TITLE

THE PROBLEMS OF COMMUNICATION FACING OVERSEAS NURSES IN TRAINING IN ENGLAND AND WALES.


VOLUME 1

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Abstract.

This investigation studied the problems of communication, as affected by social, educational, linguistic, psychological, political and economic factors, facing overseas nurses in training in England and Wales, taking into account the nature of their training and their work in hospital wards.

Three field studies were conducted:

a) interviews with 30 Principal Nursing Officers for Education;

b) a survey by questionnaire of 219 overseas nurse learners from East/West Africa, South East Asia and Mauritius, with 59 indigene learners as control;

c) eight weeks participant observation in classrooms and wards of 8 Nurse Training Schools. The field of study covered General, Psychiatric and Mental Subnormality Training at both student and pupil level.

A survey of the literature showed that very little research specific to overseas learners has been conducted but there was evidence to suggest that serious problems of communication exist for all nurse learners, particularly with regard to patients and senior staff.

The findings of the field studies indicate that overseas learners have many additional problems, both linguistic and cultural, which severely hinder their ability to communicate effectively either in the classroom or the clinical situation. Some problems are directly related to and accentuated by background factors; some originate in unsatisfactory recruitment and selection methods and others are engendered by tutorial and clinical staff.

Evidence in both the literature and the field studies suggests that little or no opportunity for orientation is provided before training begins and that the situation is further complicated by the presence of severe culture shock.

There is, therefore, an urgent need - and suggestions are made - for an orientation programme, including a language component, before training begins, to provide the cultural information and the language skills which most overseas learners lack and a Central Clearing House for overseas applications to eliminate problems arising from
unsatisfactory selection.

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1. INTRODUCTION

1.1. Problems of Overseas Nurses: Aims of this Research.

In 1971 the United Kingdom Council for Overseas Student Affairs (UKCOSA) submitted evidence to the Briggs Committee on Nursing (1) concerning overseas nurses in Britain.

In its evidence (2, p.2) UKCOSA listed eight major areas of concern in which the problems facing overseas nurses seemed to lie:

1. "Training of overseas nursing students is often spoken of as aid: we see it most frequently as the use of labour.

2. "The selection of overseas nursing students is carried out in a random and unco-ordinated way; there is little competent evaluation of their qualifications before they arrive. Such further assessment as is made after they arrive is often hasty and inadequate ..."

3. "Immigration regulations affecting overseas nursing students ... are noticeably different from those imposed on other categories of overseas students; it is simpler for nurses to come, and simpler for them to stay.

4. "Very few overseas nursing students receive any introduction or orientation to life in Britain. A girl may leave Mauritius on Monday and be on duty in a Manchester ward on Wednesday without having adequate spoken English or any elementary awareness of British life and customs.

5. "By her language, culture and passport, an overseas nursing student is from the first subjected to pressures which a British nurse does not suffer. The frequent absence of orientation, the grouping together of overseas nursing students in Nurses' Homes, the lack of facilities inside the Homes and the absence of any adequate adviser for overseas nurses to refer to add to this pressure.

6. "After training the overseas nursing student is often encouraged to stay in Britain, explicitly by her hospital, implicitly by the Home Office. Any value her training might have had for her home country is postponed or lost ..."

7. "Most of the nurses who do return lack any training in those nursing skills particularly relevant to their own country.

8. "No comprehensive or accurate evidence, statistical or descriptive, on overseas nurses exists". A PEP Survey on overseas nurses in Britain, published
in 1972 (3), tended to corroborate UKCOSA's findings and in an earlier study by Sen (4), in which a sample of overseas nurses was included in a survey of overseas students as a whole, many of the problems discussed in the UKCOSA and PEP Surveys had already been adumbrated.

All these surveys concluded that many of the problems are related to the choosing of a course and hospital, often through lack of prior knowledge; inadequate selection procedures; language problems and a general lack of knowledge about Britain and its culture.

This last conclusion is the most disturbing for, since the quality of nursing care is almost totally dependent on the quality of communication - in the widest sense of the word - an extensive knowledge of the culture of a particular society is necessary to understand the attitudes of that society to birth, illness, death and the human body and of patients' reactions to illness and treatment.

In the field of psychiatric nursing particularly, where, according to the Clark Committee (5, paras.45-55) the functions of the nurse include: encouraging normal behaviour, taking into account differences of race, class, individual preferences and so on; collecting and receiving information from both patients and their relatives and objective reporting on patients' moods and behaviour, a highly sophisticated level of cultural knowledge is an essential prerequisite to effective nursing care and treatment.

In the light of this and of the findings of the Surveys, not least UKCOSA's eighth area of concern, it was felt that a wider and deeper investigation of the whole question of overseas nurses, their background and their selection for training in National Health hospitals was necessary for two reasons. Firstly, the surveys would suggest that the problems of overseas nurses are much more serious than is immediately apparent in their conclusions - that is, that face serious problems of communication when working in an alien culture under conditions of inherent stress, for nursing is by definition a stressful occupation.
Secondly, UKCOSA's finding that no comprehensive evidence, particularly descriptive, exists on overseas nurses suggests that nurse educators and trainers have virtually no resource material on which to draw for information and guidance.

It should be noted that all three surveys mentioned were concerned with qualified staff as well as learners. This research is concerned only with nurse learners. The aims of this research are fourfold:

1. to establish to what extent problems of communication exist for overseas nurse learners.
2. to establish to what extent such problems are affected by social, educational, linguistic, psychological, political and economic factors.
3. to establish the main areas of difficulty:
   a) as expressed by nurse educators and trainers.
   b) as expressed by overseas learners.
   c) as observed during a period of participant observation:
      i) in hospital wards and departments.
      ii) in classrooms of Schools of Nursing.
4. to establish whether overseas learners feel that a specialised course would be useful and, if so, to establish criteria for such a course.

In order that the groups involved in the research should be as representative of the total overseas learner population as possible, existing statistics were examined not only for comparative figures in a particular year but also for general trends in rise and fall over a period of time so as to select those groups which consistently formed the majority and which might therefore be expected to continue to do so.


The two main sources of statistics are the Annual Reports of the General Nursing Council for England and Wales (GNC) and the statistics of overseas born nurses in training kept by the Department of Health and Social Security (DHSS) and attempts to establish accurate figures
from either tended to substantiate UKCOSA's eighth area of concern.

The GNC Annual Reports give figures for the total learner population for the relevant year but they include not only overseas learners but also nurses who have qualified in one type of training and are re-registered for further training. Figures for overseas nurses are not given separately. (6).

The DHSS Statistics are based on returns from Regional Hospital Boards, which are in turn dependent on information received from the various Nurse Training Schools in the region concerned. The DHSS Statistics Department states that its figures are unlikely to be accurate but, if anything, they must be regarded as a conservative estimate. (7).

With these provisos the statistics quoted here are the most accurate available and figures over a 3-year period were compared.

Table 1 (see Vol.2, A.1.) gives the figures for all nurses in training for the years 1970-3 (10) inclusive, showing the distribution in the three main types of training. 1973 shows a more detailed statistical analysis. In previous years trainees in Sick Children's Nursing and those undergoing integrated courses were included in the three main types of training. (11).

As can be seen, the vast majority of learners are engaged in general training and the ratio between the three types of training remains much the same throughout the period, as do the ratios between students and pupils. There are slight fluctuations but no major swings.

Table 2 (Vol.2, A.2.) shows the figures for the overseas born learner population for the years 1970-2 inclusive.

If the overall yearly totals are compared it can be seen that there is a slight decline in the numbers of overseas learners from the Commonwealth, though the numbers from foreign countries increased. The numbers from Ireland fluctuated.

In 1970 just over one quarter of all nurse learners were overseas born, whereas in 1972 the figure was just
under a quarter. Of that number the vast majority were from the Commonwealth.

However, while figures in Table 2 are concerned only with overseas born learners, they nevertheless include those who were recruited after taking up residence in England and Wales. Also included are recruits from countries where English is the mother tongue, such as Australia, Canada and so on.

In order to select groups for this research, therefore, only those countries where English is not the mother tongue were considered, and comparison of numbers for gauging the rise and fall was made on the basis of recruitment direct from the country of origin.

This does not in any way suggest that overseas nurses recruited after taking up residence in England and Wales do not have problems. However, their problems would be unlikely to be more severe than those of learners recruited direct from overseas and they would, in any case, be included at the sampling stage.

Tables 3a and 3b (Vol.2, A.3 and A.4) give the figures for recruitment direct from countries of origin for Commonwealth and Foreign countries respectively and selection of groups for research was made on the following basis:

a) All South African countries were omitted because, in view of the suspicion of overseas nurses in general regarding the motives of research (4, p.8) and the sensitivity of the current political situation in South Africa, inclusion of subjects from these countries might have caused unnecessary apprehension.

b) All countries with steadily decreasing numbers were discarded on the assumption that the diminution would continue in subsequent years.

c) Bearing in mind that the figures represent the total population in England and Wales from the respective countries, all those where student/pupil-nurse numbers were non-existent or too small to allow expectation of a reasonable concentration in any one Group Hospital were omitted.
The countries then remaining were:-

<table>
<thead>
<tr>
<th>Commonwealth</th>
<th>Foreign</th>
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<tbody>
<tr>
<td>Brunei</td>
<td>Finland</td>
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<td>Gambia</td>
<td>Norway</td>
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<td>Ghana</td>
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<td>Uganda</td>
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Those underlined had numbers far in excess of all others.

In view of the result it was decided to take certain areas as the groups rather than individual countries: South East Asia, East/West Africa and Mauritius. The latter was selected as a separate entity because of its large numbers of learners in relation to the size of the island. "S.E.Asia" will comprise Malaysia and the Phillipines, since they account for virtually the whole S.E.Asian learner population. "East/West Africa" will comprise Nigeria, Ghana and Kenya for the same reason.

Table 4 (Vol.2, A.5) gives figures for these three groups for 1972 and shows the percentage of the total overseas learner population, excluding mother-tongue speakers of English, covered by this research.

These figures show that the vast majority of overseas learners were from developing countries, almost half coming from S.E.Asia. Well over half were recruited direct from their countries of origin and of these by far the larger number was admitted to student-nurse training.

The research population (all areas) thus formed represented 80.0% of the total overseas learner population, within the definition of Table 4, (S = 82.1%; P = 75.8%) and 11.7% of the total learner population (S = 11.9%; P = 11.4%).

Since it is impossible to discuss the problems of communication facing overseas nurse learners without reference to the nature of their education and training, their work in hospitals, the people with whom they most...
frequently come into contact and the methods of communication at their disposal, it is necessary at this juncture to describe these things in some detail.
REFERENCES AND NOTES.


2. OVERSEAS NURSING STUDENTS IN BRITAIN. Evidence to the Committee on Nursing. UKCOSA, Jan. 1971.


5. PSYCHIATRIC NURSING: TODAY AND TOMORROW. Ministry of Health Central Health Services Committee (Clark Committee).

6. In 1973 the GNC began transferring their records to computer but at the time the groups were selected for this research it was still not possible to acquire separate statistics for overseas learners.

7. Private communication.


9. The term "psychiatric" is used throughout this thesis to indicate "Mental Illness" as distinct from "Mental Subnormality", although it is often used by the nursing profession as a generic term for both.

10. Since the GNC figures are taken as at 31st March in each year and the DHSS figures as at 31st December, 1973 was included in the GNC Table to cover the overlap.

11. The three main types of training and student/pupil status are discussed in 1.3.

1.3. Nurse Education and Training.

1.3.1. Definition of a nurse and the objectives of nurse education and training.

The international Council of Nurses (ICN) has defined the responsibility of the nurse thus:

"The fundamental responsibility of the nurse is four-fold: to promote health, to prevent illness, to restore health and to alleviate suffering ..." (1)

In order to meet these obligations a nurse must be competent so to do. The General Nursing Council for England and Wales (GNC) defines competence in nursing, whatever the type of training, thus:

observation - an interested awareness in the total situation ... always requiring training and knowledge ... The nurse should be able to recognise that the patient is functioning and behaving within normal limits for his age, temperament, mood, social status and so on ...

interpretation - is reasoned foresight or anticipation of the needs, not only of the patient, but of the total situation.

planning - is deciding on the sequence of the programme of nursing care, both immediate and in the long-term ...

action - is putting into use such effective, interpersonal, communication, personal care or managerial skills which will provide the appropriate patient care in a suitable therapeutic climate.

evaluation - is observation and interpretation that is continued concurrently with action, from the start of action until completion when a final assessment of the effectiveness of the care given would be made. (2)

It is towards the achievement of these objectives that nurse education and training, in Teaching and non-Teaching Hospitals (3) is directed. In England and Wales this is controlled by the General Nursing Council, a Statutory Body, whose main relevant functions are, through its various committees, the formulation of policy on and the control of: registration and enrolment; education and training; examinations. (4, pp. 27-9).
1.3.2. Types of Nurse Training.

There are five types or categories of training in England and Wales:

i) general
ii) mental illness (psychiatric)
iii) mental subnormality
iv) sick children
v) other - e.g. specialities, such as orthopaedic, ophthalmic etc. (not controlled by the GNC).

This thesis is concerned only with the first three, since they account for the vast majority of nurse learners, particularly those from overseas.

1.3.3. Status.

Not only are there several types of training available; there is also a two-level system of training:

i) student-nurse training, leading to State Registration.
ii) pupil-nurse training, leading to State Enrolment.

The main differences between the two are:

a) length of training.
b) scope and depth of syllabus.
c) method of examination.

Student-nurse basic training, whatever the type, is a minimum of three years; pupil-nurse training a minimum of two years. The content of student-nurse training is part-theoretical, part practical; pupil-nurse training concentrates much more on the practical since:

"It is frequently stated that pupil-nurses find it difficult to maintain interest and enthusiasm if the preliminary course is too theoretical". (5,6, p.3)

This difference is reflected in the format of the examinations at both levels.

1.3.4. Content of Education and Training.

A. General:

a) student-nurse: leading to the Certificate of State Registered Nurse – SRN.

In 1971 a new Syllabus was introduced since it was felt
that nurse training should reflect shifting trends in the type of patient population and changing attitudes towards modes of care. Thus the new Syllabus takes account of the rising accident-rate, the higher number of beds needed for psychiatric and geriatric care, increasingly early discharge from hospital and the greater emphasis on community care. (6).

Although as set out in the Syllabus sections run sequentially, this is purely for convenience. In practice many aspects run pari passu throughout training. Syllabus. (7)

This is divided into four main sections:

i) principles and practice of nursing, including First Aid; covering such areas as: general care of patients and nursing procedures; human behaviour in relation to illness; administration and storage of drugs; tests and investigations; First Aid and treatment in emergencies; preparation for management, including ward management, organisation of work, communication within and without the hospital.

ii) study of the human individual: anatomy and physiology; psychology and mental health; sociology.

iii) concepts of the nature and cause of diseases and the principles of prevention and treatment.

iv) general principles of medicine and surgery and associated nursing care.

The amount of time for and spacing of study-periods and the required type and minimum amount of clinical experience are specified. Study-time is usually arranged on a "block" system; that is, on a 5-day weekly basis from one to eight weeks. The Introductory Block, during which learners are taught much of the basic knowledge and practise many of the skills needed to operate at the simplest level on their first ward, should be not less than six and not more than eight weeks. A further period of study should occur at about the sixth month. Otherwise organisation of study-time is at the discretion of the individual School of Nursing.

The minimum clinical experience, based on allocation-
periods of eight to twelve weeks each, must include all age groups, accident and emergency and long-term care, and, in some cases, community nursing. Experience within these three fields must be as varied as possible.

b) pupil-nurse: leading to the Certificate of State Enrolled Nurse - SEN.

Syllabus. (8)
The current Syllabus for pupil-nurses was introduced in 1964. It falls under three main headings:

i) principles and practice of nursing: introduction to nursing and its milieu; general care in the ward unit; routine nursing care; care of babies and children; medicines and poisons; other nursing procedures; First Aid.

ii) the individual and his environment; personal development; promotion of individual and communal health; elementary anatomy and physiology; nutrition.

iii) outline of cause, course and treatment of disease: general medical and surgical conditions; nursing of babies and children; nursing of patients with chronic conditions.

The minimum period for the Introductory Course is not less than four and not more than five weeks and part of this must be spent in the wards. Subsequent to this an average of three hours per week, either as three separate hours, or as a weekly half study-day or as a fortnightly whole study-day. It is recommended that long periods of study should be avoided.

B. Psychiatric training:
a) student-nurse: leading to the Certificate of Registered Mental Nurse - RMN.

Syllabus. (9)
(1964) 3 Sections:

i) introduction to the study of mind and body: human development and behaviour within family and society; introduction to psychological concepts; human biology; psycho-physical disturbance and physical illness; human behaviour in relation to illness.
ii) principles and practice of psychiatric nursing, including First Aid: history and background to nursing; mental nursing; Mental Health Services; the role of the nurse in the psychiatric team; ward management; general care of the patient; nursing care in relation to psychiatric treatment; nursing procedures; First Aid and treatment in emergencies.

iii) psychopathology; psychiatry and psychiatric treatment: legal and administrative aspects.

The time for study and its organisation is the same as for General training.

Minimum compulsory experience is specified. It must include components in: an admission ward (for acutely ill patients); long-stay disturbed patients; neurotics; occupational and industrial therapy; psycho-geriatrics and convalescents.

b) pupil-nurse: leading to the Certificate of SEN (psychiatric).

Syllabus. (10)
(1964) 3 Sections:

i) psychiatric nursing: introduction to hospital and personnel; history and background of nursing, particularly psychiatric nursing; outline of the Mental Health Services; introduction to the Mental Health Act 1959; legal and administrative aspects; general outline of mental disorders.

either: mental illness or subnormality:
- admission and discharge of patients;
participation in the patient's day; nursing care and management of:
- either: patients with mental disorders.
  or: patients with mental subnormality.
  - occupational therapy; recreational and social therapy; after-care; First Aid.

ii) the individual and his environment: personal development; promotion of individual and communal health; elementary anatomy and physiology; nutrition.

iii) principles and practice of nursing: general care.
in the ward unit; general care of the patient; medicines and poisons; nursing procedures.

The arrangement and length of study-time are the same as for General pupil-nurse training.

C. Mental Subnormality training:
   
a) Student-nurse: leading to the Certificate of Registered Nurse for the Mentally Subnormal - RNMS.

Syllabus. (11)
(1970) 3 Sections:

i) as for psychiatric student-nurse training, with the addition of social biology and related aspects of sociology.

ii) concepts of mental subnormality nursing, teaching and training of mentally handicapped: history and background of nursing practice relating to the mentally handicapped; outline of Mental Health Services; ethics; the role of the nurse in the care-team; concepts and nature of mental subnormality; the mentally subnormal in the hospital and in the community; education and training of children and adults; occupational and industrial therapy; psychological aspects of treatment; social training, recreation and rehabilitation; legal and administrative aspects.

iii) care and management of the patient and his environment; First Aid.

The arrangement and length of study-time is as for other student-nurse training.

Compulsory experience must include: newly-admitted patients; subnormal and/or severely subnormal adults and children; physically handicapped and/or physically sick patients; school training methods; occupational and industrial therapy.

b) Pupil-nurse: leading to the Certificate of SEN (Mental Subnormality)

Syllabus. (11)
Psychiatric and Mental Subnormality pupil-nurses share the same Syllabus, following the appropriate subsections of Section (i).
1.3.5. Examinations.

Both Registration and Enrolment are dependent on the successful completion of all prescribed examinations. In all three types of training and at both levels, examinations comprise both written and practical elements. All student-nurses, whatever the type of training, have an external written Final examination; students in General Training have two 3-hour papers, students in Psychiatric and Mental Subnormality sit one 3-hour paper.

Pupil-nurses have a written paper set by GNC, which is kept very simple; for example, sentence-completion.

The practical work of all learners is judged by assessment. For all students, this comprises four ward-based assessments: one on aseptic technique, one on drug administration, total care of a gravely ill patient throughout one work-shift and, finally, being in charge of a ward for one work-shift - or Communication Assessment.

For pupils in General training the assessments are ward-based and patient-centred, one in a medical, one in a surgical and one in a geriatric situation, and cover the syllabus of training as fully as possible. All assessments must be successfully completed before entry to the written examination. The assessments in Psychiatric and Mental Subnormality training are similar, though situation-centred rather than skills-testing. This is due partly to the nature of the work involved in these spheres and partly to the fact that many patients are not present in the wards during the day-time.

Practical tests may be taken in any order and students may indicate when they feel they are ready. Each test may be taken three times but after a third failure of the same test a student may not continue. However, failure of one test does not preclude attempts at the other two.

Responsibility for the implementation of the GNC Syllabus, the arrangement and conduct of study-blocks, the acquisition by nurse learners of the relevant required experience and the arrangement and conduct of examinations lies with the School of Nursing. (12).
1.3.6. Schools of Nursing.

The School of Nursing is the Educational Centre where Introductory courses and subsequent study-blocks are conducted. During these study-periods both theory and initial practical instruction in, and demonstration of, nursing procedures are given.

The School of Nursing serves one or more hospitals and includes one or more types of training. (13) It is under the direction of a Principal Nursing Officer for Education (PNOE) (14), who works in close liaison with the PNO Nursing Services, (15), regarding the nurse learners' clinical experience.

The PNOE's function is mainly administrative since, apart from responsibility for the entire educational programme and clinical experience of all nurse learners, he or she is also responsible for the recruitment and selection of new learners.

Teaching in the School is carried out by Registered Nurse Tutors (RNT), who qualify as teachers through a 2-year or a 1-year course, and Registered Clinical Nurse Teachers (RCNT), who qualify after a 6-months course. In some Schools the RNT's are concerned with the teaching of student-nurses only and RCNT's with pupil-nurses. In others, the teaching staff is divided into teams, teaching both students and pupils. (16). The RCNT also goes into the wards and teaches learners in the actual work situation.

In addition to the RCNT's contribution to ward-teaching, it is also part of the function of qualified nurses, in particular the nurse in charge, to teach students and pupils. Thus there is a very close link between education and training.

1.3.7. Relationship between Education and Training.

This relationship is summed up by the ICN in its Statement on Nurse Education (17). Under the heading: Nursing Practice and Service, it states:

"Nursing education and practice are interrelated and the standard of practice is dependent upon the quality of basic ... education ..."

The Raven Report (18, p.3) defines both education and
training separately:

training: "... is bringing a person up to a desired state of efficiency by instruction and practice".

education: "... may be regarded as the broader process of intellectual development by which understanding is brought to the work and attitudes are helped to mature".

Nurse education might properly be described as both formal and informal, since much of what is taught formally in the School is either reiterated or supplemented in the clinical situation by the Clinical Teacher, in conjunction with other qualified nurses.

Training, on the other hand, is closely related to service needs, since the practical part of nursing is training by apprenticeship. The learner first observes the skill to be acquired; then, after observation with instruction, performs the skill under supervision. Once the nurse in charge is satisfied that the necessary knowledge has been acquired and the level of competence needed has been reached, the learner is allowed to carry out the task unsupervised.

Basic nursing skills, such as blanket-bathing, are acquired very early. Other procedures, such as taking temperatures, are repeated so often that they very quickly become second nature to the most junior nurse. Such skills form the basis and the substance of the learner's working day.

Superimposed upon this basic structure is the acquisition of more complicated and/or less common techniques, from the dressing of wounds, to emergency resuscitation.

Within this framework of training, learners at all levels and of either status meet the service needs of the hospitals which, together, form their Group Training School. Without them there would be no nursing services. It is necessary, therefore, to examine more closely exactly what the provision of nursing services entails.

1.3.8. Job Description.

Since the three types of training being considered here, while having some elements in common, differ
fundamentally in many aspects, each will be examined separately.

a) General Nursing.

Bendall (19, p.7), in her study of various job analyses of nursing activities, shows that while there is slight variation as to definition of minor specifications within the main categories, broad categorisation is universal. The most wide-ranging analysis was conducted in 1953 by the Nuffield Provincial Hospitals Trust, the geographical spread being broad, the size and type of hospital varied and the age-range being from children to adults. Other studies were more confined.

Nursing activities are divided into:

i) basic nursing - which is summarised by the NPHT Project (20, p.27) as dealing with the patient's comfort, hygiene, feeding and bodily functions. This includes such activities as bed-making, blanket-bathing, and so on.

ii) technical nursing - dealing with all aspects of treatment of the patient. This includes: preparation and/or escorting the patient for tests, examination or operation and associated nursing care; carrying out or assisting with technical procedures; checking/giving drugs and medicines and so on.

iii) administration and organisation - including:- clerical work (charting, writing reports etc.), giving and receiving verbal reports, passing information to other wards and departments; work-allocation, teaching and training.

iv) domestic work - general tidying, dusting, cleaning sinks and baths; hotel - serving and clearing meals, providing drinks.

v) miscellaneous - including time spent off the ward, unoccupied and so on.

The amount of time spent on each of these categories will depend on various factors: (20, pp.29 et seq.) basic nursing is influenced by the individual patient's requirements and the degree of physical dependence; size,
of ward; the number of staff, affecting the individual workload; the type and availability of equipment; the design of the ward.

One must add here the experience of the staff. Jackson and Armstrong (21, p.65) and Perry (22, p.210) stress the need for the movements associated with any task to be taught so that economy of muscular movement is developed, which leads to quicker and more efficient execution. Also, the more often a task has been performed the more efficient is the operator.

Technical nursing is influenced by the type of ward—medical, surgical, etc. — and the individual patient's needs and ward organisation by the number of staff and the amount of clerical work.

Though these five broad categories remain, Bendall found (19, p.32) that the weighting of nurse-time per category had markedly altered and that in the last twenty years or so there had been a shift in emphasis. Slightly less time is now spent on basic nursing activities, with a corresponding increase in technical nursing activities. On the other hand there has been a considerable decrease in the amount of non-nursing activity, since non-nursing staff have largely taken over the distribution and clearing of patients' meals and drinks. The increase in technical nursing activities is attributed more to the number of times a technical nursing task is performed rather than the introduction of any new technical activities, and what non-nursing activity occurs is more concerned with moving patients and their accoutrement than with cleaning, washing-up and handling stores.

This job description covers the activities of all grades of staff, both qualified and trainee. Ideally a student- or pupil-nurse participates more or less in each activity, depending on the stage of training and previous learning experience. However, as the Nuffield team observed:

"... a student is more or less a student, depending on circumstances". (20,p.71)

Thus, if there is a shortage of qualified staff, or during the latter's off-duty period, a student-nurse will
often find herself in charge of a ward and doing the work of a qualified nurse. Alternatively, if there is a deficiency of first-year nurses, a third-year student nurse will have to do the work of a first-year nurse. Similarly, first- and second-year nurses have to do more senior work in the absence of third-year nurses.

Hence the role of both student and pupil is often ambivalent and it is hard to describe, with any degree of accuracy, the job of either at any particular point in her training. The effects of this ambivalence will be discussed later.

b) Psychiatric Nursing.

The psychiatric, or mentally ill patient is, as defined by Roberts (23)

"... a once apparently healthy and whole person [who] suffers from an impairment of previous mental or social capacity due to the onset of an illness which may be emotional or somatic".

The activities of psychiatric nursing are directed towards removal or alleviation of that impairment.

Unlike general nursing, where the broad categories of job description can be applied whatever the type of ward, the skills and procedures which psychiatric nursing involves are much less easy to define. Nor can any definition be applied universally to all wards for, as the Clark Committee Report observes, (24, para. 6) the functions of the staff vary according to the type of ward. Patients are admitted either because they can no longer cope in the community, or are a nuisance to others, or are a danger to themselves or others and each will be admitted to the ward which caters for his particular illness, its degree and type. Thus a mildly depressed patient will not be put into the same ward as a suicidal patient or an aggressive psychotic.

The Clark Committee describes the functions of the psychiatric nurse, thus: (24, paras. 43-55):

personal - accepting patients as they are, disturbed, anti-social, threatening, dependent, and developing therapeutic relationships with them without becoming emotionally involved; recognising signs peculiar to particular disorders - exaggerated expectations of manics,
slowing up of thought and feeling in depressives; organis-
ing and encouraging patient activities, such as sport or occupational therapy; encouraging normal social behaviour, taking into account differences of race, class, individual preferences and so on; collecting and relaying information from patients and relatives.

**Psychological treatment** - coping with strong emotions evoked in patients by psychotherapy; taking part in group therapy; persuading patients to take care of personal hygiene.

**Technical and physical** - basic nursing care; technical procedures; assisting with and recognising side effects of electro-convulsive therapy, insulin therapy and so on.

**Social, occupational, recreational** - helping with and encouraging activities in these fields.

**Observation** - physical and psychological.

**Communication** - talking and listening to patients; objective reporting; participation in ward meetings and case conferences.

**Organisation** - of the patient's day and of appropriate activities, physical and mental.

Each ward provides an entirely different environment and the nursing activities will vary accordingly. In the wards where patients are acutely ill intensive clinical care, technical and psychological, is needed, whereas in the rehabilitation wards the nurse's role is more a supportive one, with social, occupational and recreational activities. In the wards where patients are chronically sick - often psychogeriatric - the nurse is concerned mainly with basic nursing care and on the children's wards with play activities and with social training and mixing.

It has been found (24, para. 79) that psychiatric patients make better progress when looked after by a team. Therefore, unlike General Nursing, tasks are not necessarily allotted according to status and the psychiatric nurse learner takes part in all ward activities, sometimes taking charge in the absence of the qualified staff. It is very often the learner who accompanies and supervises patients in occupational therapy and recreational activities, which are usually conducted outside the ward;
it is therefore the learner who observes and reports on the progress and reactions of patients to extra-ward activities.

c) Mental Subnormality Nursing.

A mentally subnormal patient, again using Roberts' definition: (23)

"... has a basic and in the main unalterably diminished mental capacity which may be congenital or of traumatic origin (brain injury at birth or later)."

Nursing of the mentally subnormal is therefore concerned with training, habit-forming, socialisation and education in so far as each or all are possible.

The patients belong to one of three groups:

- children of differing age and potential;
- high-dependency adults, who need a considerable amount of supervision and care;
- low-dependency adults who might — and often do — go out into the community.

