancement of patient/client care.

• CURRICULUM MODEL •



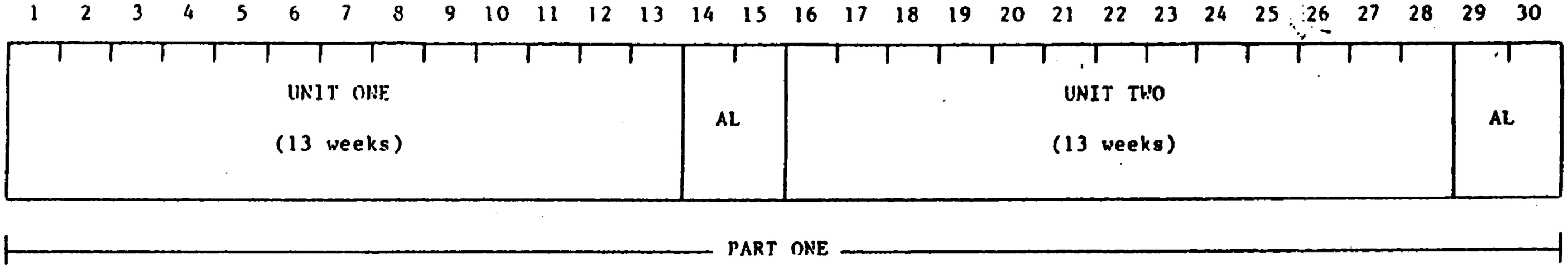
APPENDIX 14

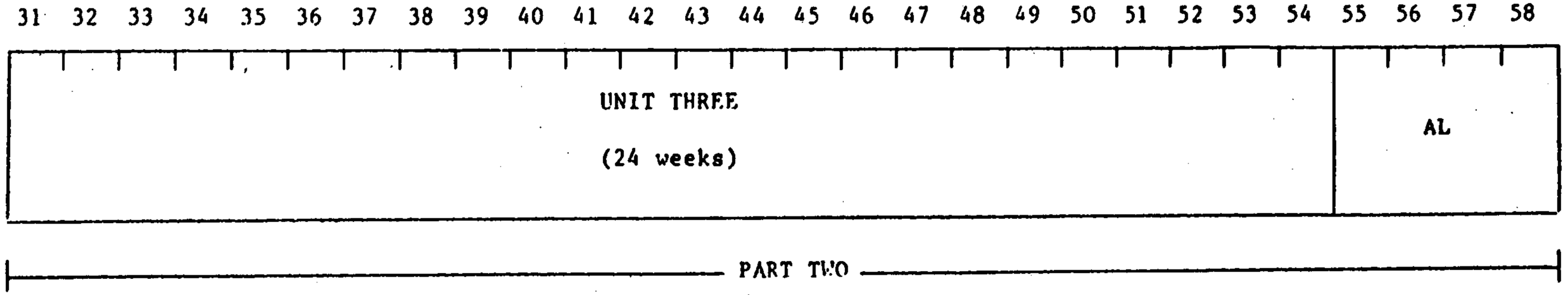
BLACKSTONE

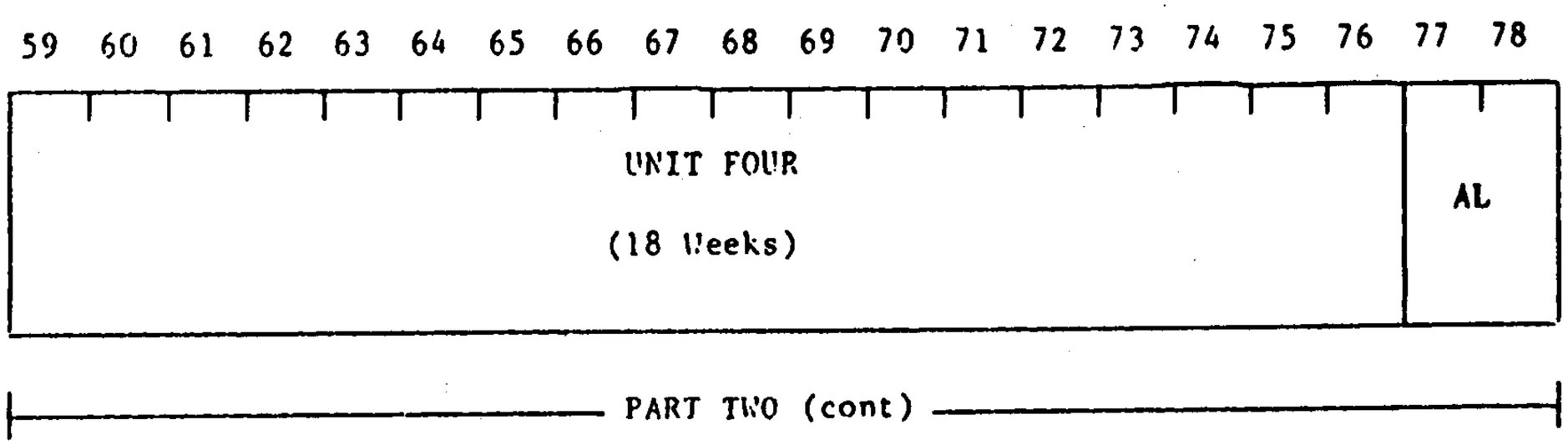
Fig 6a

COMMON FOUNDATION PROGRAMME

COURSE PLAN





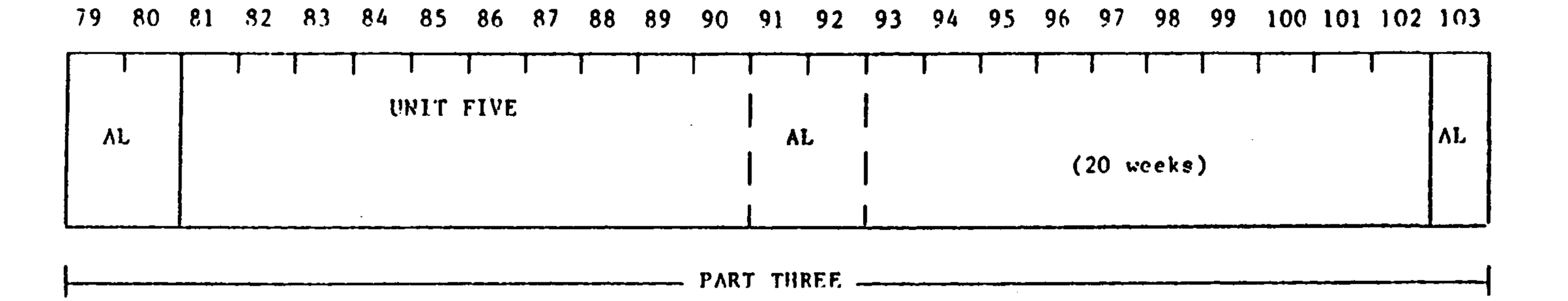


AL = Annual leave

Fig. 6b

BRANCH PROGRAMMES

COURSE PLAN



AL = Annual leave

PAGE NUMBERING AS ORIGINAL

Fig. 7

MAJOR DEVELOPMENTAL FOCI - IN EACH UNIT.

Post Registration Education (P.R.E.P.P.)

UNIT	1	2	3	4	5	6	7	8	9
	C.f.f.P.				First rostered service BRANCH				
Acclimatisation									
Adaptation									
Observation									
Socialisation									
Exploration									
Participation									
Identification									
Internalisation									
Dissemination									
Consolidation									
Professionalisation									

Note : ALL ELEMENTS ARE INCLUDED TO SOME EXTENT IN ALL UNITS

Fig. 8

LAWTON'S CULTURAL ANALYSIS MODEL AND THE NURSING CURRICULUM

4 major curriculum disciplines	LAWTON'S SYSTEMS: SOCIAL	ECON/POLITICAL	COMMUNICATION	RATIONALITY	TECHNOLOGICAL	MORALITY	BELIEF	AESTHETIC
SOCIAL SCIENCES	✓	✓	✓	✓		✓	✓	✓
BEHAVIOURAL SCIENCES			✓	✓		✓	✓	
BIOLOGICAL SCIENCES			✓	✓	✓			
NURSING SCIENCES	✓	✓	✓	✓	✓	✓	✓	✓

5.6. NURSING STUDIES COMPONENT (C.F.P.)

THEMES	UNIT ONE	UNIT TWO	UNIT THREE	UNIT FOUR
PHILOSOPHIES OF NURSING	Nursing philosophy; Course aims; Images of nursing; Concepts of caring;	The uniqueness of Nursing; Diversity of nursing roles.	Applied to child, maternity, mental health care, and people with special needs.	Applied to adult and elderly health-care.
SYSTEMATIC CARING	Problem-solving in nursing care; Introduction to models of nursing.	Matching nursing models to client groups and needs.	Applied to child, maternity, mental health care, and people with special needs.	Applied to adult and elderly health-care.
CARING SKILLS	Personal standards in nursing practice; Maintaining a safe environment; First aid; Lifting & moving (1).	Assisting the client with the activities of living; Introduction to the effects of incontinence on health.	Caring skills; Maintenance of health & safety; Expressing sexuality. (related to the above client groups)	Caring skills; Maintenance of health & safety; (related to adults & elderly) Sexual health & ageing; Caring for adults in pain; Care of the dying & their family; Lifting & moving (2).
COMMUNITY CARE & HEALTH PROVISION	Role of the Community Nurse; Nurse-client relationships; Patient advocacy; Community & Locality Health-profile; Introduction to epidemiology and demographic trends; Social deprevation; Introduction to Statutory & Voluntary Health Agencies.	Influence of socio-economic factors on health and health-care; Health-screening; 'Outreach' support schemes; Evaluating Community care.	Role of the Community Nurse in organ-ising care & services; Meeting the needs of the above client groups; Role of the Community Nurse in health promotion.	Role of the Community Nurse in organ-ising care for adults & elderly; Co-ordination of care & team-work; Financial benefits & support; Role of the Community Nurse in health promotion.
PROFESSIONAL & MANAGEMENT ISSUES	Being a P2000 student; Introduction to the UKCC Code of Professional Conduct; Nursing & accountability; Overview of nursing history and development.	Public and Private health-care; The N.H.S. The Community Care Act.	Supernumerary status; Methods of organ-ising nursing care; Role of the multi-disciplinary team; Developments and current trends in care of the above client groups.	Coping with & adapting to change; The exercise of power in large organis-ations; Role of the multidisciplinary team in adult & elderly care; Supporting the carers.
INFORMATION TECHNOLOGY	I.T. in society, & its contribution to patient/client-care; Introduction to computer Soft and Hard-ware	Keyboard skills (1).	Keyboard skills (2).	Keyboard skills (3);
RESEARCH AWARENESS	Contribution of research to Nursing knowledge and patient/client care; Introduction to research methodology (1).	Introduction to research methodology (2).	Using research in nursing practice (1);	Using research in nursing practice (2); Disseminating findings & factors affecting implementation.

OVERVIEW OF CONTENT.

SOCIAL SCIENCES COMPONENT (C.F.P.)

THEMES	UNIT ONE	UNIT TWO	UNIT THREE	UNIT FOUR
PEOPLE, POLICY AND SOCIAL PERSPECTIVES	Theoretical perspectives of Sociology: -development of the Welfare State -theories & definitions of social class -sociological explanations for gender and gender-roles -racial equality and racism.	Historical and cultural variations in family life; Role of the family in health and illness; Family and social policy.	Social construction of childhood; Historical & cross-cultural comparisons of childhood; Children and social policy.	Ageing and the 'Life Course'; Retirement and resources; Cultural values and ageing; Culture and the 'Work Ethic'; Unemployment and health. Homelessness and health (2).
SOCIOLOGY OF HEALTH AND ILLNESS	Lay interpretations of health and illness; Illness as a 'social state'; Family and social policy.	Inequalities in health; Informal and Formal health care provision; Caring as a gendered concept. Homelessness and health. (1)	Historical development of reproductive technologies, contraception, abortion, infertility & pregnancy care; The politics of motherhood. Mental health & illness - how is 'normal' defined? Influence of race & gender on diagnosis and treatment.	Chronic illness & disability - prejudice & stigma; Effects of legislation; Death & Bereavement - cultural aspects; Alternative care-facilities for the terminally ill.
ETHICS & LAW	Introduction & relevance to nursing; Moral development, values and beliefs, values clarification; Ethical theories of deontology and utilitarianism; Moral codes; Human Rights & responsibilities.	Principles of Medical Ethics; Informed consent & Research Ethics; Laws relating to health-care; Overview of the British Legal System; Accountability & Responsibility.	Legal status of the human embryo; Selective non-treatment of neonates; Reproductive techniques & technologies; The Mental Health Act; treatment and controversy.	Ethical issues surrounding death & dying; Principles of double-effect and intention.
HEALTH PROMOTION & EDUCATION	Concepts and Models of health; Factors influencing health; Measurement of health; Principles of Health Education; Self-help Groups; Health and safety at work.	Nurses' role in the promotion and maintenance of health; Preventative health care; Role of the Primary Health Care Team; Community services.	Health education in schools; Children and the Health Service; Developing health behaviour and attitudes; Preventative measures against infection.	Defining & promoting health in later life; Preventative services; Assisting clients to make informed choices.

OVERVIEW OF CONTENT.

BEHAVIOURAL SCIENCES COMPONENT (C.F.P.)

HOURS	UNIT ONE	UNIT TWO	UNIT THREE	UNIT FOUR
PSYCHOLOGY	Relevance of psychology to nursing; Basic psychological processes; Individual & group processes.	Introduction to social & emotional processes; Social relationships; Development of 'self'; Behaviour in altered health-states: - coping with stress, death and dying, change in body image. - the psychology of pain.	Developmental psychology: - overview of child development, - psychosexual development, - language development, - function & value of play; Family development & function.	/
INTERPERSONAL SKILLS	The Communication Process.	Effective communication; Interviewing skills; Barriers to communication: eg - language, cultural aspects.	/	Communications within organisations: - formal & informal networks; Information Technology & patient care; Interviewing skills - in practice.
PERSONAL AND APPLIED HEALTH PSYCHOLOGY	Introduction to personal well-being; The student as a member of a group; Assertiveness skills (1).	/	Mental Health: labelling & prejudice; Abnormal psychology.	The art of negotiation: Leadership skills; Assertiveness skills (2).
ORGANISATIONAL AND TEACHING SKILLS	The adult learner; The management of learning; The management of Self; The management of time. Study skills.	Learning applied to practice: - teaching a skill.	/	/

OVERVIEW OF CONTENT.

BIOLOGICAL SCIENCES COMPONENT (C.F.P.)

UNITS ONE AND TWO	UNIT THREE	UNIT FOUR
Introduction to control mechanisms and Homeostasis; Levels of organisation: - cells and tissues, - properties of atoms and molecules, chemical actions and reactions (organic chemistry applied to human physiology) The Musculo-skeletal System. The Cardiovascular System. Environmental exchange: - The Respiratory System, - The Urinary System, - Temperature control. Communication and control: - The Nervous System, - The Endocrine System. Introduction to Molecular Biology and Genetics. Body Defence Mechanisms: - Immunity and immune responses. Continuity of Life: - The Reproductive System. Nutrition and Metabolism. Introduction to Microbiology.	Embryonic and Foetal development. Maturation. Physical growth and development. RELATED SPECIFICALLY TO CHILDREN: - Fluid and electrolyte balance, - Hypersensitivity, - Abnormal brain cell activity eg convulsions & epilepsy. - Problems of elimination. Introduction to Pharmacology.	The Ageing Process. Overview of/and consequences of functional changes in body systems. Nutrition in the Adult & Elderly. Drug Therapy in the Elderly.

OVERVIEW OF CONTENT.

