DAVID BOORER

Over recent years there has been growing unease within the nursing profession about the nurses vulnerability and insecurity within the hospital hierarchy. It is the nurse who stands in the front line of psychiatric care day after day manning the wards and having to respond immediately, and often intuitively, to any crisis that occurs. If, in retrospect, the hurried response is seen to be the wrong one, it is the nurse who has to 'carry the can.'

At a moment of acute tension within their hospital, the nurses at Farleigh Hospital, sent a petition to the Secretary of State for Health and Social Security, of which a copy came to the National Association for Mental Health.

In this petition the nurses asked:
1. Are we to restrain a patient who is self mutilating?
2. Are we to restrain a patient making a violent attack on a weaker patient?
3. Are we allowed to protect ourselves when attacked by patients?

The reaction of the Association to this cry of pain was to help the nursing profession by calling together a working party to examine the need for a code of conduct for nurses in these matters. Discussions have now reached the point where draft guide lines are to be presented for discussion.
PRACTICE

This article examines the need for a code of practice and assesses the consultative and preparatory work that will need to be done if it is to be of any practical value.

At this moment a code of practice for people who work in or who run psychiatric hospitals, thrashed out by an NAMH committee, is being re-drafted. If properly used, this document could have far reaching effects on Britain’s psychiatric hospitals and upon the whole nursing profession. The committee, composed mainly of psychiatric nurses, hope that their code will clarify the nurses’ role and responsibilities, not only in the day to day routine of the job, but also in coping with some of the delicate situations which inevitably arise in the custodial care of potentially violent patients admitted from the courts.

The initiative for this committee came from the NAMH as a direct result of the wave of unfortunate publicity to which certain hospitals have been subjected—not without justification—over the last few years. Impetus to the idea was added by a cri de cœur from some Farleigh Hospital nurses asking for guidance.

The committee have had three meetings so far and have now reached the stage when a document for discussion by the interested and involved professions is being drafted. The document will probably be published early next year but before it comes out people should surely be considering the implications of the whole exercise, its feasibility and the effects it will have on nurses in general and upon psychiatric nurses in particular.

Is such a code needed? Yes, it is. It is needed, not only for nurses—and not only to clarify the nurses’ role in relation to the care of potentially violent patients but also to enable them to define their own boundaries within the hospital service. Where roles and boundaries are clear, where people are aware of each others’ tasks and responsibilities, tensions and problems tend to diminish because people feel secure and don’t mind too much when someone else appears to take an interest in their work.

But the code is also needed for other hospital staff. It is needed by doctors, administrators, social workers, cooks, porters, occupational therapists—in short, by anyone whose work brings them into contact with patients. It is needed by these staff members not only so that their behaviour can be subject to a generally agreed set of standards, but also so that they too can understand what nurses are trying to do and the problems they are likely to meet in carrying out their tasks.

Most important of all a code of practice is needed because nurses must put their own house in order. The profession must attend to its own needs, correct its own shortcomings. It is time that nurses stopped looking to others for help. It is time that others stopped analysing, poking and prying into what must surely be the most over-researched profession in the country today. It is time that nurses grasped the nettle and told other people exactly what it is that they, as a profession, need to be able to do their job in the most efficient and humane manner possible. The code of practice presents a useful opportunity for such an initiative.

If nurses are able to clarify and codify their own standards of behaviour, then they can justly expect other members of the health team to support them. It is not a bit of good for doctors, administrators, members of HMCs and so forth, to go on making demands on nurses if they are not prepared to pay attention to nursing problems. They must understand these problems, they must consult with nurses regularly and they must constantly review the situation. Nurses must not, in the future, be left to stand alone. This is implicit in the code of practice.

The code, then, offers a golden opportunity for nurses to bring about their own reforms. But it will never succeed as an edict from on high. Certainly the professional bodies, the trade unions and the Depart-
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ment of Health and Social Security (all of whom are represented on the committee) must be aware of the content and purpose of the code and must support it fully. But, as Florence Nightingale so rightly said, ‘Reports are not self-executive’ and a code of practice sent out to the profession, no matter how warmly it may be recommended by nursing organisations, will fail dismally unless the rank and file of the profession is involved in it and feel committed to it.

This may appear a little strange to those who know the code for the sensible document it is. It is mainly concerned with defining the problems and courses of action open to nurses faced with difficult and potentially violent patients. It tries to bring up to date patterns of care in nursing which have not, generally, kept pace with sociological changes in society as a whole. It recognises the realities of the problems inherent in trying to nurse patients from the courts in secure conditions—conditions rarely possible in the average mental or mental subnormality hospital. Above all, it seeks to avoid the kind of incident which took place at Farleigh. This is no easy task as has been shown by the committee’s attempts to draft and re-draft a document which not only gives guidelines but which is also politically acceptable to doctors and nurses.

Nurses will soon be able to judge the code for themselves, but how it is accepted will depend, entirely, upon the way in which it is handled.

It needs no crystal ball to see that reactions to the code will vary widely. The conservatives among nurses (those who believe that all is well in this best of hospital worlds and who, deep in their hearts, don’t believe that Farleigh ever happened) will reject it out of hand. A few progressives will seize upon it as an opportunity for reform and change, while the majority will be filled with indecision and will await guidance.

Doctors will show similar reactions and some, indeed, will see an implied threat to their own professional status in any attempt by nurses to control their own affairs. HMCs, in the main, will be influenced by their medical men and many will do no more than pay lip service to the whole idea despite the code’s clear statement for full understanding and involvement.

This is what will happen if the code is issued as an edict. In such a situation it will do nothing at all to reassure nurses faced with impossible tasks in sub-standard wards. It will certainly not deter the unpleasant few from acts of cruelty.

But if the code is widely published, widely discussed and criticised then there is a good chance of creating a groundswell of opinion in its favour. And if this wave of opinion does become evident, then the next step, albeit a slow and painful one, is to encourage discussion in hospitals.

This is essential. It is not always realised, even now, that participation is the key to real progress; that reform in the hospital service can only come from within the wards. It is not always realised that many nurses are simply bursting with good ideas and that they only want help to realise them and to change their own situations. Despite the shining examples of hospitals like Northgate, Leavesden and St. James’s, there are still people who believe that nurses are there, really, to be told what to do and when to do it.

If, however, this code of practice is issued as a basis for discussion and if those discussion groups include nurses, doctors, administrators, other staff and members of HMCs, and if these groups set out, in all humility, to learn from each other, to explore their working relationships and are genuinely concerned to bring about improvement, then the code of practice could be the starting point for some useful reform.

In time it could form the basis for a really clear code of nursing practice, evolved and agreed by the profession, clearer and simpler than the Nurses’ Rules and more precise than the current code of nursing ethics. It could, in time, become generally accepted and possibly enforceable.

The timing is right. Despite the anguish created by ‘Sans everything’, Ely and Farleigh, good has emerged. The wave of concern about the problems of mental and mental subnormality hospitals has led to some useful action and to a general sense of awareness that things need improving.

But it cannot be stressed too strongly that although nurses are aware of their problems and shortcomings they are also acutely sensitive. What is really needed is not a code of practice but a change of attitudes. The first, correctly handled, could be the key to the second.