In its report on the function, scope and training of the RNMS (25, pp. 6-8), the Royal College of Nursing (RCN) describes nursing activities thus:

**physical** - feeding, personal hygiene and general care and the teaching of self-care.

**educational** - teaching in school and in occupational and industrial therapy.

**social** - training of children and adults in acceptable social behaviour patterns and the teaching of simple skills.

"School-habits" and "work-habits" are first taught in the wards by the nurses in preparation for eventual transfer to the hospital school, the occupational therapy department or the industrial therapy unit. Later the patients may progress to real work situations, either inside the hospital as gardeners, craftsmen and so on, or in the community in sheltered employment.

According to the RCN Report (25, p.7) the extent to which the nurse is involved in the total care of patients varies considerably for in some hospitals many of the functions outlined above have been either partially or wholly taken over by specialists, such as occupational therapists, social workers, teachers and craftsmen. In such cases the
nurse's role, in particular that of the learner, tends to become that of observer or assistant.

Ward organisation and administration in psychiatric and Mental Subnormality nursing, while differing in certain aspects from General nursing, is nevertheless sufficiently similar not to need reiteration.

1.3.9. Recruitment and Selection.

a) Recruitment.

The recruitment field for nursing is potentially a very wide one, being open to both school-leavers and the more mature of both sexes, indigenous and overseas.

In a comprehensive survey of all studies from 1940-1966 on recruitment and selection in nursing, MacGuire (26, p.15) found that one in three of all women and girls develop an interest in nursing and about one in six a strong interest. For girls this interest is at its peak between the ages of 13 and 16.

Most if not all studies up to 1966 were concerned with unmarried females, little or nothing being available on males or married women. However, later research includes male recruitment and, in a survey of 88 male and 69 female nurses, Rosen and Jones (27, p.88) found that whereas 44% of the female sample had looked to nursing while still at school, only 13% of males had done so.

Brown and Stones, in a survey of male nurses (28,p.50), found that of the 273 indigenes in their sample, only 15% intended to become nurses when they left school.

Factors influencing recruitment.

Before the Second World War there was no problem of recruitment for Registration, either in the General field, where, in fact, more nurses were being trained than could find post-Registration posts (4, p.129), or in the psychiatric field, where numbers were sufficient.(24,para. 26). There were, however, too few nurses at bedside level, particularly for the chronic sick and the infirm, and it was at this stage that the idea of assistant-nurses (now pupil-nurses) was mooted and later adopted.

MacGuire observes (26, p.40) that at that time nursing was looked on as an opportunity of furthering
one's education and of gaining qualifications which, before the proliferation of various grants, were not otherwise available. Now, however, with so many other jobs and courses open to school-leavers, nursing is much less competitive and this is reflected in the recruitment-rate. Furthermore, since the minimum age of entry to nursing is 18, many potential recruits in the 16-17 age-group take up other jobs and their attitude to nursing is subsequently modified by work-experience. (26, p.42)

Knowledge about nursing is sketchy and inaccurate and, according to a National Opinion Poll in 1966 - cited by MacGuire (26, p.37) - a large proportion of the people did not know what SRN meant (40%), fewer still knew the meaning of SEN (40%) and only 20% could differentiate between the two.

MacGuire also found that few potential recruits had any accurate idea of actual educational entry requirements, minimum age of entry, length of training, status, conditions or career-structure, though the lower socio-economic groups and Secondary Modern pupils were less well-informed than middle-class and Grammar School pupils. Moreover, the former were likely to self-select out on grounds of "unsuitability". In addition, vocational preparation of any kind was minimal and links between hospitals and schools were tenuous. (26, p.17).

Since those who had received careers information on nursing were more interested than those who had not (26, p.18) and since actual recruits to nursing were more conversant with types of training and career opportunities, it follows that the perennial shortage of nursing recruits is partly linked to lack of knowledge and careers guidance.

Another factor is the dichotomous image of nursing: on the one hand it is seen as having high social standing and as a worthwhile job, the nurse being competent, self-possessed and intelligent. On the other hand it involves much menial work, it is underpaid, leaves no time for outside life and educational entry demands are low, all of which are seen as disincentives. Reactions to taking up nursing are coloured by whichever image is prevalent at any particular moment. (26, p.38).
To what extent any or all of these factors contribute to the shortage of indigenous nurse recruits, attempts have been made to improve the situation by the recruitment of overseas nurses in all types of training.

MacGuire points out that recruitment to non-teaching hospitals tends to be based on geographical locality and, owing to a shortage of local recruits, is often supplemented by overseas learners. (26, p.20). Perry states that:

"... great reliance has been placed on overseas students from other countries" (22, p.235).

The Clark Report observes (24, para. 26) that the lack of numbers in psychiatric nursing has often led to recruitment of overseas learners. The Report of the Committee on Nursing (Briggs Report) notes the high ratio of overseas nurses in psychiatric hospitals (29, para. 459) and also comments on the high dependency of London on overseas nurses. (29, para. 471 (c)).

b) Selection.

In the Platt Report (30, Appendix VIII, para 1) it is suggested that selection is only possible, in the strictest sense, when there is an excess of well-qualified candidates and that the effectiveness of selection methods is dependent to some extent on selection ratios.

In nursing the number of candidates relative to vacancies is not very great (31) and the educational attainment level of applicants varies widely. In addition, the number of candidates who apply to a particular Nurse Training School will depend on its locality and its level of prestige. Thus a famous London teaching hospital will receive far more applications than will a Mental Subnormality Nurse Training School which is miles from the nearest town and with no regular bus service. It is hardly surprising therefore that there is considerable variation between Training Schools regarding entry requirements and selection procedures.

1) **entry requirements:**

*student-nurses.*

The minimum Statutory educational requirements are set out in Appendix I (Vol.2, A.6).
In view of the difficulty of determining which overseas certificates are equivalent to the GCE O Level, the GNC asked the Schools Council to provide an equivalent list. (See Vol.2, Appendix II. A.7-18).

Further, following information from the Schools Council that the evaluation of educational certificates from countries where English is not a national language should not include English as an acceptable subject because the medium of instruction was not English, the GNC decided to adopt the same policy with regard to student-nurse training. (32, p.5). Therefore any overseas applicant holding an otherwise acceptable certificate, must either produce evidence that the medium of instruction in the subject English was English or a certificate of competence in English, such as the London or Cambridge University Certificate of proficiency in English.

However, this is the minimum only and some Training Schools demand a much higher educational attainment level. In 1966 the GNC asked Training Schools for details of actual educational requirements and the results showed that of 462 Training Schools:

- 14 (3%) could ask - and get - 5+ O Levels
- 19 (4.1%) " " " 4 " "
- 24 (5.2%) " " " 3 " "

The remaining 405 asked for the statutory minimum. (4, p.260).

There is at present no minimum educational entry requirements for pupil-nurses.

This low educational entry requirement has its effect on recruitment for, according to Bendall and Raybould (4, p.260), headmistresses, seeing the minimum statutory requirements, advise their more academically-minded pupils to take up other careers. Similarly the Platt Report (30, para. 14) observes that the low educational requirements discourage many potentially good students and one of its recommendations was that the minimum requirements should be not less than 5 GCE O Level passes, of which one should be a science. (30, para. 71).

A minimum educational requirement for pupil-nurses
has been mooted both by the Enrolled Nurses Committee (33) in 1962 and as a recommendation by the Platt Report (30, para. 108), where CSE or its equivalent is advocated.

If an applicant for student-nurse training holds no formal educational certificate or the subjects included thereon do not comply with the statutory requirements, he or she may take an entrance test set by the GNC.

ii) The GNC Test D. (34)

For reasons of security it is not possible to discuss the test contents in detail but, generally speaking, it is a test of general intelligence. It has six parts, Parts 1-3 containing verbal items, Parts 4-6 numerical items. Each part is preceded by a Practice Test, with two examples and two or three practice items.

According to the Manual accompanying the Test its purpose is to measure the intellectual ability of applicants, in particular general intelligence. In the words of the Manual it is:

"...a test of general problem-solving ability for use with applicants for nurse training. It is intended to predict an applicant's capacity to learn, to cope with theoretical work and to pass examinations". (34, Manual, p.1).

The pass-mark as set by the GNC is 75, or a little over half, since the test contains 140 items. The Manual acknowledges the limitations of such intelligence tests and warns the users [Schools of Nursing] against the possibilities of inaccurate assessment. It also points out that prevailing conditions influence a candidate's performance:

"If, however, a candidate is very nervous, tired, in poor health or is not used to tests and is not fully aware of the importance of factors such as speed, then she may achieve a score which is not representative of her true ability".

The Manual also notes the effect of variations in cultural background and states that:

"Candidates from outside the U.K. will in general achieve scores which do not represent their true capacity".

Test D may be retaken but after a minimum period of six months to rule out practice effects.

It is difficult to compare annual figures for those.
entering student-nurse training via the GNC Test since the format of the GNC Annual Report has not remained consistent and statistics are presented differently. However, some figures are available, which give an idea of the implications of the Test for applicants for student-nurse training. In the GNC Annual Reports for 1970-1 and 1971-2 the numbers are divided by type of training; in the three subsequent Reports they are combined. (35). Figures as at January 1976 are divided by type of training and indigene/overseas origin. (36).

**Nos. entering student-nurse training via the GNC Test.**

<table>
<thead>
<tr>
<th></th>
<th>General/Sick</th>
<th>Psychiatric/Mental-Subnormality</th>
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<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
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<tr>
<td>1970-1</td>
<td>32.2</td>
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</tr>
<tr>
<td>1971-2</td>
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<td>66.0</td>
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<td>1972-3</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>1973-4</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>1974-5</td>
<td></td>
<td>33</td>
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<table>
<thead>
<tr>
<th>Jan.1976</th>
<th>U.K.</th>
<th>Overseas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>General</td>
<td>27.59</td>
<td>7.49</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>56.62</td>
<td>21.15</td>
</tr>
<tr>
<td>Mental Subnormality</td>
<td>65.17</td>
<td>28.19</td>
</tr>
</tbody>
</table>

The GNC, in its statistical analysis of nurse trainees (36) states that: "... for all courses significantly fewer overseas students enter through the GNC Test". This may be assumed to be due to the expressed unsuitability of the Test for overseas candidates and is substantiated to a certain extent by the results of a study carried out by Bannister et al. (37, pp. 76-77) in 1962. In attempting to assess the validity of using cognitive tests as an initial screening procedure, the Raven Progressive Matrices Test and the GNC Test were applied to 46 nurses, all of whom had passed the Preliminary Examination, Parts I and II. (38), and who had been working successfully in hospitals for more than two years. Since the GNC suggest that the rejection-level for their Test should be Grades
D and E, 30% of the 46 subjects would have been rejected had they sat the Test as an entry qualification. It is perhaps significant that all 30% were from overseas.

As a policy the GNC are not in favour of the use of their Test for overseas applicants (16) though, in the absence of a relevant overseas test, its use in this context is not forbidden.

iii) other tests.

Some Training Schools have internal tests over and above certificated evidence of educational attainment, such as essay-writing, or a test of their own devising. However, since no comprehensive research has been conducted in this field, no further comment can be made.

iv) other means of selection: personal interview, references and so on. Most Training Schools rely on the personal interview, backed by head-teachers' reports and other references, to judge the suitability of a candidate for nurse-training with regard to general bearing, attitudes, qualities and so on which are considered as pre-requisites for the "good" nurse. As regards overseas candidates, a personal interview is not always possible and great reliance must then be placed on the school report and references. Sometimes, however, overseas candidates are offered a place provisional upon a satisfactory personal interview on arrival at the Training School. (16).
REFERENCES AND NOTES.


2. Indications of competence which are not objectively examinable, drawn up by GNC Working Parties as a guide to Assessors.

3. A Teaching Hospital has a Medical School attached. A non-Teaching Hospital does not.


5. Guide to Syllabus for State Enrolment (General). (V.infra.)

6. Explanatory leaflet accompanying Syllabus for State Registration (General) (V.infra.)


12. There is some doubt as to the actual meaning of the term "School of Nursing". It is the view of the General Nursing Council that it should mean exactly the same as "Nurse Training School": i.e. the whole area in which both theory is given and practice obtained. However, in some places it is taken to refer to the actual classroom. (Private communication). In the context of this thesis it will be taken as meaning the classroom area.

13. With the current trend towards District General Hospitals and amalgamation of nursing services, the majority of Schools of Nursing cover a group of hospitals, including one or more giving psychiatric and/or mental subnormality care.
14. Now Director of Nurse Education.
15. Now Divisional Nursing Officer.
16. Private communication.
20. WORK (The) OF NURSES IN HOSPITAL WARDS: REPORT OF A JOB-ANALYSIS. Nuffield Provincial Hospital Trust. 1953.
24. PSYCHIATRIC NURSING: TODAY AND TOMORROW. Ministry of Health Central Health Services Committee (Clark Committee) HMSO. 1968.
30. A REFORM OF NURSING EDUCATION. First Report of a Special Committee (Platt) on Nurse Education.
31. It must be said that owing to the current economic situation Nurse Training Schools now have 2-year waiting-lists and recruitment of indigenes is high. However, since the economic situation is the only variable which has altered, it must be assumed that when the economic situation improves indigenous recruitment will fall again.
33. Standing Committee of the GNC.
34. GENERAL NURSING COUNCIL FOR ENGLAND AND WALES ENTRANCE TEST FOR CANDIDATES FOR NURSE TRAINING: Manual/ Instructions to Examiners/ Test Booklet.
35. GENERAL NURSING COUNCIL FOR ENGLAND AND WALES: ANNUAL REPORTS. 1970-75.
The Student and Pupil Nurse Population - Jan. 1976
General Nursing Council for England and Wales.


38. The Preliminary State Examination, once a statutory examination in two parts - Part I taken after six months training and Part II at the end of the first year - has now been discontinued. Success in both Parts indicated ability to cope with the theoretical and practical demands of training and expectation of passing the Final examinations.
1.4. Communication in Nurse Training Schools in Relation to Nurse Learners.

1.4.1. Channels of Communication.

a) hierarchical structures.

i) Nursing hierarchy.

Fig. 1. Nursing hierarchy.

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REGIONAL NURSING OFFICER (RNO)
   
<table>
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<th>AREA NURSING OFFICER (ANO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISTRICT NURSING OFFICER (DNO)</td>
</tr>
</tbody>
</table>

DIVISIONAL NURSING OFFICER (DIV.N.O.)

<table>
<thead>
<tr>
<th>SENIOR NURSE (SNO)</th>
</tr>
</thead>
</table>

DIRECTOR OF NURSE EDUCATION (D.N.E.)

<table>
<thead>
<tr>
<th>REGISTERED RNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSE TUTOR</td>
</tr>
<tr>
<td>CLINICAL NURSE</td>
</tr>
<tr>
<td>TEACHER (RCNT)</td>
</tr>
</tbody>
</table>

EDUCATIONAL SECTION

SERVICES SECTION

<table>
<thead>
<tr>
<th>NURSING OFFICER (NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WARD W.S.</td>
</tr>
<tr>
<td>SISTER/CHARGE NURSE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STAFF- S/N NURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(S/N)</td>
</tr>
</tbody>
</table>

STUDENT-NURSE 1st/2nd/3rd YR. NURSE 1st/2nd YR.
PUPIL AUXILIARY NURSE
Fig.1. shows the lines of communication in the nursing hierarchy following re-organisation of the National Health Service in 1974.

At regional, area and district level the Nursing Officer's function is that of administrator, co-ordinator of services and policy-maker or interpreter at the respective level and of liaison officer between the level immediately above and below. The dotted line indicates that although each level serves as a monitor for the one below, there is no line management as such.

In the Services Section, at divisional level the Nursing Officer's responsibility covers a particular type of activity in all the relevant units in the Group. For example, the Divisional Nursing Officer (General) covers all the units in the Group concerned with general nursing, the Div. N.O. (Psychiatric) covers all psychiatric units and so on.

Senior Nursing Officers supervise particular nursing services within a hospital and/or in the community. Thus the SNO (General) covers all male and female medical and surgical nursing services.

Nursing Officers are responsible for all wards in a hospital concerned with a particular branch of nursing; as, for example, a Nursing Officer (General) covering all surgical wards. (1)

A Ward Sister, or Charge-Nurse if male, is in charge of one ward or department and staff-nurses assist with the daily running of the ward or department and deputise in the Sister's absence.

Student-, pupil- and auxiliary nurses form the last link in the chain which ultimately leads to the consumer, the patient.

In the educational section, the Director of Nurse Education is the Divisional Nursing Officer responsible for the education and training of all student- and pupil-nurses in all types of training within the Group. She (sc. also he throughout) is also the Appointing Officer for trainee nurses and her function is mainly administrative.

The number and function of Senior Nurse Tutors varies
according to the complexity of the organisation. A large Group Hospital covering the three main types of training will very likely have a Senior Nurse Tutor responsible for the implementation of the educational programme for each type of training, with two or more RNT's to assist with the teaching and RCNT's to carry out ward-teaching duties.

In smaller organisations there may be one Senior Tutor in charge of the student-nurse school and one in charge of the pupil-nurse school, with perhaps a Senior Nurse Tutor in charge of a speciality within the organisation. Other RNT's and RCNT's assist with the classroom and ward teaching. (2)

ii) Medical hierarchy.

Fig. 2. Medical hierarchy.

![Medical Hierarchy Diagram]

Fig. 2 shows the medical hierarchy, which will be discussed only in so far as it interacts with the nursing hierarchy and in particular with nurse-learners.
b) **Closeness and Frequency of Contact.**

Fig. 3. **Closeness and Frequency of Contact in relation to nurse-learners.**

---

**Nursing (Services)**

- **Div. N.U.**
  - **SNO**
  - **SNO**
  - **NO**
  - **NO**

**Medical (Education)**

- **DNE**
- **RNT**
- **RCNT**
- **CONSULTANT LEVEL**
- **REGISTRAR LEVEL**
- **SHO LEVEL**
- **HO LEVEL**
- **MEDICAL STUDENT LEVEL**

**ANCILLARY SERVICES.**

- **PHARMACY**
- **KITCHEN**
- **STORES**
- **ETC.**

---

**WARD / CHARGE NURSE**

- **S/N**
- **S/N**
- **STUDENT**
- **PUPIL**
- **NURSE**
- **AUXILIARY**

**PATIENT**

**PARA-MEDICAL DEPARTMENTS**

- **PATHO-**
- **LOGICAL**
- **LAB.**
- **X-RAY**
- **PHYSIO-**
- **THERAPY**
- **RADIO-**
- **THERAPY**
- **ETC.**

---

Legend:

- **_____** = close contact
- **-----** = distant contact
- no. of arrows = frequency of contact.
Fig. 3 shows the relative closeness and frequency of contact between nurse learners and other groups within the organisation. The continuous line, signifying close contact, means that contact with nurse learners is bound to occur as part of the normal function of the member of the hierarchical level or group indicated. The number of arrows indicate the frequency with which such contact might be expected to occur. The interrupted line, signifying distant contact, indicates that contact is not necessarily bound to occur. (This is not based on, nor is it meant to indicate, a numerical count. It is a representation, for illustrative purposes, based on extensive knowledge of the field).

It is immediately clear from Fig. 3 that, in the Services Section, a nurse-learner's closest and most frequent contacts are with the patient, other nurse-learners and the senior qualified staff in the ward or department. This is hardly surprising since the patient is her raison-d'être, the other nurse-learners her co-workers and co-learners and the senior staff her instructors, supervisors and trainers while she is on their ward.

However, there is a sudden cut-off point in contact above the level of Ward-Sister/Charge Nurse and there is unlikely to be much contact with the higher echelons in the Services Section. If there is, it will almost certainly be confined to the learner being asked to locate the whereabouts of the nurse in charge or similar casual interchange.

Regarding contact with the Educational Staff, though contact is close its frequency is often sporadic, as indicated by the clusters of arrows, and less easily determinable. Frequency of contact with the Director of Nurse Education depends to a large extent on the DNE concerned and on the size and complexity of the Group Training School. Some DNE's are present at all applicants' interviews; others are not. Some talk to the learners during their Introductory study-block; some do a little teaching during subsequent study-blocks; some are available for consultation by their learners. Others do some or none of these things. Some Schools of Nursing operate
an individual tutorial system; some leave it to the
learners to seek advice or help, professional or personal,
when required. (3)

As regards nurse tutors, frequency of contact varies;
while learners are attending study-blocks contact is
virtually continuous. Subsequent contact depends on
whether and what type of project-work is set, whether a
tutorial system exists and, to some extent, on the
learner's own initiative.

Contact with the Clinical Nurse Teachers will depend
on the number of RCNT's available and the method of
deployment - whether, for example, they concentrate on
first-year learners or whether a particular Clinical
Teacher follows a specified learner-intake through all
stages of training.

As can also be seen from Fig.3, contact between
learners and medical personnel, particularly at consultant
and registrar level, is not bound to occur and if it does
it will be infrequent.

Consultants and registrars, when visiting wards, are
usually met and accompanied by the nurse in charge or her
deputy, though learners may be invited to attend the ward-
round for learning purposes.

At House Officer level contact is more likely to
occur, at least with senior learners, since the latter
often assist with technical procedures or chaperone the
examination of a female patient. Such contact is, however,
relatively infrequent.

Later discussion on communication will therefore be
confined to those areas where contact is bound to occur
frequently between nurse-learners and others: viz., patient-
learner; learner-learner; senior staff-learner and teach-
ing staff-learner.

1.4.2. Methods of Communication.

a) Services Section.

Communication in hospitals serves two main functions:
the giving and receiving of information and the giving and
receiving of instructions.
Giving and Receiving Information.

The transmission of information in hospitals almost always concerns the patient, either directly or indirectly, and may be relayed either verbally or in writing.

Verbal.

Verbal information is transmitted between medical staff and nurse; nurse and nurse; nurse and patient.

Communication between doctor and nurse, as has been described elsewhere, (4, p. 174) is concerned with the patient's condition from the point of view of the organic and biochemical effects produced by it and its diagnosis and treatment. Nurses, on the other hand, are more concerned with how to carry out the treatment prescribed and the associated general and specific nursing care.

Transmission of information between nurses may be individual, as, for example, a nurse-learner reporting to the nurse in charge any treatment or nursing care she has carried out and what she noticed or the patient did or said during that time. Or it may be collective, as with the off-going day-nurse's report on all patients to the oncoming night-staff and vice versa, or the senior nurse's report to the nurses coming on duty for the late shift.

Between nurse and patient the transmission of information is mainly concerned with explanation of nursing procedures and interpretation of treatment and the patient's reactions to both, either physiological or psychological.

Written.

Presentation of information in writing takes several forms and, as expressed by Perry (5, p. 63)

"... provide a comprehensive, continuous record of the patient's progress and his response to treatment and nursing care".

These are the Kardex Report Cards, Nursing Record forms and Report Books written by nurses; the patients' notes, treatment sheets, laboratory and X-ray reports written by doctors. All such records of patients currently in care are kept in the ward office for reference at any time by nurses or medical staff and, particularly for the nurse learner, provide a source of learning.

Giving and Receiving Instructions.

Instructions are often linked with information, both
verbal and written, and are usually issued in conjunction with reporting. A doctor gives instructions as to treatment and the nurse in charge passes on these instructions, interpreting where necessary in terms of the relevant nursing care, both general and specific to the patient's condition and the Consultant's modus operandi. Such instructions may be issued collectively at the time of reporting and/or individually to the nurse concerned with implementing them.

While the transmission of information is a two-way process, the giving of instructions is usually downward only.

b) Educational Section.

On the educational side various methods of communication are used. In the School of Nursing theoretical knowledge is presented through lectures and audio-visual aids such as films, slides, wall-charts and models of human organs. Nursing procedures are taught by demonstration, using an adult or infant dummy where appropriate. The acquisition of knowledge is tested by Question and Answer revision classes, essay writing and test-papers, while acquisition of practical skills is measured by a learner's ability to perform the requisite procedure on a dummy and/or the preparation of the bed and equipment for the procedure in question. Such practical testing is usually supported by a Question/Answer session on the theory underlying or associated with the procedure.

Group-discussion is often used to explore a subject in depth, particularly in later study-blocks when ward experience allows for greater contribution to the discussion by learners and therefore for considerable cross-fertilization through shared experience.

Most, if not all, Schools of Nursing have a library attached, which learners may use whether or not they are in study-block.

Private study, project-work and writing of case-histories of patients they are actually caring for provide learners with opportunities for further learning and research when they are not in study-block. Project-work and case-histories provide tutors with material on which
to base the learner's understanding of what has been taught, her ability to relate theory to actual practice and her ability to communicate her findings accurately and succinctly in writing.
REFERENCES AND NOTES.

1. Private communication, GNC.
2. " " "
3. " " "
According to Ruesch and Bateman (1, p.274) communication is
"... an extremely dynamic phenomenon with a rapid rate of change of levels and functions, which range from evaluation to transmission and conduction".

Within a particular culture or society knowledge of the range of levels and functions, both permitted and prescribed and the ability to evaluate, transmit or act upon a given stimulus or response within that range is acquired through learning by long association and continuous experience. Such learning begins in childhood with mother, extending later to members of the family. It continues in a wider sphere at school with contemporaries and teachers and on through adolescence to adulthood with peer groups and other adults.

Throughout this learning process the individual becomes aware of his role within the family, the group and the society in which he lives and his responsibilities and status within each role. He learns the local and societal norms of speech and behaviour and in doing so he assimilates the beliefs, attitudes, values and taboos upon which those norms are based.

This complex network of interpersonal relationships and communication is referred to by Ruesch (2, p.8) as the social matrix.

Before investigating the problems of communication which might follow upon the migration of overseas nurse learners from one social matrix to another, therefore, it is necessary to discover what similarities or differences exist between the original and target matrices and to what extent overseas nurse learners are equipped by the original matrix to operate in the target matrix.

The division of this section into subsections, social, educational, linguistic, psychological and political and economic, is purely for convenience of discussion since no one factor can stand in isolation: education is the key to social mobility; it is also linked to economic development; language both expresses and is generated by the culture it serves and, particularly in the areas included in
this research, the use of one language as opposed to another is of major political and psychological significance.

However, it is not intended to discuss the three research areas separately under each subsection since all three areas have so many features in common that, within the context of this thesis, it is possible to make general statements while acknowledging the differences. Nor is it intended to give detailed descriptions in each section, for that is neither possible nor necessary, but rather to give an overall picture of the current situation.

2.1. **Social Background.**

Sociologically, in spite of their cultural diversity, East and West Africa, South East Asia and Mauritius show certain similarities, many of which arise from the fact that they are all developing countries.

"Development" is a formidable task for these areas are attempting to achieve, in a few decades, a standard of living which it took the advanced world centuries to reach, and they must consciously plan and organise economic and educational expansion, health services, road, rail and air transport and telecommunications on a vast national and international scale, all of which occurred in the developed world largely as a result of historical evolution. The impact which such events have on the existing social matrix is enormous and manifests itself in every aspect of life.

Firstly, all three areas are experiencing rapid increases in population. West Africa, for example, with a population of 90 million in 1966, is described by Hallett (3, p.28) as having a "... population explosion as violent as any country in the world has ever known", and, according to Kee (4,2.2.), Malaysia's annual rate of increase is 3%, which is one of the highest rates of increase in the world - as is that of the Phillipines. (5, p.16). Mauritius, until 1972, also had a rapidly increasing population, though with the official encouragement of family planning the annual rate of increase is now declining. (6, para.16).
This increase is due in part to such health programmes as malaria eradication, already completed in Mauritius (6, para.16) and East Africa (7, p.63), and well under way in West Africa and Malaysia (4, 2.5). Expansion of rural health services, improved child care, and massive health education programmes are also, to some extent, contributing factors. Nevertheless these programmes must be seen in perspective. Infant mortality rates are still high; in East Africa, for example, 33% of children die before reaching school age (8, p.25), while in Malaysia the rate is as high as 56.8% (4, 2.5). Furthermore, life expectancy is short. In East Africa, for example, the average life expectancy is forty years (9, p.5). The nearness of death and the likelihood of losing one's child at a very early age or of death before middle age have both social and psychological effects which will be discussed later.

However, as Davis observes (7, p.63), the infant mortality rate is widely disparate between urban and rural areas, partly due to the imbalance in health care in favour of urban areas and partly due to the reluctance of health personnel - of which there is, in any case, a serious shortage - to work in rural areas. This is not altogether surprising since, outside the major towns, the comforts of modern living and good working conditions - electricity, running water, reasonably good supplies of drugs and equipment, a good transport system, easy communications and supportive professional networks - are absent. Secondly, then, other than in the big towns these areas have serious transport and communication problems, with the exception of Mauritius which, being a small country, does not suffer the same problems of distance and terrain and has therefore been able to build up its transport services more quickly and comprehensively, and a lack of basic amenities.

Nor do these conditions apply to minorities in these areas: for example, in Malaysia in 1965 almost 90% of Malays lived in rural areas (10, p.16); in 1966 the majority of West Africans depended on subsistence agriculture for their livelihood, with 75% of the total working population engaged in farming (3, p.65) and in 1970 the picture was similar in East Africa (9, p.2). In 1968,
80% of the Filipinos lived in rural areas and although, as Cameron points out (9, p.1), routine statistical information is extremely difficult to obtain for various reasons, it is unlikely that these estimates have fallen significantly within the last decade. Thirdly, therefore, again with the exception of Mauritius, the vast majority of people are rural dwellers, living by subsistence farming. Mauritius is becoming increasingly urbanised and the distinction between "rural" and "urban" is rapidly becoming blurred. (6, para. 28).

The fourth common factor is that all these areas have similar social systems in that they all have strong kinship ties and they all adhere to the concept of the extended family system, whether or not the social unit is outwardly a nuclear one - as, for example, in Mauritius (11, p.28). In the Phillipines the kinship network is extended among Christians to include those not directly related by blood or marriage as a form of ritual kinship (5, p.99) and in Africa it includes the home village and tribe (3, p.39).

The extended family and the powerful kinship bonds exert considerable influence upon members. Family obligations are far-reaching and the more successful a member of the family is, the more is expected of him. His family looks to him to pay school fees not only for his younger siblings but for others outside his immediate family. If he is in a position so to do, he is also expected to provide jobs for other members and also to look after and maintain the elderly. (3, p.39). Family responsibilities are clearly defined; older children look after the younger ones and they are taught filial obedience (5, p.99), the older generation having the final say in almost all matters (12, p.14). Many generations live under one roof or within the same village compound so that many of the Western problems associated with old age are non-existent (5, p.100).