SUMMARY OF NON INSTITUTIONAL EXPERIENCE IN CFP & ADULT BRANCH

COMMON FOUNDATION PROGRAMME

UNIT 1 Length 13 weeks

Focus: Geographical neighbourhood - people and environment.
Activity: Student centred assignments, neighbourhood study.
Number of students: 125 (4 groups of 32)

UNIT 2 Length 13 weeks

Focus: Personal health & health care needs.
Activity: Student centred assignments, neighbourhood study.
Number of students: 125 (4 groups of 32)

UNIT 3 Length 24 weeks

Focis:	Learning difficulties	-	2 weeks
	Mental health		5 weeks
	Child health		5 weeks
	Maternity		4 weeks
*	Normal child in the community		2 weeks

Number of students: 125 (5 groups of 25)

UNIT 4 Length 18 weeks

Foci:	Adult health	5 weeks
*	Older adult	5 weeks

Number of students: 125 (4 groups of 32)

***UNIT 3** "Normal child in the community". This is the first point within the programme that the community nurses are involved. At this stage each student will spend 5 days (based in a health centre) focusing on Primary Health Care provision and child health maintenence. Health visitors and school nurses will be involved at this stage.

***UNIT 4** At this stage the focus is Primary Health Care for Adults and Older People. The student will spend 5 days at a health centre, and will involve Health Advisors for the elderly/health promotion nurses, Health Visitors and District nurses.

SUMMARY OF NON-INSTITUTIONAL EXPERIENCE CPP & ADULT BRANCH

ADULT BRANCH

UNIT 5 Length 13 weeks

Foci:	Acute care	6 weeks
	Surgery/theatre	6 weeks
*	Continuing care	4 weeks

Number of students 60: (3 groups of 20)

*In **UNIT 5** The student will undertake a client centred case study to look at in more detail the effect of handicap and disability. It is envisaged the student will be client/family linked, but will liase with the professional carers as appropriate to look at methods of planning and delivery care.

UNIT 6/7/8 Length 4 weeks

Foci: Rostered service in community.

20 students in units 6. 7, and 8, will be allocated to the community nursing service and work under the supervision of a qualified community nurse and undertake practical experience and give care commensurable with their stage of training within clients homes and nurse lead clinics. It is expected that the student will work a 37½hr week based on community nurses shift patterns.

WAVERLY

COURSE AIMS

The student will:

1. Attain the competencies as outlined in Rule18a(2) of the Nurses, Midwives and Health Visitors Act (1983).

2. Be competent in providing care for clients in both an institutional and non-institutional setting.

3. Show the ability to consider the ethical, economic, legal and political factors in delivering care to clients and take these into account in planning care in a variety of settings.

4. Be able to manage and organise the human and material resources in the delivery of nursing care to specific client groups.

5. Be competent in discussing the contribution of the subject disciplines of the behavioural, biological, social sciences to nursing theory and its application.

6. Have research awareness and understanding of research methodology and the ability to use this to enhance the quality of care delivered to the client.

i. COURSE RATIONALE

The course is based on a health/illness continuum in which the student will encounter the patient/client during specific pre-defined phases.

The first module, health maintenance allows the student to explore the notion of health, both as a personal concept and what is meant by health to those in the community in which they live and work. Practical placements to which the student is allocated will reflect the complexities involved in defining concepts of health held by various people

In the second module, impaired health, the student will be exposed to that client group who, for a variety of reasons, require input from health professionals to a degree which does not involve hospital admission. Examples of this may be those clients visited by a district nurse who changes a dressing on a leg ulcer, by a community nurse actively engaged in a programme of desensitization or attendance at the diabetic clinic.

iii. Common Foundation Programme

College = 34 weeks
Placements = 33 weeks

TOTAL = 67 weeks

Branch Programmes

College = 33 weeks
Placements = 35 weeks (service contribution: 26 weeks)

TOTAL = 68 weeks

Programmed Hours for the Course

Common Foundation Programme = 2345 hours
Branch Programmes = 2380 hours

TOTAL = 4725 hours

Student Numbers for Each Branch

Adult = 50
Children = 15 Alternate intake
Mental Health = 15
Mental Handicap = 15 Alternate intake

iv. Distribution of Hours

Common Foundation Programme:

Lecture - Small Group Work

Psychology	=	2	+	2	=	4
Sociology	=	2	+	2	=	4
Philosophy/Politics	=	1	+	1	=	2
Research Studies	=	1	+	1	=	2
Health Studies	=	2	+	2	=	4
Biological Science	=	2	+	2	=	4
Nursing Studies	=	2	+	2	=	4
Study Time					=	11
					TOTAL:	35 hours

Progression & Integration of Course Material

Student nurses entering the course will be exposed to a variety of elements aimed at enabling them to develop self-directed learning skills. The course will commence by introducing the student to study, information finding and literature searching skills. Each student will be allocated a personal tutor who will explore with the student their individual learning needs.

Subject disciplines which contribute to nursing will be an integral feature of the course, but within this, it is important to stress that the major focus is on nursing theory and practice. The course team feel it is important that subject disciplines are not taught, or seen by the student as isolated factors, but instead, are integrated into nursing and this will be ensured by the small group work and through projects and application in the clinical setting.

In the past, many students embarking on a Diploma Level course in nursing have done so after completion of a Certificate in Nursing, which helped equip them with many of the skills necessary to undertake study at this higher level. Students on this course will not have this advantage and progress through the programme will require them to develop the skill of critical analysis in relation to the subject material covered by the programme. The course team thinks this is best accomplished through integration of the subject disciplines with each other and their relationship to nursing in small group work following a lecture.

The knowledge gained from this system of integration will be developed in the practical settings to which students are allocated and the concepts, principles and hypothesis tested and challenged for validity and reliability. A practical placement log will be used by the student to record the problems and successes of the application of theoretical principles to direct patient care and will be evaluated both on an on-going basis with the supervisor and on their return to College.

It is the intention of the course to introduce the student to increasingly complex concepts in a developmental fashion, allowing time for reflection and study in order to promote self-direction and understanding. The common foundation programme is designed to provide the student with a substantial knowledge base, therefore entering their chosen branch with propositional experiential and practical knowledge of nursing theory, the contribution of the supporting disciplines and research material and methodologies

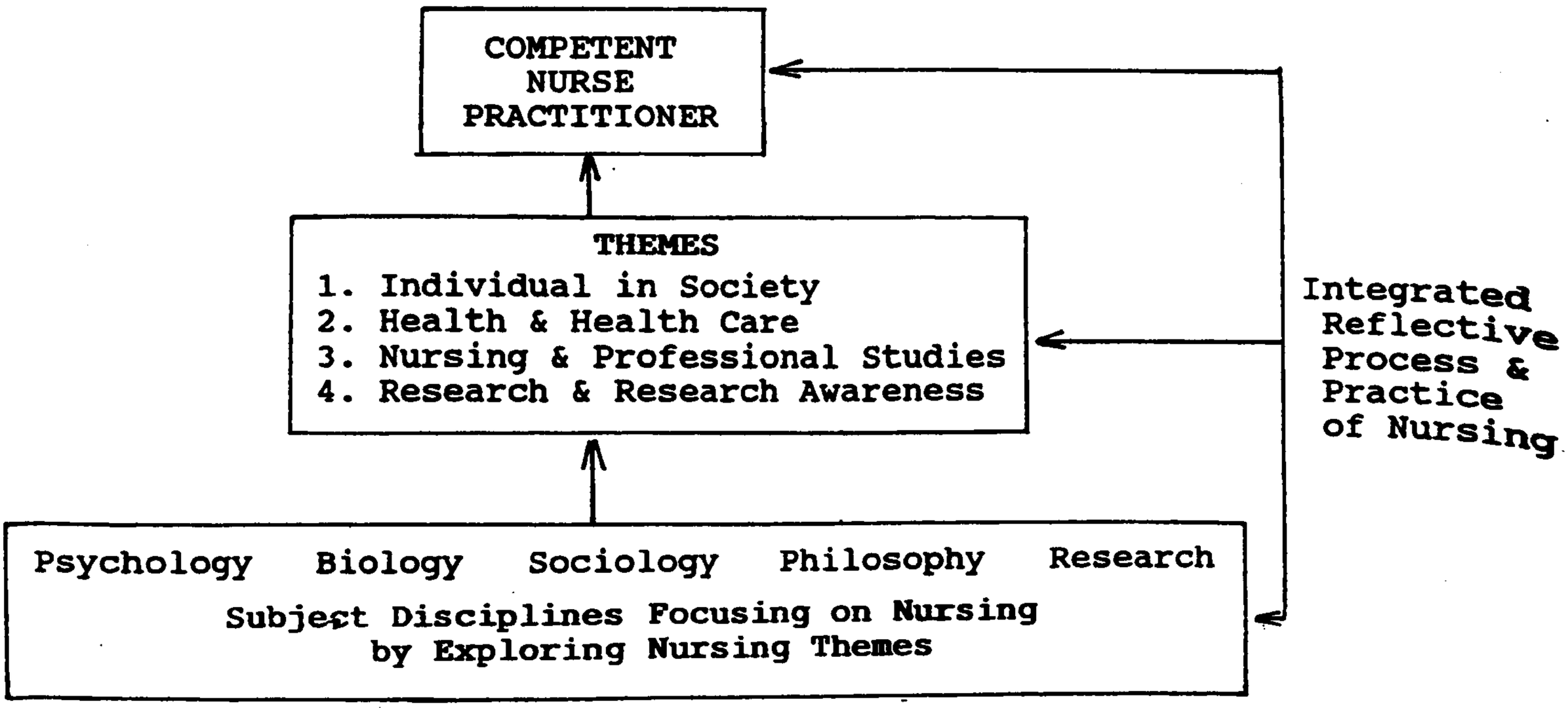
PROGRESSION FROM CFP TO BRANCH PROGRAMME

Progression from the CFP to the branches will encompass a move from the general to the specific, emphasising the special qualities of each branch. There will be increasing depth of knowledge and application of skills particularly during the rostered practice. Much of the content of the branch programmes will build on learning acquired in the CFP. However, new material will be included which is specific to each branch but which has its foundation in concepts and principles laid down in the CFP.

Nursing and professional studies has been the major theme of the CFP but an even greater emphasis on nursing knowledge and skills will occur in the branches. Personal and professional development of the student is seen as a thread running throughout the course and it is envisaged that the branches will develop more clearly the professional identity and focus of the student in preparation for his/her role as a Registered Nurse.

The chosen branch programmes will use this basis as a springboard to focus more specifically on the essential elements of the branch and develop further the student's understanding. On completion of the branch programme the student will be competent at Diploma Level in the UKCC's list of competencies outlined in Rule 18(a)2 allowing them to practise nursing care, manage the nursing environment and be confident providers of care in both institutional and community settings.

INTEGRATION OF THE COURSE



respect is not discussed explicitly in all modules in every branch programmes, the skills, attitudes and knowledge necessary to carry out the role have been developed from early in the CFP and throughout the branches. These include communication skills, particularly counselling skills, teaching/facilitative skills, problem-solving skills, empathy; and the specific knowledge base required to inform clients and/or their families in an authoritative and objective manner.

COHORT LEARNING

Students in all the branches will come together to share learning experience in areas of nursing and related themes/topics of common significance and value.

Whilst each of the branches is unique, cohort learning in each of the modules is seen as an important feature in:-

a) identifying and enhancing the fundamental aspects of nursing theory and practice common to all.

b) fostering for the future the concept of continuing shared learning and professional growth as practitioners.

c) enabling increased intercommunication and peer support within the whole student body.

d) maximizing efficient use of teaching/learning resources within the College.

From each of the course themes, areas of learning seen as common to all branches have been identified. Although present in all four modules, the main focus of sharing is in modules 5 and 6 to enable the uniqueness of each branch to be increasingly demonstrated towards the end of the course by placing the final emphasis on the professional nursing knowledge and skills special to each branch.

COHORT LEARNING

MODULE 5

Health & Health Studies

all H.E. 3hrs.

- Development & Physiology of CNS.
- Brain Chemistry & Neural Pathways.
- Physiology of Language & Cognition.
- Genetics, Inheritance in relation to CNS.

CHISWELL

THE COMMON FOUNDATION PROGRAMME

PART 1	PART 2									
FOUNDATIONS FOR NURSING	DEVELOPMENT OF NURSING									
ORIENTATION	Introductory Studies Health in Society 24 weeks includes 2 wks vacation	VACATION 2 wks	Early Years 14 weeks	VACATION 2 wks	Middle Years 14 weeks	VACATION 2 wks	Late Years 14 weeks	CONSOLIDATION	VACATION 2 wks	

JP/PT 17.1.92

APPENDIX 5

THE COMMON FOUNDATION PROGRAMME

PRACTICE PLACEMENTS

Part	Weeks	Module	Group A	Group B	Group C	Theory	Practice
PART 1 — FOUNDATIONS FOR NURSING, HEALTH IN SOCIETY	1	MODULE 1	ORIENTATION	ORIENTATION	ORIENTATION	5	
	2–11	MODULE 1	NEIGHBOURHOOD PLACEMENT 1	NEIGHBOURHOOD PLACEMENT 2	NEIGHBOURHOOD PLACEMENT 3	5 5 5 5 3 3 3 3 3 3	2 2 2 2 2 2
	12–13		VACATION 2 wks	VACATION 2 wks	VACATION 2 wks		
	14–19	MODULE 1	NEIGHBOURHOOD PLACEMENT 2	NEIGHBOURHOOD PLACEMENT 3	NEIGHBOURHOOD PLACEMENT 1	3 3 3 3 3 3	2 2 2 2 2 2
	20–26	MODULE 1	NEIGHBOURHOOD PLACEMENT 3	NEIGHBOURHOOD PLACEMENT 1	NEIGHBOURHOOD PLACEMENT 2	3 3 3 3 3 3 5	2 2 2 2 2 2
PART 2 — DEVELOPMENT OF NURSING	27–28		VACATION 2 wks	VACATION 2 wks	VACATION 2 wks		
	29–33	MODULE 2	Maternity Care	The Child In Hospital	The Child with Special Needs	5 5 2 2 2	3 3 3
	34–37	MODULE 2	The Child In Hospital	The Child with Special Needs	Maternity Care	5 2 2 2	3 3 3
	38–42	MODULE 2	The Child with Special Needs	Maternity Care	The Child In Hospital	5 2 2 2 5	3 3 3
	43–44		VACATION 2 wks	VACATION 2 wks	VACATION 2 wks		
	45–49	MODULE 3	Physical Illness	Mental Health Problems	The Adult with Special Needs	5 5 2 2 2	3 3 3
	50–53	MODULE 3	Mental Health Problems	The Adult with Special Needs	Physical Illness	5 2 2 2	3 3 3
	54–58	MODULE 3	The Adult with Special Needs	Physical Illness	Mental Health Problems	5 2 2 2 5	3 3 3
	59–60		VACATION 2 wks	VACATION 2 wks	VACATION 2 wks		
	61–65	MODULE 4	The Elderly In Hospital	Community Care	The Elderly In Hospital	5 5 2 2 2	3 3 3
	66–69	MODULE 4	Community Care	The Elderly with Special Needs	The Elderly with Special Needs	5 2 2 2	3 3 3
	70–74	MODULE 4	The Elderly with Special Needs	The Elderly In Hospital	Community Care	5 2 2 2 5	3 3 3
	75–76		CONSOLIDATION	CONSOLIDATION	CONSOLIDATION	5 5	
	77–78		VACATION 2 wks	VACATION 2 wks	VACATION 2 wks		

17.1.92

PRE REGISTRATION NURSE EDUCATION

COMMON FOUNDATION PROGRAMME		BRANCH PROGRAMME	
PART 1	PART 2	PART 3	PART 4
Foundations for Nursing	**Development of Nursing**	**Analysis of Nursing**	**Management and Evaluation of Nursing**

JPPT 8.5.91.

2300 Hours 78 weeks ← → **2300 Hours 78 weeks**

APPENDIX 3

THE BRANCH PROGRAMME IN

• ADULT NURSING •

PART 2									
ANALYSIS OF NURSING				MANAGEMENT AND EVALUATION OF NURSING					
VACATION 2 Wks	Care in the Community 16 weeks	VACATION 2 Wks	The Adult with Special Needs 15 weeks	VACATION 2 Wks	The Adult in Hospital 27 weeks includes 1 week vacation	VACATION 1 Wk	Preparation for Professional Practice 10 weeks	VACATION 2 Wks	

← Rostered Service →

LGPT 9.8.93.

Appendix 2

IN ADULT NURSING

LG / PT 12.8.93.

Appendix 4

CORE SUBJECTS	MODULE 5 16 weeks (600 hrs)		MODULE 6 15 weeks (562.5 hrs)		MODULE 7 27 weeks (1012.5 hrs)		MODULE 8 10 weeks (375 hrs)		TOTAL	
	CONTACT	STUDY	CONTACT	STUDY	CONTACT	STUDY	CONTACT	STUDY	CONTACT	STUDY
NURSING THEORY	108	32	57	28	52	25			217	85
NURSING PRACTICE	300		337.5		712.5		262.5		1612.5	
BIOLOGICAL SCIENCES	32	16	28	14	37	25			97	55
SOCIAL & BEHAVIOURAL SCIENCES	32	16	28	14	37	25			97	55
PROFESSIONAL NURSING STUDIES	48	16	42	14	74	25	67.5	45	231.5	100
TOTAL	520	80	492.5	70	912.5	100	330			

APPENDIX 15

BLACKSTONE

4.2. SEQUENCE OF ASSESSMENTS

4.2.1. FORMAL SUMMATIVE ASSESSMENTS

	Unit	THEORY	PRACTICE
PART 1	1.	Community, locality profile (units 1-4)	NOVICE -
Early Late	2.	Seen, written (biological sciences) Seen, written (social sciences & community Seen, written (nursing)	-
PART 2	3.	Seen, written (behavioural sciences) Seen, written (biological sciences) Seen, written (nursing)	Diary (skills, child & mental health)
Early Week 68	4.	Seen, written (nursing) Unseen written (all elements)	Diary (skills, adult & elderly) Continuous assessment of practice (counsellor, carer/surrogate, adult learner, developing professional, technical expert.

PART 2	3. Nursing analysis	Continuous assessment of practice
Early Week 68	4. Research critique (include potential implementation difficulties)	"
PART 3	5. Seen, written (nursing, analysis & synthesis)	-
	6. Seen, written (problem solving in practice)	**ADVANCED BEGINN**
PART 4	7. Seen, verbal (biological sciences case study)	-
week 135	8. -	**COMPETENT PRACTITIONER**
	9. -	Seen, written (management, observation & analysis)

PORTFOLIO OF SUMMATIVE + FORMATIVE ASSESSMENTS & COUR.
WORK

N.B. Self assessment by students will be utilis.
throughout.

UNIT 1 CFP SEPTEMBER 1992

TEACHER

Week 1 :
25.9.92
11 - 12.00 — Introduction to Non-institutional Studies and Neighbourhood Study - Assessment.

Week 2

28.9.92
N.P Group A
- Neighbouthood Study Unit 1 Clarification Localities
- Walk About Preparation
- "The Log"

29.9.92
N.P Group C
- Neighbourhood Study Unit 1 Clarification Localities
- Walk-About Proparation
- "The Log"

1.10.92
N.P Group D
- Neighbourhood Study Unit 1 Clarification Localities
- Walk About Preparation.
- "The Log"

2.10.92
Group B
- Neighbourood Study Unit 1 Clarification Localities
- Walk About Preparation.
- "The Log"

Week 3

5.10.92
N.P Group A
- Walk About

6.10.92
Group C
- Walk About

8.10.92
Group C
- Walk About

9.10.92
Group B
- Walk About

Week 4
- Introduction to B & I Health Authority

15.10.92
9 am - 12.00
- Management Directorate
- Community - Nursing Service
- Concept of Community Care

Week 4

Reception
into new wo

N.P
12.10.92 - Library Skills - Literature Searching
Group A
13.10.92
Group C - Library Skills - Literature Searching
15.10.92
Group D - Library Skills - Literature Searching

UNIT 1 CFP SEPTEMBER 1992

Week 5 — Locality Assignment - Neighbourhood study

19.10.92
N.P
Group A

20.10.92 — Locality Assignment
Group C

22.10.92 — Locality Assignment
Group D

23.10.92 — Locality Assignment
Group B

Week 6 — Locality Assignment - Neighbourhood study

26.10.92
N.P
Group A

27.10.92 — Locality Assignment
Group C

29.10.92 — Locality Assignment
Group D

30.10.92 — Locality Assignment
Group B

Week 7

2.11.92 N.P

13.30 — Neighbourhood Studies - Bring in Rough Draft Version - references

15.00 — "How to Evaluate?"
Group A

3.11.92
Group C

13.30 — Rough Draft Neighbourhood Study - references
Group C

5.11.92

15.00 — How to Evaluate
Group D

Cont/...

6.11.92

09.00 Rough Draft Neighbourhood Study - References
10.30 How To Evaluate

Week 8

N.P

9.11.92 Library Skills: Referenceing and Bibliography
Group A

10.11.92 Library Skills : Referencing and Bibliography
Group C

12.11.92 Library Skills: Referencing and Bibliography
Group D

13.11.92 Library Skills : Referencing and Bibliography
Group C

12.11.92 AM Social Deprivation and Social Indicators
N.S
09.00 Concept of Need

Week 9 Locality Assignment

N.p

16.11.92
Group A Locality Assignment

17.11.92
Group C Locality Assignment

19.11.92

Group D Locality Assignment

20.11.92 Locality Assignment
Group B

Week 10 — Information Technology

N.P
Group A

24.11.92 — Informtion Technology
Group C

26.11.92 — Information Technology
Group D

27.11.92 — Information Technology

Week 11

N.P — Locality Assignment
Group A

1.12.92
Group C — Locality Assignment

3.12.92 — Locality Assignment
Group D

4.12.92 — Locality Assignment
Group B

Week 12

N.P 13.30 — Neighbourhood Study - Any Problems?
7 .12.92
Group A

8.12.92 — Neighbourhood Studyu - Any Problems ?
Group C

10.12.92 — Neighbourhood Study - Any Problems ?
Group D

11.12.92 — Neighbourhood Study - Any Problems ?
Group B

N.S — Multisectorial Approaches To "Who" Health .... Project
10.12.92
09.00/12.00

Week 13

N.P 14.12.92 Group A	Presentation Of Projects (2 Groups)
15.12.92 Group C	Presentation of Projects ''
17.12.92 Group D	Presentation of Projects ''
18.12.92 Group 13	Presentation of Projects ''

COMMON FOUNDATION COURSE NEIGHBOURHOOD STUDY

PURPOSE

This assignment is designed to enable the student to study and appreciate the concepts of community health and community care. It includes features of a local geographical area within Bloomsbury & Islington Health Authority, factors which affect the health and the subsequent health care needs of individuals and groups within a given area. Strategies for health promotion and the W.H.O. "Health for All" European targets will also be considered within the context of the area.

The study is in 3 stages with a cumulative final grade being awarded at the end of Unit 3, although the students are required to complete and hand in assignments at the end of Unit 1 and Unit 2. A flexible and innovative approach to both the individual written and group presentations will be encouraged, with the inclusion of appropriate charts, maps, profiles, photographs etc.

The student should also keep a log/diary of experiences planned for this assignment, recording appropriate events and their usefulness to the study.

DEVELOPMENTAL FOCI

It is expected that over the three units the students written presentation skills will develop and reflect the following developmental foci:-

UNIT 1 **ACCLIMATISATION AND ADAPTATION** to the geographical area, the local community, its people and cultures.

UNIT 2 **ACCLIMATISATION, ADAPTATION AND OBSERVATION** of particular groups of people within the local area to gain greater understanding of community issues, health care needs and community care provision.

UNIT 3 **FURTHER OBSERVATION AND SOCIALISATION** and understanding of groups of people with special health care needs. That is, those with learning difficulties, the young, mother and baby, and mental health problems. Likewise socialisation to, and understanding of professional roles and behaviour in the Primary Health care setting.

UNIT 1 - FOCUS

The focus of the first stage of the neighbourhood study is "People and the Environment". Each student will develop a study of a given area which encompasses a population perspective and addresses some of the environmental health issues relevant to the area. There will also be a group presentation of the area studied thus sharing findings with students who have studied other areas within Bloomsbury & Isling.

Population Perspective

To determine the health needs of a community it is important to describe the population in terms of demographic detail and relevant epidemiological information. To do this you will need to produce information about a defined area, seeking to identify various factors which may influence the health of the population studied. The European Health for All by the year 2000 Goals (especially Nos, 2, 6 and 12) will focus your thoughts. The first activity is designed to help you define the area and give your first impressions. You should then identify and pursue various sources of information, keeping a log of appropriate visits.

Environmental Study

This part of the assignment involves all students in small group work. The work will be presented (as a group) to peers and tutorial staff. Each presentation should take 10-15 minutes and involve a variety of methods.

Each student should take part in the presentation. In addition, material from the environmental study will be included in your written assignment. Again, various assignments will help you gain information and a log/diary record should be kept.

Each group will take one aspect of the environment related to the European H.F.A. goals. This aspect should be studied in depth, drawing out its links with health.

Statistical, descriptive and evaluative material should be included.

GROUPS

8 groups will present material on area focusing upon the relevant H.F.A. target.

1) Target No. 11 . Accidents - traffic, home and work (4 students).

2) Target No. 13 . Leisure and transport provision (4 students).

3) Target No. 20 . Provision of safe water (3 students).

4) Target No. 21 . Provision of clean air (3 students).

5) Target No. 22 . Food production, distribution, storage, sale and use (3 students).

6) Target No. 23 . Hazardous wastes. Policies and disposal (3 students).

7) Target No. 24 . Provision of housing (4 students).

8) Target No. 25 . Work (4 students).

Example

If your group were to study education in the area, information could be provided on - numbers and types of schools, age ranges, pre-school and adult education provision. Location and accessibility in terms of housing, traffic and transport would be relevant as well as facilities such as play-grounds and after school clubs. Other relevant factors might include school meals policy, truancy rates and measures of achievement. Local and national information could be used.

Assessment of Unit I Neighbourhood Study

The student must produce three pieces of work for this assignment.

1) **Group presentation of the environmental study**: this should enable the students in each group to build up a composite neighbourhood profile.

2) **A Log/diary** of your investigations and their relevance to your work. This should be submitted to your tutor with your written presentation.

3) **A written presentation** of approximately 2000 words. This will include your population perspective and written information on the environmental issue you studied.

It should be set out in the following format:-

Introduction

This should be 300-400 words long and include the following information.

a) The purpose of this work.

b) A description of the area profiled - its boundaries, geographical and physical features. It may be appropriate to include your first impressions.

c) Clarifications of concepts such as 'neighbourhood' and 'community'. This may include an explanation of why you choose that particular area.

d) An explanation of the environmental issue your group will explore.

Development and main body of work

This should be approximately 1200 words long and be presented in a logical way. It should include the following.

a) Relevant demographic and epidemiological data - identifying information sources e.g. O.P.C.S., D.H.A. statistics, etc. To illustrate information about the health of the population studied it will be necessary to compare local statistics with perhaps regional and national.

b) Information regarding the environmental issue you have studied related to the health of the population.

Conclusion

Approximately 300-400 words.

In the conclusion you should answer only questions posed in the introduction.

Use the information to identify the main issues as relevant to the health of the population studied.

Consider the feasibility of using this information to determine the needs of the population studied.

Discuss any difficulties experienced in assessing appropriate information.

Summary

200 words.

This describes how and why you reached your conclusions.

References

Your work should be correctly referenced throughout. If possible with at least 10 references.

N.B. Journal articles are usually more relevant and up to date due to the spped of publication. You should attempt to provide at least 2 journal references.

SUBMISSION - to your personal tutor by at the latest.

PRESENTATION - The completed study should be submitted to the Personal Tutor neatly presented in a folder. A copy must be retained by the student. The front cover should state:-

1) COURSE 2) NEIGHBOURHOD STUDY 3) STUDENT'S NAME

You are expected to work closely with the community tutors throughout this project.

W.H.O. 'HEALTH FOR ALL' TARGETS- EUROPEAN REGION

1. Reduce inequalities in health by meeting the needs and improving living & working conditions of disadvantaged group.

2. Promote the health potential for full social and economic life especially for older people and people with disabilities.

3. Remove obstacles handicapping those with disabilities.

4. Reduce major disease and disability through comprehensive prevention programmes.

5. Eliminate diseases such as measles, polio and rubella.

6. Cut differences in life expectancy among geographical areas and socio-economic, race and gender groups.

7. Cut inequalities in infant deaths with particular attention of socially disadvantaged groups and areas.

8. Cut inequalities in maternal deaths.

9. Cut circulatory disease in under 65's by altering environment and lifestyle re smoking, food and physical activity.

10. Cut cancer deaths in under 65's via policies re smoking and well-woman screening.

11. Cut accidents in traffic, at home, at work especially for disadvantaged socio-economic groups with focus on children and older people.

12. Cut suicide by reducing social strain such as that caused by unemployment, social isolation, school failure.

13. Develop healthy public policy via strategic planning at Cabinet and all other levels re tax & subsidies, consumer protection, advertising, labelling, leisure and transport.

14. Enhance the problem-solving capacity of local people by supporting informed and effective social networks.

15. Educate for health to oppose adverts and sponsorship which encourage unhealthy lifestyles.

16. Increase positive health behaviour re food, smoking, exercise, stress management, alcohol.

17. Reduce damaging behaviour re dangerous driving, social intolerance, problem use of pharmaceuticals,drugs & alcohol.

18. Establish multi-agency and corporate policy on environmental health: internationally, nationally and locally.

19. Establish effective monitoring and control mechanisms re environmental hazards.

20. Control water pollution:drinking water,rivers,lakes.seas.

21. Control air pollution: indoor and outdoor.

22. Control food safety: production, distribution, storage, sale and use.

23. Control hazardous wastes.

24. Provide healthy and safe housing.

25. Protect against work-related health risks including those in the home.

26. Base health care system on primary health care (PHC) supported by more specialist services.

27. Distribute resources for health according to need.

28. Organise PHC to meet basic health needs and give special attention to high risk, vulnerable and undeserved groups and invidiuals.

29. Use teamwork amongst service providers and cooperation with individuals, households and community groups.

30. Use a community level coordinating mechanism for all services relating to health.

31. Set up mechanisms to ensure quality of care.

32. Employ a research strategy for health for all.

33. Bring national and other legislation and regulations in line with HFA.

34. Bring planning and resource allocation in line with HFA clearly designed to produce specific outcomes.

35. Bring health information systems in line with HFA.

36. Bring, planning, education and use of health workers in line with HFA.

37. Bring planning, education and use of workers in health related areas in line with HFA.

38. Use appropriate health technology which is effective, efficient, safe and acceptable.

As amended by O'Keefe, E. (1990) Camden in the W./H.O. Healthy Cities Project. <u>The Planner</u> 21 Sept. 1990

UNIT 2 NEIGHBOURHOOD STUDY

Focus

The first "Health For All" European target (1990) is to "Reduce inequalities in health by meeting the needs and improving living and working conditions of disadvantaged groups." This part of the neighbourhood study is based upon the needs of the people you encounter in the Unit 2 community placement, which is designed to help you discover more about the types of groups and care available in Bloomsbury and Islington. The following key points must be included.