Such closeness engenders a strong sense of group responsibility and loyalty (13, p.20). For example, only a small group of educated West Africans think of themselves first and foremost as Nigerians or Ghanaians. Most
think in terms of the tribe to which they belong. (3, p. 32). This closeness also brings with it a great sense of security and immense sociability, with frequent celebrations and constant family contact. Consequently members of such families find the advanced countries with nuclear families "... barren, strained and dull". (3, p. 32).

The only exceptions to this group affinity are the Filipinos. While their family and kinship loyalties and responsibilities are just as intense and binding, they do not extend beyond these limits. An African has his tribe or village; the Chinese and Indians in Mauritius and Malaysia have their cooperatives and their cultural groups and so have a sense of community organisation. Such community organisation is lacking in the Phillipines (5, p. 10) because of the Filipinos' inability to maintain affective group ties outside the kinship network (14, p. 220). This is possibly due to the Filipinos' urge to succeed at all costs. They have a word lamangan, meaning "by hook or by crook to get on top", which makes anyone outside their kinship network fair game for competition, thereby undermining their ability to form community associations.

The fifth common factor is that, with the effects of modernisation, the traditional family pattern outlined above is undergoing significant change. Shortage of facilities for secondary education and the concentration and development in towns of what facilities do exist, and the pressing need to find employment - both of which issues will be discussed more fully in their appropriate sections (v. infra: 2.2 and 2.5) - have led to a constant drift to the urban areas. Thus most children gaining access to secondary education and young school leavers seeking employment must move away from their families and villages during their most formative years and with this spread of education, and increasing sophistication and urbanisation, there is growing conflict between the norms of traditional culture and the new social norms of modernisation (13, p. 21): between traditional concepts of responsibility and the more self-centred needs of urban life. Youngsters going to the towns straight from their traditional roots, are experiencing great problems of adjustment in trying to adapt to the
demands of modern living (15, p.92).

Not only is the family structure affected but traditional authority-groups are being displaced by modern equivalents; the traditional ruling classes are giving way to the bureaucrats, and teachers and other professionals are ousting religious specialists (16, p.120).

Following Independence, new educated élites, centred on the towns, have emerged, comprising the expanding Civil Services, Government personnel and the higher echelons in the professions.

This is both encouraged and enhanced by the attitudes of the new society and the bias of the educational curriculum, which will be discussed later. A Government post, however junior, is the chief avenue of social mobility upwards (11, p.6), and therefore much coveted by school-leavers. Competition for such jobs is intense and since access to such jobs is based on educational qualifications, this is one of the prime areas of ethnic rivalry and conflict (11, p.27).

In all other fields of employment nepotism and corruption are rife (5, p.100;3,p.120;11,p.27), for the difficulties of not complying with the demands of family and kinship ties are very great. It is not easy for a man returning to his village to tell his kinsfolk that he gave a job to someone from another ethnic group or tribe, perhaps at variance with his own, because he was better qualified than his brother or cousin. However, many States are beginning to take an official stance against such practices - and it must be said that few countries, advanced or otherwise, are wholly untainted. Furthermore, it is easier to frown upon such practices when success has already been achieved but when the choice lies between giving a kinsman a job or leaving him to unemployment and severe hardship, the issue is not so clear-cut.

The sixth common factor is that, concomitant with the breakdown of traditional socio-cultural patterns and allegiances, all countries are seeking, and many are beginning to find, a sense of national identity and unity. Hallett suggests (3, pp.41-4) that this is the result of the growing gap between the older, uneducated members of...
the family and the successful, urbanised, more sophisticated members and it is certainly true that, particularly among the higher echelons, the new society has less and less in common with the old.

Again, these changes must be seen in perspective. While the social matrices in all three areas are being subjected to fundamental reorganisation and modernisation is rapid, such changes affect only the minority as yet, even though the circle of influence is widening. Goh Keng Swee's comment regarding South East Asia is equally applicable to East and West Africa: "The general picture [is] one of co-existence of modernity and tradition, with growing modern cities in the midst of a sea of rural traditional agriculture". (15, p.85).

The concentration of facilities in the towns at the expense of rural development and the growth of a small socio-economic élite has led to a considerable widening of the gap between affluence and poverty (16, p.130) and the overall pattern, summed up neatly by Cameron, is "... one of little homogeneity, great inequality and appalling difficulties". (9, p.3).

The extent to which the educated élite is a minority is amply demonstrated by an examination of the education systems in all three areas.

2.2. Educational Background.

2.2.1. Role and Status of Education.

In advanced countries education is usually compulsory, free and universally provided at both primary and secondary level until the termination of the latter in some form of examination of educational attainment. The quality of education, the appropriateness of curriculum content to the employment needs either of school leavers or of employers, and the genuineness of equality of opportunity are all matters of continuing debate but, theoretically at least, all children have the opportunity to benefit from full primary and secondary education.

In developing countries, however, education is neither compulsory, completely free nor by any means universal.
This is due to several factors, which together form a vicious circle. All developing countries, in spite of external aid, suffer a serious lack of financial resources and what resources there are must be divided among areas of development with equally urgent needs. As Cameron observes, the difficulties are appalling.

Expansion of education requires buildings, teachers, equipment and textbooks, the provision of which requires manpower at all levels — who must first be educated. None of this can be achieved without financial resources, so the GNP must be increased by economic expansion, which can only be achieved by the expansion of education ...

While Governments are only too aware of the dilemma — whether in Beeby's words (17, p.21), to build more schools to expand the economy or improve the economy to afford more schools — the initiative has, to some extent, been taken out of their hands by mounting social pressures. The growing demand by parents, who see education as the key to better lives for themselves and better prospects for their children, constitutes "... a political force that no democratic Government could long resist". (17, p.9). Not only is education "... virtually the only way in which a young person can upgrade himself socio-economically" (18, p.49), but the obligations of kinship demand that he do so for the betterment of his whole family. For example, in a study conducted by Moock among Kenyan school-children, the two most outstanding reasons why pupils wanted to raise their earning potential through education were: a) to help their parents and b) to pay their siblings' school-fees. (19, p.108) In addition, educated girls can marry into well-to-do families and they bring a higher bridewealth. (p.111).

Many Governments have attempted to meet the increasing demand for education by rapid expansion at the primary level but yet another problem inhibits the narrowing of the gap between supply and demand. With the phenomenal rise in population, further demand outstrips whatever expansion there is. Consequently, as Cameron so graphically comments, developing countries "... have to run fast to stay in the same place". (9, p.1).
Such is, and has been, the clamour for education that in some countries where Governments were either unable or unwilling to make provision, the people have taken the initiative themselves. Thus, in Malaysia, the Chinese and Indians created their own education systems without benefit of Government aid (20, p.4), a fact which caused considerable political strife when a national, unified system of education was introduced in the 1960's. In the Philippines, where "a passion for prestige and diplomas as status-symbols" (5, p.125) was added to the thirst for education, the number of private schools increased greatly to meet the growing demand.

This quantitative expansion has created several new problems, the effects of which are discernible throughout the entire system; its quality, its availability, its content, its examination system and its effectiveness.

Since few if any developing countries have "... either adequate sources or efficient machinery with which to process them" (9, p.1), the statistics which follow should be regarded as reasonable approximations rather than accurate assessments.

2.2.2. Availability of education.

All three areas have primary, secondary and tertiary levels of education and many have pre-primary provision. The most significant factors concerning educational facilities, however, are the limited availability at all levels and the effect of this not only on the system but on the attitudes of pupils, teachers and society as a whole towards education.

No country has 100% of its school-age population enrolled in primary schools and even those with a high primary intake show a sharp drop in enrolment at secondary level. The figures below give some rough comparisons:
<table>
<thead>
<tr>
<th>Region</th>
<th>Primary intake</th>
<th>Lower/ Middle Secondary intake</th>
<th>Secondary/ Upper Secondary intake</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.Africa (Ghana)</td>
<td>Varies between regions from 90-20</td>
<td>43.4 *</td>
<td>16 *</td>
<td>(21,p.1)</td>
</tr>
<tr>
<td>1972</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Nigeria)</td>
<td></td>
<td>-</td>
<td>16 *</td>
<td>(22, Table 13, p.15)</td>
</tr>
<tr>
<td>1972</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.Africa (Kenya)</td>
<td>65 †</td>
<td>-</td>
<td>25 *</td>
<td>(23,p.9)</td>
</tr>
<tr>
<td>1973</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Uganda)</td>
<td>48 †</td>
<td>-</td>
<td>4 *</td>
<td>(9,p.145)</td>
</tr>
<tr>
<td>1965</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.E.Asia (Phillipines)</td>
<td>90 †</td>
<td>30 *</td>
<td>-</td>
<td>(5,p.126)</td>
</tr>
<tr>
<td>1968</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(W.Malaysia)</td>
<td>91 †</td>
<td>52 †</td>
<td>16 †</td>
<td>(24,p.9)</td>
</tr>
<tr>
<td>1970</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mauritius</td>
<td>91 †</td>
<td>-</td>
<td>52.3 †</td>
<td>(6,para 71,85)</td>
</tr>
<tr>
<td>1973</td>
<td></td>
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</tbody>
</table>

† = % of total relevant school-age population

* = % of initial primary intake.

The Mauritian high primary intake is misleading for in overpopulated areas a double-shift system operates in an attempt to meet demand, with about 30% of the total primary intake involved. Instead of a full 5½ hour school day, these pupils attend either morning or afternoon for 3½ hours. (25, p.9). The effect of this on the implementation of the full curriculum is obvious.

All countries have both public and private primary provision, the public sector being either wholly or partially free. For example, in Mauritius and Malaysia, it is completely free; in Kenya only the lower standards are free.

The sharp drop in intake at the secondary level is due to a corresponding lack of facilities and competition for existing places is therefore extremely fierce. Entry to secondary education is by selection examination,
usually at the end of the primary stage. Malaysia, however, on the introduction of free primary education in 1961 also offered three years of free secondary education at lower secondary level, terminating in the Lower Malaysian Certificate of Education (lower MCE). This examination is the selection examination for further secondary education. Ghana, on the other hand, has two cut-off points, one at the end of the primary stage and the other between the middle and upper secondary levels, though access to the selection examination for upper secondary education is from Primary Class 6 to Middle School Form IV.

These selection examinations are conducted on a national basis and since they arbitrarily disbar thousands of pupils from continuing their education further, they have become the focal point of primary education and their influence is felt throughout the whole system. The vital importance of success has inevitably led to the adoption of various devices, both legal and otherwise, to increase the chances of passing.

It is legal, for example, both in Mauritius and Kenya, for pupils who fail or who wish to improve their score to repeat Primary Standard VI and resit the examination at the next opportunity, provided they are of the statutory age. Illegal repeating, however, is frequent in Kenya and since a school's status is dependent on its successful selection rate, some teachers are party to the illegality and allow pupils to repeat more than once.

In Mauritius the need to succeed has led to the development of a private coaching system at all levels of education but most flourishing in examination years. It is described as a "vicious national industry" for parents, whether or not they can afford it, are often obliged to participate for the sake of their children and educational staff, from primary school teachers to senior Ministry of Education officials, use it as a means of supplementing their income.

For those who are successful in gaining the opportunity for secondary education, public or private, there are.
usually several alternatives - not all equally attractive - ranging from the highly prestigious Government or Government-aided schools, usually built for Europeans during the Colonial era, to the local private schools such as the self-help Harambee Schools of Kenya (27, p.71). Unlike primary education, where at least a certain proportion is free, all secondary schools are fee-paying.

Entry to the various types of school is also on a competitive basis, selection being made on the basis of order of merit in the selection examinations, the most successful candidates sometimes being awarded scholarships or bursaries.

For example; the national catchment schools of Kenya (26, p.71) make their selections before all other secondary schools. They are highly selective and take only the very ablest pupils, with a generous bursary scheme for those who need financial help. They account for about 4% of the secondary population. Local catchment schools have next choice, taking 10-15% of pupils who sit the Certificate of Primary Education (CPE). Fees are relatively low and competition is fierce, though not quite so exclusive as the national catchment schools. The rest of the pupils eligible for secondary education either go to the Harambee schools or go without. These latter schools are non-selective, the only entry requirements being a bare pass in CPE and, more importantly, ability to pay the fees. Not all pupils have a "bare pass" however; many may have been in the top quartile of the selection examination. Nevertheless, pupils at this level regard themselves and are regarded as failures - a situation somewhat akin to the days of the English Secondary Modern Schools versus the 11+ and the grammar schools. This example, while varying in detail, is fairly typical of the African situation as a whole.

In Malaysia, on the other hand, since the introduction of comprehensive education in 1961, at least at lower secondary level, all children theoretically have access to a certain amount of secondary education. In practice, however, since secondary schools are located in the towns, children living in isolated rural areas have considerable,
difficulty in attending and, as most of them come from low-income families, the cost of travel and board is prohibitive (24, 5.3).

Filipinos do not suffer quite the same problems since the high schools and colleges (based on the education system of the United States) are usually local and though geared to local employment needs, do have the capacity for those able to go on to liberal arts degrees (28, p.4). Their problem is much more that of a generally low standard of education altogether (5, p.126). However, the number of places available is still limited.

In Mauritius there are two hurdles on the road to secondary education. All pupils sit the Primary School Leaving Certificate examination (PSLC), the top third being allowed to sit the Junior Scholarship examination. Admission to Government or Government-aided schools is based on order of merit in this examination, the top 200 — 120 boys, 80 girls — being awarded scholarships (25, p.10). As in Malaysia, however, the system favours the urban-dwelling pupil for, although the rural/urban distinction is much less marked than in Malaysia, there are still many low-income families outside the urban centres who cannot afford the cost either of secondary education or of sending their children to the towns. Even when parents can afford it, children often have to make long journeys to and from school (6, para.137).

It is evident, then, that although selection for secondary education is initially by examination, not all those who pass — and are therefore eligible to enter the secondary stage — can necessarily take up their options. It is not always sufficient to pass the examination; one must also have the money to pay for the privilege of secondary education.

It is therefore not to be wondered at that 14-year-old school-children should be preoccupied with their earning potential, nor that the high-prestige white-collar jobs, with their relatively high salaries, should be so highly prized and sought after for the sake of family advancement, nor that pupils and parents take what measures they deem necessary to improve their chances.
Clearly education in developing countries is in no way an automatically ongoing process and for the vast majority the primary level is a terminal stage. Therefore, as Cameron points out (9, p.10), those who survive the selection ordeal are a privileged minority, accounting for about one-fifth of the school-age population, taken on average. However, not even this small number actually complete secondary education. Many drop out during the first year, either for financial reasons, or because they cannot cope with the studies or because the number of places available diminishes as the pupil passes upwards through the system. The overall drop-out rate in Mauritius from Forms I - V is 37% (6, para. 132) and in East Africa it is even higher (9, pp. 144-5).

Those who do stay the course have access to the coveted secondary school certificates, equivalent to the English General Certificate of Education, (Ordinary Level), which in their turn are selection examinations for Advanced Level courses, where facilities are even scarcer.

The function of examinations has therefore become that of selection - device for the next stage of education rather than a measure of aptitude or educational attainment (23, p.13) and as such they "... determine parent, student and teacher attitudes, govern curricula and syllabuses and control (to a large extent) teaching methods".(6, para. 118). As a result it is often very difficult to implement the full range of the official curriculum and curricular or methodological change is still harder to achieve.

2.2.3. Content and Method.

In theory developing countries aim to provide, both at primary and secondary level, a widely-based, balanced curriculum which will ensure a satisfactory level of general education on completion. However, given the all-importance of success in examinations at all levels, this is seldom achieved. Politicians, education planners, curriculum developers and experts in all fields of education draw up programmes based on the needs of the country, of employers and of the pupils themselves but, until the,
function of the examinations and the attitude of parents and pupils to the purpose of education and to employment afterwards is altered, these programmes seem doomed to failure.

In Mauritius, for example, the official primary school programme is well-balanced and the time allotted to the various subjects reasonably apportioned, with adequate scope for the preparation of pupils for both the academic and the technical/vocational secondary school streams. (6, para. 78). In fact, primary education is geared mainly to the needs of the more able pupil and the demands of the PSLC, with more time being spent on the examinable subjects—English, French, Mathematics and Geography—than on any others. No history is taught, although included in the official curriculum, and environmental studies, though prescribed, are largely ignored (6, para. 124).

A similar situation exists in Kenya, where the CPE dominates teaching to the virtual exclusion of all else. Non-examinable subjects fail to hold the interest of the pupils and any teaching not directly related to the passing of the CPE is resented. Thus pupils have no wish to carry out rudimentary experiments to prove scientific laws; the examination demands only that the laws are known. Similarly with geometry and the drawing of graphs; the figures appear on the examination paper, the candidates only draw the inference (26, p.127). Since written English is no longer an examinable subject, teachers have to ignore the teaching of compositional skills (26, p.125). The examination is a multiple-choice question type; therefore the teacher must employ similar teaching techniques. So overwhelming is the preoccupation with the CPE that no pupil would willingly be without a copy of the CPE Pupil's Companion and the Complete CPE Guide Book for they contain previous CPE questions and answers and examples of question-types. King calls them the "unofficial" syllabus (26, p.126) and they rate far more highly than the official one.

Kenya's primary schools may be drastic in the way they meet the exigencies of the CPE but they are, nevertheless, only manifesting the extreme of an examination-based
attitude - described elsewhere as the "ground-to-be-covered" attitude (29, p.112) - which is prevalent throughout all three areas.

Both East and West Africa have centralised primary curricula, which are described by Hawes as "most inappropriate" (29, p.108), in spite of the fact that efforts are being made in many respects to re-orientate the contents of some subjects from Western to local data. (9, p.100). Since the curricula are examination-based, they take no account of the thousands of pupils who will not progress beyond primary level and who will therefore have to find employment or return to subsistence farming, nor of the low- and middle-level technical and vocational manpower so desperately needed by all developing countries.

Malaysia's curricular problems are somewhat different from those of other countries, though their content is rather similar. In 1965 not only was comprehensive education introduced but it was, at the same time, an attempt to create a unified, national system of education from the three separate, racially-oriented systems which were then in existence; Chinese, Indian and Malayan. A unified system requires a common curriculum but difficulties arise, particularly in respect of the cultural aspects of such a curriculum because "Malaysian" culture has not yet been defined. Any attempt at "comparative cultural studies" would only heighten the differences at this stage for, although the Chinese and Indians are prepared to be Malaysians politically, they are not yet willing to submerge their cultural identities (19, p.10).

In addition, in spite of the name "comprehensive" there has been no real change in the content of education. Vocational and technical subjects have been introduced but basically the syllabus is an attenuated version of the traditional academic content (24, p.20).

The position at secondary level is very similar. Based on secondary certificate examination requirements, all countries have highly theoretical, academic curricula, usually weighted heavily in favour of arts subjects (9, p.100; 20, p.9; 25, p.18). Students often concentrate on five or six subjects because of examination requirements
and tend to choose those which are easiest to pass. (30, App.1, para. 7). Consequently they have little knowledge of the physical or natural sciences, nor their interrelationships one with the other.

The theoretical basis of the examinations and therefore of the curricula has resulted in an emphasis on memorisation and rote-learning (9, p.10; 19, p.116; 30, 3.02), thus neglecting the development of thought-processes and the ability to correlate or transfer learning (30, App.1, para. 7).

Several countries have drawn up programmes for curricular reform at both primary and secondary level (5, p.125; 27, p.23; 29, p.109) but various factors militate against their implementation. Firstly, while examinations continue in their present form, parental pressure is brought to bear upon teachers to maintain an academic education (17, p.33). Secondly, parental pre-occupation with prestige and social advancement inhibits the introduction of technical and vocational subjects (6, para. 53). Thirdly, particularly at secondary level, much of education is in the private sector, over which Governments have very little control (30, 3.05) and which, for financial reasons, do not want curricular reform. (30, p.i). Fourthly, teachers are often unable or unwilling to implement new syllabuses (29, p.109); unwilling because of parental pressures and unable because of the limitations in their preparation for teaching.

2.2.4. Teachers.

In their assessment of the educational situation as a whole in Mauritius, Chisman et al. comment that: "The situation is compounded by often inadequately qualified and untrained teachers". (25, p.18). This is equally true of other developing countries and it is a serious hindrance to the introduction of curricular change and improved teaching methodology.

That teachers are underqualified is perhaps even more serious than their being untrained, for it is possible to be a competent subject-teacher, particularly if the syllabus is mainly theoretical and academically oriented,
if one is a graduate and therefore knows one's subject, with numerous text-books and other educational aids, with frequent inspection and other professional support - as witness the situation in England until fairly recently.

No-one, however, would suggest that GCE Ordinary or even Advanced Level Certification was sufficient qualification to teach, yet this is the state of affairs in much of the developing world, with the majority of teachers even less "qualified" than this. For example, in Kenya in 1970 35% of the primary teaching force was untrained and of these roughly 17% did not even have the Preliminary Examination Certificate, which indicates completion of full primary education. In Uganda 40% of supposedly trained primary teachers had a Grade I Certificate - that is, six years' primary education and one year of teacher-training (9, p.78).

Hawes suggests that the situation is similar in West Africa (29, p.109) and that, in addition to the difficulties inherent in knowing little more than one's pupils, teachers face long hours and large classes, with a very indifferent inspection service and inadequate facilities for in-service training. Not only, therefore, are teachers ill-prepared for their work but they are professionally isolated and get very little on-the-job support or opportunity for betterment.

In Malaysia, too, in 1970 20% of the teaching force were under-qualified; that is, they did not meet the minimum requirements of five years secondary education (4, 5.7).

In Mauritius in 1971, of 1,770 secondary school teachers, 4.5% were graduates and teacher-trained, 19.3% were untrained graduates. The rest were untrained, with either Cambridge Higher School Certificate, Cambridge School Certificate or less as their basic and only qualification (25, p.11).

Under such conditions it is understandable that the morale of many teachers is very low, trying as they are "... to do the near-impossible and being criticised for not doing it". (29, p.115). Nor is morale improved by the low status of the teaching profession and in both...
Africa and Mauritius teaching is often used merely as a stepping-stone to higher status/higher salaried posts (9, p.77; 6, para.134). This is perhaps truer of teaching at primary level and in the less prestigious secondary schools, for to teach in a good Government school confers as high a social status on the teacher as gaining a place through the selection examination does on the pupil. Such schools thus attract the graduate teacher, trained or otherwise – but, like the pupils they teach, they are a very select, chosen few.

Teacher-training itself, on the whole, has been inadequate; often too short and with more concentration on content than methodology (25, p.18) and to many who seek it it is a very poor alternative to secondary or university education (9, p.78), when they can go no further along either of these avenues. Motivation, therefore, is at its lowest.

However, gloomy though the picture may seem, many countries do realise that if education is to improve, teacher-training must be a first priority (29, p.109) and to this end Teacher Training Colleges and Institutes of Education are being developed as rapidly as possible. East and West Africa already have Teacher Training Colleges and Institutes of repute, whose function in upgrading the quality and status of teachers and their training is gradually producing some improvement in this state of affairs.

Nevertheless, there is little point in improving either the teacher’s status or his preparation unless provision of facilities increases pari passu.

2.2.5. Effectiveness of Education.

Added to the lack of any or adequate training and preparation, the exigencies of examinations and the power of parental pressure, teachers must, on the whole, face their task with little or no equipment, inadequate or non-existent laboratory and library facilities and insufficient and/or unsuitable textbooks. (5, p.123; 4, 5.3; 29, p.108). The serious shortage of textbooks makes even the academically oriented syllabuses difficult
to teach and even when mass production and distribution of educational materials is tried, it is rarely successful (29, pp. 108-9). Physical conditions are often extremely bad, with ramshackle or temporary buildings being used as schools (4, 5.3; 6, para.134) and overcrowding is a common complaint. Both this and the lack of laboratory and other equipment makes the teaching of the sciences virtually impossible and explains in part the concentration on arts subjects. Even if the equipment and laboratory facilities were available, it is doubtful whether the majority of teachers would either understand their use or be able to explain them to their pupils. Limited by their own lack of education and the consequent lack of confidence or ability to diversify, teachers must take refuge in didactic teaching methods and in rote-learning.

Even when - as a survey of primary school teachers in Buganda in 1968 showed - young teachers are willing and keen to try out new techniques (29, p.110), they get very little encouragement to do so. Always under pressure to produce a quantitative increase, teachers are forced to process pupils for examination and white-collar employment and to ignore non-examinable educational aims (19,p.114). Moreover, the predominance of the private schools, which are often "... purely commercial ventures of doubtful educational standards" (31, 3.02); the sending of as many children as possible to school, thus overloading the system and lowering already suspect standards, and the failure of Governments to give education any reasonably high priority in terms of finance and materials, makes the introduction of new techniques and curricular reform an impossibility. In all but the good Government schools, therefore, where teachers are mostly qualified graduates and laboratory and library facilities are adequate and sometimes excellent (27, p.71; 7,para.132), the "bewildering sequence of educational innovation" (29, p.109) - new mathematics, new science, integrated science programmes and so on - have almost no chance whatsoever of implementation.

Many teachers resent the fact that they are unable to implement even the existing curriculum properly - as, for
example, in Kenya where, as has already been mentioned, the "unofficial" syllabus often takes precedence over the official one. Not only are teachers unable to "compete" with the CPE but the system of repeating in Primary Standard VII has led to a situation where the repeaters set the pace and fresh entrants have to pick up the basic curriculum on their own (26, p.138).

The multiple-choice nature of these national examinations not only limits the teaching techniques at primary level, as has previously been stated, but it also has its repercussions at secondary level. The lack of attention paid to compositional skills at the primary stage results in difficulties for pupils in secondary schools in expressing themselves coherently in writing and the limited techniques which the primary teacher is forced to adopt result in retardation of the cognitive learning processes. (26, p.140). It is noteworthy, for example, that there is a very poor correlation between high CPE scores and East African Certificate of Education results (26, p.142).

It is evident then that at both primary and secondary level - except in the best Government and Government-aided schools - the quality of education is poor and that its effectiveness is commensurate.

With a substantial section of the teaching force both underqualified and untrained, and with the severe shortage of facilities of all kinds, both teaching methods and subjects taught are strictly limited, largely excluding, from necessity, those subjects most essential to any modernising society, namely in the scientific, technical and vocational fields. Thus, as has already been observed, learning processes are retarded and the lack of facilities must preclude the development of learning habits such as private study and experimentation.

Another factor which complicates the already difficult problem of education is the question of language and the changing Governmental policies regarding national languages, official languages and the medium of instruction in schools.
2.3. **Linguistic Background.**

The role and linguistic status of English in developing countries is, for political, social, and economic reasons, in a constant state of flux. Therefore, as Spencer suggests: "... any comment concerning English in [developing countries] can only be an 'interim report' " (31, p.2) and it will be a long time before the position stabilises and the final report can be written.

The role of English varies from country to country relative to the use of vernaculars and its linguistic status ranges from that of second language to foreign language. Attitudes towards the use of English as an official language and/or a *lingua franca* are frequently ambivalent and its adoption as such is often *faute de mieux*.

Before continuing it might be useful to define certain terms so as to avoid confusion later.

1. A **national** language is one used for all purposes, official and unofficial. It is the language of the home; the medium of instruction in schools and the language of the school playground; it is the language of society for all formal and informal purposes and it is the vehicle for creative writing and for the culture of the country. It is usually, though not always, the mother tongue.

2. An **official** language is used for all official purposes. Thus it is the language of Government, administration and commerce; it is usually the medium of instruction in schools and of official broadcasting and of the newspapers. It is not, however, the language of the home, nor of the school playground; it is not necessarily used in a social context, except formally, unless as a *lingua franca* between members of different ethnic groups. It may or may not be the vehicle for creative writing but it is certainly not the primary cultural vehicle. It is almost never the mother tongue of the greater majority.

3. The term **foreign** language is used of a language which is learnt as a means of access to a foreign culture, whether for educational purposes, business or pleasure. It is not a necessary adjunct to the learner's daily life unless he chooses to live or work within that culture or to have business or other associations with members of it.
4. The term **second language** is employed when a language which is not the mother tongue is necessary for use as a lingua franca, as the medium of instruction in education, or for other purposes in societies which do not share a common mother-tongue, as in plural or tribal societies.

2.3.1. **National and official Languages.**

One of the first questions which any newly independent country asks is: what shall the national language be? In their new-found and often hard-won freedom the immediate reaction is to remove all traces of the Colonial era and one of the most obvious legacies of their recent domination is the language of the colonising country - in education, in Government and in commerce. In East and West Africa and in much of South East Asia this was English; in Mauritius it was French.

However, having asked the question, the answer does not come readily. Among new nations "... the desire to use language as a sign of national identity is a very natural one, and in consequence language has played a prominent part in national movements". (32, p.3), but the cost of implementing a national language policy may be very high in terms of political stability and the practical difficulties are enormous.

In Malaysia, for example, the implementation of the national language policy caused political bitterness and strife which has not yet been fully resolved. A national language, it was felt, would be instrumental in breaking down existing cultural barriers between the three main ethnic groups - the Malays (53% of the population), the Chinese (35%) and the Indians (8%). Malay was chosen as the Bahasa Malaysia (language of Malaysia) because a number of non-Malays already spoke it and because it is relatively easy to learn by comparison with Chinese, Tamil or English. (33, p.75). English, in any case, was an unlikely choice since a national language was regarded as an essential component of nationhood and English, with its colonial associations, was seen as the antithesis of independence and freedom. (33, p.75).
Far from unifying the country, however, it caused considerable polarisation, from extreme pluralism to complete unification, and feelings over the question of Bahasa Malaysia ran very high. Non-Malays regarded the Malay language as inferior not only by comparison with their own languages but also in terms of English. So great was the resentment and bitterness that in 1969 racial riots broke out and this resulted in strong Government action. In 1971 the Law of Sedition was amended and it is currently an offence to discuss the national language policy (2D). Implementation of the language policy continues on these terms and it is expected that it will have been completed by 1984 (24, p.19).