1. Introduction and Description of Placement
   What are the groups aims, its compostion, policies and its philosopy. Include some relevant demographic information of the groups.

2. Nature of Disadvantage/Identification of needs
   An exploration of why and how this group of people, or some of its members, are disadvantaged incorporating relevant sociological theories. Consider the difficulty in defining and measuring need.

3. Effectiveness of the Group

   How does the organisation attempt to meet perceived needs and what are the obstacles encountered.

4. Health Promotion
   Various "Health for All" European targets (Nos. 9 & 10, 12-17, 26,27 & 29) describe some strategies to improve health. Demonstrate how health is promoted in your placement. Not all targets will be appropriate for your placement.

5. Primary Health Care
   Discuss this concept in relation to the care group. Identify members of the primary health care team who must have contact with this group.

ASSESSMENT OF UNIT 2 NEIGHBOURHOOD STUDY

The student must produce three pieces of work for this study.

1. A written assignment of approximately 2,000 words, including an introduction, development, conclusion and summary. The assignment will be graded (see marking sheet). You should include appropriately presented references.

2. A log/diary of your investigations. This must be submitted to your tutor with your written assignment. Non-submission will constitute a fail.

3. A Presentation of some original health promotion material appropriate to your care group. This could, for example, inform non-users about the group or group members/carers about a relevant issue. You should be prepared to discuss the advantage and disadvantages of this material which will be displayed to your peers and tutors. Non participation will constitute a fail.

10.7. SOCIOLOGY

KEY TEXTS

Bilton, T. et al (1989)	Introducing Sociology (2nd Ed) MacMillan, London.
Giddens, A. (1989)	Sociology Policy Press, London.

ADDITIONAL READING

Anderson, R. Bury, M. (1988)	Living with Chronic Illness: the experience of patients and their families. Unwin Hyman, London.
Ashton, J. Seymour, J. (1988)	The New Public Health: the Liverpool Experience O.U.P., Oxford.
Blaxter, M. (1990)	Health and Lifestyles Tavistock/Routledge, London
Bond, J. Coleman, P.(1990)	Ageing in Society: an introduction to Social Gerontology Sage Pubs., London.
Dally, G. (1988)	Ideologies of caring, rethinking community & collectivism MacMillan Ed. Ltd., London

10.8. ETHICS AND LAW

KEY TEXTS

Bandman, E.L. Bandman, B. (1989)	Nursing Ethics through the life span. 2nd ed. Appleton & Lange, Norwalk.
Dimond, B. (1990)	Legal Aspects of Nursing Prentice Hall, Hemel Hempstead.
Rowson, R.H. (1990)	An Introduction to Ethics for Nurses Scutari Press, London.

ADDITIONAL READING

Byrne, P. (Ed) (1988)	Health, rights and resources. King's College Studies 1987/8 King Edwards Hospital Fund, London
Downie R.S. and Calman, K.C. (1987)	Healthy respect: Ethics in Health Care Faber, London.
Doxiadis, S. (Ed) (1987)	Ethical Dilemmas in Health Promotion John Wiley & Sons, Chichester
Kings College London (1988)	The Living Will Consent to treatment at the end of life Centre of Medical Law & Ethics/ Arnold, London.
Raphael, D.D. (1981)	Moral Philosophy Oxford U.P., Oxford.
Reiser, S.J. et al (1989)	Divided Staff Individual Selves A case approach to mental heatlh ethics Cambridge U.P., Cambridge.
Tschudin, V. (1986)	Ethics in Nursing The caring relationship Heinemann, London.

PROJECT 2000 ADULT BRANCH ASSESSMENT

RESEARCH AWARENESS AND HEALTH PROMOTION ASSESSMENT

UNITS 7 & 8

RATIONALE

The Health Promotion Assignment has been chosen and designed to meet the following student educational developmental needs.

a) The developmental emphasis in Units 7 & 8 is on

- synthesis and evaluation
- precision to articulation
- participation, identification, internalisation, dissemination, consolidation and professionalisation
- competence level is that of competent practitioner

b) Provision of health promotion education and patient/client teaching is recognised as an important and integral part of the nurse's role (UKCC 1986); and this is reflected in the student learning outcomes for Units 7 & 8. During these units, the student is required to gain increased appreciation of and skills in his or her role as health educator, and to be able to function effectively in that role.

AIMS OF THE ASSESSMENT

To encourage the valuing and application of current research in the fields of teaching, learning and health promotion education; and to facilitate personal and professional development by;

- developing further the student's ability to recognise and consider critically situations which affect health and general well-being.

- increasing the student's skills in assessing the specific educational needs of both individuals and groups of patients/clients.

- enhancing those skills which underpin health education by exploring and applying the many facets involved in teaching and learning, and using these creatively to produce and present a defined health care related teaching session and/or package.

THE ASSIGNMENT

The assignment will require the student to produce and present

either a teaching session specific to the identified needs of an individual or small group of patients/clients.

or a health promotion package appropriate for the needs of the group of patients or clients who share a common health problem/need.

or a strategy for Health Promotion change for an individual or group of clients.

The student, as part of the assignment, will also be required to undertake a detailed literature search, including current research into teaching, learning, and health promotion in its widest sense. In addition, the student will be asked to reflect upon the approaches and methods used nationally and/or locally for addressing their chosen area of health education/care.

Precise topic, and time and place of the practical teaching session, will be decided by the student in negotiation with his or her personal tutor and clinical facilitator.

WAVERLY

SUMMARY OF THEORETICAL ASSESSMENT OF THE COURSE

	MODULE	FORMATIVE	SUMMATIVE		WEEK
COMMON FOUNDATION PROGRAMME	ONE	REFLECTIVE JOURNAL PRACTICE LOG	COMMUNITY PROFILE	1000 WORDS	16
	TWO	"	COMMUNITY HEALTH PROJECT	1500 WORDS	26
			COMMUNICATION STUDY (LIT.REVIEW) LONGITUDINAL (STAGE ONE)	1000 WORDS	30
	THREE	"	SOCIOLOGY & NURSING	1500 WORDS	36
			BIOLOGY & NURSING	1500 WORDS	42
			CARE STUDY	1500 WORDS	46
	FOUR	"	COMMUNICATION STUDY (STAGE TWO)	3000 WORDS	50
			CARE STUDY	1500 WORDS	58
			WRITTEN EXAMINATION		60
BRANCH PROGRAMME	FIVE	INDIVIDUALLY NEGOTIATED	THE NATURE OF DYSFUNCTIONAL HEALTH	3000 WORDS	74
			CARE STUDY	2000 WORDS	80
	SIX	"	MORAL DILEMMAS IN NURSING	3000 WORDS	98
	SEVEN	"	CARE STUDY	3000 WORDS	112
			RESEARCH CRITIQUE	2000 WORDS	116
	EIGHT	"	MANAGEMENT STUDY	3000 WORDS	130
			WRITTEN EXAMINATION		132

DESCRIPTION OF THEORETICAL ASSESSMENTS

COMMON FOUNDATION PROGRAMME

Module One

In this first module, students are exposed to a foundation of the theoretical underpinnings of the course, while practical placements involve allocation to a number of health care professionals involved in helping to maintain health in community settings.

The assessment in this module requires the student to submit a profile of some of the resources available in the community involved in health maintenance of the population. Undertaking this project will offer the opportunity to liaise with skilled supervisors and the student's personal tutor, who can make formative judgements regarding the student's writing ability, presentation and identification of strengths and weaknesses, which can be utilized in the planning of the students future study programme.

Module Two

Students are required to submit two pieces of work during this module. Firstly, an essay which focuses on an aspect of health within the community, such as the role of the family in caring for a dependent relative; the effectiveness of multi-disciplinary team work; or the effects of poverty on health.

The second assignment is a literature review which forms the first stage of a longitudinal study of communication and requires the student to undertake a review of the literature relating to a specific aspects of communication within nursing.

Module Three

In this module, students will be tested in three main areas, namely sociology, biological sciences and a care study of a client with whom they have been involved in nursing.

Sociology and Nursing This is a major piece of work to be undertaken in Module III of the course. The assignment is designed to assess the student's ability to understand the relevance of sociological theory to nursing practice. Examples may include: An Analysis of the Role of the Family; the Effects of Stereotyping, or Socialisation into Nursing. The studies should be of 1500 words and be supported by relevant reference material from sociology and nursing.

Biological Sciences and Nursing This is a major piece of work to be undertaken in Module III of the course. The assignment is designed to assess the student's ability to understand the relevance of the biological sciences to nursing practice. Examples may include: Patients' Problems associated with Oxygen Transport in the Body; the Aetiology and Nursing Implications of Oedema, or the Effects on the Individual of Abnormal Fluid and Electrolyte Balances. The study should demonstrate the student's ability to provide a sound rationale for the nursing care delivered to the client with a physical illness.

BRANCH PROGRAMMES

Assessment in the Branch Programmes focuses on each specific branch, with the emphasis on the application of the theoretical base gained in the C.F.P. to the specialist area of care. It is important that skills, knowledge and attitudes developed in the Common Foundation Programme are consolidated, while new skills applicable to the branch are studied in greater breadth and depth with the student concentrating on integration of this knowledge to nursing practice.

Module Five

Students enter their chosen Branch in this module and are required to submit two pieces of work. The first, a 3000 word essay on the nature of dysfunctional health and the second a 2000 word care study. The studies may be discrete or linked.

Module Six

Moral Dilemmas in Nursing Study In this Module VI assignment, the student will be required to draw upon both personal experience and previous course material in order to both identify and make an analysis of a dilemma associated with the delivery of nursing care. The student will have been exposed experientially, through both practical placements and case studies, to a series of moral dilemmas which have involved him/her in prioritising, decision-making and rational argument. The study is designed to assess the student's ability to identify the multi-factorial elements involved in everyday nursing ethics.

The 3000 word study should be related specifically to the student's particular branch and be supported by relevant reference material from both nursing and philosophical theory. Examples might include:

- Standards of care in times of limited resources.
- The dis-empowerment of clients with mental health problems.
- The extent of client involvement in decision-making in people with learning difficulties.
- Truth telling and the terminally ill child.

Module Seven

Students are required to undertake two assignments during module seven. A care study of 3000 words, which reflects the increasing depth of knowledge acquired during branch programme studies, and a research critique. The research critique will be written about a specific nursing topic chosen by the student. This will be presented as a paper of 2000 words, which will be presented to their peer group during seminar work.

Module Eight

During rostered practice and branch programme studies, the student will increasingly gain in confidence regarding management and organisational skills.

GUIDELINES

1. Community Profile: This 1000 word community profile is to be submitted during week 16 of the course. The study should be based on the resources available to the community and a description of the roles of the health care professionals involved, e.g. Health Visitor, Community Midwife, Health Centres, School Nurses, etc.

   The work should be referenced and presented with any relevant information, such as philosophy of care statements or profiles of services offered by surgeries, in the appendices (appendices will not count as part of the maximum 1000 words).

2. Community Health Project: This 1500 word project should focus generally on the notion of health within a community setting. The topic area must be negotiated with the personal tutor and submitted during week 26 of the course. The essay should not merely be descriptive, but convey some point of view, argument and discussion about an aspect of health. Examples of topic areas might be:

   - The role of the family in the health care of a dependent.

   - The effectiveness of the multi-disciplinary team in maintaining a client's independence.

   - Maintaining positive health in the community.

   The study should be referenced and include a bibliography.

The Nature of Dysfunctional Health (3000 words)

The essay should be carefully researched and published material employed to support the main points/ideas being presented. The content of the essay should reflect adequate background reading and the ability to select relevant information from this. Most importantly, it should demonstrate an understanding of the application of concepts and principles of nursing care. Independence, originality and critical analysis will also be rewarded.

The essay should be structured in a logical manner, demonstrating the sequence of the discussion being presented and, where appropriate, a conclusion being drawn which relates to the title of the essay and the points presented.

DIPLOMA IN HIGHER EDUCATION (NURSING) COMMUNITY MODULE

NO OF HOURS 37.5 hours
25 hours theory taught/guided 12 hours free study

PROPOSAL In order to facilitate the application of theory to practice, it is proposed to include 6 hours community placement within the 25 hours, as guided study.

AIMS: To develop participants knowledge of community and community care and to highlight the need for inter-professional collaborative practice in order to meet the total health needs of client group within their practice area.

LEARNING OUTCOMES: It is expected that the unit will

1 Introduce the student to revelant theories and concepts of community and community care.

2 Develop an awareness of the way in which the political and economic climate influences the provision of community care.

3 Explore the notion of mulit disciplinary teams and the roles individual practitioners play in the provision of total health care within their practice area.

4 Raise awareness of the scope and diversity of community nursing practice within an multi disclipinary setting.

5 Highlight the importance of developing communication networks to forge a partnership between community and hospital professionals in. in order to improve the provision and quality of care.

b) *Mrs Betts is described by the Health Visitor as a "difficult woman". What impact may this label have on the care Mrs Betts receives?* 33.3%

c) *How might Mrs Betts' recent loss of her husband affect her behaviour?* 33.3%

Section B Candidates will answer ONE question from this section.

1. *Using knowledge from nursing, psychology and sociology, discuss the role of the nurse as a professional in advancing informal and responsible practice.* **100%**

2. *'Health care is an entitlement for all'.*

   a) *How may the nurse's values and beliefs affect the delivery of this statement?* **50%**

   b) *What factors relating to resources may affect an individual's access to health care?* **50%**

Mod3 or

Module 4 - (Assessment of an Individual) Client Profile on Health Promotion

Mod 3 ↓ Mod4.

Word limit: *2,000 words.*
Submission by: ~~*Week 62*~~ weeks 51 or 67

This assignment will assess students' ability to:

1. *Identify health promotion opportunities in nursing practice.*

2. *Relate the basic principles underpinning health promotion to nursing practice.*

Students should identify an appropriate client, i.e. one who requires some form of health promotion. Permission should be sought to use client-based information as per the care study guidelines. The client's true identity should be concealed in the assignment with the use of a pseudonym.

As this assignment is practice-based, students are strongly advised to seek the advice and support of qualified staff in the relevant placement.

The assignment should include the following:

a) *An introduction, followed by a definition of health promotion.*

b) *A brief descripton of the health promotion opportunity and why it exists in this client.*

c) *A short discussion of relevant personal strengths and/or deficits possessed by the client and/or his family, e.g. age, culture and social class, knowledge, skills and attitudes, motivation, finances, etc.*

d) *A discussion of the approach which could be taken to promote health, to include the plan of action, the contribution of relevant staff and, where relevant, the health promotion model chosen.*

e) *A brief discussion of potential difficulties, e.g. lack of resources, including staff knowledge and skills, time constraints, evaluation of success/failure, etc.*

f) *A conclusion.*

The essay should be supported throughout by relevant literature from the fields of nursing and health promotion, and other related areas, e.g. communications theory, sociology, psychology, etc.

Possible examples:-

Personal hygiene in a client with learning disabilities.
Discharge advice regarding drug therapy.
Nutritional advice in child care.
Stress reduction in a client with hypertension.

N.B. Students are <u>not</u> expected to carry out a health promotion activity with the client for the purposes of this assignment.

HEALTH AND HEALTH CARE; OUTLINE OF CFP

The health and health care theme is concerned with health, health promotion and health policy.

In Pre-module One The concept of health is explored; The main aim is to ensure that students are aware that if they can not establish a clients' view on health, they will be unlikely to be able to meet the clients' health needs. If client and nurse are to work together towards the goal of health they must share a view of that which is being aimed for

1Ai	Concepts, definitions and values clarification about health I	Group Work
Aim:	For students to explore their own views on health	
1Aii	Concepts, definitions and values clarification about health II	Group Work
Aim:	Exploration of definitions/views on health	
1Aiii	Life chances and health - the "Seedhouse" case studies	Group Work
Aim:	Exploring how people decide whether other people are healthy	
-----	An introduction to the Primary Health Care Team	Community staff
-----	Exercise, nutrition and relaxation (Biology lecture)	
1Aiv	Discussion of articles used in formative assignments	Group Work
Aim:	To give an overview of topics explored and enhance students ability at referencing and critiquing the literature.	

Post 1/Pre 2 Explores Health Promotion. The Aim is to discover why people undertake the health and non-health behaviours that they do and what can be done to help people engage in healthy behaviour. We also see why people do not respond positively to health promotion campaigns.

1Bi	Introduction to the concept of health promotion	Lecture/Group Work
Aim:	To define and outline the aims of health promotion and gain an overview of how health promotion can be evaluated.	
1Bii	Using Communication skills within health promotion	Lecture/Group Work
Aim:	**(see Sue Wilson)**	
1Biii	Health promo and the Individual "Whose health is it anyway?"	Video/GroupWork
Aim:	To further explore peoples views on their health needs	
2Ai	Lay perceptions of health and illness	Paper/Group Work
Aim:	To discuss the reasons why people respond differently to illness	
2Aii	Health Belief and Health Action Models of Health Promo.	Paper/Group Work
Aim:	**(see M.Ford)**	
2Aiii	A critical evaluation of a health promotion campaign; "Half hearted about Semi-Skimmed"	Video/Group Work

CFP = Hours 2 per session

Post 2/Pre 3 Shows us why we have the health care system that we have today. Knowing what has happened in the past helps us to understand why we have the health care system that we have today. Knowing how we came to have the current system might show us what is to be expected in the future.

2Bi Health and health care in the 19th Century Slides/Lecture
Aim: To discuss why the state became increasingly involved in people's lives and health, and the origins of the welfare state.
2Bii The role of Medicine in the 19th Century Lecture/Group Work
Aim: Argues that improvement in health and increases in life expectancy had little to do with the input of doctors.
2Biii Orthodox Medicine/Holistic medicine Lecture/Group Work
Aim: To show why the doctors of today have the status that they have and the affect this has on nursing.
3Ai Alternative and Complementary medicine Paper discussion/Group Work
Aim: **(see L. Nicol)**
3Aii The Power of the Medical Profession in the 20th Century Lecture/Group Work
Aim: Argues that medicine has been, and still is, used as a form of social control, and discusses the importance of this for nursing.
3Aiii Preparation for Health promotion assignment Case studies/Group Work
Aim: Uses students experiences from placements to discuss the assignment requirements.
------ Biology lecture;

Post 3/Pre 4 Is concerned with Health Policy. The Aim here is to explore how health policy affects people and how people can effect health policy. It will be seen that the influences on and influences of health policy, are many and varied as well as unequal.

3Bi Inequalities in health "Dead Poor" Video/Group Work
Aim: Revisits poverty and contrasts the health of those on low incomes, with those who are financially comfortable.
3Bii "Health of the Nation" and its Targets Paper discussion/Group Work
Aim: **(see M.Ford)**
3Biii Empowerment; Myth or Reality Teachers Debate
Aim: Debates whether or not, people are empowered through health promotion.
4Ai Policy I :The role of the consumer in policy making Lecture/Group Work
Aim: Discusses *who* the consumer of health care is and whether he/she has any influence on government policy for health.
4Aii Policy II: The impact of political ideologies on policy Lecture/Group Work
Aim: Explores the two main political philosophies that have affected the nature and function of the N.H.S.
4Aiii Policy III: Current Health Service Changes (NHS&CCAct1990)Lecture/Group Work
Aim: Gives the key elements of this important Act of Parliament and discusses their impact on health care today and in the future.
---- Biology lecture

Post 4 Brings the strands of the theme together when we see how Health policy and Health promotion work together (and conflict) in the case study of HIV and AIDS

4Bi	Rationing health care and allocating resources including International comparisons	Lecture/Group Work
Aim:	Argues that rationing of services has, and always will, exist in health care.	
4Bii	HIV and AIDS I	Group Work
Aim:	Deals with the known facts and the current myths of HIV/AIDS and explores personal views and issues of sexuality.	
4Bii	HIV and AIDS II	Group Work
Aim:	(As above)	
4Biii	Student-led Seminar on the future of health care	Seminar
Aim:	Opportunity to discuss a current issue that affects health care.	

ADULT BRANCH H & HC SESSIONS

AIMS AND METHODS OF SESSIONS

PRE MODULE 5

SESSION I - The Elderly and the NHS and Community Care Act 1990

To revisit 1990 Act and explore policy issues specific to the long-term care needs of elderly people.

Method: Lecture/video/discussion.

SESSION II - Care Management and the Elderly

To introduce the concept of care management in the community, and highlight the potential for nurses to act as care managers.

Method: Lecture/groupwork with case study.

SESSION III - The social construction of dependency - implications for health promotion in later life

To explore the concept of dependency and its origins in disability and later life; its implications for health promotion.

Method: Lecture/paper/discussion.

POST 5/PRE 6

SESSION I - Clarification of values re: ability and disability

To explore the meaning of disability with emphasis on the problems of classification, and therefore of care provision.

Method: Lecture/groupwork/discussion.

SESSION II - Policy implications of disability

To discuss the impact of national and local policy in respect of disability on the lives of disabled people.

Method: Lecture/video/discussion.

Adult Branch 2 2 hours per session

SESSION III - Health screening and prevention strategies

To understand the key principles that underpin health screening strategies as a form of health promotion.

Method: Lecture/groupwork/discussion.

SESSION IV - The future of community nursing

To discuss the impact of policy on current and future community nursing practice.

Method: Lecture/discussion (with Community Team).

POST 6/PRE 7

SESSION I - The changing pattern of acute care

To discuss the impact of new technologies in health care on the management of care.

Method: Lecture/groupwork/discussion.

SESSION II

Prep time.

SESSION III - Resource allocation and discrimination within the NHS

To explore, through simulation, the realities of making resource allocation decisions in health care./

Method: Group exercise.

SESSION IV - Student-led debate on the role of the nurse as a health promoter

To identify and discuss the pros and cons of the nurse acting as a health promoter.

Method: Student-led debate.

POST 7/PRE 8

SESSION I - The health needs and attitudes of adolescents

To discuss the values and beliefs about health that adolescents hold, and their implication for nursing action.

Method: Lecture/discussion.

SESSION II - Current issues in health care delivery

To discuss specific current issues in health care delivery.

Method: ? Outside speaker/paper and discussion.

SESSION III - Marketing health care

To explore the concept of marketing and its relevance to health care provision, and the use of marketing tactics for self advancement.

Method: Lecture/groupwork.

SESSION IV - The relevance of epidemiology nursing

To explore the potential of epidemiological methods in resolving nursing management problems.

Method: Lecture/groupwork.

POST 8

SESSION I - Fish bowl discussion of a relevant health - related issue

Explore a very pertinent health care issue.

Method: Fishbowl discussion.

SESSION II - Quiz on H & HC Theme in course as a whole

Recap (with fun) the content of the H & HC Theme in the whole course.

Method: Quiz.

SESSION III - Evaluation

Evaluation of theme in Adult Branch (to be incorporated with Quiz session when only 2 H & HC sessions occur in Post 8).

Method: Focus group/questionnaire.

JM/RFN/December 1995

CHISWELL

[redacted] College of Higher Education
SCHOOL OF NURSING AND MIDWIFERY

INTRODUCTORY WEEK

GROUP OCTOBER "94 TUTOR P. MURRAY/V. THORNES/J.FORD DATE 10TH OCTOBER 1994

	9.00	10.30	11.OO	1.00	2.00	3.00	4.00
MONDAY 10.10.94	9.30 Welcome to CCHE S of N &M Coffee CASwindells	Administration I.Walsh K.Kelly	Allocations L.Barnacle P.Jones	Introduction to Course CASwindells		Finance Bursaries William Tse	
TUESDAY 11.10.94	ALL GROUPS TEAM BUILDING			ALL DAY			
WEDNESDAY 12.10.94	ALL GROUPS TEAM BUILDING			ALL DAY			
THURSDAY 13.10.94	GROUP 1 TEAM BUILDING GROUP 2 LIBRARY			GROUP 1 LIBRARY GROUP 2 TEAM BUILDING			
FRIDAY 14.10.94	Head of Nursing Studies Mrs. J.Passey	10.30 Coffee	Student Services Cathy Shepherd R.C.N. Union Reps UNISON	1.30 Mrs. Lesley Vernon		Course Content Peter Murray.	

College of Higher Education
SCHOOL OF NURSING AND MIDWIFERY

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SCHOOL OF NURSING AND MIDWIFERY

OCTOBER '94 TIMETABLE FORMAT MODULE 1 WEEK 17.10.94

		AM				PM			
		9.30 am			12 noon	1pm			4pm
MONDAY 17.10.94	GROUP 1	NURSING	What is Nursing		JF	1.	NURSING	Roles and Images	JF
	GROUP 2	NURSING	What is Nursing		VT	2.	NURSING	Roles and Images	VT
TUESDAY 18.10.94	GROUP 1	PNS	Research		JF	1.	PSYCHOLOGY	R. Whittington/S.Morgan	
	GROUP 2	PSYCHOLOGY	C.Moore/G.Astbury-			2.	PNS	Research	VT
WEDNESDAY 19.10.94	ARROWE PARK: CREWE & MACCLESFIELD STUDENTS) OCCUPATIONAL HEALTH AND UNIFORMS) CHESTER STUDENTS - UNIFORM ONLY)						SITE LIBRARIES		
THURSDAY 20.10.94	GROUP 1	BIOLOGICAL SCIENCE	Introduction to	PM		1.	BIOLOGICAL SCIENCE	Homeostasis	PM
	GROUP 2	BIOLOGICAL SCIENCE	Introduction to	JB		2.	BIOLOGICAL SCIENCE	Homeostasis	JB
FRIDAY 21.10.94	GROUP 1	NURSING -	What is Health		JF	1.	SOCIOLOGY & SOCIAL POLICY	Introduction	JF
	GROUP 2	NURSING -	What is Health		VT	2.	SOCIOLOGY & SOCIAL POLICY	Introduction	DA

SCHOOL OF NURSING AND MIDWIFERY

WEEK:- 13 February 1995 | **OCTOBER '94** | **TIMETABLE FORMAT** | **MODULE 1**

		AM			PM		
		9.30 am		12.00pm	1.00pm		4.00pm
MONDAY	GROUP 1	NURSING	Health Environment LK/SW		1	NURSING	Complementary Therapies (Whole Group) LJ
	GROUP 2	NURSING			2	NURSING	
TUESDAY	GROUP 1	PNS	Ethics II	GE	1	PSYCHOLOGY	Personality RW/SM
	GROUP 2	PSYCHOLOGY	Personality	GA/CM	2	PNS	2a Research - IT JJ/PM/JF 2b IT - Research JJ/PM/JF
WEDNESDAY	GROUP 1	1a Research - IT 1b IT - Research	JJ/PM/JF JJ/PM/JF		1	PTT/STUDY	
	GROUP 2	Ethics II	DS		2		
THURSDAY	GROUP 1	BIOLOGICAL SCIENCE	Intro. to Central Nervous System JB		1	BIOLOGICAL SCIENCE	Autonomic Nervous System
	GROUP 2	BIOLOGICAL SCIENCE			2	BIOLOGICAL SCIENCE	JB
FRIDAY	GROUP 1	SOCIOLOGY & SOCIAL POLICY	Social Policy Exercise Preparation Time AL		1	NURSING	Interpersonal Skills 2
	GROUP 2	SOCIOLOGY & SOCIAL POLICY			2	NURSING	MW/JB/SC

SCHOOL OF NURSING AND MIDWIFERY

WEEK:- 20 February 1995 | **OCTOBER '94** | **TIMETABLE FORMAT** | **MODULE 1**

		AM		PM		
		9.30 am	12.00pm	1.00pm		4.00pm
MONDAY	GROUP 1	NURSING	Introduction to Primary Health Care Placements	1	NURSING	
	GROUP 2	NURSING		2	NURSING	SW
TUESDAY	GROUP 1	PNS	Ethics 12 GE	1	PSYCHOLOGY	Intro. to Social Psychology RW/SM
	GROUP 2	PSYCHOLOGY	Intro. to Social Psychology GA/CM	2	PNS	Ethics 12 DS
WEDNESDAY	GROUP 1	PTT/STUDY (ALL DAY)		1		
	GROUP 2			2		
THURSDAY	GROUP 1	BIOLOGICAL SCIENCE	Endocrine System (ALL DAY)	1	BIOLOGICAL SCIENCE	AR
	GROUP 2	BIOLOGICAL SCIENCE		2	BIOLOGICAL SCIENCE	PB
FRIDAY	GROUP 1	SOCIOLOGY & SOCIAL POLICY Social Policy Exercise Feedback Time	JF/DA/AL/AD/KM	1	NURSING	Interpersonal Skills 3
	GROUP 2	SOCIOLOGY & SOCIAL POLICY		2	NURSING	MW/JB/SC

SCHOOL OF NURSING AND MIDWIFERY

27.3.95	OCTOBER '94 AM		TIMETABLE FORMAT	MODULE 1 PM		
	9.30am		12.00pm	1.00pm		4.00PM
MONDAY	GROUP 1	NURSING	Reflection and Evaluation	1.	NURSING	Care Planning - (1315 start)
	GROUP 2	NURSING	SW/SC/LK/PM/VT/JF	2.	NURSING	PM/VT/JF
TUESDAY	GROUP 1	PNS	1a IT Research 1b Research IT	1.	PSYCHOLOGY	Psychological Dimensions of Health SM/RW
	GROUP 2	PSYCHOLOGY	Psychological Dimensions of Health GA/CM	2.	PNS	2a IT Research 2b Research IT
WEDNESDAY	GROUP 1	History of Nursing	TA	1.	Research	PM
	GROUP 2	Research	PM	2.	History of Nursing	VT
THURSDAY	GROUP 1	BIOLOGICAL SCIENCE	Digestive System and Accesory Organs IH	1.	BIOLOGICAL SCIENCE	PM Pharmacology - Metabolism of Drugs
	GROUP 2	BIOLOGICAL SCIENCE	JB	2.	BIOLOGICAL SCIENCE	JB
FRIDAY	GROUP 1	SOCIOLOGY AND SOCIAL POLICY	Social Policy Exercise Feedback DA/JF/AL/AD/KM	1.	NURSING	Interpersonal Skills MW/JB
	GROUP 2	SOCIOLOGY AND SOCIAL POLICY		2.	NURSING	

Longitudinal Health Assignment Related to Nursing

Aim

To enable the student to gain an awareness of how the health of individuals can be influenced by features of the community in which they live; and the role and function of nurses in promoting the health of these individuals.

This study is an opportunity for you to demonstrate your developing knowledge and understanding of the key determinants of health and the range of people and health needs you will encounter as a health care professional. The area of study is the one to which you are allocated for your community care placement. You are required to focus on a specific issue relevant to your neighbourhood area.

What type of information is relevant?

The aim of the assignment suggests that you should focus on aspects of community and community life that could influence health. What you select and how you locate and interpret the evidence will demonstrate to the examiners your appreciation and understanding of a variety of learning outcomes. There is a wide range of things you could include. Here are just some ideas:-

- environmental characteristics
- population characteristics
- social and economic influences
- health status of local population
- public service provision
- local organisations ... is there a strong voluntary sector?
- how do locals perceive the community?
- employment patterns
- major employers
- housing - council, private, housing association, rented? ... condition?
- transport
- closure of large institutions in area?
- family type and living conditions, e.g. number of people on their own with children
- proportion of elderly people - who cares for them?
- is there a strong private sector?
- political influence
- history of community - how has it changed over time? e.g. when were the drains installed, lead pipes laid, have major industries declined?
- does it have a migrant population or do people have strong family or social networks here?
- is homelessness a problem?
- what proportion of elderly people are living independently?
- what is the level of informal care?
- what are childcare arrangements like?
- are there many working mothers?