Most of the other countries in the three areas have opted for official rather than national languages. In much of East and West Africa and in Mauritius the official language is English. In no case, however, was it a positive choice but rather as the lesser of evils. In Nigeria, for example, it is often suggested in high places and in the Press that there should be a national language but the difficulty of choosing between Hausa, Ibo and Yoruba - the three principal languages - is so great that the question has been shelved (34, p.46) and Ghana avoids the issue on similar grounds (35, p.52).

In Mauritius the situation is somewhat more complex. The Indo-Mauritians, who form 66% of the population and who are also the ruling Government Party, do not want Creole - which is the mother-tongue of many and the lingua franca for all - upgraded to the status of national or official language. They are afraid that if it is, Indian languages will be forced out of existence - as has already happened to the Chinese languages. (3% of the population is Chinese). Nor do they want French, since historically the Franco-Mauritians, still a powerful élite, were the planters and the Indians were the labourers, imported during the nineteenth century to work in the sugar plantations. Their treatment then has left a legacy of mistrust and dislike (11, p.18) and the Indian community does not want to officially adopt the language of its erstwhile oppressors. English has therefore been adopted as the
2.3.2. **Language in the Social Context.**

While the adoption and use of national or official languages is necessary for both internal and external communication because of the multiplicity of indigenous vernaculars, they do not permeate the whole of life. They are, in Spencer's words: "... still primarily the language[s] of westernised areas of life - institutional rather than domestic. The vernacular remains the language of the home, affection and emotion". (31, p.4).

First contact with the national/official language is usually when the child goes to school, where he meets it in the first instance as a foreign language. Even at school, although vernaculars usually play a secondary role in the classroom, pupils revert to the vernacular outside it (34, p.46) and many have more than one vernacular.

For example, Nigeria has over 400 different languages (34, p.36) and Ghana has more than 40 (35, p.49). These are the languages of the tribal subdivisions of the main tribes. Thus an African will speak the language of his tribal subdivision with its members and the main tribal languages with members of other subdivisions. Only when he moves outside the main tribe will he use the official language informally.

In Mauritius no-one uses the official language outside official situations. Either Creole or an oriental language is used (25, p.17) and in Malaysia the non-Malays use either a Chinese or an Indian one.

2.3.3. **The Medium of Instruction in Education.**

In West Africa the medium of instruction is English. In Nigeria it comes into force from the third year in primary school (34, p.35) and in Ghana the official policy is that it is introduced as soon as possible. Implementation varies, however, according to the location of the school. For example, in country areas where pupils share the same vernacular there is less onus on the teacher to use English and therefore it may be several
years before he does so. In towns, however, where pupils are less likely to share a common vernacular, it is essential to introduce English almost if not immediately (35, p.57). In East Africa the position is similar (37, pp. 137-8).

In education lies one of the reasons for the hesitation in Africa in adopting indigenous languages as opposed to English as an official language. Quite apart from the political caveats, there is the question of the ability of the indigenous language to express the concepts of modern education, particularly in science and technology. Many vernaculars have either no orthography at all or a very limited one (34, p.45) and although in some instances attempts are being made to remedy this (35, p.50), orthographical development to the point where a particular vernacular could serve the purposes of education would be a lengthy, expensive and arduous business.

Malaysia is indeed facing this very problem since Bahasa Malaysia became the medium of instruction at all levels. The language is deficient, particularly in technical lexis, and the Centre for Language and Literature is busily engaged in producing suitable neologisms but until this is completed English has to be interspersed with Bahasa Malaysia (33, p.78).

Another, and perhaps even greater, problem is that of the production of textbooks and so on in the vernacular. Translation of existing textbooks or preparation of new educational material in a new national language would be difficult for advanced countries with the manpower and finance possibly available. In developing countries where both are in extremely short supply, the task it imposes beggars description and one of Malaysia's chief difficulties in implementing the language policy in schools has been the severe shortage of textbooks and educational material in Bahasa Malaysia (33, p.78). In the Philippines the situation is similar as Pilipino, the national language, takes over from English - though at present both are used. (38).

In Mauritius there is no clear-cut medium of instruction. In principle no Creole is used, English and French
being the official language of education from the age of five. In practice, however, in view of the difficulties of teaching in two languages, which at that stage are foreign languages to pupils, teaching is conducted in a mixture of Creole and French with a little English, though written work is in English only. The pedagogical implications would daunt the most gifted and dedicated teacher - but, as described earlier, the quality of teaching falls well below this level.

Examinations are conducted in the same language as that of the medium of instruction, though the position of English as an examinable subject has changed. In some countries in East and West Africa English is no longer a compulsory subject (9, p.100; 39, p.86); in Malaysia, Mauritius and Ghana it is, though its significance varies. In Ghana and Mauritius, for example, a failure in English at secondary certificate level is more serious than in Malaysia where it is no longer a key subject.

2.3.4. The Role of English.

Clearly, the role of English, and therefore the individual's exposure to it, depends on its function in society and its relative usefulness as a tool of communication.

In West Africa, for example, the role of English is unlikely to change, since it is the official language, the language of education and of the mass media. In addition it is the lingua franca and is a prerequisite for any employment where English is the medium of communication. It is also the principal language of the live arts (34, p.35). Therefore, although, as Constable observes, it is as yet only the small, educated élite who can use it adequately, (37, p.131) the exposure of that élite is both constant and diverse and the status of English is that of a second language.

In East Africa, although the contact-language between many tribes is Swahili (37, p.138), the role of English for the educated East African is unlikely to change its function as that of principal second language.

In South East Asian countries, however, where the
tendency is towards introducing national languages, the role of English is already undergoing marked change. In the Phillipines, where the national language is gradually taking over from English, although English still has the status of a second language, this is likely to change as the balance alters in favour of the national language. Similarly in Malaysia, where the tendency already is for the status of English to become that of a foreign language. While tensions and bitterness regarding the national language remain, English continues to be used by the educated elite as a neutral means of communication. Also, while English is still necessary for scientific and educational purposes, it retains its status in schools as an official second language and is taught as a compulsory subject (20), but this must be seen as a temporary phase. Once English is no longer needed in schools, it will lose this status and become a foreign language and once the current school population become working adults, the use of English among the educated will presumably decline. The process may take a little longer in the Phillipines but not appreciably so. Consequently, in the not-too-distant future, the exposure of South East Asians to English will be the same as that for any foreign-language learner.

2.3.5. **Proficiency in English.**

Proficiency is a relative term and judgement of proficiency depends on the level of acquisition required. It also implies a recognised norm against which proficiency is measurable.

For example, a Nigerian trader who has acquired sufficient English to be able to sell his wares at a reasonably bargained price to an expatriate speaker of English might be said to be proficient in English within the limits of his need to use the language. A university professor, however, needs a much wider range of use and a much higher level of attainment in order to be judged proficient.

The norm recognised by all English-speaking countries is that of Standard English. (A word of explanation may be appropriate here concerning the use of the term).
There is a tendency on the part of the British people to equate the term Standard English with Standard British English (32, p.5) and to regard other forms of Standard English as inferior versions of the latter. Some people in developing countries share this view (35, p.53; 40, p.123). However, as Quirk points out:

"It is unreasonable to regard any language as the property of a particular nation and with no language is it more unreasonable than with English". (32, p.5)

Grieve defines Standard English as:

"... the vocabulary and structure used, whatever the accent, by all educated speakers of English". (39, p.7)

He goes on:

"The similarities between educated British English and any other educated form of English are so extensive when compared with the differences that we are quite justified in speaking of a universal Standard English used by educated people, with minimal regional differences, everywhere". (39, p.7)

It is these regional differences which mark a particular Standard English as being American, Nigerian, Ghanaian and so on. These different forms of English are referred to as varieties and such varieties emerge as a language becomes naturalised. In multilingual societies, such as Africa and South East Asia, where English comes into frequent and daily contact with the indigenous vernaculars, various changes occur as vernaculars and English influence each other in what Spencer calls "reciprocal seepage" (31, p.7). Thus lexical, phonological, syntactic and semantic divergencies begin to appear as the imported Standard English adapts to and is influenced by the indigenous languages and cultures, gradually stabilising to produce the new norm of the adoptive country. In countries such as Canada and the United States such norms have already stabilised; in developing countries they are still in the transitional stage. While Nigeria acknowledges its own Standard English, the norms of that variety have not yet been formalised (40, p.125), and in Ghana the question is asked whether, in view of the diverse linguistic backgrounds, several forms of Ghanaian Standard English ought not to be possible (35, p.53).
When a particular variety of Standard English is in the process of evolution, problems of correctness arise, which must be a matter of difficulty for the teacher. When, for example, is a local variant an error? Bamgbose illustrates this question with an example: "It was my first time of going to hospital". (34, p.41). He remarks that while the above would be marked as wrong by the Overseas Cambridge Examination Board, a Nigerian examiner would almost certainly accept it as a local variant. Such instances are numerous and pose problems for teacher and student alike, not only in the use of English but also in the teaching and learning of it.

There is a further dimension to the use of the term variety. Not only does it refer to varieties of a language but also to those within a language, summed up neatly by Fishman as Who says What to Whom and When (41, p.15). Any speaker of any language will use various forms of that language depending on a) the situational context and b) his role in that situation. Thus the form of language used by a teacher during a class will be different from that which he uses with his colleagues in the staff-room; it will be different again when he speaks to a pupil individually, and again when he goes home to his family. If he takes his car to the garage to be mended he will use yet another variety. Hence "... circumstance, convention and convenience determine which language or variety of language will be used". (39, p.6). Knowledge of and the ability to use the appropriate variety in given circumstances depends on an intimate knowledge of the culture concerned and the level of proficiency in the language.

Although Standard English has international currency, pronunciation - or accent - does not. While the divergencies between the varieties of Standard English are minor, the influence of indigenous vernaculars on pronunciation are considerable.

According to Quirk:

"Most of us have an image of ... a normal or standard English in pronunciation, and very commonly in Great Britain this is 'Received Pronunciation' [RP], often associated with the public school, Oxford and the B.B.C. ..." (32,p.91).
He continues:

"... At the same time it must be remembered that, so far as the English-speaking countries are concerned, this 'R.P.' approaches the status of a "standard" almost only in England ..."

Grieve suggests that, associated as it is with a particular social or educational background, RP is more a status symbol and that it has no intrinsic merit (39, p.6). In developing countries it can be a definite disadvantage.

All other English-speaking countries have developed their own norms of pronunciation and their divergence from RP often owes as much to sociolinguistic factors as to linguistic ones. There is always, as Spencer points out (31, p.27) an imitative tendency in language use, mother-tongue or otherwise. Peer-groups and reference-groups set tolerance or acceptance levels for linguistic traits and members or would-be members seek to conform in order to secure acceptance. In West Africa, for example, there is a communal resistance to the cultivation of RP, both in Nigeria and Ghana and it is therefore avoided. Of Nigeria Bamgbose comments:

"... it is generally agreed that the aim is not to produce speakers of British RP (even if this were feasible!) [sic] ... Many Nigerians will consider as affected or even snobbish any Nigerian who speaks like a native speaker of English ..." (34, p.4).

In Ghana, as in Nigeria, it is generally felt that an African who imitates the native English-speaker loses some of his identity and: "... that affectation and artificiality should be excluded from educated Ghanaian English". (35,p.53).

It is true that, given the sound-patterns of the indigenous vernaculars and their effect on the pronunciation of English, speakers from all three areas would have to make a conscious and prolonged effort to approximate to RP even should they wish to. For example, many West African languages appear to be syllable-isochronous; that is, syllables follow each other at regular intervals, as with French; whereas English is stress-isochronous. Stressed syllables occur at regular intervals, and the unstressed syllables fit in as best they may. (31, p.26). Also, as with Chinese languages, West African languages are tonal and pitch is used to make syntactic or other distinctions.
These two traits are transferred to the pronunciation of English, making it syllable-isochronous and marking the syllables known to be stressed in English with a higher pitch (31, p.27). Thus the influence of the sound-patterns of the vernaculars, widely divergent from English as they are, conflicts with the need to remain intelligible to the wider English-speaking world, resulting in a recognisable West African accent.

Similar vernacular influences and sociolinguistic factors affect members of the South East Asian and Mauritian communities. These influences, coupled with social pressures, make the teaching of English in such countries both confusing and difficult and this is reflected in the ultimate proficiency of pupils. It is within this context, with its uncertainties, its shifts of emphasis and the consequent lack of clear-cut guidance, that the teacher of English must operate.

The most important prerequisites for the teaching of any subject are:

1. That the objectives are clearly specified.
2. That a suitable syllabus reflecting those objectives exists, with adequate facilities with which to implement it.
3. That the teacher has an adequate knowledge of the subject.
4. That the teacher is suitably qualified and trained to teach the subject.

The extent of the problem of English Language Teaching (ELT) varies from area to area but one factor is constant; that on initial entry to primary school all pupils meet English as a foreign language. However, their needs, both immediate and long-term, are far more wide-ranging than those of the average foreign-language learner and this makes the specification of objectives that much more difficult, though not impossible. Where English is the medium of instruction, the official language and the lingua franca for many, it is clear that both Spoken and Written skills, in many varieties, are necessary. Where it is taught only as a foreign language the same skills are needed but to a markedly lower degree.
Nevertheless the fundamental question - how what is taught when and why - remains. This question presupposes prior knowledge about the standard or norm - the facts about language and its usage. As has already been noted, this is not yet the case in Africa, and in Malaysia, with the shift of English from a second to a foreign language, there is a need to redefine ELT objectives (20).

The current state of ELT in all three areas is not good. Apart from the lack of detailed specification of objectives (20; 35, p. 60; 42, p. 3), those that are self-apparent are not always met. For example, although in Ghana the Secondary Selection examination includes an oral examination in English, in Nigeria and Mauritius little or no Spoken English is taught (35, p. 60; 36) and the ELT syllabus orientation is more often towards examinations than to wider objectives, with a disproportionate amount of time being spent on Western literature (25, p. 17; 35, p. 62). Pressure of examinations, described earlier, is partly responsible but shortage and unsuitability of textbooks, also discussed previously, play a part.

Motivation on the part of the pupils is another factor which cannot be discounted. It has already been demonstrated that non-examinable subjects receive scant attention both at primary and secondary level and that the rating of English is in direct proportion to its usefulness in the passing of examinations. Thus in Malaysia, where previously the function of ELT was linked with preparation for the Cambridge School Certificate and where a pass in English was essential to gain certification, its role was obvious and pupils were therefore motivated by educational and economic necessity. However, now that Bahasa Malaysia has replaced English as the medium of instruction and as the key subject for certification, motivation in the learning of English is likely to decline (20).

In addition to these difficulties ELT teachers, like the majority of their colleagues, are both underqualified and untrained or undertrained and their knowledge of their subject is severely limited. In the best schools pupils may well be taught by qualified graduates and these are
sometimes ex-patriate mother-tongue speakers of English (35, p.59). The vast majority, however, are taught by teachers who themselves have a poor grasp of English.

Several reasons for this have been suggested, apart from the generally poor facilities and low standard of Teacher Training. One is that the swamping of all countries with large numbers of primary schools and the ensuing unmanageability of the numbers of pupils admitted, coupled with a serious shortage of teachers, has led to the employment of primary school-leavers as pupil-teachers, many of whom are barely capable of secondary education (35, p.56). Another is that Teacher Training is itself deficient and that not enough time is spent on teaching language skills to students (35, p.59), so that they have sufficient grasp of them to teach them.

Malaysia and particularly Mauritius have an even greater problem in that pupils face more than one new language in primary school. In Malaysia Bahasa Malaysia is a new language for a substantial proportion of the primary school population and in the current situation it is bound to take precedence over English. In Mauritius children are faced with learning two or even three new languages right from the start and the consequences of subjecting children to such a multiplicity of new languages at the beginning of their school career has led to general concern among educators (42, p.1) regarding both language teaching and language in education. In addition to the teaching of English and French because they are the media of instruction, many children are also obliged to learn Hindi as part of the Government's attempt to preserve the Indian languages. This has the added effect of preventing any attempts to upgrade Creole to the status of a national language (36); it also adds another competitor to the field of language teaching.

The results of such undirected and inadequate ELT are serious. In Nigeria, for example, many primary school pupils who gain access to secondary education have extremely inadequate English (34, p.37) and a similar state of affairs pertains in Ghana (35, p.57). Furthermore, even those students who are successful in reaching universities
have difficulty in grasping scientific concepts (35,p.56) through lack of linguistic proficiency, although in view of earlier observations on education and facilities, language limitations cannot be the sole factor. Nevertheless, as in Mauritius, there is wide-spread concern with regard to ELT particularly at the primary level and its effect on students' ability to cope with secondary and tertiary studies.

In Malaysia, until the changeover to Bahasa Malaysia, English - both Spoken and Written - was taught to a high standard but now, in spite of its being a compulsory second language in schools, there are very real fears that standards will fall sharply, particularly as it must compete with the more important Bahasa Malaysia.

In Mauritius a survey in 1971 showed that out of 31,000 primary school candidates for the PSLC, 8,000 could not read or write in French and for English the figures were little better, many pupils being unable to read the examination papers and many more being unable to write the answers. (25, pp. 15-6).

Clark (36) puts the illiteracy rate at the end of primary education at about 30% in both French and English, though a very few cope with both extremely well. He further suggests that although many who complete secondary education seem to be able to cope with English, this ability is more superficial than real. This may be partly because Chinese- and Franco-Mauritians and the greater majority of Indo-Mauritians manage French better than English and only a small minority of the latter are better at English.

With regard to Spoken English there is little opportunity for using it in class, either because it is not encouraged (20) or because of inability to use it. In the words of Clark:

"It is impossible for children to verbalise their experience, to ask for information, to volunteer it and generally to be active partners ... through a medium of a language that they have not yet mastered ... The teachers do all the talking ..." (42, p.10).

In consequence, either the pupils remain silent or both pupils and teacher fall back on Creole.

In Africa it follows that if little or no Spoken
English is taught it cannot be used freely as a means of communication. In any case, such is the calibre of the average teacher and the quality of education that the system is of necessity didactic and the need to cover the examination ground precludes too much interruption by pupils.

It is clear, therefore, that implementation of official policies, particularly regarding English, is not at all uniform, that the quality of ELT is poor and that the general level of proficiency is fairly low.

Nor is educational attainment an entirely reliable guide to proficiency for Bamgbose (34, p.38) and Boadi (35, p.52) both suggest that many of the most highly educated Africans, for example, are restricted in their range and use of English.

2.4. Psychological Background.

(With particular reference to attitudes to sickness and health).

As described in the social background, the majority of people in developing countries still live in rural areas, many of them cut off from towns, or even from the main roads, by extensive tracts of bush or jungle. Not only does this involve reliance on a subsistence economy but also necessitates the ordering of their own affairs and mutual support in times of sickness. Being a basically agricultural community the people live very close to nature and each member of the community plays a necessary part in the survival of all. Thus the sickness of one member poses a potential threat to the entire community and therefore becomes the concern of all. Traditional attitudes to natural disasters, sickness and death are fatalistic, all three being attributed to magico-religious forces which cannot be controlled, only propitiated. These beliefs, profoundly held are considered by Foster (43, p.85) to be the main cause of the slowness of the diffusion of modern thought and life.

Fundamental to these attitudes to sickness and death is the belief that evil forces external to the sufferer are either totally or partially responsible for the condition and that the delicate balance between mind and
body is disturbed by these forces. This disturbance is manifested in the symptoms and, according to Davis (44, p.8), there is therefore not always a clear distinction in people's minds between mental and physical illness. This lack of distinction is reflected in the names used for sickness. For example, among the Tiv tribe of Nigeria, the generic term for sickness is Akombo, though it may equally refer to misfortunes of a wider nature, such as failure in agriculture, business and so on (45, p.10). Akombo are non-human forces which can be manipulated by humans, to the detriment of others. They are also magical emblems, symbolised by realia such as a pot, stick, plant and so on.

Beliefs regarding causes of sickness vary in detail from culture to culture but basically these beliefs differ very little. In Ghana, for example, organic illness is attributed to witchcraft, bad medicine and sin (45, p.29), while mental illness is caused by the influence of a god and/or of ancestral spirits angered by failure to revere them according to customary rite (46, p.69). In Kenya God, ancestral spirits, sorcery, broken taboos, disharmony with the supernatural and possession by evil spirits are all possible causes, the latter being characterised by hysterical behaviour.

In cultures which sustain ancestral cults such as Africa and South East Asia, ancestor spirits are considered to occupy an ambivalent role. One's own ancestor-spirits are usually benevolent, but capable of retributive measures if taboos are broken or the proper rituals not observed. Other people's ancestors are liable to be hostile, particularly where rivalry or enmity existed in the past or is still present among the living (45, p.75).

There is a widespread horror of ritual uncleanness and in many cultures it is considered to be a cause of illness. The Samburu tribe in Kenya, for example, look upon disease as being an inner poison, caused by broken taboos. Similarly the Digo, also Kenyan, see kwoshiorkor not as a protein-deficiency condition but as being caused by the parents breaking the sex taboos on intercourse during the proscribed postnatal period. The child is
said to be suffering from *chirwa*, which is the passive form of the verb "to break a taboo". (45, p.30) and is a cause for great shame. Not everyone adheres to taboos but after illness has occurred both patient and others find causes for it in taboo violation or in other forms of non-observance (13, p.92). Some foods are thought to contribute to this inner poison or to be disease-specific. Thus the Samburu will not eat hen's eggs since they regard them as the hen's excrement and all contact with any form of excrement is assiduously avoided. Fresh fish is thought to be poisonous or to cause impotence and other meats such as donkey or monkey are considered unclean (45, p.32). Certain food combinations are also dangerous. For example, in the Phillipines it is believed that to eat chicken and squash together causes leprosy (43, p.104).

Another potent source of illness is witchcraft and there is a widespread fear of the "evil eye". Thus it is believed that the jealousy of other women - who have perhaps lost their babies or whose children are diseased - can harm a healthy child and all kinds of subterfuges are adopted to hide the child's real state of health or even its sex - like dressing a boy in girl's clothing (45,p.76).

In Nigeria the Yorubas believe that childbirth and the menstrual flow are controlled by witches and that witches can also cause impotence, which is quite common among the Yorubas. They also believe that to name something may cause it to happen and so, for example, Sopono, the Smallpox God, is always referred to by the initials SP, to avoid angering the God and thereby causing an incidence of the disease (13, p.79). It is also anathema to a Yoruba to tell him that he is sick as this is likely to exacerbate the disease (13, p.92). Similarly, many Africans become extremely upset if called "silly" "foolish" or other such epithets, since they feel that the curse of insanity has been laid upon them (48) and madness is greatly feared in many societies, almost to the point of phobia (45, p.103).

Regarding childbirth, it is not of itself considered to be an illness but many societies seclude mother and baby for a prescribed period ranging from ten to forty
days. The woman is considered to be unclean and the actual birth and postnatal period is seen as a danger period for her, the baby and the whole community, which fears contamination (45, p.69). Pain is also often endured in silence or repudiated in many societies, particularly in childbirth, because a difficult labour is thought to be the result of a wife's infidelity.

Death also is often associated with pollution and those who handle and bury the dead are thus contaminated. Not only that, but the widowed spouse is seen as a potential threat to the wellbeing of the community, since in some way the surviving partner is thought to be connected with the death of the other (45, p.72).

The various causes of illness are often associated with particular maladies. For example, among the Sebei in Kenya, ancestor-spirits are thought to cause ear and eye diseases, witchcraft is manifested by general weakness and sin or the evil eye give rise to fever and stomach pains (45, p.30). In addition to this causatory classification, the nature of the illness is also classified. In Africa, for example, sickness may be one of three things: a trivial complaint, a European disease or an African disease (45, p.30). A European disease is not, as one might suppose, of European origin but is so called because it responds to Western medical science - such as malaria or yaws. An African disease, on the other hand, is unlikely to be either understood or curable by Western medical experts. Such illnesses include ritual uncleanliness, witchcraft and emotional stress (45, p.24).

Since the sickness of one member of the community is the concern of all, a person may not declare himself sick without the permission of the community, particularly in the field of mental illness. In subsistence economies, where each person's efforts are necessary for the survival of all, even temporary withdrawal by one member from his working role can be a serious matter, particularly at times of planting and harvesting. Consequently the prospective patient must present his symptoms to the group for their assessment and only if and when they accept his claim to sickness as valid, may he officially become a
patient and be exempted from his normal daily tasks (43, p.121).

The question of validity rests partly upon societal norms of behaviour and partly upon the community's beliefs concerning the symptoms of mental illness or abnormality. Certain psychiatric symptoms conform to cultural expectations of how those symptoms should appear and these vary from culture to culture (13, p.32). However, as Kiev points out:

"Acceptance by one group of what another regards as symptoms does not mean that the individual does not have a psychiatric disorder; it means only that individuals with similar disorders are permitted to function differently in different settings". (13, p.30).

It is against these cultural norms and expectations that an individual's claim to sickness will be measured. Having been diagnosed as sick, acceptance or rejection of the patient depends partly on the sufferer himself and partly on the cultural beliefs concerning the origin and nature of abnormality. (45, p.103). Thus if the patient is considered to be dangerous or an evildoer - an aggressive psychotic, for example - he will be removed from the community, whereas towards a depressive the community will be tolerant or even protective.

The group to whom the patient looks for validation of and help in his sickness is his kin-group. According to Read, illness is seen as a crisis for the whole kin group and their obligations to and succour of a patient are demonstrations of their sense of danger (45, p.12); though the obligations also arise from the fact that the kin-group are held responsible for the patient's illness, so the latter's role is not clearly defined (45, p.11). When summoned, all members of the kin-group pool advice on symptoms and treatment and institute initial proceedings themselves. If their own measures are not successful, a Traditional Practitioner is called in (45, p.9). His function is to diagnose the ailment and to order appropriate treatment and during this period his relationship with the patient is close. He is expected to take a detailed and personal interest in his client and his first
aim is to establish confidence and trust by reassuring both patient and kin. (45, p.21). He must at all times remain unhurried and calm, arriving at a diagnosis by divination. He makes no distinction between physical, social or psychological causes since such distinction serves no purpose in the traditional network of beliefs associated with the origin and nature of illness (44, p.9). Cause and effect are presented within the context of those beliefs in terms which the patient and his kin understand.

There are various types of Traditional Practitioner, many of them very highly skilled. (45, p.20). Firstly, there are the women, who are responsible for the administration of purgatives and emetics, the application of poultices and for traditional birth practices. Secondly, there is the doctor-diviner, who is the diagnostician, making his diagnosis through divination, sometimes by going into a trance. Thirdly, the bone-setter, manipulator and masseur, who also carries out traditional vaccination and primitive surgery. The fourth group are the herbalists, whose knowledge of the properties of herbs, roots and barks is extensive. Finally, there are the ritualists, whose function is to perform the appropriate ritual on a given occasion (45, p.16). One, two or even three Traditional Practitioners may be involved in case of illness, thus providing a kind of group care (44, p.7).

When the Traditional Practitioner is consulted the kin-group must be present at both the consultation and treatment and it is the kin-group’s responsibility to see that he is paid. If the first course of treatment is not successful, they seek further consultation, possibly leading to more treatment, perhaps a second opinion from another Traditional Practitioner, or perhaps transfer to a modern hospital. In the latter case, the kin-group decides who will accompany the patient and who will pay the board and lodging of those who go with the patient.

Kin-group involvement is not always as protective and caring, however. Since many societies believe that illness is the direct result of harmful influences - be they ancestral or nature spirits - working through the
There are five main methods of treatment: firstly, dietetic, when "hot" foods will be given for "cold" illnesses and vice versa, or, in some cases, where food will be withheld altogether, particularly during childhood illnesses and especially if diarrhoea is present. The latter may have disastrous results on an already undernourished child but the community, with little or no knowledge of the relationship between food and health or physical development, will consider that the child died from witchcraft or evil influences and not from starvation. Secondly, there are herbal remedies, which provide one form of treatment in most cases of illness. The juices of herbs, leaves and roots are also used extensively in childbirth to promote an easy and painless delivery. Thirdly, there is physiotherapy and fourthly, minor operations such as the removal of a cataract and male and female circumcision. Finally, there is psychotherapy, which involves the exorcism of the evil spirits inhabiting the patient, by beating, fasting, ice-baths or the smoke-hut. (45, p.24).

In the case of childbirth the initial help received by the woman comes from the kin-group, though the actual birth is conducted by a Traditional Birth Attendant, who is not necessarily a member of the kin-group. If the mother is cared for by her maternal kin, they will be sympathetic and supportive but if by the paternal kin, she is likely to get little of either. Nor will she be able to admit to pain lest she disgrace her family (45, p.66).

Most, if not all, forms of treatment are accompanied by ritual, though ritualism itself serves wider aims since its function may be preventive, purificatory or curative (45, p.72). Thus after childbirth in some societies - Northern Nigeria, for example - the placenta and blood lost during delivery are disposed of ritually (43, p.228). In other cultures there are various strictures regarding
food, cooking and visiting during the seclusion period and at the end of the latter both mother and baby are given a ritual bath. The place of seclusion is also cleansed, both actually and ritually. (45, p.69). A widower, too, in some African societies, must be ritually purified before being allowed to associate with another woman. (45, p.72).

Cult ritual, on the other hand, is prophylactic. Members of a cult are usually previous sufferers from a given illness and possession by their particular spirits during the annual festival is designed to ensure immunity from the disease throughout the following year (13, p.145).

Rituals are always associated with tension-situations, such as birth, death and so on, and they act as a form of psychotherapy by allowing for the formalising and channelling of emotional stress. Rituals linked with fertility, birth, threat of illness, death and mourning are the kin-group's responsibility, not the individual's, and obligation to participate is mandatory (45, p.73).

Rituals are based on the concept that man is powerless alone to achieve health, happiness and success and that therefore the supernatural powers must be evoked, propitiated or placated as necessary. The belief in witchcraft and external evil forces and the ritual counter-attack serve a very useful and necessary function in societies where maximum cohesion is essential for survival for, as Kiev suggests, (13, p.123), such beliefs allow for the transfer of hatreds and aggressions from the social to the mystical level, thereby providing a culturally acceptable and safe outlet for them.

The religious element in ritual is very strong and many rules relating to personal hygiene or to the taking of food and water on given occasions are often enforced by religious sanction. As Read observes:

"A religious ideology underlying health not only codifies health behaviour but gives an additional sense of security". (45, p.71).