The overview of your neighbourhood features, in conjunction with discussion with your personal tutor, should enable you to identify one appropriate focus for in-depth study. Examples of foci issues could be:

- large numbers of elderly in the beighburhood
- large numbers of single parents
- high levels of unemployment
- pollution

You need to adopt a broad approach by examining concepts such as 'community', 'neighbourhood', inequalities in health or indicators of social deprivation, and use evidence from the data you have collected to argue your case. You need to discuss the role and function of nurses in promoting the health of those affected by your chosen focus. Time spent on neighbourhood placements and community placements will assist you in your collection of data on the locality and its population.
Health professionals, e.g. Health Visitors, Practice and School Nurses etc., activity organisers and clients are all resources in addition to usual sources of information such as local libraries, council offices and the various centres of activity that are part and parcel of your chosen patch.

Putting it all together

This assignment is not like an ordinary essay as you do not have a specific question to answer. It is therefore, more of a cross between a piece of small scale research and a traditional essay. To give your work some structure you must therefore generate a set of tasks which you are aiming to achieve or perhaps this will be in the form of a number of questions to answer. There is no correct way to do this. All studies should obviously contain a core element which will include characteristics of the area; you can develop this information in a number of ways.

A useful way of gathering information during the days in the field is to keep a diary and record information in clusters of related data about such things as geography, social history, transport patterns, industry for example. This raw data can then be sorted as the basis of the chapters in your submission. **35% of the marks are assigned to health care and the role and function of professional nurses in promoting the health of individuals.** You need to reflect on this data in order to incorporate these facts and comments in a meaningful way.

In the introduction you should make a clear statement of the direction you intend to take. Remember that you are required to demonstrate in all parts of your answer an application and understanding of the relevant source material used. In other words you are not simply required to write a descriptive account but to suggest what the information tells us about the area and its needs.

[redacted] College School of Nursing and Midwifery

School of Nursing and Midwifery

Registered Nurse & Diploma in Higher Education (Nursing Studies)

COMMON FOUNDATION PROGRAMME

Longitudinal Health Assignment Related to Nursing	**5000 words** (maximum)

Group: _____

You are required to submit **TWO COPIES** of the study by **12.00 midday** on Monday of Course Week 56:

STUDENTS TO RECORD NUMBER OF WORDS USED AT THE TOP OF THE FRONT PAGE

Guidelines:

1. Discuss the features of the Neighbourhood — 20%
2. Describe the effect of Health & Social Policy on health care provision / need. — 20%
3. Discuss the role and function of nurses in promoting health of individuals, with respect to a chosen focus. — 35%
4. Demonstrate in all parts of your answer an application and understanding of the relevant source material used. — 20%
5. Presentation, structure and organisation of material. — 5%

Material used must be accurately referenced using the Harvard system. This will be considered in the marking criteria.

The assignment should be either legibly written or typed using double spacing and demonstrate an appropriate style of academic writing. **Students are required to state the number of words in the assignment at the top of the first page.**

Any diagrams used should be of a size where information can be easily seen and be referenced. In the introduction you should make a clear statement of the direction you intend to take.

IF THE ASSIGNMENT EXCEEDS MORE THAN 20%-OVER LENGTH, A PENALTY OF 20% WILL BE INCURRED.

• BRANCH PROGRAMME •

Continuous Assessment of Theory

	PART TWO
Unseen Paper	F ----------→ S
Critical Analysis Nursing Research Paper	F ----------→ S
Community Project	F ----------→ S
Nursing Care Study	F ----------→ S

9.8.93.

LINKS BETWEEN FORMATIVE (F) AND SUMMATIVE (S) ASSESSMENTS

APPENDIX 16

Lask, S; Smith, P; Masterson, A. (1994)

A Curricula Review of the Pre- and Post-Registration Education Programmes for Nurses, Midwives and Health Visitors in Relation to the Integration of a Philosophy of Health : Developing a Model for Evaluation.

Aims of the study

- "To develop a model for evaluation which can be applied to the health promotion component of any nursing, midwifery or health visiting curriculum.
- The purpose of the evaluation was to develop a framework to determine the extent and effectiveness of the health promotion component of these curricula, based on the concepts and principles of the WHO in 1984.
- In depth studies will be conducted on a range of pr- and post-registration courses in four centres. The studies will Purposeful sampling methodology was utilised. Data collection consisted of visits over 4-6days in four centres. The studies will describe and evaluate how a philosophy of health has been implemented in relation to:

  the course objectives

  curriculum content

  teaching methods

  organisation of learning

  experiences/placements
- Factors for and against the successful implementation of a philosophy of health will be identified according to the institutions, specialities and educational levels studied.

Research Questions

- How well does the structure and content of the programmes under study reflect the aims or principles of the curriculum?
- Are the programmes in harmony with the internationally agreed guidelines on the concepts and principles of health promotion set out in 1984 by the WHO?
- What are the perceptions of course providers and course consumers, patients/clients and other nurses, midwives and health visitors regarding the

process and outcomes of implementing a programme based on a philosophy of health.

- By what funding criteria does the funding body (i.e. the English National Board) measure success?

APPENDIX 17

CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

This illuminative evaluation produced rich and interesting data. As the case studies show each centre created its own 'story' of the shift towards a philosophy of health. The following conclusions and recommendations are derived from our analysis, interpretations and discussion of our findings presented in chapters 5-10. In order to create a model to assist other researchers, educationalists and policy makers we have identified certain factors which enhance integrated curricula and other factors which hinder integration. These factors are represented diagrammatically at the end of this chapter.

The study's main conclusion indicates that on balance a philosophy of health has **not** been successfully integrated into nursing and midwifery curricula. In the Diploma in Higher Education (DipHE) courses, issues relating to a philosophy of health and health promotion are concentrated within the first few months and then tend to diminish in importance and emphasis. Although we found many aspects of the body of knowledge required for health promotion represented in the curricula, it appeared in fragmented and disjointed ways, which made it inaccessible for students. Health visitor and district nursing diplomas have integrated concepts of health and health promotion into their curricula more successfully. Other post-registration courses have however had difficulty integrating these concepts.

Our recommendations to remedy or prevent this situation include:

Concepts of health and health promotion should be revisited regularly throughout all courses. The Branch programmes need to continue the momentum and enthusiasm generated in the Common Foundation Programme.

Consolidation classes need to be designed and taught by a lecturer with a relevant higher degree. During the sessions, components of health promotion taught in other modules or topics need to be identified and integrated into the students' nursing or midwifery skills.

Secondly, the majority of students held medical and educational models of health promotion. Students commonly gave examples of preventive advice on lifestyles, leaflets and smoking cessation. All responses were confined to promoting physical health. There was little evidence of familiarity or use of the newer more progressive paradigms.

We recommend therefore that:

Students be exposed to both the theory and practice of the social and political models of health promotion and these approaches are reinforced and integrated into nurses' and midwives' repertoire of abilities and skills.

The newer paradigms become as much part of nursing and midwifery knowledge and theory as the medical and educational models.

Although these approaches are evident in some programmes, the practical applications need to be reinforced with examples of how these approaches can be applied clinically.

It was apparent in some centres there was a poor understanding of the body of knowledge and the skills required to implement health based curricula. There appeared to be an assumption that lack of disease or normal body functioning was the same as health and that health promotion came as a consequence of not discussing disease.

We recommend therefore that:

The body of knowledge which comprises health and health promotion be made more explicit by the policy makers and educationalists by acknowledging that time and education are required to perfect this innovation.

We concluded that the health care professions have not yet developed their own conceptualisation of health promotion for nurses and midwives. In some centres the concept of health in use was indistinguishable from a philosophy of health on health studies programmes.

Our recommendation on the basis of this finding is that:

Nurses and midwives need to develop their own *nursing* and midwifery strategy for promoting health which is distinctive from a generic philosophy of health. This could be achieved by creating a working party of experts convened by the ENB.

Two models of lecturer preparation were observed. The first model was the specialist approach, where lecturers were supported in pursuing academic qualifications in their chosen subject. The second model was the generalist approach, where all staff taught most subjects. Each approach has its own strengths and weaknesses. In a specialist approach, lecturers achieve in-depth knowledge, along with a sense of self worth, commitment to their subject and academic credibility. Fragmentation of the curriculum however is possible when consolidation and communication is weak.

With the generalist approach, lecturers lack in-depth academic knowledge across all subjects often associated with lack of confidence (particularly if the lecturers are non-graduates). But there is the likely advantage of subject integration.

We recommend:

The specialist model be adopted provided consolidation and integration are made priorities and lecturers are academically prepared in their chosen specialty.

Communication skills teaching and experiential learning were apparent in all DipHE curricula, but less so in some post-registration courses.

We recommend therefore that:

Communication skills teaching should be encouraged in all courses concerned with health promotion. Skills in negotiation, advocacy and lifeskills should be included.

Placements during the Common Foundation Programme were generally perceived to have limited success. Students usually experienced health damaging rather than health enhancing placements. Creative placements are difficult to achieve with large student cohorts. A creative and different format to placements needs to be developed with new role models. The only models of health promotion which students were exposed to used individualistic traditional approaches. The students looked to clinical practitioners as role models and for guidance on promoting health but found it was not always a priority for them.

We recommend:

Students are exposed to health care workers who are confident and able to promote the health of both well and sick individuals and communities. Lay health care workers, working in the voluntary sector, psychologists and social workers all work to promote mental health and could be approached to offer student placements.

The development of links with Community Action projects and Health Promotion Units in order to identify placements with health care workers who use social action models.

A lecturer/practitioner or facilitator could be developed with the principal aim of providing guidance and support for both students and qualified staff in enhancing and promoting the health of their patients and clients.

The Health Visiting profession has not been consulted in the design of DipHE curricula, nor has the experience of first wave demonstration sites been used to help and advise second and third wave colleges.

We recommend that:

The regulating bodies for Nurses, Midwives and Health Visitors encourage and recommend professional groups be consulted and their experience used for innovation.

It was apparent that the views of purchasers and patients and clients, about their health promotion needs had not been sought.

We recommend therefore that:

The perceptions, needs and health beliefs of patients and also of purchasers regarding the type and content of health promotion provided by nurses, midwives and health visitors needs to be elicited by further research. This could be undertaken in parallel with an action research project concerned with facilitating the integration of health promotion in nursing theory and practice.

Separate and distinct Branch Cultures exist which further inhibits the integration of a philosophy of health in the DipHE curriculum.

We recommend:

Shared learning and reading lists, placement exchanges and teaching by specialist lecturers across the Branches.

Lecturers, students and practitioners are unsure about the 'finished product' of a philosophy of health curriculum. The role of the DipHE diplomates and their ability to promote health needs to be established.

We recommend this might be achieved through:

Conferences and academic debate, workshops and consciousness raising activities to identify this topic as an issue for discussion in the profession.

Further research on the impact of a philosophy of health curriculum on practice and patient/client outcomes.

There is a myth of the 'useless' DipHE student. Practitioners in our study had difficulty in accepting the shift to a philosophy of health and negative attitudes were expressed about the diploma status of nursing students.

We recommend that:

More time, energy and resources are spent in developing practitioners.

Lecturers taking degree and diploma courses in 'nursing studies' reported that some courses had little health promotion content.

We recommend:

All colleges offering courses in nursing should be identified and surveyed by the ENB for their health promotion content and advised accordingly.

The NHS structural changes have resulted in competition between Health Promotion Units and Colleges of Health/Nursing and Midwifery.

We recommend that:

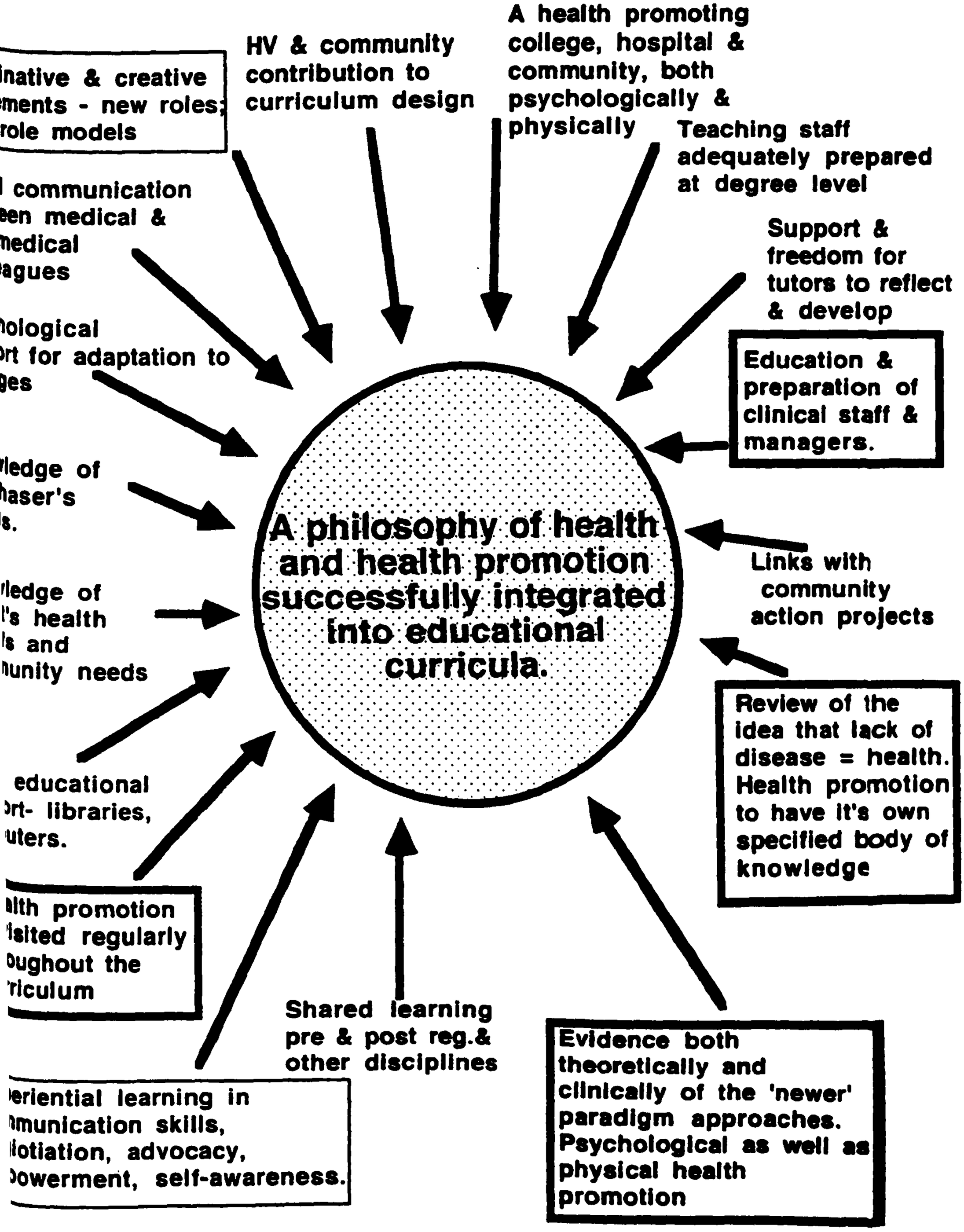
Nurse educationalists re-negotiate their community networks to keep abreast of changes in NHS and community care.