Thus strict adherence to taboos and cultural rules engenders a sense of immunity against evil influences and since attitude of mind is very closely linked with illness and recovery, such security of mind can be very powerful both as a prophylactic and curative agent. In addition,
as Kiev suggests (13, p.113), many magical practices based on supernatural beliefs are empirically sound, as, for example, traditional vaccination, where serum from a smallpox pustule is applied to an incision.

There are many rituals associated with death, burial and mourning, some purificatory, to remove the pollution of death and some socio-psychological, to draw the kin-group together and to reform their ranks so that no gaps are left in the social structure. To this end the roles occupied by the dead person are reallocated to other members of the kin-group (45, p.72).

Many of these rituals, however, are associated with man's need to come to terms with death and with his hope for continuation of life hereafter. This need and hope is demonstrated in the strong continuity with the dead which exists in many cultures. In Africa, for example, many people still believe that ancestral authority is invested in the fathers and elders of the tribe and ancestral spirits are thought to influence life on earth through the medium of the Chief (13, pp. 20-1). In South East Asia, particularly among the Chinese, there is an obligation to honour one's ancestors by raising one's status, both morally and materially. Hence the motivating force in their religion is the predominance of the need to achieve honour, status, wealth and good health and many powerful taboos and symbols are linked with these objectives (47, p.163). Great care is taken in the observance of these taboos, to avoid ancestral retribution. For example, the name of a dead person is never mentioned, to avoid causing anger and resentment and rituals are performed to prevent the dead from harming the living. Other practices are associated with the prolongation of life and the securing of an easy passage to the next world and of a comfortable life hereafter (13, p.121).

These beliefs and needs are not confined only to members of ancestor-cults; they lie at the heart of every religion, whatever its nature. Christians, for example, are much concerned with Purgatory, Paradise and Heaven and practising Christians observe taboos and rituals the better to prepare themselves for the life after death.
There are many analogies to be drawn between Christianity and the cultural patterns and beliefs outlined above. For example, the Sacrament of Extreme Unction is a purificatory ritual equatable with the practices of many non-Christian societies and there is little functional difference between prayer to God and the incantations of the animist. Indeed, many cultures embrace both Christianity and their traditional beliefs without apparent difficulty. For instance, 90% of Filipinos are Roman Catholics but many sects exist which combine animistic beliefs with Catholicism (5,p.102) and many West African Christians adopt similar religious dualism. Although many West Africans have become Christians or Muslims (3, p.33), there is an upsurge in cult membership and, according to Kiev (13, p.145), these cults are increasingly becoming focal points for preserving the traditional cultures, as demonstrated by the growing number of Healing Churches in West Africa. These churches combine tribal beliefs with Christianity and Kiev suggests that these cults are forming in response to the anxieties created by urbanisation and detribalisation and that they focus on African renewal or function as a protest against missionary influence.

The introduction of modern medical science into traditional cultures is proving difficult and attitudes of the people towards it are ambivalent.

According to Read (45, p.94) evaluation studies of health programmes, while they show the beginnings of co-operation, nevertheless indicate resistance to certain types of programme, with an overall indifference to the scientific underpinnings. Thus, while there is enthusiastic acceptance of modern midwifery and ante- and postnatal care, traditional ideas and beliefs about pregnancy, childbirth and lactation are not necessarily altered (45, p.66). For instance, in Northern Nigeria, after a hospital delivery, the relatives still ask for the placenta and blood lost to be returned to them for ritual disposal, so sheets and bedding must be washed and the water given to the relatives along with the placenta (43, p.228). Again, while malaria and yaws eradication programmes are now widely accepted, Ugandans were opposed to the introduction
of a tuberculosis health programme. They believe that tuberculosis is caused by illwill and therefore they do not believe that it is transmissible from mother to baby because no mother would want to harm her offspring (45, p.101). Nor are Kenyan mothers whose children are suffering from kwoshiorkor willing to take their children to Western medical personnel because they do not like to admit to the existence of kwoshiorkor with its related stigma (45, p.36).

Even where modern hospital treatment is accepted - and Traditional Practitioners sometimes prescribe it in cases of serious organic illness, such as respiratory or cardiac disease - its efficacy is regarded as limited. Since the causative factor is still considered to be of supernatural origin, ritual and magical practices are still thought to be necessary to render the hospital treatment effective and to prevent worsening of the condition (45, p.29). Furthermore, the Traditional Practitioner will continue to give advice and psychotherapy. Among the Digo there is a belief that hospital medicine is diluted and therefore ineffective without the fortification of traditional practices (45, p.31).

There is also often major conflict between hospital treatment and traditional belief and practice, not least in the separation from kin-group care that hospitalisation entails. The patient may be obliged to eat foods which are taboo and isolation in the case of infectious diseases is regarded, not as a safety measure for other patients or hospital personnel, but as rejection. Considerable fear and distress is caused to both patient and kin-group through this interference with understood cultural norms and patterns of social behaviour in sickness. Naturally enough this leads to a reluctance to accept hospitalisation (45, p.41). Furthermore, the role of the modern doctor is both inexplicable and resented. The patient does not understand the purpose of questioning in the taking of a case-history. Traditional Practitioners are not expected to nor do they ask detailed questions about the symptoms of an affliction; they divine the nature and cause of it by the magical powers invested in them. The
questioning of modern doctors therefore is interpreted as either lack of training or lack of ability and hurry over the questioning and diagnosis is very disturbing to the patient. (43, pp. 138-9). In addition, as Foster points out (43, p.91):

"The impersonality of modern medicine, largely taken for granted in Western countries, is not a part of the understanding of most of the rest of the world ..."

and Muslims in particular find it unthinkable that any man, other than the husband, should have the intimacy with a woman that gynaecological examination, for example, requires. Nor are female doctors always the answer for in cultures where fear of witchcraft and the evil eye is very great, a woman might well be afraid of losing her sexual powers by exposing herself to a strange female. (43, p.91). Even in cultures where obstetric care is accepted, examination may have to be conducted under cover of the woman's garments, as in Northern Nigeria, if only for the sake of modesty (48).

Acceptance of modern treatment does not as a rule involve changes of ideas or beliefs regarding the cause of illness, according to Read (45, p.113). For example, people might be compelled or persuaded to be vaccinated or inoculated but they will still employ traditional protective measures (45, p.113).

While formal education conflicts in part with traditional beliefs and practices (44, p.9), evidence would suggest that its effect is slow (45, p.110), for what is learnt in the home is far more influential than what is learnt from hygiene books at school (45, p.81), or even from superimposed modern medical science. Social structure and relationships change much more slowly than cultural habits - as, for example, changes in diet or economic patterns - and sometimes people will refuse to change even their cultural habits if such a change is at variance with social relationships or religious conviction (45, p.53).

This is one of the reasons why the introduction of modern health programmes is so difficult for even if people come to realise that a particular practice is
either scientifically invalid or dangerous to health, they might not discard it because of its relationship to other cultural patterns or rituals or because it might cause offence to ancestor-spirits or upset social relationships. (45, p.78).

However, the reasons for the slowness of change are many and various, and nowhere is change slower than in the field of mental health care. Quite apart from the continuing belief that mental illness is caused by evil spirits (46, p.69), modern facilities for the care of the severely mentally ill patient are lamentably inadequate. With the exception of such schemes as Lambo's (45, p.103) for the boarding out of psychiatric patients in very carefully selected villages neighbouring the hospital, what hospital care exists is usually custodial (13, p.210). Many developing countries have some form of modern psychiatric programme but on the whole psychiatric and mental health services are not a high Governmental priority because of other massive health problems (8, p.25). For example, Kenya has a few psychiatric hospitals and psychiatric out-patient clinics attached to general hospitals, but only three trained psychiatrists, all of whom are based in Nairobi (8, p.26). Conditions are usually appalling, with overcrowding, severe shortage of staff, drugs, food and other facilities (8, p.27;13, p.210;46, p.68;48) and what staff there is is usually untrained. Moreover, with the lack of space, admission to hospital is usually restricted to the most severely disturbed and 50% - 85% of the hospital population in developing countries are schizophrenics or psychotics. Hope of recovery without proper treatment is minimal and the staff, untrained as they are, often apply traditional measures such as isolation or beating (8, p.26).

Consequently, mentally ill patients try to avoid hospital, preferring to consult a Traditional Practitioner in the first instance (46, p.68) and many patients admitted to hospital - often forced upon them by a Court Order (13, p.210) - will have undergone a long period of traditional treatment before eventual arrival at the hospital (8, p.26).

It is clear, therefore, that Traditional Practitioners are still very much in demand and while they are not
recognised by the Medical Associations of their countries, they continue to flourish (44, p.8). Indeed, their role is recognised by some Western-trained personnel, who sometimes use them to help make contact with villagers (45, p.21). In some countries Traditional Practitioners have formed themselves into Associations, which hold examinations, give certificates and control practice by issuing licences (45, p.23). Nor is their sphere of operation confined to rural areas for many have set up business in urban areas, with all the paraphernalia of consulting rooms, white coats and telephones (44, p.9). Although in towns the Traditional Practitioner's function is mainly confined to the treatment of chronic or psychosomatic disorders since acute cases are mainly treated in hospitals, his role is perhaps even greater in towns, where people are separated from their kin-group and their support and where, therefore, psychological stresses and strains are the greater.

2.5. Political and Economic Background

(With particular reference to employment opportunities and level of unemployment in countries of origin).

The widespread population explosion in developing countries, coupled with the reduction in the death-rate in the early years as a result of health programmes, has resulted in a predominantly young population. This fact, in conjunction with the rapid expansion of education, particularly at primary level, has given rise to serious problems regarding employment.

It has already been noted that the principal aim of the vast majority of school leavers is to acquire a white-collar job, partly for prestige and partly for socio-economic reasons. Ten or so years ago this aim was reasonably justified, even for primary school leavers (49, p.36). This was the era of newly-acquired Independence and of indigenisation, particularly of the Civil Service, and also of expansion of Government administration, all of which required large numbers of Civil Servants in all grades. Consequently considerable numbers
of School Leavers were absorbed as soon as they left school. For instance, in Kenya a School Leaver Tracer Project between 1965-8 showed that 68% of School leavers were absorbed into Central Government employ, 22% into public corporations or semi-Governmental bodies, 5% into the East Africa Community and 4% into Local Government (50, p.59).

Now, however, this process is finished and most employers, both in the public and private sector, are demanding secondary school certification (49, p.36) and are becoming increasingly more selective as regards the level of performance in secondary school examinations (50, p.59).

Hence school-leavers are having to compete for shrinking opportunities in all post-secondary fields - Further and Higher Education, training and employment.

Technical and vocational alternatives do exist but they absorb a tiny minority of school leavers (51, p.38) and in any case these fields are not very popular, particularly among the Chinese, because they regard such work as inferior (52, p.2). In spite of the fact that all developing countries have great need of technical and vocational personnel, and that vacancies do exist, (52, p.1; 53, p.26), education in technical and vocational schools is considered to be second-best and both students and teachers regard themselves as second-class citizens (54, p.22).

An added problem is that many primary school leavers, in search of jobs which offer prospects of training, promotion and security, are also moving to the towns, hoping to find employment commensurate with their educational qualifications (51, p.37). This move is, to a certain extent, forced upon them by the growing incapacity of the home farm to support its rising population - as in Africa - or because of stagnation of the rural economy as in Malaysia (4, 2.3). Mauritius faces similar problems for, although its economy is now expanding rapidly, the effects of twenty years of stagnation are still visible in the lack of employment opportunities (30, 2.08).

This rural-urban drift to already overcrowded towns is causing considerable problems by adding to a job-
seeking labour force chasing fewer and fewer openings.

Unemployment figures are, therefore, high. Recorded figures for open urban unemployment show, for instance, that in 1973 Malaysia's rate was 9.8%, that of the Phillipines 11.6%, that of Ghana 11.6% and that of Kenya 14.9% (54, p.2), while in 1974 the rate for Mauritius was 17.3% (30, 2.08). Of these, large percentages are school leavers in the 15-20 year age-range. Although reliable statistics are difficult to come by - for, as Blaug remarks, few developing countries provide either detailed or comprehensive analyses of unemployment by age, education, duration of unemployment and hours worked per week (54, p.11) - there is sufficient evidence to suggest that school leavers usually do form the bulk of the unemployed. Furthermore, what figures do exist are, if anything, conservative since only those looking for work are counted, not those who have either not started looking or who have stopped (54, p.3). For instance, in Mauritius in 1972, 50% of the 15-19 year-old group and 26% of the 20-24 year-old group were unemployed (6, App.F (F2) 4). In Malaysia, in 1974, 50% of the 15-19 year age-group were unemployed and the rate for the 15-24 age-group was twice that for the total labour force. In 1966 Nigeria had about half a million people out of work and three quarters of these were aged between 15-25 and in 1974, 65% of the total Filipino urban unemployed were between 15-24 years old. (49, pp. 37-8). In the same year in Kenya 50% of school leavers were out of work (51, p.44). However approximate these figures may be, there is no doubt that a substantial proportion of the 15-24 age-group is out of work and although, as Blaug argues (54, p.11), statistical information would be more valuable if it recorded not only the number out of work but also the average waiting time between leaving school and getting a job, there is evidence to show that a considerable disparity exists between adequate employment opportunities and the size of the labour force (4, 2.3; 54, p.63; 51, p.64).

What of the role of nursing in the labour market? Statistics, reliable or otherwise, regarding the number
of nurses either registered or employed, are virtually impossible to obtain - as one glance at Table 5 (Vol.2, A.19) will show.

However, there is evidence to suggest that there is a shortage of nurses in all three areas, particularly in the field of psychiatric nursing - as described in an earlier section. There are many contributing factors: the low status of nursing and the unsatisfactory working conditions in all but the prestigious hospitals; lack of finance and misdirection of what is available; shortage of nurse training facilities and qualified nurse educators and competition from other fields of employment demanding equivalent levels of educational attainment.

In Mauritius the nursing establishment is 80% of what it ought to be and only 70 new entrants per annum are admitted to nurse training. (56, p.255). In Malaysia there is great need for nurses and medical technicians (53, p.26) and, with the expansion of the health services, there is an added need for nurses with Public Health and psychiatric experience (57, p.15). However, any nurse wishing to specialise in psychiatric nursing must be State Registered in general training also. Psychiatric training on its own is not sufficient. (13, p.49). Selection is by Public Services Commission interview and training is on a scholarship basis. After qualification the nurse is bonded for five years to Government Service. Males are trained as Hospital Assistants, to assist doctors in running clinics, treating minor ailments and doing laboratory work (12, p.42). A second-tier training exists for Assistant and Community nurses. According to Kettle, (12, p.41), there is no lack of applicants, since there are about 12,000 applications each year for 250 places for training for the Register, for which the minimum educational requirement is the Malaysian Certificate of Education. For Assistant Nurse training there are about 8,000 applications for 800 places.

In Nigeria the system of selection is a little different. Not only is the basic requirement the West African School Certificate (WASC) or its equivalent, but the prospective candidate must also have passed the
TEDRO (Technical and Educational Development Research Organisation) Aptitude Test. Each Nurse Training School is sent a computer printout of the results and from this they select whom they will summon for interview and, in some cases, a local Entrance Examination set by the Nurse Training School. In certain Schools a regional quota system operates to avoid overloading of the intake by any one region (48). It is necessary, under this system, to send for 300-400 candidates in order to achieve a full intake.

However, not all candidates who sit the TEDRO Test have necessarily passed WASC, and some Schools find it difficult to achieve a full intake. For example, Nwokolo (58, p.271) suggests that few females with WASC want to nurse and that very few males are interested in nursing per se but look upon it as a stepping-stone to some other occupation or merely as safe and steady employment. Since motivation is often a deciding factor in ultimate selection, some Nurse Training Schools are prepared to accept a reduced intake rather than admit candidates whose motives are suspect. For instance, Nwokolo records that at the Benin Nurse Training School in West Nigeria, of 105 candidates summoned for interview, 68 presented - 40 males and 28 females. Of these 16 were accepted, 7 males and 9 females (58, p.271). (A full intake ranges from 40-60).

Few Nurse Training Schools in Nigeria accept males for training, one reason given being lack of accommodation - the Nigerian Nursing Council recommends that nurse learners should be resident. (48). Ogundeji, however, suggests that the non-acceptance of males is attitudinal, an unwelcome legacy of the early days of nursing in Britain and introduced into Nigeria by Westerners (59,p.6).

The situation in Ghana is much the same. The basic entry requirement for training for the Register is also WASC or its equivalent but as few candidates with this qualification apply, ten years of schooling and a pre-Nursing Certificate are accepted in lieu (60, p.206). This lack of applicants with WASC is interesting since clearly the places are available and so are suitably
qualified candidates, for in 1972 332 Ghanaians were accepted for student nurse training in England and Wales. (See Table 3a, Vol.2, A.3). For this they must have held either WASC or GCE Ordinary Level, unless they were all accepted only for psychiatric or mental subnormality training. Unfortunately there is no way of establishing this.

It is possible that the reluctance of suitably qualified Africans to enrol in their own countries stems from the poor conditions in which they must work and the lack of facilities both at clinical and educational level (58, p.272). Certainly, there is a scarcity of qualified nurse tutors at all levels and in all countries in the three areas and finance for either extending or improving present training facilities is very restricted (61, pp.1-2). Morley (62, p.10) sets the per capita health budget at no more than £1 per annum, about 1-2% of what advanced countries spend. These resources are clearly inadequate, yet even this meagre sum is not used to overall advantage. Since most developing countries have at least one prestigious teaching hospital, a quarter to one-third of the annual health budget is required to run it. This leaves very little for the rest of the health services, preventive or curative.

It is, perhaps, clearer why Malaysians and Mauritians seek training outside their own countries, since the number of places available for training are obviously inadequate. It has been suggested, however (20), that many Malaysians seek training in England and Wales because they may not have gained a high enough Grade in Bahasa Malaysia in MCE to allow for admission to their own Nurse Training Schools or for other employment. Alternatively, with the Malaysian Government's employment policy of favouring Malays over Chinese or Indian Malaysians at a ratio of 4:1, those who seek training overseas are likely to be Chinese or Indian Malaysians. As for Mauritians, they are, according to Kendall (56, p.255), officially encouraged to emigrate as one way of reducing the unemployment problem. Regarding Filipinos, since the title of Registered Nurse does not even have the legal status that Registration in the other countries does, the incentive
to acquire State Registration in Britain is very great, for its value, both as a status symbol and as a priority ticket for employment, is high. Furthermore, the high unemployment level among the under-twenty-fives forces Filipinos to seek employment or training elsewhere (38).

2.6. Discussion.

To what extent, then, given the background, might one suppose that overseas nurse learners are or are not equipped to operate in the target matrix?

Socially, the original and target matrices differ sharply in fundamental aspects. For instance, the nuclear family of England and Wales, with early separation from parents in teenage years, is in complete contrast to the system of the extended family living together, even in old age, which characterises the social matrix of all three areas. Even though overseas nurse learners coming to the UK may well have left their families to go to the towns for educational purposes, their families may well have made great sacrifices in order that they might do so and filial ties and responsibilities still remain strong and binding.

In addition, the climate, for much of the year, precludes the outdoor, communal gatherings familiar in tropical countries. Hence people in England and Wales remain, for the most part, shut up in their houses and often hardly knowing their next door neighbours - a custom succinctly described by one Austrian immigrant as: "... the English habit of minding their own business". (38).

From the educational point of view, overseas learners, given the didactic nature of teaching in their schools and the serious shortage of facilities, might be expected to encounter difficulties with their nursing studies, which require private study, use of libraries, project work and the writing of case-histories. All of these activities require the ability to think and plan for oneself and to correlate information. As has already been observed, these faculties are not developed at school, owing to the reliance on rote-learning and the paucity in the curricula of scientific content which encourages logical thought
and deduction.

Linguistically, one might expect difficulties both in written and spoken English, though Africans would seem to be the better equipped in both fields, since they use the language more extensively than it is used in either Mauritius or the South East Asian countries. However, difficulties might arise, even with Africans, in operating in spoken English because for one thing it is not taught in schools and for another, the use of spoken English in a social context is limited in Africa. Furthermore, as has already been stated, ability to use the appropriate variety in given circumstances depends on an intimate knowledge of the culture concerned.

Psychologically, problems might arise over conflicting cultural definitions of illness, and recognition of the sick-role and acceptance of the patient might depend on cultural expectations, particularly in the field of mental illness. On the other hand, since talking to the patient is an intrinsic part of the caring process in traditional cultures, this could well be an asset, again, particularly in mental illness, where talking to the patient has therapeutic value - unless language limitations make it difficult.

However, there are three factors which will profoundly influence overseas nurse learners' ability to operate in the target matrix; firstly, the amount of information received and/or knowledge acquired about the target matrix before arrival; secondly, the length of the orientation period permitted on arrival and before beginning their training; thirdly, the length and degree of culture shock experienced during the first months.

According to Foster (43, pp. 191ff), culture shock is a mental illness. It is not usually recognised by the victim but it is characterised by irritability, depression and lack of attention, which leads to a state either of annoyance or of despondency on the part of the sufferer. He longs to be back home, among familiar surroundings and with people he knows and understands. His own cultural cues are missing and he does not recognise those of the foreign culture, which both frustrates and angers him.
There are four recognisable stages. At first Euphoria, when everything is new and exciting and local people are courteous and helpful. Next comes the Crisis stage, when the novelty wears off. There are language, accommodation and shopping problems and courtesy for the new arrival diminishes as he becomes a familiar sight and indifference takes over. All the things he took for granted at home become insuperable difficulties and he joins with his compatriots in complaining about the people, the country and its customs. His own country, by comparison, becomes an ideal, its less lovely aspects forgotten.

Gradually, as he begins to adjust to his new environment and its demands, he enters the Recovery stage. He begins to recognise cultural cues and customs begin to make sense. Problems are either solved or reduced to manageable proportions and he feels a sense of superiority over other newer arrivals. The fourth stage is Full Recovery and by now the victim has adjusted to the new way of life to the extent that he can accept even those aspects of it which he likes least.

The causes are many and arise from what Mead refers to as "... the incommensurability of ... experience ..." which inhibits cross-cultural understanding. Apart from the common ones of climate-change, lack of cultural cues and so on, overseas nurse learners from the three areas face others: lack of kin-group support; living indoors in hostels; the shock of finding that Britain is not the friendly, sociable place depicted in the books they read at school (20) and the take-it-or-leave-it attitude of large towns are added to the immeasurable difficulties of having to adapt and recuperate from culture shock in the stressful atmosphere of the hospital. Intensifying factors are: the length of time (of training), which viewed from the beginning seems interminable (43, p.194) and the absence of accepted cultural outlets for the relief of anxieties, stress and aggressions.

The duration of culture shock varies, the average length being somewhere between six and twelve months. It is noteworthy that specialists, highly skilled in their
own fields, take - on an average which is worldwide - one year to start functioning properly when they take their expertise abroad, and the realisation that they are not reaching their full potential - even if they do not know why - heightens the symptoms of culture shock. It is therefore reasonable to suppose that the need to relate to ill people and to come to terms with working almost permanently at a high level of stress, coupled with the demands of study in a language which is not their mother tongue, both prolong and heighten the culture shock experienced by overseas learners.

Foster observes (43, p.196) that knowing of the existence of culture shock may help to reduce the severity of the attack but it cannot prevent it. Nor is it an affliction of the over-sensitive or the easily-deterred. It happens to anyone and everyone, to a greater or lesser degree, who moves into a culture other than his own.
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PROBLEMS OF COMMUNICATION OF NURSE-LEARNERS: A SURVEY OF THE LITERATURE.

3.1. The processes of communication.

According to Noble (1, p.15), very little direct research has been carried out in the U.K. concerning communication in the nursing profession. Much more has been done in the U.S.A. but, as Noble observes, (1, p.15) such research has limited application in the U.K. because of differences in attitudes and format of training. Noble's comment concerning the paucity of material was substantiated by Lelean (2, p.14) in 1973 during a study of communication between ward sisters and nurses. Nevertheless, a certain amount of the American research is generally applicable and there is much informed opinion and anecdotal evidence in the U.K. to suggest that problems of communication exist, particularly for nurse-learners. Many of these problems affect all nurse-learners but some are peculiar to, or more acute for, overseas learners. They will be discussed within the framework, where applicable, of Ruesch and Bateman's description - following their definition (see 2, Introductory) - of the process of communication. They describe this process under three headings: (3, p.276):

1. the social situation, or context of communication.
2. networks.
3. the technical characteristics.

1. The social situation, or context of communication.

Correct interpretation of a situation depends on various factors:

i) "perception of the other's perception", or a shared system of codification and evaluation. (3, p.203).

ii) identification of the rules of communication pertaining to a social situation:

"... any social situation is governed by explicit or implicit rules. In the context of communication rules can be viewed as directives which govern the flow of messages from one person to another" (3, p.27).

iii) identification of the roles in a social situation.
2. **Networks.**

**intrapersonal** (3, pp. 278-9): the origin and destination of messages are sited in one and the same person and the system of codification cannot be examined, only inferred. **interpersonal** (pp. 279-80): participants are individuals so the origin and destination of messages are known and the system of codification can be examined. With regard to nurse-learners, interpersonal communication is, as described in 1.4.1.b, bound to occur between them and patients, fellow-learners, senior (sc. qualified) staff and teaching staff.

**group** (3, pp. 280-1): group communication is organised and is of two types: one person to many and many persons to one. Both are primarily one-way flow. As described in 1.4.2., participation by a learner in group communication may be during the giving of the report by the off-going senior nurse to the oncoming shift (1.4.2.a) or during group activities in the classroom (1.4.2.b).

**cultural** (pp. 281-2): messages are transmitted from many persons to many and, in many cases, people are unaware that they are transmitting or receiving signals. Such messages include: language and linguistic systems and ethical premises. In the context of nursing such signals will relate to the patient's attitudes to life, death, sickness, entry into the sick-role, treatment, nursing care and hospitalisation in general. Communication between nurse and patient will be effective to the extent to which the patient's attitudes are shared or understood by the nurse and the latter's ability to cope with the demands made upon her [sc. also him] by the patient, and the clinical situation.

3. **Technical characteristics** (3, p.283): These include:

i) the machinery of communication.

ii) the methods of codifying data.

iii) the effect of these data on the functioning of the system.

Codification (3, pp. 283-4) at the interpersonal level is concerned with the use of both verbal and non-verbal symbols.
At group level, in addition, there is a body of information which is the property of the group and not of its individual members. This information is transmitted to new members and the effectiveness of the group depends on the adequacy of the transmission. Communication channels are organised and individuals are links in the communication chains.

At the cultural level there is no such organisation and the individual is the unconscious bearer of cultural messages, which are implicit in his everyday behaviour.

According to Ruesch and Bateson (3, pp. 284-6), there are several factors which influence the functioning of the communication networks. These include:

a) the capacity of the receivers, transmitters and channels in relation to the load they carry.

b) threshold problems - problems which arise when the prerequisite conditions for effective communication between two sections of the network are incomplete or absent.

c) the effects of the adequacy of the transmission of the organisation's information on the recipient's future actions and responses.

d) the process by which the organisational continuity is maintained and new members assimilated.

3.2. Problems for all nurse-learners.

3.2.1. Interpretation of the social situation.

i) perception of the other's perception.

Several studies of the relationship between shared systems of codification and evaluation and effective communication have been made. According to Triandis (4, p.175), the greater the cognitive similarity between participants, the more effective is communication and Newcomb suggests (5, p.395) that where such similarity pertains, less explanation of the situation is required. Muntz, however, (6, p.45) adds the caveat that sufficient time must be allowed to determine that the message has been received and interpreted as intended. Noble (7,p.30) concurs but suggests that not only must there be shared concepts but also that the language used to express those
concepts should be mutually accepted. This aspect of communication is particularly difficult in nursing for, as Lewis observes (8, p.20):

"... medical and nursing language represents symbolic meanings not shared by many of our patients. This means that we must translate our symbols into meaningful language for our patients. Likewise patients do not describe their discomforts in our symbolic terms, but it is our responsibility to ascertain their meaning".

The task is made even more difficult by the necessity to be able to "translate" for a very wide variety of people:

"We [nurses] are dependent on our ability to communicate effectively with persons of all ages and with various backgrounds and occupations". (8, p.20).

The development of this ability, is, as has already been noted (1.3.1.1), a mark of the competent nurse and a function of nurse education and training (1.3.4. A.a.ii), particularly in psychiatric nursing (1.3.4. B.a.i.). Nowhere is this ability more important than in the field of psychiatry for, in the words of McKeighan: (9, p.80):

"The mentally ill patient is characterised by his inability to communicate with others".

That nurses find communication with such patients difficult is demonstrated by McKeighan's findings, which showed that there was very little meaningful interchange between nurse and patient, but that talk was centred on activities such as table tennis, television and so on. (9,p.86).

There is an added danger, of special significance in interchange with patients, and that is the assumption of shared word-meanings and experience. As Pease comments (10, p.14), people are not likely to admit failure to understand and therefore:

"If it is important, shared knowledge of word-meaning should be established, not assumed".

Good interpretation of the situation vis-à-vis the patient is also dependent on the degree of specialised knowledge and experience acquired for, as Webber observes (11, p.237), the individual's reaction to a situation is
not in terms of the absolute character of the situation but of his perception of it and without the necessary knowledge and experience, no nurse-learner can correctly interpret a situation. In the words of Muntz (6, p.51):

"How can [the nurse] know how to communicate, what to communicate and at what level her communication should be unless she understands the psycho-social and physical factors which influence health".

It must therefore be assumed that in the early months of training a nurse-learner is unable to interpret correctly the greater part of what she encounters since she does not yet possess that understanding.

Other factors interfere with shared evaluation between learner and patient: Lewis suggests (8, p.59) that there is a difference between the nurse's and the patient's perception of the latter's situation and condition. For example, what the nurse looks upon as a minor operation or as a familiar procedure, such as anaesthesia, the insertion of a drainage-tube or the giving of an intravenous infusion, is often regarded by the patient with considerable fear (12, p.24). Consequently, according to McGhee (13, p.44), a patient's perception of the standard of nursing care is related to the level of emotional support which accompanies it. In addition to this, patients object strongly to the mixing of learning with treatment (14, p.287), while for the nurse-learner it is a sine qua non of her training. Furthermore, patients resent the invasion of their privacy incurred by having to spend time with strangers (15, p.2532) - often in very intimate circumstances - while for the nurse this is the normal state of affairs on a ward.

It is hardly surprising, under these conditions, that the emotional state of the patient undergoes considerable change during hospitalisation, though nurses are apparently unaware of this (14, p.205). This is perhaps because of the widespread good humour and tolerance which most patients exhibit but Levitt (15, p.2532) suggests that this is a sophisticated devise for avoiding anxiety, fear or depression. Barnes found (12, p.23) that patients tend to regress to child-like behaviour, with child-like fears and fantasies. Adult reasoning gives way to
irrational interpretations and acute sensitivity. Profound implications are read into the slightest word or phrase, look or action and the patient becomes very egocentric. If, as suggested, a nurse is unaware of this, how can she share the patient's perceptions and therefore how can she communicate effectively with him?

ii) **Identification of the rules of communication in the social situation.**

As Ruesch and Bateson stated, communication in the social situation is governed by explicit and implicit rules. Regarding the nurse-learner, these rules dictate what and how much she may or may not say to whom. Thus there is an explicit rule that learners do not give details of a patient's diagnosis or prognosis to him without first seeking the permission of the nurse in charge (16) and this is implicitly maintained by the patient, who, according to McGhee (13, p.63) does not believe that a young nurse has any information or, if she has, that she does not know how to use it. Moreover, there is a belief among patients that it is unethical to involve learners in such discussions.

Nevertheless, as Lewis points out (8, p.71), there is often a need for the learner to ask for highly personal information from patients, who are near-strangers. It is therefore important to ask for it in the right way and to ask for no more than is required. In addition, a learner is expected to talk to the patient, providing him with emotional support and explanation of nursing procedures.

With respect to colleagues it is understood - because it is a function of education and training - that a learner may expect to be taught by and ask questions of senior staff, to which she may equally expect answers. However, in a study of first-year learners, Hutty (17, p.134) found that learners were not encouraged to talk to patients as much as they had supposed they would be and also that far from welcoming their questions, senior staff expected the learners to know much more than they in fact did. These learners had also been led by the School of Nursing staff to expect that they would be taught how to read patient's case-histories, and in some wards they were. In others not only was this not done but learners who read
patients' notes of their own accord, felt guilty when they did it (17, p.153). Similarly, Revans found (18, p.52) that many ward sisters actively discouraged learners' questions, though the Briggs Committee suggests (19, para. 107, iii d) that this is because senior staff feel threatened by learners who are knowledgeable or who show initiative. As a result, as Noble found (7, p.33), learners were hesitant about asking questions, even for clarification.

One factor which Hutty found caused considerable distress (17, p.44) and which learners evidently do not accept as being included in the rules is public criticism. This was listed in Hutty's findings as one of the major problems for first-year learners.

Clearly there are no standard rules governing communication between learners and colleagues, and the dichotomy between learner-expectation and the actual state of affairs makes it difficult for the learner to identify those rules.

iii) Identification of the roles in the social situation.

As was shown earlier (1.3.8.a), there is considerable ambivalence regarding the role of the nurse-learner and this ambivalence is both physical and psychological; physical in terms both of the work demanded of the learner in relation to level of training and of the extent to which she is learner or employee; psychological in terms of the learner's own attitude to and fulfillment of her functions as a nurse.

The question of senior learners having to do the work normally allocated to juniors and vice versa was touched upon earlier (1.3.8.a). These role-changes are, to a certain extent, inevitable for two reasons. Firstly, in the words of Jaco (20, p.305):

"... unlike industrial and other large-scale organisations, the hospital relies very heavily on the skills, motivations and behaviors of its members ... The flow of work is too variable and irregular to permit co-ordination through mechanical standardisation. And the product of the organisation - patient-care - is itself individualised rather than uniform or variant".

Secondly, as the Nuffield team, in its Report of the
"The work of a ward is determined independently of the staff who are there to run it".

Thus work allocation will be governed not by what a learner should be doing in terms of learning or reinforcement but by the proportion of students or pupils per year of training on duty at the time. Consequently, if a third-year student must do the work of a first- or second-year student or pupil, learning opportunities are reduced. Conversely, and perhaps more seriously, if there is a preponderance of first- and second-year learners, they may well find themselves performing tasks in which they have been inadequately instructed or shouldering responsibility for which they are ill-prepared. With respect to these last two points there is considerable and continuing evidence, much of which will be considered later in another context, to suggest that this is indeed the case. In Hutty's investigation in 1965, one of the subjects summed up the feelings of many by remarking succinctly: "We're either in the sluice or in charge", staff-shortage being given as the main reason. (17, p.121). The range of comments made also suggested that first-year learners often had to perform tasks for which they had been inadequately prepared. Perry, in 1968, indicated (22, p.48) that this was a continuing and serious problem:

"One serious failing of the present system lies in the possibility of [nurse-learners] having to carry responsibility before they are sufficiently knowledgeable and experienced to do so with safety and confidence. They may also have to perform, without supervision, tasks in which they are unskilled ..."

In 1972 the Briggs Committee observed (19, para. 108) that there was too much variation in levels of responsibility from day to day. 75% of student-nurses and 65% of pupil-nurses agreed about this.

This sudden role-switch is perhaps most distressing, and first encountered in its full seriousness, when the first-year learner does her initial spell of night-duty for not only may she have to perform unfamiliar technical procedures, which, in itself, is frightening enough, but she will also have to cope with situations which, on day-duty,
are normally dealt with by senior staff. Three situations which many of Hutty’s subjects mentioned in this context (17, p.219) were: new admissions (such patients are, by definition, extremely ill); responsibility for intravenous infusions, and death.

The second question, the extent to which a learner is learner or employee, is also a very thorny problem. As quoted earlier (1.3.8.a):

"... a student is more or less a student, depending on circumstances". (21, p.71).

and in 1964 the Platt Committee, in its recommendations for the reform of nurse education (23, para. 8, A iii) declared that:

"... a student must be a student in fact [sic] and not in name only".

and later (para.13), that educational needs should govern the service that the learner gives. Nevertheless the Committee were of the opinion (para. 13) that the conflict between education and service needs was inevitable within the existing framework, pointing out that in some hospitals nurse-learners accounted for over half the establishment.

Perry corroborates this (22, p.48), commenting that:

"Indeed, in many hospitals [nurse-learners] form the largest proportion of the nursing staff in the ward team".

However, Perry considers that it is unrealistic to suppose that it could be otherwise, for she continues:

"... Clearly, under these circumstances it is unrealistic to suppose that what [the learners] must do in order to meet the patients' needs is necessarily related to their needs as students".

Bendall, however, is not so convinced. (24). She feels that it is not necessary to have conflict and that if the School of Nursing and Services co-operate on planning, and if recruitment is good, it is perfectly possible to evolve a programme which meets learners' needs and service requirements. If such collaboration is missing, Service requirements may well take precedence over training needs. It would therefore seem to be a question of planning rather than inevitability. Nonetheless, as will be demonstrated in a later context, the role-conflict for nurse-learners continues.

Revans suggests (18, p.65) that the sister's
unwillingness to admit the learner-status by accepting and answering their questions arises from the "clay-foot" syndrome, which is very prevalent in hospitals. The fear of being found wanting leads to the development of defence-mechanisms to prevent the exposure of weaknesses, the main one being to repel all questions and to refuse to listen to what is said.

The third question, that of the learner's attitude to and fulfilment of her functions as a nurse, raises further issues in an already confused learner-employee situation. Not only must the employee cater for the needs of the sick and carry out duties and procedures with which she is often unfamiliar, learning as she goes - by instruction if she is lucky; by trial and error if she is not - but part of this hybrid's function is to provide emotional support and reassurance for the patient. Many of the physical tasks are, in the words of Menzies (25, p.97):

"... distasteful, disgusting and frightening".

added to which is the psychological stress arising from involvement with suffering and death, the full effects of which will be discussed later. Furthermore, not only must the learner come to terms with her own stress but she also has to cope with that of colleagues and patients (25,p.99). Thus, according to Menzies (25, p.97) her deepest emotions are aroused almost all the time. Nor is she given the opportunity to come to terms with all this against a stable background for, as Anderson points out (26, p.73) patient-turnover is very rapid within wards and, in addition, learners themselves are moved every few weeks. (See also: 1.3.4. A.a). Such moves require constant re-learning of roles and situations, including new illnesses (25, p.113). These moves are often sudden and therefore the learner has no opportunity for psychological preparation (25, p.113) for the ensuing trauma of broken relationships (25, p.103), the unfamiliarity of the new situation and the insecurity. As a result, senior staff consider that it takes a learner new to a ward two weeks to settle down, though in Menzies' opinion (25, p.113) the time required is much longer.

It is understandable, therefore, that, faced with so much actual and anticipated trauma, both Menzies (25,p.113)
and Anderson (26, p.73) found that learners tend to opt out of or restrict their contacts with patients and to concentrate on physical or technical skills. This is perhaps made easier for them by the increase of technical nursing during the last two decades (see 1.3.8.a) and though MacKeith suggests (27, p.171) that this increase causes a conflict of priorities for the nurse, it appears to be more of a welcome escape-route.

It is evident from this that a nurse-learner must have considerable difficulty in identifying either her own role or that of her colleagues. Her learner-status is denied or confused by the system and her role as emotional support for the patient, which she finds difficult to maintain against the concomitant stresses, is submerged in the technical role.

If, as Ruesch and Bateson suggest, correct interpretation, and therefore effective communication, is dependent upon shared perceptions, shared acknowledgement and understanding of the roles and shared identification of the roles in a social situation, then it follows that learners are in no position to interpret their particular situation and that therefore effective communication must be virtually non-existent.

2. Networks.

These have already been described along with Ruesch and Bateson's categorisation.


1) The machinery of communication.

From the learner's point of view the machinery of communication is concerned with two aspects: education and training. Education, in this context, may be considered as being acquired in the School of Nursing and training as being acquired in the clinical situation.

Education.

As already described (1.3.6) learners are taught theory and given initial practical instruction in, and demonstration of, nursing procedures. Such information is imparted by lecture, demonstration and discussion and attainment is tested either verbally by question-and-answer techniques or by written test-papers.
Teaching (see 1.3.6) is carried out by Registered Nurse Tutors (RNTs) and Registered Clinical Nurse Tutors (RCNTs). The function of the latter is to augment and reinforce, at ward level, what has been taught in the School. This is the ideal.

Apart from the formal tuition in the School of Nursing, the learner has the opportunity for self-teaching through the School library, private study, project-work and the writing of case-histories. Most Schools also set a compulsory written paper on a weekly basis so that learners can check on their own progress. Some Schools of Nursing (17, p.156) organise optional weekly revision classes, but in Hutty's investigation at least, these had to be attended in off-duty hours.

As regards the learner, the writing of weekly papers, project-work and the writing of case-histories is usually compulsory. Visiting the library and private study is not and there is evidence to suggest that the number of learners who do actually read books is minimal (28, pp. 984-5). Nor, according to Hutty, (17, p.44) do some learners consider private study to be necessary, except immediately prior to examinations, since her sample considered that material was easily retained because of the way in which it was taught.

With respect to the tutors, a recent report by the General Nursing Council (GNC) (29, 30) would suggest that their teacher-training leaves much to be desired and that the trained manpower problem is acute.

According to Lancaster (31, p.8):

"It would appear that there is at present no planned national policy regarding the preparation of the people responsible for the professional education of nurses".

This conclusion is amply borne out by the GNC Report.

There are, basically, two types of course (30, p.3): Technical Teachers' and City and Guilds courses and the more traditional courses run by such bodies as the Royal College of Nursing. The former stress methodology, while the latter concentrate in the main on the knowledge to be taught.
In an opinion survey, to which 2,874 tutors responded (30, p.1), it was evident that those trained by a Technical Teachers' or City and Guilds course felt much better prepared than those who had followed the more traditional courses.

When asked to evaluate the adequacy of their preparation, the following replies were received (29, p.4):

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<td>testing</td>
<td>56</td>
<td>44</td>
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<tr>
<td>planning/management</td>
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<td>counselling</td>
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73% of tutors were reasonably or wholly satisfied with their jobs (29, p.5), though only 56% of those in Schools of Nursing, which accounted for 73% of the total, intended to stay in Schools of Nursing (29, p.6). Of the 73% in Schools, only 29% intended to stay in post for a number of years.

Three main problems were isolated: the tendency of RCNTs to become RNTs; the general feeling of inadequacy of preparation for teaching and the instability in Schools of Nursing staff.

Since 1967 there has been a significant move out of Schools of Nursing by tutors, which has increased in percentage each year (29, p.8). Consequently, there is a serious shortage of trained manpower, particularly in the tutor-grade (29, p.10), thus:

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<td>Principal Nursing Officer</td>
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As a result tutors are overworked and RCNTs have been brought from the wards to teach in the Schools to cover the shortage. Their training of six months does not
necessarily equip them for this and, what is more, they are no longer available for reinforcing learning in the clinical situation. (30, p.11).

Tutors felt that the four most important improvements needed were: more staff; better control of nurse education; better facilities for staff; and more liaison with ward staff.

When those who had left Schools of Nursing were asked what would encourage them to return (30, p.24): 15% said nothing would; 7.5% said recognition and clarification of the RCNT's role; and 5.2% said more co-operation between education and services.

The conflict between education and services was the chief bone of contention for tutors (8.6%) and senior tutors (10.4%) and was the second highest cause for dissatisfaction for RCNTs (11.0%) and Principal Nursing Officers (8.4%). This conflict is therefore clearly a matter for considerable concern.

Part 2 of the GNC's report suggests that data collected later indicated a healthier situation than in 1973-4 and it was estimated that if the growth-rate then apparent was maintained, a ratio of one tutor to fifteen learners could be achieved by 1981-2. However, it has not been maintained (24) so it must be assumed that the situation remains serious.

Learners are therefore faced with understaffing in Schools of Nursing and are often taught by inadequately prepared tutors, both of which would suggest that the quality of teaching is thereby diminished.

Services.

In the clinical situation there are several avenues of communication open to the learner, whereby she can acquire information regarding patients' diagnoses, progress, treatment and nursing care. As well as being sources of current information, they are also potential sources of learning, allowing the learner to augment or reinforce knowledge acquired in the School of Nursing and to correlate it with, or transfer it to, other situations. Perry, (22, p.213) gives a fairly full list of opportunities
for learning and teaching: demonstration; supervision; when a learner gives a verbal report; during the giving of the collective ward report; during the patients' rest-period or visiting time; from the patients' notes; from books kept on the ward; private study; observation; making succinct reports and asking and answering questions.

The last, direct questioning by the learner, has already been mentioned and will be discussed more fully later, as will learning by demonstration and supervision.

Learning from the patients' notes, reading or consulting text-books kept on the ward and reading reports of investigations all require access as a prerequisite. It has already been noted that not all learners feel able to do this without a sense of guilt, as if they were doing something wrong. In addition, all such material is usually kept in the ward sister's office and McKeighan found (9, p.80) that this formed a physical barrier beyond which nurses were reluctant to pass. Also, even if a learner feels satisfied that she is welcome to consult notes and so on, doctors, consultants, administrative and other hospital personnel often visit a ward and the office is then not available to the learner. Furthermore, without guidance and explanation from senior staff, much of what a learner reads in reports may be unintelligible to her. Moreover, in many cases, they are inadequate in serving their prime function. Healey and McGurk, in an investigation into the effectiveness of nurses' notes, found (32, p.32) that most of the respondents - comprising both medical and nursing personnel - felt that they lacked detail, that they were incomplete or repetitive, some gave no information at all and that such reports usually concerned procedures carried out rather than observations on the patient. 56% of the nurses and 70% of the doctors included in the research felt that while being a useful adjunct to a verbal report, such reports were not, of themselves, an adequate method of communication. Lelean (2, p.25) also found evidence to suggest that important details of medical care for post-operative and critically ill patients were often omitted, and other such deficiencies. In addition to this, as
the Nuffield team observed (21, p.124), ward reports and treatment lists do not explain normality or typicality, nor the reasons for treatment.

With regard to teaching or learning during the giving of the collective report, Geddes comments (33, p.116) that, while such a session is a good opportunity for teaching, it is more often a recitation of facts about patients, with little or no regard for whether junior or untrained staff have understood. Moreover, such reports contain abbreviations and jargon which may be incomprehensible to the uninitiated and it is difficult for the learner to ask questions without losing face.

With regard to planned teaching by senior staff during visiting-time, rest-periods or actually on-the-job, Geddes found (33, pp. 116-7) that when tutors in training were asked how they would organise ward-teaching of students and pupils, the usual topics mentioned - based on 500 written answers - were: inanimate objects, medicines, equipment and so on. When asked to describe the methods by which they would assess learners' needs, they usually listed tasks which would be entrusted to senior or junior nurse-learners. When asked to describe records kept of any teaching done, they referred to the GNC Record of Instruction - a record of proficiency in the compulsory and optional nursing procedures, required to be kept by the learner and presented at examination. Yet many of the tutor-trainees admitted that the Record of Instruction was often hastily filled in in collusion with the learner immediately before the latter left the ward. Hutty also found (17, p.155) that there were four main methods of teaching: by direct observation; participation; during visiting times and slack periods; and by accompanying a doctor. Most of the subjects in the survey, however, reported (17, p.156) that wards might offer only one or two of these and that what was offered might be conditional or sketchy.

It would seem, therefore, that the machinery of communication, whether in human, situational or mechanical terms, is often inadequate or under-used or both.
ii) **Factors influencing the functioning of the communication networks.**

a) **the capacity of the receivers, transmitters and channels in relation to the load they carry.**

The overload, in psychological terms, which inhibits learners' effective communication with patients, has already been noted. Levitt (15, p.2532) found a similar reluctance on the part of patients to seek contact with nurses, except in emergencies, because of the widely-held belief that nurses are too busy to be worried with non-urgent matters. However, many of Hutty's subjects commented that, while there was sometimes too much to do, there was as often too little to do. They also said (134) that they had expected to be able to talk to patients more. Nevertheless, according to Duff and Hollingshead (14,p.286), nurses do not always avail themselves of the opportunity, even when it presents itself. In their study, discussions with patients were limited and discontinuous concerning hospital or home life, the patient's illness or his feelings and this was not necessarily because of lack of time since this was true even if the patient had a private nurse. Since both Menzies and Anderson, both previously cited, found that nurses avoided contact with patients, it is a reasonable assumption that nurses, while cherishing the idea that they would have more contact with patients if circumstances permitted, shy away from it by being otherwise engaged.

With respect to communication between learners and senior staff, Caine and Wijesinghe found (34, p.177) that there was insufficient contact between learners and senior staff, though this apparently was not felt to be the case by the latter. However, a possible explanation for this is provided by Webber (11, p.247), whose findings showed that superiors tend to exaggerate contact downwards more than subordinates do upwards. Certainly Revans found (18, p.64) that there were difficulties for learners in making effective upward contact and he lists the vocabulary of discontent and frustration used by interviewees. Nevertheless, he also points out the high level of stress
under which hospital staff must work (p.64) and elsewhere (35, pp. 121-3) he observes that the stresses under which a ward-sister has to function sets up a chain reaction which affects the learner adversely. Hutty also observed (17, p.104) that seniors did not speak to juniors and that the latter dared not speak. According to Caine and Wijesinghe (34, p.179) this breakdown in communication tends to lead to alienation and cynicism on the part of the learners and Noble suggests (7, p.33) that when such a breakdown occurs, directives downwards are resented and problems moving upwards are seen as complaints, resulting in a state of mutual isolation.

This, then, is often the background against which ward teaching must take place. According to Revans (18, p.6), the extent to which nurse-learners find their work intelligible is an indication of security. Where they feel that they may, beyond reasonable limits, be expected to take responsibility for matters which they cannot understand, they are likely first to fall ill and then leave.

The extent to which work is intelligible will depend on several factors, not least the amount of preparation for it by teaching, the quality of that teaching and the amount of guidance and supervision given. However, according to Bendall (36, p.12) supervision of learners by senior staff is minimal and Revans found (35, p.124) that few sisters gave more than 1% of their time to learners, as opposed to 50% to clerical and related duties. Lelean suggests (2, p.16) that it is because of the shorter working week that there is such a shortage of time for teaching on the wards, and sisters themselves feel this (18, p.50). Revans, however, found (18, p.51), that senior staff felt that sisters could find more time for teaching if they chose, while nurse-learners were of the opinion (18, p.52) that sisters were not particularly interested in teaching juniors and that many discouraged questions. Many learners felt that senior staff were often "unapproachable and uncommunicative" (18, p.52), particularly regarding patients' diagnoses and treatment. Consequently, where such conditions prevailed, and instruction was inadequate, nurse-learners expressed less interest in their work and
a greater likelihood of mistakes. Hutty's findings also suggest (17, p.153) that the amount of teaching done depends on the sister's interest and ability to teach but that the level of ward-staffing in relation to the work-load is a contributing factor. Anderson found (26, p.49) that most nurses, qualified or otherwise, in her survey felt that more time should be devoted to teaching nurse-learners and more thought given to who teaches them and the sources of their learning. As matters stand, over 50% of learning is acquired from experience and only 37% from senior staff (26, p.50). The Briggs Committee reached similar conclusions (19, para. 107 iii b), suggesting that there was insufficient demonstration of nursing procedures and that sisters and senior staff were too busy to do more than distribute cursory directions with minimal teaching of the procedure.

According to the Briggs Committee, this reluctance to teach extends to the Schools of Nursing for the Committee found (19, para. 107 iii b) that questions were not welcomed by tutors either and that communications, both personal and organisational, were generally poor. Hutty had found earlier (17, p.64) that 40% of nurse-learners were afraid to ask questions of tutors and many were apprehensive of voicing their opinions during group discussions, though she does point out that this technique had only recently been introduced (17, pp.61-2). Much of the reluctance, according to Caine and Wijesinghe (34, p.179), seems to stem from learner-shyness and tutor-inexperience and as a result learners do not express their opinions either in the School of Nursing or in the ward.

With respect to communication between learners and senior staff, there is clearly much evidence to suggest that the capacity for effective communication is grossly under-loaded and that channels are seriously distorted.

b) **threshold problems.**

It has already been noted that the patient's assessment of nursing care is influenced by the level of emotional support accompanying it but that this is not always forthcoming, given the tendency of nurses to opt out of or restrict contact with the patient. There is diverse
evidence to suggest that this lack of support is widespread, though reasons given differ somewhat. McGhee (13, p.64) suggests that it is the climate of bustle, the lack of privacy and the lack of time which makes communication difficult and Moos and Houts (37, p.56) stress the importance of the social climate of the ward, particularly in psychiatric nursing. The current form of treatment in this field, according to Morrice (38, p.640), is the therapeutic community, where treatment is planned on a group basis of both staff and patients. During group discussions feelings and decisions are shared and evolved. However, there are considerable difficulties in developing this style of treatment, partly because of the reluctance of both staff and patients to relinquish their traditional roles and partly because of the difficulties of reconciling the principles of the therapeutic community with the strongly-held tenet that the nurse should not become emotionally involved with the patient. As Noble puts it:

"... The introduction of [the therapeutic community] presents a great problem in persuading nurses, who for years have been conditioned not [sic] to speak, to speak freely. Faced with the dilemma of being told to give patients sympathy, to listen to their problems, to treat them as human beings and at the same time to avoid becoming emotionally involved with them, nurses may find themselves in an impossible position".

McGhee suggests (13, p.61) that the communication needs of patients are both intellectual and emotional. At the intellectual level it is concerned with the basic needs of the patient in hospital, particularly if for the first time, and this is heightened by having to live publicly among strangers - often at a level of considerable intimacy. At the emotional level there is an extension of the ordinary human need for sympathy and understanding, which is enhanced by physical dependence on strangers, pain and fear - of death, disability, being a nuisance or making a fool of oneself. This care for the patient's emotional and social needs is considered by the patient (13, p.76) to be an essential adjunct to physical nursing care but on the whole nurses are unable or unwilling to give it, partly because empathy is inhibited by
anxiety and fear and partly because of the cultural norm which encourages non-involvement with one's neighbour (27, p.171). On the physical side, according to Cartwright, (39, pp. 35-7) patients, although they make excuses for nurses, find that the latter are often unskilled, untrained or not gentle. This last may be because, as McKeith found (27, p.171) staff tend to treat patients as they themselves are treated by their superiors and certainly Revans observed (18, p.21) that the atmosphere in a ward and staff relationships had a direct effect on the patients' recovery-rate.

The inability to be empathetic towards patients has very deep psychological origins and according to Menzies (25, p.97), the level of tension and distress among nurses is very high and they are not always able to cope with it. This tension is increased and maintained by the constant threat of crisis under which nurses operate and since trauma-anticipation is high, nurses tend to avoid involvement (25, p.113). Anxiety is further heightened by the attitude of senior staff towards learners' errors, where reprimand is more common than consolation (25, p.105), particularly since blunders or inexperience are often regarded as "sheer stupidity" (18, p.52), though Revans suggests that these are probably increased by the senior staff's attitude and by fear of the sister. While, as Jaco remarks (20, p.306): "when human life is at stake, there is little tolerance for error or neglect", this intolerance is often extended to non-critical errors, and such an attitude shows scant appreciation of the learner's dual role. This is reflected in Hutty's findings that nurse-learners are expected to know too much (17, p.134). The result according to Revans (18, p.50), is that:

"Most students learned very little except caution on their first ward".

It is not surprising, therefore, that nurses should develop defence-mechanisms against such trauma and fear (25, p.10), the more so in that, unlike doctors, the nurses are in the ward all the time and therefore cannot so easily divorce themselves from patients' anxieties in the same way that doctors can (12, pp. 37-8). Nor do
they get any relief from stress and they are therefore in a perpetual state of pathological anxiety, which interferes with their ability to develop the understanding and skills necessary to master such anxiety. Thus the impact of physical illness is enhanced by having to cope with almost unbearable psychological stress (25, p.99).

If to this non-provision of opportunity for the resolution of psychological stress and the reluctance of senior staff to admit their teaching-role is added the inability of many of the latter to even recognise the needs of learners - and Geddes considered this to be a major problem (33, p.116) - it will be evident that the number and extent of threshold problems which interfere with effective communication between learners and other groups are considerable.

c) the effects of the adequacy of the transmission of the organisation's information on the recipient's future actions and/or responses.

It was suggested earlier that what was taught in the School of Nursing was reinforced and supplemented in the clinical situation, such learning being co-ordinated by the RCNT. However, it has been shown that, due to serious staffing shortages in the Schools of Nursing, the RCNT's are not always available for in-service teaching. Thus the full burden of ward-teaching falls upon the senior nursing staff. Some evidence has already been proferred to show that such staff are often unwilling or unable to meet their teaching commitments and that learners therefore suffer accordingly. In addition to these difficulties, there are several other problems which exacerbate the learner's situation and their effects are far-reaching.

Firstly, there is a conflict between education and training. MacGuire (40, p.25) observed that there was a discrepancy between School teaching and ward practice and Caine and Wijesinghe's overall impression during their study (34, p.179) was that not only did this discrepancy exist but also that contradictory information was often given to learners by tutors and ward staff. According to the Briggs Committee (19, para. 226), many senior staff were aware of the differences between theory and practice
but complained that teaching in Schools of Nursing was unrealistic because: "... things are not done in the same way on the wards". In spite of this awareness, Revans found (18, p.48) that teaching staff were not encouraged to visit the wards. It follows, therefore, that a common policy is neither sought nor established.

Consequently, learners become confused and discouraged (18, p.49) and the School of Nursing is increasingly regarded as the place where learners learn how to pass examinations, with little relevance to "real" [sic] nursing (36, p.11).

Secondly, as Hutty points out (17, p.153), in the School learners acquire a planned, gradually increasing body of knowledge from a standard pattern of teaching and all learners are exposed to the same amount of knowledge for the same period of time. In the wards, however, there are no formal standard practices concerning either the amount of teaching time to be allocated or the content and range of such teaching. This is substantiated by Caine and Wijesinghe (34, p.179), who suggest that many learner-problems arise from a lack of any recognised training programme, added to which is the indifference of some of the senior staff. Bendall also observes (36, p.12) that learners receive little help from senior staff. Anderson states (26, p.67) that lack of adequate teaching is seen by learners as a major problem and MacGuire's findings (40, p.26) show that the "training" [sic] that learners receive often falls short of their expectations. MacGuire also commented in an earlier study (41, p.9) that ward-teaching was not sufficiently comprehensive, either in basic or technical nursing, to give learners an adequate foundation upon which to build. It would appear from the survey carried out by the Nuffield team (21, pp. 123-4) that, with respect to ward-sisters, opinion was divided concerning the teaching of nurse-learners in the ward.

Some expressed the view that if learners were keen enough, they would find out what they wanted to know and that therefore the onus was on the learner. Others thought that they should be taught and the Platt Committee (23, para. 131) certainly emphasizes the role of the senior
staff in this respect. Nevertheless, it must be said—
as the Briggs Committee observed (19, para. 226) — that
very few senior staff have any teaching preparation and
Perry points out (22, p.11) the very real difficulties
facing the ward sister. While acknowledging the necessity
for senior staff to be aware of the factors influencing
the rate and extent of, and the response to, learning
(22, p.188), she comments that the learner-population on
any ward is very heterogeneous: not only are both students
and pupils working together but standard and experimental
training schemes are often running pari passu and some-
times learners from general training are on three months'psychiatric attachment and vice versa. All have different
needs and the extent of knowledge and skills required may
vary. (p.11). Senior staff have therefore to be familiar
with all syllabuses if they are to meet those needs and
the appropriate teaching is to be given. Perry also under-
lines (22, p.71) the importance of teaching a learner the
necessity for a particular type of treatment, since it is
thus more likely to be carried out effectively and she
further points out (p.182) that although learners acquire
much knowledge from experience, the latter should be
guided, otherwise the wrong lessons might be learnt or
wrong deductions made.