The diagrams below have been devised as an evaluation model by the research team in order to identify enhancing and hindering factors in integrating a philosophy of health as a basis for curricula. Those factors in emboldened boxes indicate a priority for policy action on the part of the ENB advisers. The thin lined boxes are about the processes of transmitting a health promoting theory. The other factors are associated with local initiatives such as organisation and collaboration between educationalists, managers and practitioners.

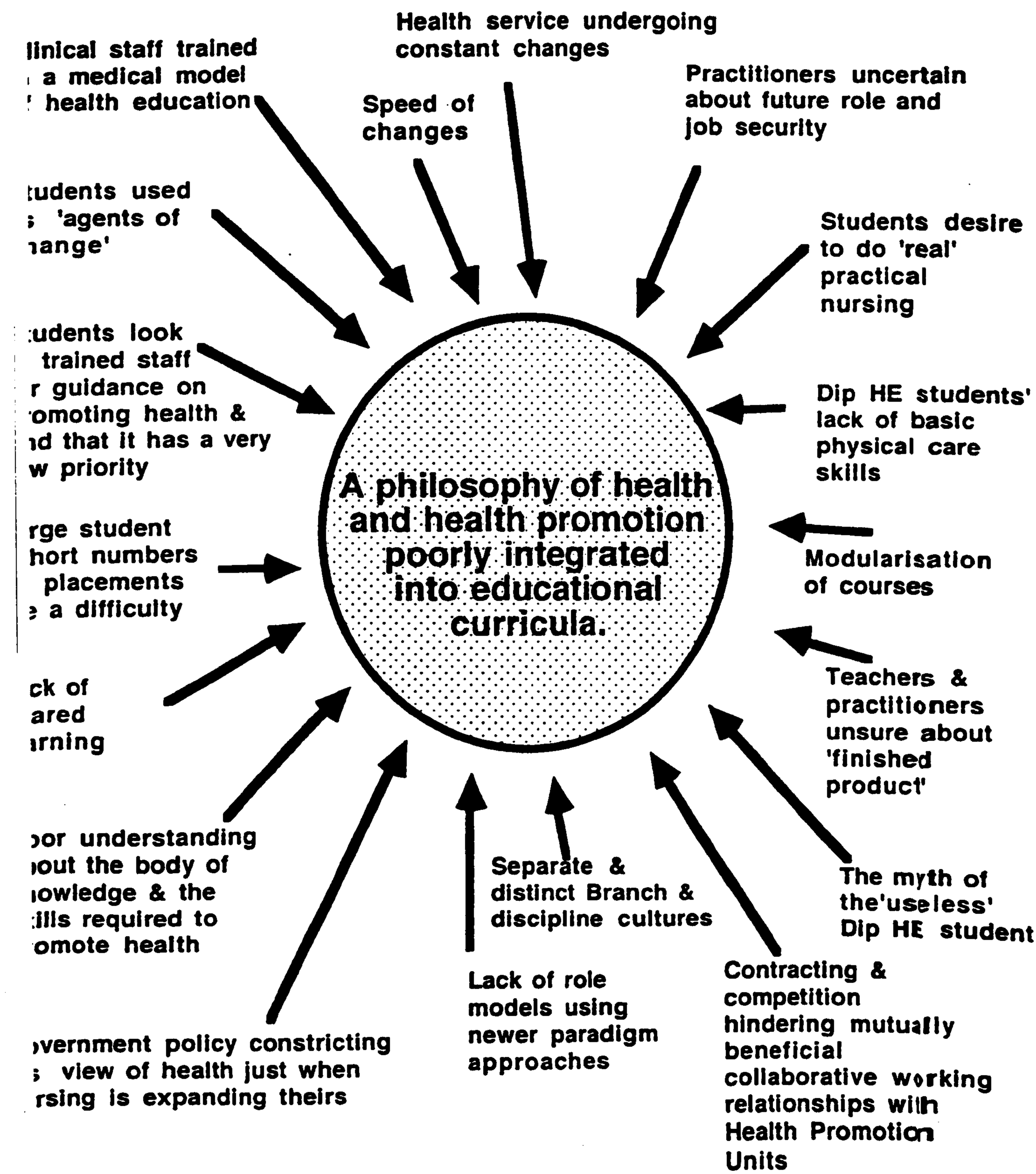
TEXT BOUND INTO

THE SPINE

Enhancing factors affecting the integration of a philosophy of health and health promotion in educational curricula



Hindering factors affecting the integration of a philosophy of health and health promotion in educational curricula



APPENDIX 18

Lesley Vernon and Jane Muncaster outline their collaborative approach to the design of a P2K module about meeting the health needs of people with learning difficulties.

Educating the nurses of tomorrow

In the discussion paper submitted to the Tomlinson Enquiry by the London Division of MENCAP, it was estimated that 80–90 per cent of people with learning difficulties had unmet health needs (MENCAP, 1991).

Sines (1993) states that it is estimated that up to 80 per cent of people with learning difficulties live at home in the community, therefore, most of their health and social care needs should be met through their right of equal access to primary health care services in the NHS, social services and the voluntary and private sectors.

Development

With regard to the implications of these issues for nurses, the development of P2K courses requires all students to gain some experience of the needs of people with learning difficulties.

This article describes how a teacher and practitioner working in a college of nursing and a community trust in central London worked together in the design and implementation of a module about people with learning difficulties in the common foundation programme.

Although the future of the RNMH qualification has recently been assured not all P2K courses offer a branch programme in mental handicap nursing. When we first began to design this module, we were both of the opinion that its presence in any pre-registration course for nurses was of paramount importance in improving the quality of healthcare provision for people with learning difficulties. We also think that the positive attitudes and interest that have generally been displayed by students, could be viewed optimistically with regard to the future of this discipline in nursing.

In the initial planning stages ourselves, the senior nurse from the Community Trust Resource Team for people with learning difficulties and the community tutor, were the key members of the planning team which was led by the course director for community studies. The curriculum model adopted was based on Peplau's (1987) model of nursing. It was also felt that in order to attempt to bridge the 'theory practice' divide a consumer approach to the aims and intended learning outcomes of the module should be adopted.

The senior nurse was at that time facilitating a client advocacy group. She asked the group questions regarding their experiences in hospital. Nurses' attitudes and behaviour towards them as well as their opinions of the attributes of good or bad nurses. Responses were consistent with other anecdotal and documented reports (MENCAP, 1991) in that, experience of using health services and being nursed feels disempowering and distressing, feelings they would rather be without.

Education

Bad nurses were described as patronising, ignoring their wishes by presuming their 'incompetence'. Good nurses were thought of as being kind, wanting to listen and explaining things to them.

From this it could be deducted that education which brought about change was the minimum requirement. The educational requirements also appeared to reflect the values upon which good services are based. These values, which are a product of Wolfensbergers' normalisation theory (1972) and O'Brien and Lyle's (1987) five service accomplishments namely: Community presence, choice, competence, respect and community participation, were thought to be equally appropriate core themes for the learning experience. The overall aim was therefore defined as being:

'To enable students to develop an awareness of the individual rights of people with learning difficulties to receive the same access to and standards of healthcare as all members of society.'

The common foundation programme in this college has two intakes of approximately 120 students per year. This module takes place in the third out of four learning units in the programme. The first two units are mainly college based and this twenty four week unit occurs about six months into the course when the balance between theory and practice is beginning to change.

Over a period of five months, students rotate through the following modules: Maternal health; the normal child; the normal child in the community; mental health and the health of people with learning difficulties.

At the beginning of unit three there is a two week preparation period which is theory based. All subject disciplines make a contribution. Because our programme occurs at the end of this study period we are able to build on and apply theoretical concepts already addressed to our particular client group. It is assured, therefore, that psychological, sociological and policy issues are covered.

The two week practice based module is of seventy hours duration, this is divided into approximately twenty five hours theory and fifty hours practice *(Table 1)*.

Teaching methods are student-centred and attempt to relate theory to practice through the notion of the reflective practitioner as described by Schon (1987) and the development of skills from novice to expert as promoted by Benner (1984). Students are asked to keep a reflective diary of practical experience. This is used to form the basis for reflecting on critical incidents, which helps to focus discussion in the evaluation of the learning experience on the last study day.

Experience

Because of the fear, anxiety and prejudice that can be associated with this client group, it was felt necessary to devote an entire day to preparing stu-

A COLLABORATIVE APPROACH TO TEACHING ABOUT THE HEALTH NEEDS OF PEOPLE WITH LEARNING DIFFICULTIES IN THE COMMON FOUNDATION PROGRAMME OF A P2000 COURSE

Table 1: Division of practice based module

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1:	T	P	P	P	T
Week 2:	T	P	P	P	T

NB. T = Theory. P. = Practice.

dents for their practical experience. Information about placements is given to students in the week preceding their allocation to this module. This gives them time to contact their supervisors and formulate any questions they may wish to ask.

Time is also built into the introduction session to discuss queries and the hopes and fears session on day one addresses both expectations and anxieties. Normalisation principles are reaffirmed, this is mainly to reinforce learning in the unit preparation days, since some weeks may have elapsed before students enter this module.

A video 'Gwen, a working life' is also shown. This is part of the Open University learning package *'Patterns for Living'* (1991) which demonstrates the application of these principles in practice and generates discussion.

Networking

It was also felt necessary to demonstrate how community services interelated, not merely focusing on the needs of people with learning difficulties, but their families as well. This is achieved by including a networking exercise in the preparatory day.

The framework for this is based on O'Brien and Lyle's (1987) notion of choice. The students are given a case study describing the history of a person with learning difficulties and the thoughts and feelings of the client and her family, in conjunction with the professionals involved in her life after an incident at home. The students role play the interaction that could occur at a case conference. They are also given material for private study and discussion from the Open University learning package (1991).

Group support is also provided at the end of the first three days of the practical placement. Because the module is so short, it was felt that students would gain maximum benefit from having a forum where issues could be clarified and problems resolved through general discussion. Ethical issues are raised during the process of debate. For this session the framework of the five service accomplishments is utilised, this time focusing on the concept of community participation.

One of the main problems associated with the implementation of the module has not only been concerned with the logistics of coordinating such a large number of students, but with locating practical placements for them in central London. NHS provision in inner London is limited and all practical experience has to be gained in the social service and voluntary sector. Locations that are used are in social service day-care, residential and respite care services. The Pathways Employment Agency which is run by MENCAP has also been very helpful. Various YTS schemes are also used as well as some schools, and work preparation and skills training workshops are run by Camden Society for Mental Handicap.

Evaluation is triangulated in that, in addition to student evaluation, comments are requested from service users and providers. One evaluation that was completed by trainees and instructors on a YTS scheme was four pages in length. This is supportive in demonstrating the positive outcomes that can be achieved by students and people on workschemes learning together.

With regard to student evaluation we have concentrated on the outcomes, which are organised into themes. Two main themes emerged over a six month period of evaluation, these being:

Personal qualities: Awareness; acceptance; insight; confidence; understanding; patience; enthusiasm.

Skills developed: Communication; teaching; problem solving; risk assessment; negotiation.

In addition to the identification of these themes, it is also significant to add that of the first cohort of students to complete this module, six wished to complete the common foundation programme by opting to gain further experience about the health of people with learning difficulties in their elective module.

Considering the paucity of available resources and the logistical problems associated with providing an entirely non-institutional practical experience for common foundation students, the effort involved in this initiative as reflected in the evaluation, is entirely worthwhile. Problems associated with student motivation in some instances need to be overcome. This could be addressed to some extent by the provision of a more sensitive integrated profiling tool, which would allow students to take more control over their learning and enable them to negotiate their own placements.

Prior learning

In the light of the current situation regarding issues of assessment, although they are not directly addressed here they need some mention. One way forward, especially in colleges where a branch programme is not being offered, is with regard to the accreditation of prior learning (APEL). Modules such as this could in the future contribute towards acceptance on a course leading towards a qualification in nursing people with learning difficulties.

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A COLLABORATIVE APPROACH TO TEACHING ABOUT THE HEALTH NEEDS OF PEOPLE WITH LEARNING DIFFICULTIES IN THE COMMON FOUNDATION PROGRAMME OF A P2000 COURSE

INTRODUCTION

This paper describes how a teacher and practitioner working in College of Nursing and Midwifery and Community Trust implemented a module about people with learning difficulties in the Common Foundation Programme. The debate surrounding the future of the RNMH qualification is not specifically addressed. However, it is felt that, while the inclusion of such a module is important in improving the quality of healthcare provision for people with learning difficulties, the positive attitudes and interest that have generally been displayed by students, could be viewed optimistically with regard to the future of this discipline in nursing.

PLANNING

In the initial planning stages the authors, the senior nurse from the Community Trust Resource Team for people with learning difficulties and the community tutor, were the key members of the planning team, which was led by the Course Director for Community Studies. The curriculum model adopted was based on Peplau's (1987) model of nursing. It was also felt that in order to attempt to bridge the "theory practice" divide, that a consumer approach to the aims and intended learning outcomes of the module should be adopted. The senior nurse was at that time, facilitating a client advocacy group. She asked the group questions regarding their experiences in hospital, nurses' attitudes and behaviour towards them as well as their opinions of the attributes of good or bad nurses. Responses were consistent with other anecdotal and documented reports (MENCAP

1991), in that, experience of using health services and being nursed feels disempowering and distressing, one they would rather be without. Bad nurses were described as patronising, ignoring their wishes by presuming their "incompetence". Good explaining things to them. From this it could be deduced that education which brought about change was the minimum requirement. The educational requirements also appeared to reflect the values upon which good services are based. These values, which are a product of normalisation theory (Wolfensberger 1972) and O'Brien and Lyle's (1987) five service accomplishments (namely: community presence, choice, competence, respect and community participation), were thought to be equally appropriate as core themes for the learning experience. The overall aim was therefore defined as being:

> "To enable students to develop an awareness of the individual rights of people with learning difficulties, to receive the same access to and standards of healthcare as all members of society".

IMPLEMENTATION

The CFP is collaborative in that it is taught by staff at Bloomsbury and Islington College of Nursing and Midwifery and Charles West School of Nursing at Great Ormond Street. Students from both institutions participate in this programme. We have two intakes of approximately 120 students per year. This module takes place in the third out of four learning units in the programme. The first two units are mainly college based and this twenty four week unit occurs about six months into the course

when the balance between theory and practice is beginning to change. Over a period of five months five groups of students rotate through the following modules; maternal health, the normal child, the normal child in the community, mental health and the health of people with learning difficulties. At the beginning of unit three there is a two week preparation period which is theory based. All subject disciplines make a contribution. Because our programme occurs at the end of this study period we are able to build on and apply theoretical concepts, already addressed, to our particular client group. It is assured, therefore, that psychological, sociological and policy issues are covered. We draw on this by introducing students to normalisation theory (Wolfensberger 1972) and O'Brien and Lyle's (1987) service accomplishments in the assessment of need and evaluation of service delivery. We move on to a discourse of historical perspectives which have influenced policy decisions regarding the care of people with learning difficulties. In the light of the recent implementation of the Community Care Act (1990), issues regarding health needs and access to Primary Health Care are also addressed. Ethical dilemmas associated with specific concepts of autonomy and paternalism are also highlighted.

The two week practice based module is of seventy hours duration, this is divided into approximately twenty hours theory and fifty hours practice.

Teaching methods are student-centred and attempt to relate theory to practice through the notion of the reflective practitioner as described by Schon (1987) and the development of

skills from novice to expert as promoted by Benner (1984). Students are asked to keep a reflective diary of practical experience. This is used to form the basis for reflecting on critical incidents, which helps to focus discussion in the evaluation of the learning experience on the last study day.