It is evident, however, that Perry's exhortations are
not acted upon by all qualified ward staff and the result
of this is that learners seek advice and help from each
other. Revans (35, p.129), Hutty (17, p.188), Noble
(1, p.32) and Bendall (36, p.12) all comment on this.
Hutty found that first-year learners left in charge on
night-duty rang their friends on other wards for advice
if in difficulties, referring to Night Sister only as a
last resort. Bendall suggests that new learners are often
taught by another learner only a few months senior and who
may well know little more than the learner she is "teaching"
[sic], while Noble observes that what is passed on in this
way may well be in contrast to formal teaching. To this
Perry adds (22, p.48) that the passing on of skills not
properly mastered can be dangerous for the patient as well
as being a source of anxiety and stress for the learner.
In consequence, as well as becoming discouraged and losing interest, MacGuire's findings showed (41, p.9) that learners experienced training as both confused and haphazard, viewing good teaching as a matter of luck. They had considerable difficulty in seeing their training as either planned or coherent (41, p.10).

Thirdly, such deficient teaching and haphazard training has a serious complication. A constant fear from which learners suffer is that they will be asked to perform services for patients without prior and adequate instruction. The lack of proper supervision, the lack of teaching and the learning from each other makes this fear a frequent reality, as the literature suggests. (6, p.49; 13, p.37; 17, p.219; 19, para.107 iii,b; 35, p.125). Revans found (18, p.50) that senior staff admitted that learners were not always shown how to perform unfamiliar tasks and MacGuire found (41, p.9) that this was a common reason for nurse-learners leaving the profession early in training. Perry comments (22, p.211) that it is important that the patient should not know that a learner is unfamiliar with a task or he may be tense and anxious and difficulties may arise. However, McGhee suggests (13, p.37) that patients are aware when this occurs and that it is a cause of anxiety to them.

Fourthly, there is the problem of varying standards of nursing care required by different wards (17, p.147) and also the difference in technique both expected and practised by senior staff trained in other hospitals (16), both of which confuse learners and make it difficult for them to establish standards or norms.

Finally, there is the question of the interpretation of specialised language. Roose (42, p.113) found that there were discrepancies between doctors and nurses, as well as among nurses and among doctors, in the interpretation of the activities implied in the doctor's orders. For example, while all nurses understood "complete bed-rest" to mean that under no circumstances should the patient put foot to floor, there were wide divergences of opinion as to the extent to which a patient was allowed to sit up, feed and wash himself. Although Roose's research was
conducted in the USA and is therefore possibly of limited application, Lelean (2, p.15), in her investigation, discovered similar differences of interpretation. Her study of six female wards showed:

"... a vast discrepancy in the interpretation of instructions among nurses and it has shown the ambiguity of certain instructions and their many shades of meaning even on the same ward".

For example, (2, p.107) "up and about", while being a widely-used and well-known instruction in hospitals, was found by Lelean's team to have eight different shades of meaning.

There is therefore clear indication that the transmission of information by the nursing profession to its newer members leaves much to be desired and is, in many cases, transmitted in such a way that the effects of that transmission are somewhat deleterious to the performance and attitudes of nurse-learners and effective communication is thereby often severely hampered.

d) the process by which organisational continuity is maintained and new members assimilated.

The nursing profession maintains its continuity by the training of new recruits at both student and pupil level. Most if not all Training Schools have three intakes per annum. According to MacGuire, however, (41, p.3) 25% of those recruits leave, almost without exception of their own accord, before completing training. The main reasons given, in MacGuire's research, were insufficient teaching and inadequate preparation for responsibility. (41, p.4). The long history of the difficulties in attracting new recruits was discussed earlier (1.3.9.a).

New recruits have, in theory, student-status, yet, as already noted, little more than lip-service is paid to this theory. Furthermore, Hutty found (17, p.25) that learners felt that they were treated like children, a practice which was highly resented. As students, Perry suggests (22, p.189) that learners should be told what they can expect to learn, since they may not be aware of what there is to learn. However, far from this being done, Hutty found (17, p.104) that learners complained of having no formal introduction to wards and that there was no clear
As adolescents, many of them away from home for the first time, and sampling their first taste of institutional life, (17, p.25), new learners need a considerable amount of help, guidance and counsel, particularly given the nature of their work and its psychological impact. Yet, according to Menzies (25, p.103), they get little or no support of any kind.

In addition to these initial difficulties, pupil-nurses have even greater difficulties in that they must contend with being regarded and regarding themselves as inferior. According to the Dan Mason Committee (43, p.6) pupil-nurses have a deep-rooted and long-standing sense of inferiority and this is substantiated by Anderson (26, p.51), who observes that not only are pupil-nurses regarded as inferior but also that there is a lack of clarification of their role. That this feeling is widespread was shown by the Platt Committee (23, para.17), which noted that the number of pupil-nurses was small in relation to the number of student-nurses, which it attributed to the lack of status of the pupil-nurse. In its investigation the Committee also found that some Training Schools which had been converted from student-nurse to pupil-nurse Training Schools considered the conversion to be a downgrading rather than a change of function.

Thus the effort to assimilate new members would seem to be as indifferent as the effort to give them a comprehensive training and the high rate of non-assimilation, as demonstrated by the wastage-rate, would suggest that the profession has difficulty in maintaining itself at a properly functioning level. It would also seem that those learners who succeed in qualifying often perpetuate the difficulties of learners coming after them by adopting the attitudes and practices of the senior staff who trained them since the more recent research (2,19,26,29, 30,31 and 36) shows little improvement regarding the fundamental problems militating against effective communication.

These, then, are the problems faced by all nurse-learners, most of which arise from the job itself. For
overseas learners there are additional problems, many of which are extraneous to, but affect performance in, nurse-training.

3.3. **Problems specific to overseas learners.**

The literature available would suggest that many of the problems specific to overseas learners are of a social, linguistic or psychological nature. Educational problems appear to be less prominent, though some of their difficulties arise from nurse education and training, recruitment and selection.

i) **Social and psychological problems.**

When a person from another culture is placed as a learner in the nursing milieu described above, with all its attendant difficulties, her ability to communicate effectively with both colleagues and clients will be influenced to a very great extent by her understanding of that milieu and her acceptance of and into it. The degree to which both occur may be considered as the level of orientation achieved. It is axiomatic that the more active assistance and guidance offered, the easier will be the task of the overseas learner in coming to terms with her new environment and, consequently, the sooner she will be able to function effectively both as a learner and as a nurse.

However, there is little evidence to suggest that orientation courses for overseas learners are organised very often and where orientation programmes are said to be in existence, there appears to be much misunderstanding as to the meaning of orientation, as the Kings Fund Working Party discovered during its investigation of the subject (44, p.34). Many Training Schools confuse induction - an introduction to the hospital - with orientation; which, as suggested, has a much wider application and UKCOSA's findings (45, p.25) were similar to those of the Kings Fund Working Party.

Provision of either orientation or induction programmes is scanty, though UKCOSA found (45, p.18) that most overseas learners assumed that the Training School would have one. In their survey in 1971 only 28.4% of the
respondents said that such a programme was provided (45, p.25) and in a survey conducted by the Political and Economic Planning Unit (PEP) in 1972 (46, p.23), none of the sample mentioned a formal orientation course or even an induction programme. In 1973 the situation was no better (44, p.30), with only 76 Training Schools out of a total of 405 (47, p.26) running any kind of programme. These varied in length from one day to two weeks and many were therefore no more than "...a guided tour round the corridors", as Thompson puts it (48, p.18).

Nor do all new arrivals have the opportunity to organise their own orientation, since the greater majority either go straight to their respective Training Schools or go there after one or two days with relatives or friends. For example, according to the PEP survey, (46, p.21) 50% of overseas recruits went straight to their Training School on arrival and a further 25% after one or two days. Thus the majority go straight into nurse training with virtually no preparation and must therefore adjust to the situation as best they may.

The Kings Fund Working Party suggests (44, pp. 32-3) that there are four major adjustments facing the overseas learner: - adjustment to an alien environment - which includes culture patterns, geographical and climatic conditions, religion, ethics, food and language.
- adjustment to an abnormal environment - in which are sick people who may exhibit abnormal behaviour patterns and in which the overseas learner may be faced with different views concerning birth, death, sickness, pain, sex and bodily functions.
- adjustment to a learning environment - where dialect, slang and colloquial English are as much a part of the working environment as the technical language of medicine and nursing.
- adjustment to a social environment - where learners must be able to interact with all sorts and conditions of men.

Zajonc observes (49, p.206) that in changing cultures a certain amount of conformity to the host-culture is necessary but since the individual has already conformed to his own culture he must, in many instances, re-organise
many of his original values, habits, beliefs and attitudes, often having to adopt new ones imposed by the host-culture (p.207). Zajonc's research showed that, where there was a need to conform, frustration arose because of conflict with originally acquired norms. This led to aggression against the source of the conflict and the strength of the aggression was related to the difficulty experienced by the individual in so conforming (p.208). However, Zajonc suggests (p.213) that such aggression takes time to develop.

Martin, in a study of West Indian pupil-nurses found (50, p.1079) that they exhibited aggression in three ways: by open criticism and disapproval; by minor instances of undisciplined behaviour and by hostility towards colleagues and superiors. Martin suggests several causes for the aggression (p. 1079): firstly, all were pupil-nurses who had expected to train as student-nurses; secondly, they wanted to be "proper" nurses [i.e. student-nurses] and thirdly, they were in a geriatric hospital - with which, presumably, they were not best pleased. Stones, in a study of overseas male recruits, found similar critical attitudes (51, p.143) towards both conditions and relationships within nursing but he observed, like Zajonc, that such attitudes took a year to develop.

Many overseas learners have commented on relationships between themselves and their colleagues or clients, much of the comment being concerned with the existence of racial prejudice or discrimination. In a survey by Sen (52, pp. 69-70) learners showed great sensitiveness to remarks made by patients who did not want to be tended by "coloured" [sic] nurses, 63% saying that they encountered racial prejudice often or sometimes (p. 203, Table 16). In the PEP survey, 3% mentioned racial prejudice in general terms (46, p.26) and Thompson also acknowledges that racial prejudice exists (48, p.18), though she adds the caveat that, in psychiatric nursing, what sometimes appears as prejudice is often a rejection of the nurse as a nurse, not as a foreigner, and that indigenes are as likely to face such rejection as overseas learners. Be that as it may, the PEP survey showed (46, pp. 37-8) that 30% of overseas learners felt that English nurses did not treat them as
equals but thought themselves superior. Nor did senior staff treat them the same as they treated English nurses and this was attributed to racial prejudice. The contention that English nurses consider themselves superior is given weight by research carried out in the USA by Cohen. His study showed (53, p.10) that white people expected black people to operate at a lower level, both qualitatively and quantitatively, in valued roles in work situations. Consequently, black people were inhibited and less willing to argue their case at work (p.24). There is evidence to suggest (48, p.19) that patients in wards with a high percentage of overseas nurses feel "socially uncomfortable" and that they cannot communicate freely with overseas staff. As Thompson points out, (48, p.19) whether or not such feelings are justified, they do exist. Thus effective communication, both with colleagues and clients, is inhibited for overseas learners.

Added to the difficulties of not being fully accepted into the nursing milieu, overseas learners must adjust to the abnormal milieu of the sick and to the cultural differences of approach. For example, as Beck observes (54, p.29) attitudes to death and disease influence attitudes to medicine and nursing. If "Allah wills it" there is no incentive to seek help and where infant mortality is high or life-expectancy is short, the approach to death is philosophical. Reaction to pain varies from culture to culture and assessment of the genuineness and degree of pain will be determined by the strength of the reaction in relation to accepted cultural limits. For example, the stiff upper lip of the British is well-known, while a Frenchman in pain is often vociferous about it in a manner which would be embarrassing in a British ward, and which would also cast doubt upon its genuineness (16).

Even more serious are the fundamentally different ethical premises, where lack of knowledge of those differences may have disastrous consequences. For example, the Kings Fund Working Party were told (55, p.4) of a student-nurse who considered it her moral duty to help a patient contemplating suicide to achieve his objective.
Similarly, acceptance of the sick-role is culturally determined. Thompson observes (48, p.18), for instance, that Ghanaians initially find difficulty in accepting that neurotics need psychiatric treatment and since depression and anxiety are not regarded as mental illnesses in Ghana, overseas learners from that country are sometimes impatient with such patients. Furthermore, hospitalisation of people whom overseas learners consider to be only mildly mentally ill sometimes causes a lack of sympathy with relatives (48, p.18), since such people would be cared for by the family. On the other hand, the tradition of kinship caring and respect for age often stands the overseas learner in better stead than the indigene. Malaysians, it seems, make very good geriatric nurses, while the gentleness of Mauritians makes them excellent psychiatric nurses (48, p.18).

Nevertheless, the very factors which so often make for good nurses, those of family caring and close kinship, cause overseas learners much unhappiness, for they are often extremely homesick and lonely. Although the majority have friends and/or relatives in medicine or nursing - in Sen's survey 54% (52, p.65) and in the PEP survey 65% (46, p.14) - they are not necessarily in the same Training School and the homesickness is by no means always short-lived. For example, the PEP survey showed (46, p.37) that 40% of those interviewed were still homesick after a year or more in training, the main reason given being that they missed their parents and families. Moreover a sizeable minority found difficulty in making close friends with indigenes, 30% having no close friends at all (46, p.36) and approximately 75% making their first friends with compatriots (p.23).

ii) Educational problems.

There is little evidence in the literature to suggest that overseas learners have serious problems on the educational side of nursing. Sen found (52, p.156) no significant difference in final examination performance between those who had had schooling to secondary level and those who had not and only 4% of the subjects in her study said they had difficulty with classroom work (p.67).
No comparative statistics for the failure-rate in final examinations between indigene and overseas learners can be given since none appear to exist, though even if such statistical data were available it would not necessarily reflect educational difficulties. Indeed, Sen found (52, p.157) that failure in final performance was related more to the adverse effects of public criticism and lack of supervision than to educational factors.

iii) Language problems.

Kelber, in a keynote address to the 1965 Quadrennial Congress of the International Council of Nurses (56, p.30), spoke of the difficulties inherent in a mixed-language situation. When using a language not one's mother-tongue and in which one's competence is limited, it is necessary to restrict oneself to what one can say rather than what one wants to say.

On the other hand, the mother-tongue speaker, according to Hoggart (57, p.15), is often incomprehensible to anyone who is not a mother-tongue speaker:

"... as in those conversations which never quite touch a substantive or verb and which move, like fish gliding past rocks and huge growths in those underwater films, from 'you know ... sort of ...I mean ... like ... kind of ...' all the way to the end".

Not only must overseas learners cope with both types of situation but they also face the difficulties of understanding the non-verbal communication which so often accompanies or stands in the stead of speech. La Barre suggests (58, p.212) that there is no "natural" [sic] language of gesture and that the interpretation of emotional expression is culturally subjective (p.207). For example, laughter in Africa is neither necessarily nor often a sign of amusement but is more likely to denote surprise, embarrassment or discomfiture (58, p.210) and in Mauritius it is quite acceptable for young men to hold hands (24), while in England this would be regarded as distinctly abnormal. Failure to appreciate such differences is liable to cause grave misunderstandings cross-culturally. Moreover, many gestures have opposite meanings (58, p.213): For example, some Chinese put the tongue out slightly when embarrassed; in England it is
rude; Africans shake their heads as a sign of affirmation and nod in negation, the opposite of the English. Thus overseas learners must not only recognise that their gestures may convey messages diametrically opposite in meaning to those of the host-culture but they must learn those of the latter for, as Beck observes (54, p.41) a nurse-learner needs to be able to communicate in writing, verbally, by voice and by gesture with members of the health team, the patient and his relatives. Nurses are sometimes obliged to communicate non-verbally in front of a patient and very ill patients are often only able to manage a feeble non-verbal gesture.(16).

However, the evidence available would suggest that many overseas learners are not able to do this and also that the senior staff are either not aware of learners' difficulties or, if they are, that little is done to help. In its Second Annual Report in 1972, the Pathway Centre commented: (59, p.7):

"The picture we have been building up of language and communication problems at each of the levels of medical, nursing and ancillary staff is most alarming. At the professional levels there is great reluctance to admit such problems let alone seek solutions, although deaths have occurred which are euphemistically referred to as 'linguistic deaths' ..."

Sen suggests (52, p.71) that failure to take action is due to lack of understanding of the overseas learners' difficulties on the part of senior staff. One of the interviewers in her team had difficulty in interviewing a learner because the latter did not always understand the questions. Sen continues:

"... Later, in conversation with senior members of the staff the interviewer then put it to the staff that perhaps it was not so much disobedience as a failure to understand instructions. It was evident that the nurse's shortcoming in English and its implications for her ability to carry out the instructions given to her had not been considered by some of the staff".

The PEP survey, on the other hand, revealed (46, p.38) a widespread feeling among overseas learners that senior staff expected them to be stupid or to fail to understand instructions and that therefore they did not bother to give them proper instructions. It is possible that this
feeling is justified since Perry (22, p.198) felt it necessary to warn her readers that overseas learners might appear slow and stupid when often they were highly intelligent and Kelber made a similar comment (56, p.31) regarding the seemingly low I.Q. of the non-mother-tongue speaker.

Given this, it is hardly surprising that there is a certain reluctance among overseas learners to admit to language difficulties. In Sen's sample (52, p.72), approximately 20% admitted to serious language difficulties but many who said that they had no problems were not so rated either by interviewers or tutors and in the PEP survey (46, p.25), the percentage who acknowledged language difficulties was the same, reasons given being because of local accents or too rapid speech. On interview the PEP team found (p.33) that approximately two-thirds of the sample had a good understanding of English, while only half had an accent which was easy to understand. 20% were either difficult or very difficult to understand. It should be noted that of the PEP sample - half of whom were from the West Indies or South America, a quarter from Africa and a quarter from Asia - almost two-thirds said that they spoke English at home. One-sixth of these were found to have an accent marked enough to cause difficulty in understanding them (46, p.33). In Sen's sample over half the subjects were West Indian (52, p.134).

With regard to learners' acknowledged specific difficulties, 50% of the PEP sample (46, p.34) and just under 30% of Sen's sample (52, p.71) reported difficulty in understanding instructions and this particular problem was significantly related to success in final performance, according to Sen, being significant at the 5% level (52, p.157). Of the PEP sample, approximately 30% had difficulty in understanding teaching staff and 20% in understanding patients. Concerning communication with psychiatric patients in particular, Thompson suggests (48, p.18) that:

"...there is a general feeling that inability to use language at a sophisticated level in a field
where verbal skills and communication are at a premium must affect standards of care". Particularly as psychiatric nurses are expected to establish therapeutic relationships with their patients by talking to them. However, according to one psychiatrist at least, (48, p.18) this is true only in part. Much more important is the ability of a young nurse to understand others' feelings and to express her own and it would seem that:

"... British nurses are just as bad as overseas nurses in this respect". This would suggest, however, not that overseas nurses have no more difficulty than indigenes but that to the inherent difficulty of learners in dealing with both their own and patients' feelings is added the problem of limited language ability.

Beck recommends (54, p.41) that all learners should have further tuition in the language in which nurse training is to be conducted and (p.60) that language proficiency should be ascertained before training begins.

It would seem that learners themselves would welcome help in this respect (60, p.3) and the type of help wanted, according to the PEP survey (46, p.35) is mainly concerned with understanding of technical terms (40%) and improving accent (39%). Less than a quarter wanted help with written English and 26% said they needed no help at all.

The amount and type of assistance actually given varies. Of the 42 (28.4%) subjects in the UKCOSA survey (45, p.25) who said that they had had some form of orientation programme after arrival in the UK, 7 said that language instruction was included (p.26). No other statistical evidence appears to exist regarding the number of Training Schools which offer language instruction, with or without orientation, though at a meeting, mainly of tutorial staff, at the Kings Fund Centre in 1972, the ways in which those Training Schools which did provide such facilities tackled the problem were discussed (60, p.3). Some paid for English classes to be run by local Colleges of Further Education during working hours; it was felt that otherwise learners would not attend in their own time. Others expected learners to pay for
outside classes themselves. However, as one tutor pointed out to the UKCOSA team, (45, p.35), such classes are of limited value since they do not necessarily meet the learners' needs.

iv) problems arising from nurse education and training, recruitment and selection.

Good selection, says the Kings Fund Report (44, p.13) is essential to success in nursing but existing methods of selection were considered by the Working Party to be unsatisfactory and therefore one of the main causes of overseas learners' difficulties once they had started training (p.6):

"The problem really starts in the country of origin with methods of selection and recruitment. Although some satisfactory channels ... exist, they are frequently insufficiently known and many entrants are not recruited by these means".

According to the PEP survey, based on 7,557 postal replies from overseas nurses, it would seem that the majority of overseas applicants do, in fact, bypass official channels, preferring the direct approach. The PEP survey showed (46, p.18) that: 60% applied only direct to a hospital; 28% applied only through a recruiting organisation in the country of origin; 12% applied both direct to a hospital and through a recruiting organisation.

The Kings Fund Report continues:

"Misleading and incorrect information can be supplied to applicants, particularly by agencies whose main aim is profit-making ..."

"Failures of communication in both directions can result in the acceptance of unsuitable candidates... It is not unknown for a candidate found unsuitable by one School of Nursing to be accepted by another... (p.12).

"On the other hand, prospective trainees, on arrival in this country, can, as a result of communication failure, find themselves in situations for which they are completely unprepared. For example, trainees who have fondly imagined themselves starting training for the Register in an acute general hospital, have found themselves in a Mental Subnormality hospital in the depths of the country faced with training for the Roll ..." (p.12).

In the three research studies which have dealt with this question, there is evidence to suggest that this lack of adequate or accurate information, and its consequences for
overseas applicants, is disturbingly widespread. The confusion is twofold: it concerns both type of training and status.

The PEP survey found (46, p.19) that two-thirds of the interview sample (N = 252) had had general training in mind when applying, 10% psychiatric training, approximately 10% no particular type of training and the remainder other specialities. Approximately 25% had not been aware that types of training other than general existed. Moreover, 30% of those in psychiatric training had wanted general training and 22% thought that they had been accepted for general training. (p.20). Of those in psychiatric training "very few" wanted to do psychiatric nursing in their own countries, though more than half said that such facilities existed. Over 50% intended to go on to general training on completion of psychiatric training (46, p.32). UKCOSA suggests (45, p.10) that the proportion of overseas learners in psychiatric and mental subnormality training is high in comparison with indigenes and postulates that this is because of the difficulty in recruiting indigenes for these hospitals. Certainly the statistics, compiled by the GNC in January 1976 (24), corroborate UKCOSA's statement, since percentages for the three types of training were as follows:

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<th></th>
<th>General</th>
<th>Psychiatric</th>
<th>M/Subnormality</th>
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<tr>
<td>U.K.</td>
<td>77.76</td>
<td>57.60</td>
<td>63.86</td>
</tr>
<tr>
<td>Overseas</td>
<td>22.90</td>
<td>41.43</td>
<td>36.34</td>
</tr>
<tr>
<td>(All countries)</td>
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With regard to status, many subjects in Sen's sample were not aware that there were two status-levels (52,p.66) and 50% of subjects in the PEP survey who had not been accepted for student-nurse training had never heard of pupil-nurse training. (46, p.31). Moreover, two-thirds said that State Enrolment was not recognised in their countries, though the majority did not know this before arrival in the U.K. The Kings Fund Report (44, p.2) attributes this confusion in part to a lack of understanding by Embassies, who advise their nationals to do pupil-nurse training with a view to proceeding to student-nurse training, though Sen found (52, p.66) that it was only
the exceptionally good pupil-nurse who would be recommended for student-nurse training. Although the majority of overseas applicants expect to train for the Register (46, p.28) and believe that they have the necessary educational entry requirements to do so (p.29), the PEP survey found (p.43) that overseas learners were disproportionately represented in pupil-training in relation to educational attainment, since 40% of overseas learners had O Levels, A Levels, or the equivalent, compared with 35% of all hospital nurses. UKCOSA suggests (45, p.8) that this may be because the overseas learners' spoken English is judged to be inadequate. Competence to follow student-nurse training is, however, often based on the GNC Test (see 1.3.9.b.ii).

In spite of the GNC's warning that this Test is unsuitable for overseas learners and that too-early administration of it is likely to give an inaccurate measure of a candidate's ability, it would seem that these warnings often go unheeded. Caine and Wijesinghe, in their study (34, p.179) observed that the GNC Test was sometimes upsetting because the questions were "strange" [sic] and/or because the Test was given too soon after arrival and the PEP survey shows (46, p.30) that of the subjects who took the Test, 30% did so within three days of arrival and 50% took it within a week. UKCOSA also suggests (45, p.9) that the majority of overseas learners take the Test too soon after arrival, in some cases almost immediately. Of the PEP sample (46, p.29) approximately 25% expected to have to take the Test, whereas almost one-third actually had to take it. Less than two-thirds of those who thought they had the necessary entry requirements were accepted on that basis, while just under 10% were neither accepted nor given the Test. Of the 25% who expected to have to take the Test, 20% neither took it nor were accepted for student-nurse training.

Reasons given to subjects in the PEP survey who were not accepted for student-nurse training were: that they had failed the Test; that their educational standard was inadequate or that their English was inadequate. 25% were given no reason. Over half thought the decision
unfair and attributed it to: the result of prejudice; misinformation; the unfairness of the Test as a measure of ability; the need to staff wards at pupil-nurse level.

Whatever the accuracy of the overseas learners' assessment, there is no doubt that the results of such haphazard and confused recruitment procedures are the cause of much resentment and frustration. UKCOSA cautiously suggests (45, p.8) that overseas learners "may well bear resentment" but Sen found evidence (52, p.67) of a "good deal" of both. She also observed (p.66, footnote 3) that overseas learners in psychiatric hospitals were much less satisfied with their lot than those in general hospitals and the PEP Report comments (46, p.43) that overseas learners often feel at a disadvantage from the beginning of their training.

Otherwise overseas learners' problems during education and training are those of all learners, with one notable exception. If an indigene does not like, or feels she cannot cope with, the excessive demands, both physical and psychological, that nursing makes upon her, she can leave, with no loss of face and no real difficulty in finding alternative training or employment. For the overseas learner this is infinitely more difficult, for if she does leave she will almost certainly have to leave the country - which she is unlikely to be able to afford - since immigration restrictions make it wellnigh impossible for her to change to other training or employment. In the words of the Kings Fund Report (44, p.16):

"... overseas nurse trainees who would normally have selected to discontinue training are often forced to remain by a variety of reasons such as economic, family and political pressure, loss of "face" [sic] and distance from home".

Thus, as UKCOSA points out, (45, p.7):

"... however unhappy [an overseas learner] may be she will have little choice but to remain in it".

These comments are substantiated by the GNC 1976 Statistics (24), which show the following comparative percentages for indigene and overseas "leavers".

Comparison of overseas and indigenous leavers

<table>
<thead>
<tr>
<th>Students:</th>
<th>General</th>
<th>Psychiatric</th>
<th>Mental Subnormality</th>
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<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>U.K.</td>
<td>86.64</td>
<td>80.33</td>
<td>81.66</td>
</tr>
<tr>
<td>Overseas</td>
<td>13.36</td>
<td>19.67</td>
<td>18.34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupils:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>U.K.</td>
<td>85.33</td>
<td>73.92</td>
<td>79.87</td>
</tr>
<tr>
<td>Overseas</td>
<td>14.67</td>
<td>26.08</td>
<td>20.13</td>
</tr>
</tbody>
</table>

* = percentage of all leavers

It is clear, therefore, that, while all nurse-learners face problems, many of which seriously inhibit effective communication, there is little doubt that these are increased enormously for overseas learners because of their unfamiliarity with the milieu, by language difficulties, by the current methods of recruitment and selection and by the failure of both colleagues and clients to accept them as equals. In the words of Hoggart (57, p.45):

"Living abroad ... you don't feel homesick ... you feel starved and lost; in a large, featureless landscape unable to read any of its signs, with your cultural suckers wavering anxiously to find something that they can clamp on to ...."

It would seem from the literature that, far from assisting the cultural suckers of overseas nurse learners to find holding-places, the difficulties are often accentuated by actively preventing them from gaining a hold and by the strewing of erroneous signs on an already confusing landscape.
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4. RESEARCH DESIGN AND ORGANISATION OF FIELD STUDIES.

4.1. Research Design.

The purpose of the research was to investigate to what extent general or specific problems of communication exist for overseas nurse learners in the nurse education/training situation and, subsequent to this, where the main areas of difficulty lie. It was further determined to assess the felt need for a special, purpose-designed course which might alleviate or minimise such problems as were found to exist and, if such a need were apparent, to establish what general lines such a course might follow.

In order to achieve as comprehensive a picture as possible, three separate areas of research were planned:

a) structured interviews with District Nursing Officers (DNO's) and/or Principal Nursing Officers for Education (PNOE's), (1) their function being to elicit information as to the problems of communication which might exist in the teaching/study situation as observed or experienced by the tutorial staff. Information concerning recruitment and selection procedures, including the use and efficacy of the GNC Test D, would also be sought in order to establish whether such procedures might be a contributing factor to the problems of communication as suggested by UKCOSA (2, p.2).

b) questionnaires to be sent to a sample of overseas nurse learners from South East Asia, East and West Africa and Mauritius, with a control group of indigenous nurse learners. The function of the questionnaire was to establish whether overseas nurse learners feel that problems of communication exist, either in the practical or educational sphere and, if so, in what areas. It was further intended to investigate whether any relationship exists between nursing status and/or educational and/or linguistic background and the subject's stated difficulties and attitude to a special course. A control group of indigenous learners would serve to establish to what extent any problems which exist are experienced by all nurse learners and which are peculiar to overseas learners.
c) participant observation, both at the practical and educational level. By working with a sample of overseas learners in wards or departments and tape-recording the nurse-patient interaction, and by recording teaching sessions in Schools of Nursing, it was hoped that sufficient and reasonably objective data could be collected to allow comparisons to be made between the observations and stated experience of PNOE's, the difficulties or otherwise as stated by nurse learners, and actual performance. By such comparisons it was expected that certain statements might be possible as to the nature and extent of the problems of communication which might face overseas nurse learners specifically during their training in England and Wales.

4.2. Organisation of the Field Studies.

Organisation fell into six parts:

1. The selection of Nurse Training Schools for interviews with PNOE's and for location of subjects from the three area groups for the questionnaire sample.

2. The construction of structured interview forms, questionnaires and data collection sheets for classroom observation.

3. The drawing of a sample of overseas learners for the questionnaire.

4. The drawing of a sample of indigenous learners as control.

5. The selection of Nurse Training Schools, from those already agreeing to participate at the initial stage, for participant observation.