Because of the fear, anxiety and prejudice that can be associated with this client group, it was felt necessary to devote an entire day to preparing students for their practical experience. Information about placements is given to students in the week preceding their allocation to this module. This gives them time to contact their supervisors and formulate any questions they may wish to ask. Time is also built into the introduction session to discuss queries and a hopes and fears session on day one addresses both expectations and anxieties. Normalisation principles are reaffirmed, this is mainly to reinforce learning in the unit preparation days, since some weeks may have elapsed before students enter this module. A video "Gwen, a working life" is also shown. This is part of the Open University learning package "Patterns for Living", which demonstrates the application of these principles in practice and generates discussion. It was also felt necessary to demonstrate how community services interrelated, not merely focusing on the needs of people with learning difficulties, but their families as well. This is achieved by including a networking exercise in the preparatory day. The framework for this is based on O'Brien and Lyle's (1987) notion of choice. The students are given a case study describing the history of a person with learning difficulties and the thoughts and feelings of the client and her

family, in conjunction with professionals involved in her life, after an incident at home. The students role play the interaction that could occur at a case conference. They are also given material for private study and discussion from the Open University learning package (1991).

Group support is also provided at the end of the first three days of the practical placement. Because of the module is so short, it was felt that students would gain maximum benefit from having a forum where issues could be clarified and problems resolved through general discussion. Ethical issues are raised during the process of debate.

PROBLEMS ASSOCIATED WITH RESOURCES

One of the main problems associated with the implementation of the module has not only been concerned with the logistics of co-ordinating such a large number of students, but with locating practical placements them in central London. NHS provision in inner London is limited, all practical experience has to be gained in Social Services and the voluntary sector. Locations that are used in Social Services daycare, residential and respite care services, the Pathways Employment Agency which is run by MENCAP has also been very helpful. Various YTS schemes are also used, as well as some schools and work preparation and skills training workshops run by Camden Society for Mental Handicap. At the time of presentation we have approximately twenty five separate placements that will accept our students. Each one has ben negotiated by the community tutor.

EVALUATION

This is triangulated in that, in addition to student evaluation, comments are requested from service users and providers.

Service providers, while being in the main positive in wanting to contribute to this initiative, have sometimes found it difficult to support students due to their own staffing problems. One or two, while initially receptive to the idea of taking students, found the frequency of their allocation overwhelming. This may be partly due to lack of motivation by some students, in conjunction with the fact that, in the initial stages of the implementation of this programme, placements for the numbers of students involved were difficult to locate. These factors need to be acknowledged with regard to long-term planning for this module.

Regarding student evaluation, for the purpose of this paper, we have concentrated on Learning Outcomes, which we have organised into two themes.

These are related to:

A) Personal qualities: Awareness
Acceptance
Insight
Confidence
Understanding
Patience
Enthusiasm

B) Skills developed: Communication
Teaching

Problem solving

Risk assessment

Negotiation

In addition to the identification of these themes, it is also significant to add that of the first cohort of students to complete this module, six wished to complete the Common Foundation Programme by opting to gain further experience about the health of people with learning difficulties in their elective module. Although the second cohort has not yet completed this unit of learning, one or two, more have expressed a wish to extend their studies of this discipline.

DISCUSSION

Considering the paucity of available resources and the logistical problems associated with providing an entirely non-institutional practical experience for Common Foundation students, the effort involved in this initiative, as reflected in the evaluation, is entirely worthwhile. Problems associated with student motivation, in some extent, by the provision of a more sensitive profiling tool, which would allow students to take more control over their learning and enable them to negotiate their own placements.

In the light of the current situation regarding the future of the RNMH qualification, issues of assessment, although not directly addressed here, need some mention. One way forward, especially in colleges where a branch programme is not being offered, is with regard to the accreditation of prior learning (APEL). Modules such as this could contribute towards acceptance on a course leading towards a qualification in nursing people

with learning difficulties in the future.

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AUTHORS

Lesley Vernon RGN. RHV. RNT. Dip.N.ed. Msc.

Jane Muncaster RGN. RMN. Cert. Health Education.

APPENDIX 19

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"Work for health is essentially enabling. It is a question of providing the appropriate foundations to enable the achievement of personal and group potentials. Health in its different degrees is created by moving obstacles and by providing the basic means by which biological and chosen goals can be achieved.

A person's optimum state of health is equivalent to the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for some people. Others are variable, dependent on individual abilities and circumstances.

The actual degree of health that a person has at a particular time depends on the degrees to which these conditions are realised in practice" (Seedhouse 1998).

1. "The basic needs of food, drink, shelter warmth and purpose in life.

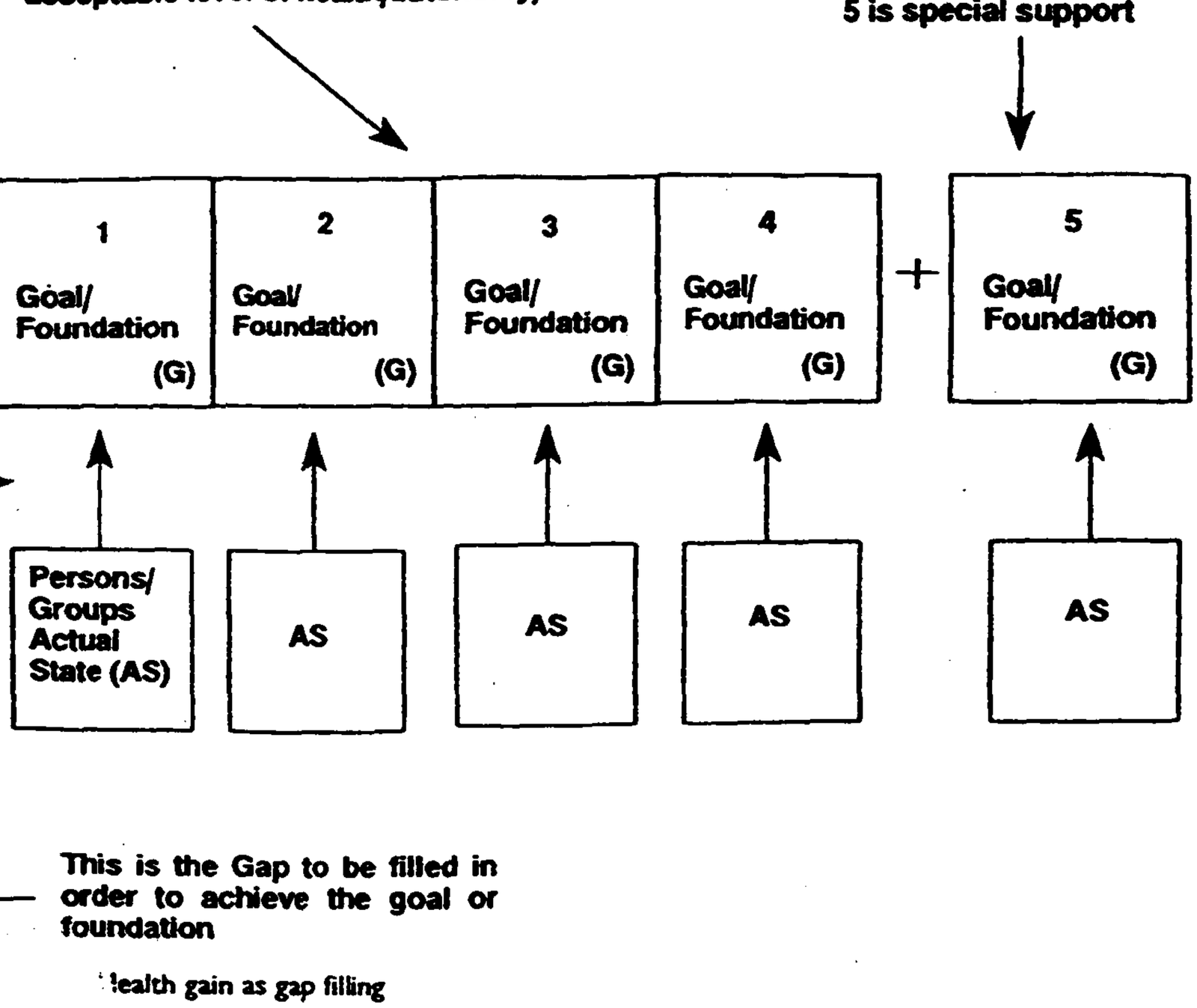
2. Access to the widest possible information about all factors which have an influence on a person's life.

3. The skill and confidence to assimilate this information. In most societies literacy and numerically are needed in older children and adults. People need to be able to understand how the information applies to them, and to be able to make reasoned decisions about what action to take in the light of this information.

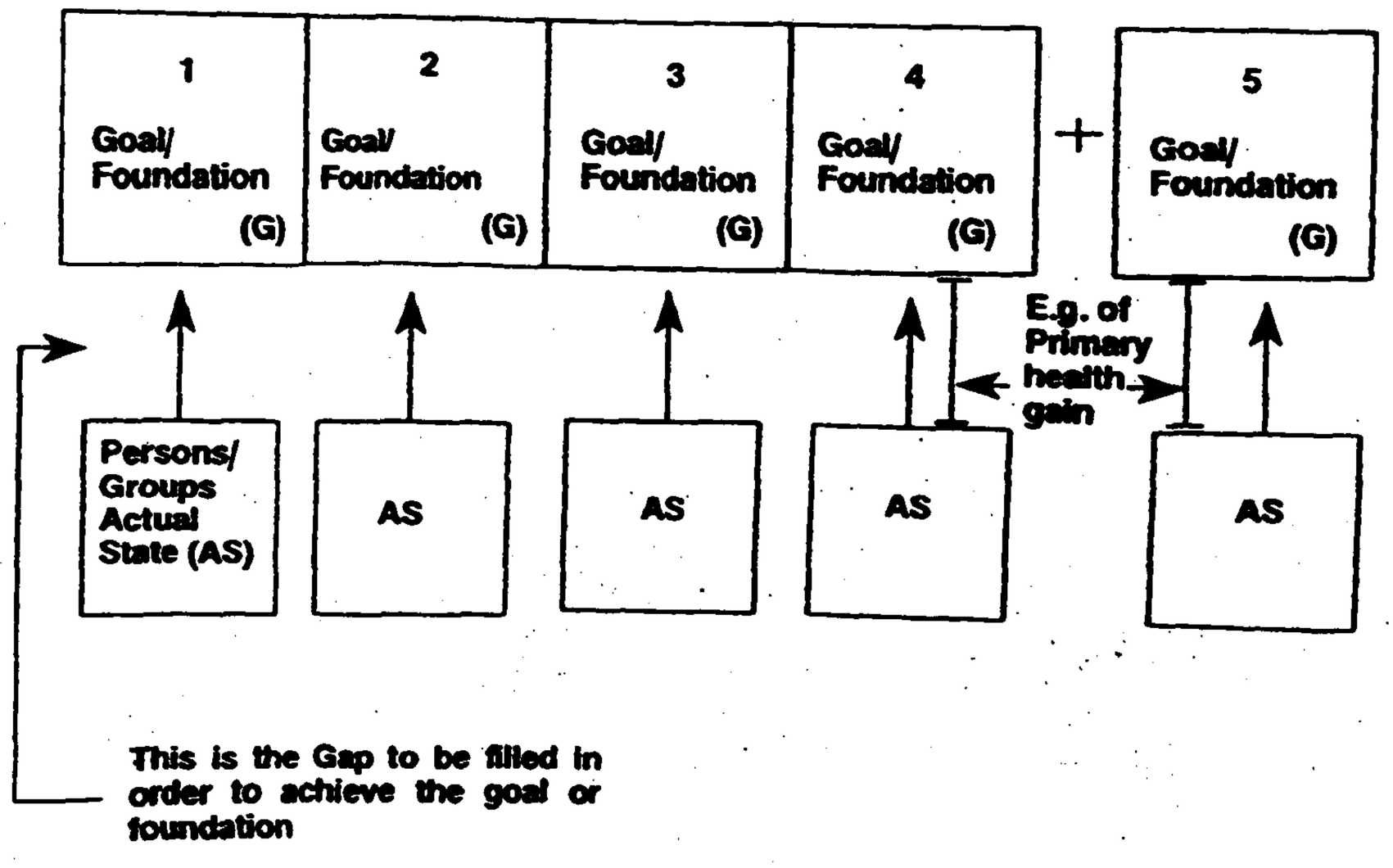
4. The recognition that an individual is never totally isolated from other people and the external world. People are complex wholes who cannot be fully understood or separated from the influence of their environment, which is itself a whole of which they are part. People are not like marbles packed in boxes, where they are a community only because of their forced proximity. People are part of their surroundings, like cells in a single body. This fact compels the recognition that a person should not strive to fulfil personal potentials which will undermine the basic foundations foe achievement of other people. In short, an essential condition for health in human beings who are aware of the implications of their actions is that they have an awareness of a basic duty of their awareness of living in a community.

5. Other foundations for achievement are bound to vary between individuals dependent upon which potentials can be realistically achieved. For instance a diseased person in prison, a fit young athlete, a terminal patient, and an expectant mother all need the central conditions which constitute part of their

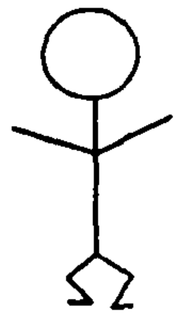
health, but in addition, they require specific conditions in order to enable them to make the most of their present lives" (Seedhouse 1998).



Health gain as gap filling



Giving real and limited content to the term health gain



A home to call her own for everyone in a particular society	Open access to the widest possible information	Education to good levels of literacy and numeracy	The constant awareness of one's belonging to a community—the awareness of the interests of others and of one's dependence upon others' thoughts, on their physical and cultural support, and on their productivity	ADDITIONAL OR CRISIS SUPPORT Access to life saving and sustaining medical services
Protection from death, assault, and undue coercion	Assistance with the interpretation of information (e.g. legal, medical, technical, bureaucratic)	Education to enable a good level of unsupported interpretation of information		Access to medical services that enable the restoration of normal function for the individual (ideally to restore the person to the full platform, left)
Adequate daily nutrition	Encouragement to find, to explore, retain and act on information	Open, continuing education without bar of age	A constant awareness of one's duty to develop oneself and to support others—and so to develop the community	Access to special context dependent support in medical crises
Assistance, whenever required, with defining and (in some circumstances) pursuing purposes/life plans	Encouragement of open discussion of information (public seminars, sponsored 'open info' sessions, public service talkback, radio and television)	Encouragement of self-education throughout life	The constant understanding that citizenship involves not only individual fulfilment but a commitment to the larger civic (global) body	The continuing fulfilment of special needs—the absence of which would constitute crisis
Meaningful, fulfilling employment				
1	2	3	4	5

The foundations with more specific content

APPENDIX 20

Chart A

Definitions of health promotion

- a strategy 'aimed at informing, influencing and assisting both individuals and organisations so that they will accept more responsibility and be more active in matters affecting mental and physical health' (Lalonde 1974)
- 'seeks the development of community and individual measures which can help [people] to develop lifestyles that can maintain and enhance the state of well-being' (US Department of Health, Education and Welfare 1979)
- 'any combination of health education and related organisational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health'(Green1980)
- 'the process of enabling people to increase control over, and to improve their health' (WHO 1984, 1987; Epp 1986)
- 'the maintenance and enhancement of existing levels of health through the implementation of effective programs, services, and policies'(Goodstadt *et al.* 1987)
- 'the science and art of helping people choose their lifestyles to move toward a state of optimal health' (O'Donnell 1989)
- 'the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health' (Stachechenko and Jenicek 1990)
- 'efforts through the overlapping spheres of health education, prevention and health protection to enhance positive health and prevent ill-health' (Downie *et al.* 1990)
- 'any activity or program designed to improve social and environmental living conditions such that people's experience of well-being is increased'(Labonte and Little 1992)
- 'any combination of educational, organizational, economic, and environmental supports for conditions of living and behaviour of individuals, groups or communities conducive to health' (Green and Ottoson 1994)