6. The selection of subjects and teaching sessions for participant observation.

4.2.1. The selection of Nurse Training Schools.

It was felt that as large a number of Nurse Training Schools as possible should be included in the research for two reasons: firstly, to provide as wide and as representative a sample of PNOE's as possible for interview and, secondly, to give access to as many overseas learners as possible for sampling, both for the questionnaire and for
participant observation.

In making the selection four criteria were applied:
1. the type of training offered - general, psychiatric and mental subnormality.
2. the status of nurse learners - student and pupil.
3. geographical location - to allow for as wide a regional survey as possible.
4. the number of overseas learners in training from the three area groups.

Official statistical information concerning the distribution of overseas learners vis-à-vis individual Training Schools was unavailable. The General Nursing Council did not keep such statistics and the Department of Health and Social Security (DHSS) Statistics Division record what information they have under Regional Hospital Boards and not individual Training Schools. (3).

However, the GNC kindly offered to produce a list of Training Schools which would meet the above criteria from information to be provided by its Inspectorate. This list, augmented by personal knowledge and private communication, resulted in a possible inclusion of 54 Training Schools.

A letter was drafted, setting out the purpose and nature of the research and requesting permission to include the Training School in question in the research project. (A copy of this letter is included in Vol.2 as Appendix III. A.20).

Visits were to begin in February, 1974. Structured interviews would take place and lists of overseas learners - students and pupils - would be requested.

Since the 54 Training Schools were widely dispersed throughout England and Wales, (see Vol.2, Fig.4, A.21), travel arrangements had to be made so as to be economical both of time and money. Attempts were made to organise visits on a regional basis but two factors made both timing and visiting difficult in several instances.

Firstly, reorganisation of the National Health Service in 1974 led to a considerable number of problems with regard to contacting the appropriate people. DNO's and/or Directors of Nurse Education had either not yet
been appointed, or had been appointed but had not yet taken office and some PNOE's (if they were being replaced by new Directors) were unwilling to commit their successors to a research project. Secondly, the national rail strike in February of the same year interfered with what arrangements had already been made.

A third factor - the suspension for six months from July to December inclusive in 1974 - of the research project (4) was instrumental in putting a time-limit on the visiting of Nurse Training Schools in this initial stage and therefore on the number contacted. Once the suspension had been agreed it was decided that the questionnaires to overseas learners should be sent out immediately prior to the suspension of the research. Otherwise overseas students and pupils included in lists already received might have left the Nurse Training School concerned.

Consequently only 47 of the 54 Training Schools were contacted. (For their training bias see Vol.2, Table 6, A.22).

Of the 47, 30 agreed to participate. Of these, 13 offered General Training, 6 Psychiatric and 1 Mental Subnormality. The remaining 14 offered more than one type of training. (For their geographical distribution see Vol.2, Fig.4, A.21).

These 30 Training Schools thus gave access to a possible 22 groups of overseas learners in General Training; 16 groups in Psychiatric; 6 groups in Mental Subnormality. (See Vol.2, Table 6, A.22).

Reasons for refusal were as follows:

1. reorganisation problems - 4
2. too few overseas learners - 5
3. other current research - 2
4. no distinction made between indigene and overseas learners - 1
5. hostility - 1

Other reasons for non-inclusion were:

1. late reply - 1
2. no reply - 3

The Nurse Training Schools which claimed to have too
few overseas learners were all Teaching Hospitals offering General Training. The replies received stated in addition that selection procedures were very stringent and only students of high ability were accepted for training.

One Training School accepted the invitation to discussion but when visited, evinced considerable hostility to research in general and overseas nurses in particular. Dissatisfaction was also expressed concerning trends in the nursing profession as a whole. It was therefore decided not to pursue the research further in that particular Training School.

For research purposes the original 54 Training Schools were numbered 1-54 and these numbers were retained throughout the research.

4.2.2. Construction of structured interview forms, questionnaires and data collection sheets.

a) Structured Interview Forms.

The form comprised 28 questions, most of which allowed for discussion of a particular topic. A copy of the form is included in Vol.2 as Appendix IV (A.23-4).

Questions were designed to elicit the following information:

i) confirmation that overseas learners from the three area groups were in fact in training at the Training School in question. Also, their status. (Q1).

ii) recruitment and selection procedures employed by the Training School and the route by which overseas candidates applied. Information relating to entry requirements was also sought. (Q2-6, 12).

iii) the use and efficacy of the GNC Test D and whether taking of the test was compulsory or voluntary. Information regarding the pass-mark set by individual Training Schools was also sought and PNOE's were asked their opinion as to whether there was a case for a more relevant test, in view of the GNC's comments in its Manual regarding Test D (6, p.1). (Q7-11).

iv) any help which overseas learners might expect to receive regarding orientation and language. (Q13-15).
v) overseas learners' extra-nursing educational and/or language activities as observed by PNOE's. (Q16, 24-5).

vi) overseas learners' possible educational difficulties. (Q17, 19-20).

vii) difficulties which tutorial staff might experience. (Q21-2).

viii) measures which might be useful in alleviating possible problems (Q18, 23).

ix) the extent to which Training Schools were willing or able to participate further in the research. (Q26, 28).

Question 27 was organisationally necessary since a nurse learner moves from School to hospital and from hospital to hospital within the group with considerable frequency and it was felt that subjects included in the questionnaire sample would be more likely to receive them if the School undertook to distribute them.

b) Construction of the Questionnaire.

The questionnaire comprised 47 questions and was in two parts.

Part 1 (Q1-35).

This was concerned with:

i) personal construct (Q1-5).

ii) educational and linguistic background:
   a) educational (Q6, 8, 12-14).
   b) linguistic (Q7, 9-11).

iii) extent of cultural and/or specific knowledge - which might facilitate or hinder acclimatisation before starting training and during the early period. (Q15-16).

iv) connections in Britain (Q17-19).

v) nursing construct (Q20-29).

vi) post-school-leaving /pre-nursing experience (Q30-33).

vii) extra-nursing studies (Q34-5).

Part 2 (Q36-47).

This is concerned with:

i) differences/difficulties in hospital/nurse education language situation (Q36-39).

ii) comparison of educational techniques. (Q40 with Pt.1. Q14.)
iii) organisation of private study time (Q41-44).
iv) further possible cause of difficulty (Q45).
v) attitude to and opinion on course and possible content (Q46-47).

The questionnaires for both overseas and indigenous learners were virtually identical, with one or two minor alterations to remove irrelevancies regarding indigenes. Thus Q19 was omitted altogether, parts of Q15 and 47 were omitted and in Q16, 17, 18, 37 and 38 the wording was slightly altered. Copies of these questionnaires are included in Vol.2 as Appendix V (A.25-29, overseas) and Appendix VI (A.30-34, indigene).

The numbering for the indigenes' questionnaire is slightly different but its organisation parallels that of the overseas one. Letters were drafted for inclusion with the questionnaire, explaining its purpose. Copies of these are included in Vol.2 as Appendix VII (A.35-6, overseas) and Appendix VIII (A.37, indigene).

c) Construction of the Data Collection Sheets.

The data sheets were designed to show whether and what type of learner participation occurred during teaching sessions. Also, to what extent indigene and overseas learners participated in relation to each other. A copy of the Data Sheet is included in Vol.2 as Appendix IX (A.38).

The Data Collection Sheet was designed to record:

i) the giving or seeking of information by learners (Cells 1 and 4).

ii) requests for clarification, whether content or language (Cells 2 and 3).

iii) the compliance or otherwise with instructions given (Cells 5 and 6).

iv) the answering of questions, asked either generally of the class or of a specified learner. (Cells 7-9).

v) the contribution by a learner of his or her own idea. (Cell 10).
4.2.3. The Drawing of the Sample of Overseas Learners for the Questionnaire.

The sample was selected in the following way. The PNOE in each of the Training Schools visited was asked to submit a list of the names of all overseas student- and pupil-nurses from the three area groups in training in his or her Group of hospitals. No instructions were given as to the format the list should take and the actual methods used varied. Table 7 (Vol.2, A.39) shows the methods adopted.

The lists were all arranged vertically but in various ways and to varying extents:

**Cols. 1, 2 and 4.**

20 lists were arranged in a single vertical column. Of these, 4 did not state the country of origin; 10 stated the country of origin but arranged learners in random order; 1 (School No.7) employs only Mauritians from overseas, and 5 stated the country of origin and arranged learners in groups by country.

3 lists stated the country of origin, arranging the countries horizontally thus:

<table>
<thead>
<tr>
<th>MAURITIUS</th>
<th>MALAYSIA</th>
<th>GHANA</th>
</tr>
</thead>
<tbody>
<tr>
<td>(etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

and the learners vertically, by country.

2 lists reversed this, arranging the countries vertically thus:

<table>
<thead>
<tr>
<th>MAURITIUS</th>
<th>______</th>
<th>______</th>
<th>______</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHANA</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>PHILLIPINES</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

and the learners horizontally by country.

3 lists did not state the country of origin but had more than one column per page.

**Col. 3.**

6 lists stated the date of commencement of training for each learner included.

**Col. 5.**

No list stated the area from which learners had come (i.e. East/West Africa or South East Asia).

**Col. 6.**

22 lists indicated the status of the learners. Of
these, 4 lists indicated that the Training School did not employ pupil-nurses from overseas. 3 lists arranged students and pupils contiguously thus:

<table>
<thead>
<tr>
<th>students</th>
<th>pupils</th>
</tr>
</thead>
</table>

thereby dividing students from pupils. 15 lists arranged students and pupils consecutively, 11 of which divided students from pupils. Of these 11, 2 placed pupils before students - the normal practice being to place students before pupils. The remaining 4 lists indicated status but arranged learners in random order.

Col.7.

6 lists arranged learners in alphabetical order.

Table 8 (Vol.2, A.40) shows the total number of names submitted, two Training Schools failing to submit a list by the deadline. Since 3 Training Schools did not divide their lists by areas or country it is not possible to give accurate percentages of the total number from each area. Table 9 (Vol.2, A.41) shows the provenance of the subjects in so far as this is possible. The total number of names submitted was 1,468 and gave access to 16.4% of the total research population.

The lists were placed in the numerical order of the Training School from which they were obtained and, regardless of the format of the list, every third name was selected, working vertically down the page and from left to right across the columns where there was more than one column per page. Thus, 488 formed the sample, being 5.4% of the total research population, to whom copies of the questionnaire were sent.

4.2.4. The Drawing of the Sample of indigene Learners for the questionnaire as control.

It had been anticipated that Training Schools might be able to furnish lists of the names of indigene learners at the same time as those of overseas learners.

However, one of the conditions that almost all Training Schools put on their participation was that no work arising from the research should devolve upon their clerical staff and lists of indigene learners would have entailed far more work than that involved for the overseas
There were two main reasons given. Firstly, reorganisation of the National Health Service carried with it considerably increased clerical workloads and secondly, many Training Schools were already collecting data for various other nursing organisations, either for statistical or research purposes.

Both reasons were fully understood and respected throughout the research programme.

It was decided, therefore, that questionnaires would be distributed to indigene learners at the time of classroom observation. Since it was intended to visit nine Training Schools in this respect, three in each type of training, it was expected that a sufficient number of questionnaires could be acquired to be statistically viable.

However, various unforeseen problems arose which had a considerable bearing on the number of questionnaires it was possible to distribute.

Firstly, only eight Training Schools were visited, since the amount of data collected from those eight was already more than adequate for research purposes and doubt was growing concerning the cost of transcription of further recorded data.

Secondly, the number of indigene learners per study-block fell far short of expectations; in the 3 General Training study-blocks there was a total of 45; in the 3 Psychiatric there were 12 and in one of the Mental Subnormality blocks there were none at all. In the eighth, a Mental Subnormality Training School, an accident with the tape-recorder used in the observation necessitated a return to London for a replacement, since no organisation in the three nearest towns could either repair it or lend another. This seriously interfered with the classroom observation in that Training School, thereby preventing possible distribution of questionnaires.

Questionnaires were therefore given only to the 45 General Training learners and an alternative strategy was devised for Psychiatric and Mental Subnormality learners.

A letter of explanation was sent to three of the Training Schools not included in the participant
observation stage, one Psychiatric, one Mental Subnormality and one mixed, and the help of the PNOE's sought. Each was asked if he or she would distribute questionnaires to the learners, student and pupil, in the current or next study-block.

One agreed and 30 questionnaires were sent.
One did not reply.
One replied but indicated that all nurse education had recently been transferred to a central Nurse Education Centre at a District General Hospital and that the new Director of Nurse Education there should be contacted. This was done, the whole research project being explained in detail, but no reply was received.

4.2.5. The Selection of Training Schools for Participant Observation.

It was decided that three Training Schools in each type of training should be asked to take part in this stage of the research so that data collected would be as widely representative as possible.

In selecting them six criteria were considered:
1. the willingness and ability to participate, as expressed during the interviews.
2. the type of training.
3. the status of overseas learners.
4. the number of learners available in each or any of the three area groups.
5. geographical location.
6. whether study-blocks would be in progress at the time of participant observation.

18 Training Schools were willing and able to afford facilities for participant observation. The type of training offered was as follows:

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>-</td>
</tr>
<tr>
<td>Mental Subnormality</td>
<td>-</td>
</tr>
<tr>
<td>General/Psychiatric</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatric/Mental Subnormality</td>
<td>-</td>
</tr>
<tr>
<td>General/Psychiatric/Mental Subnormality</td>
<td>-</td>
</tr>
</tbody>
</table>

Of these, 2 General and one Psychiatric/Mental Subnormality Training Schools were discarded since they did
not have pupil-nurse learners and both would be needed for participant observation.

When criteria 4, 5 and 6 were applied, 7 Training Schools showed overall suitability.

General Training 1 (NTS 23)
Psychiatric " 1 (NTS 10)
Mental Subnormality 1 (NTS 7)
General/Psychiatric 2 (NTS 42 and 43)
Psychiatric/Mental Subnormality 1 (NTS 32)
General/Psychiatric/Mental Subnormality 1 (NTS 26)

For numbers from the three area groups see Vol.2, Table 8 (A.40).

All Training Schools were in England and their geographical distribution was as follows:

North 1  South East 2
East 1  South 1
Midlands 2

One of those in the South East was not visited.

4.2.6. The Selection of Subjects and Teaching Sessions for Participant Observation.

Each period of participant observation was to last for one week. During that time it was hoped to work with four nurse-learners, two student and two pupil, one learner per day, from one or more of the three area groups. The maximum time set per session was two hours, to allow adequate time for nurse-patient or nurse-nurse interaction to take place.

One day of the week would be spent in the School of Nursing and during both practical and educational sessions tape-recordings would be made.

A letter was sent to each Training School outlining the proposed programme. Since this was not a standard letter, being based partly on the previous visit and therefore personal, a copy is not included. However, the main points made were:

1. the type of learner required.
2. that participant observation should take place at the busiest time of day.
3. that no nurse learner should be particularly selected, nor off-duty specifically arranged to provide the "best" subjects. Learners should be selected only if and because they happened to be on duty at the time of the visit.

4. permission was sought to attend any teaching session which was in progress on the day of observation.

5. permission to make tape-recordings was requested, assurances being given that no-one would be recorded without his or her express permission (including patients) and guarantees were given that strict confidentiality as to individuals and/or Training Schools would be observed.

6. permission was also requested to distribute questionnaires to indigenes during the teaching sessions.

7. since all correspondence and previous contact had been with the PNOE's, each was requested to explain the purpose of the project to ward personnel in charge of the wards involved in the participant observation.
REFERENCES AND NOTES.

1. Although Principal Nursing Officers for Education are now called Directors of Nurse Education, the former title has been retained for this part of the thesis.

2. OVERSEAS NURSING STUDENTS IN BRITAIN. Evidence to the Committee on Nursing (Briggs Committee). UKCOSA. Jan. 1971.


4. I was commissioned by the GMC for this period to construct a taped Listening Comprehension Test as part of their assessment of overseas doctors seeking temporary registration in the U.K.

5. Compiled from the HOSPITALS YEAR BOOK 1971. Institute of Health Services Administration.

6. GENERAL NURSING COUNCIL FOR ENGLAND AND WALES ENTRANCE TEST FOR CANDIDATES FOR NURSE TRAINING. Manual/Instructions to Examiners/Test Booklet.
5. **RESULTS OF THE FIELD STUDIES.**

5.1. **Results of Interview with PNOE's.**

5.1.1. **Confirmation of Area Representation and Availability.**

The availability of subjects from the three area groups in each of the 30 Training Schools was investigated and their sex and status were established for use in the later field studies. These details are set out in Table 10 (Vol. 2, A.43). No Training School which could not offer three or more subjects in any particular area group was included in the relevant cell since, for participant observation selection, the likelihood of finding one of two subjects available for study would be virtually non-existent, allowing for off-duty, holidays and study-blocks. With one of three the likelihood would be remote but possible.

There were no instances of total unavailability of a particular group of subjects by type of training, sex or status, though some groups were more readily available than others. Taking the higher number of Training Schools offering access to a particular group, (male or female), by area and status, the least available were East/West African pupils, only 10 Training Schools (33.3%) affording access to these. This was as might be expected, however, since East/West African pupils accounted for only 4.4% of the total research population. (See Vol. 2, Table 4, A.5, Col. 6). The most readily available were South East Asian student-nurses, 24 Training Schools (80.0%) affording access to these. This was also to be expected since South East Asian students formed 35.6% of the total research population (Table 4, A.5, Col. 4), being by far the largest group.

The availability of other groups was not entirely as might have been anticipated from their percentage representation of the total research population, their actual availability being as follows:
The shift of emphasis between South East Asian pupils and Mauritian students is slight; that between East/West African students and Mauritian pupils is more surprising. Since African student-nurses' representation of the total research population was 2% higher than Mauritian pupils it was not anticipated that their availability would be 10% lower. In only one instance was a male group more readily available than a female group, that group being male Mauritian pupils (Table 10, Col.11).

Although NTS16 and NTS48 did not send the lists of overseas learners requested and were therefore subsequently excluded from the research, results of the interviews showed that NTS16 had learners from all three areas in the following numbers:

<table>
<thead>
<tr>
<th></th>
<th>S.</th>
<th>P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/WA</td>
<td>15</td>
<td>4 ( = 180)</td>
</tr>
<tr>
<td>SEA</td>
<td>64</td>
<td>90</td>
</tr>
<tr>
<td>M</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

NTS48 had both students and pupils from South East Asia and Mauritius and pupils only from East/West Africa; though no figures were provided at interview.

It was perhaps because of the large numbers involved that no list was sent by NTS16 and NTS48 was suffering from severe staffing shortage at that time.

In order to discover, for questionnaire purposes, whether General, Psychiatric or Mental Subnormality learners were more likely to be available, the number of learners per Training School in each type of training were compared, where lists submitted allowed.

Three Training Schools offering more than one type
of training did not separate learners by type of training. These were therefore excluded in addition to the two which had not submitted lists. These five account for 2 General/Psychiatric Training Schools, 1 General/Psychiatric/Mental Subnormality Training School and 1 Psychiatric. Owing to prolonged reorganisational problems and the resultant confusion, 1 General/Psychiatric/Mental Subnormality Training School sent a list of Mental Subnormality learners only.

Figures for comparable availability in the remaining 25 Training Schools were as follows:

<table>
<thead>
<tr>
<th>No. of learners.</th>
<th>No. of NTS's.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>G.</td>
</tr>
<tr>
<td>80-90</td>
<td>2</td>
</tr>
<tr>
<td>70-80</td>
<td>1</td>
</tr>
<tr>
<td>60-70</td>
<td>2</td>
</tr>
<tr>
<td>50-60</td>
<td>3</td>
</tr>
<tr>
<td>40-50</td>
<td>4</td>
</tr>
<tr>
<td>30-40</td>
<td>1</td>
</tr>
<tr>
<td>20-30</td>
<td>0</td>
</tr>
<tr>
<td>10-20</td>
<td>4</td>
</tr>
<tr>
<td>0-10</td>
<td>0</td>
</tr>
</tbody>
</table>

Since some learners in mixed Training Schools were following combined courses it is not possible to give individual figures for learners per Training School by type of training but it is clear from the rough figures given above that the likelihood of subjects in General Training dominating the questionnaires was very great since numbers in 13 of the 17 groups in General Training exceeded 30, whereas only 5 out of 10 in the Psychiatric, and 3 out of 5 in the Mental Subnormality groups did. The percentage of General learners represented in the questionnaire, if response-rate were 100%, was therefore likely to be in the region of 61.9%, Psychiatric learners 23.8% and Mental Subnormality learners 14.3%. However, given the national percentages of learners (indigene and overseas) in the three types of training in 1972 - being 81.4%, 14.1% and 4.6% respectively, (see Vol.2, Table 1, A.1) - these anticipated percentages were high, corroborating the findings of the UKCOSA and PEP surveys (3.3.iv) in the early 1970s that overseas learners were
disproportionately represented in the latter types of training.

5.1.2. Recruitment and Selection and Route of Application.

Overseas nurses may, as noted earlier, be recruited direct from their countries of origin or they may already be resident in the U.K. Applications may be received directly by the Training School or they may be channelled through the appropriate High Commission or Embassy. Table 11 (Vol.2, A.44) shows the source of recruitment and the route of application for the 30 Training Schools.

1 General and 1 Psychiatric Training School recruited only direct from the country of origin; 3 took only UK-resident overseas candidates, 2 General and 1 Psychiatric. The remaining 25 recruited from both sources.

Of the 27 Training Schools which recruited direct from the countries of origin, 1 accepted applications only if channelled through the appropriate High Commission or Embassy; 7 received direct applications only and 19 accepted both, though for almost all Training Schools there were provisos or modifications.

4 Training Schools, NTS10, 20, 29 and 43, referred all direct applications received to the appropriate High Commission or Embassy, NTS10 commenting that the applicant was so informed. 6, NTS16, 36, 42, 45, 52 and 53, referred all applications from Mauritius to the High Commission, though NTS 36 and 53 accepted Malaysians direct, NTS53 commenting that Malaysians were "usually better" if recruited on direct application. NTS36 referred African applications also to their High Commissions, as did NTS16. NTS28 referred some applications. NTS18 processed all direct applications itself, though High Commissions and Embassies were notified. NTS23 accepted applications channelled through High Commissions and Embassies in preference to direct applications. NTS15 rarely accepted candidates who applied direct. NTS54 processed most direct applications but those from the Phillipines were only accepted if received via the Embassy. NTS49 accepted direct applications made mainly through nursing contacts. NTS40 commented that applicants sometimes wrote to the
Regional Hospital Board as well as applying direct. NTS22 observed that Filipinos applied through an Agency recommended by an international airline.

Two Training Schools applied to the appropriate High Commission for recruits when needed: NTS7 for Mauritians; NTS42 for Malaysians.

Over and above High Commission/Embassy sanction, 2 Training Schools required official sponsorship. NTS53 required letters of official sponsorship and NTS37 accepted Ghanaians and Mauritians only if sponsored by their Scholarship Secretariats.

9 Training Schools stated that preselection took place in the countries of origin and 1 suggested that it should do.

NTS8, 20, 28, 29 and 32 all mentioned Interviewing/Nurse Selection Committees in countries of origin and NTS22 stated that preselection in the country of origin operated for Filipinos. NTS37 suggested that all pre-selection might be carried out by the International Council of Nurses in the country of origin.

Apart from preselection and sponsorship requirements most Training Schools employed additional selection procedures or controls. Table 12 (Vol.2, A.45) summarises these (Cols. 7 and 8).

8 Training Schools said that interviewing of overseas applicants was either preferred or employed: NTS15, 32, 36 and 37 preferred to interview. NTS2, 18 and 30 interviewed if applications were direct. NTS16 interviewed only if the applicants were already resident in the UK.

4 Training Schools, NTS18, 26, 43 and 47, based their acceptance mainly on assessment of the applicant's academic record as well as a review of all papers sent, NTS26 adding that the educational standard was very important - for Mental Subnormality learners as well as others. Level of competence in English was also stated to be of importance.

10 Training Schools administered some form of written test:
NTS7, 8, 37 and 51 asked for essays, some to be sent, in the applicant's own handwriting, from the country of
origin. NTS7 confined essay-writing to student-nurses only and NTS51 asked for a letter in addition. NTS7 had a test for pupil-nurses, consisting of a vocabulary test and a short composition. NTS18 ran a test in conjunction with the local College of Further Education. If candidates, on performance, seemed suitable for Student-nurse training they were offered it. Apparently the scheme was less successful than had been hoped, since many who showed themselves intellectually capable of Student-nurse training could not cope language-wise.

NTS22 had a 3-part test: English, Arithmetic and an Intelligence Test. NTS23 also had a 3-part test but for pupil-nurses only and consisting of Composition, Arithmetic and Paraphrasing. NTS29 gave an English test to Filipinos. NTS32 applied Ravens Matrices to all learners and was considering introducing an educational test for pupil-nurses. NTS47 administered an English test but only if at interview a candidate's language ability was questionable. NTS16 had had an Entrance Test but having raised its general level of educational entry requirements and having made English language compulsory, with Grades I - IV, this Training School had been able to abolish its test.

As regards essays requested at the time of application, one or two Training Schools observed that it was a device which had very little real value since it was possible to acquire a model essay in the country of origin and copy it in longhand. This had come to light over successive intakes, where essay-content became familiar and comparisons were made. It is therefore no longer popular as a means of assessing language competence in the written field.

Regarding the tests, 2 Training Schools kindly supplied copies of their tests. In both tests distractors in many questions were observed to be either not mutually exclusive or ambiguous. Some questions and composition topics were culture-bound and the language used often too difficult, particularly as these were tests for pupil-nurses. It was clear, in both cases, that expert advice on English Language testing had not been sought.
5 Training Schools either exercised or preferred controls additional to other selection procedures. NTS32 and 48 favoured personal recommendation of applicants for pupil-nurse training. In addition, in NTS32 all overseas learners were recruited as pupil-nurses in the first instance unless it was possible to interview. About 33% of applicants to this School had GCE O'Levels; about 67% did not.

NTS40 required guarantees over and above academic suitability, laying great emphasis on references. NTS37 preferred applicants to have been in the UK for a few weeks prior to training and to have had "some experience of life". NTS51 put all overseas learners on three days' probation to find out whether they met hospital standards.

From comments made during interview three recognisable trends seemed to emerge:

1. Some Training Schools showed a tendency towards recruitment of certain nationalities:

NTS7 took mainly Mauritians; NTS10 and 22 preferred not to take them. NTS23 did not take East/West Africans because they seldom had the necessary requirements; NTS37 would take both Africans and Mauritians if sponsored. NTS43 had earlier taken Mauritians but were looking more towards Africa and South East Asia for recruits. NTS22 preferred Malaysians and NTS28 was tending to favour them more because, it was said, Malaysians were the only overseas applicants who met the academic standards required. NTS28 also claimed that the increase of Malaysians, with the concomitant decrease of other nationalities, had led to a dramatic improvement vis-à-vis language problems.

2. There was a marked trend towards the recruitment of students only direct from the country of origin and/or a controlled percentage of overseas learners per intake:

NTS28 admitted no more than 20% overseas learners to its student-intake and no longer recruited pupil-nurses direct from the country of origin, since it was felt that it was a form of exploitation and immoral to employ overseas learners in that capacity as cheap labour. NTS54 admitted 15-20% only. NTS10, 11, 15 and 23 no longer recruited pupil-nurses direct from the country of origin, NTS 10
because there was "too much feeling against it" and NTS11 because it was considered to be exploitation since State Enrolment was not recognised in many countries. NTS42 observed that the number of pupil-nurses recruited direct from overseas was diminishing.

3. A much less marked but definite trend towards recruitment from the UK only was visible, since 1 Training School, NTS9, had already stopped recruiting altogether direct from overseas and 2 others, NTS2 and 26 had moved a long way towards it.

5.1.3. Entry Requirements.

As stated earlier (see Vol.2, App.I, A.6), there are certain statutory requirements for student-nurse training, laid down by the General Nursing Council.

However, most Training Schools set their own requirements over and above the statutory minimum, often specifying either subject or grade or both. Table 12 (Vol.2, A.45) summarises those of the 30 Training Schools (Cols. 3 and 6).

4 Training Schools asked for the GNC statutory requirements. Of the other 26:— 7 asked for 3 O'Levels, 5 asked for 4, 9 asked for 5 and 5 asked for 6.

Of the 30 Training Schools, 23 required English as a compulsory subject, 19 specifying English Language. 18 specified grades. 3 Training Schools specified a science, though not which one. 9 Schools specified that subjects other than English should be academic ones. 3 specifying the grade. 2 Schools specified the grades but not the subjects other than English.

Various provisos or additions were applied in particular to overseas applicants: NTS53 considered English Literature and History (see GNC requirements, A.6) but English Language was compulsory. NTS52, while not specifying a science as compulsory in its requirements, made it so for overseas applicants. NTS20 required either that English should have been the medium of instruction or that the applicant should hold Grade II or III in English Language. NTS15 did not accept any applicant without Grade I or II in English Language. NTS10 only accepted
certification in subjects involving reading and writing. For example, Domestic Science and allied subjects were not acceptable.

Regarding pupil-nurse training, there are no statutory requirements and 21 Training Schools did not impose any. 9 did. 8 asked for GCE O'Levels, ranging from 2-5 subjects. Of these, 5 specified English as a compulsory subject, two of them specifying the grade. One Training School specified that the other subject(s) should be academic. In two instances GCE O'Levels were conditional: NTS22 only required them if the applicant came direct from the country of origin; NTS26 required them for General and Psychiatric Training but not for Mental Subnormality. NTS18 required CSE, general performance in which was reviewed rather than specific subjects demanded. However, for overseas-recruited pupil-nurses this School asked for 3 GCE O'Levels, without specifying subject or grade - except that certain B.Sc. subjects, such as Education, were not acceptable from Filipino applicants.

5.1.4. The GNC Test D.

Table 13 (Vol.2, A.46) summarises the findings relating to the use of Test D and the attitude of PNOE's to the desirability of a more useful test.

24 Training Schools used Test D, though in 4 of these, NTS36, 48, 52 and 53, it was only used for indigenes, or overseas applicants already resident in the UK. NTS53 commented that since applicants direct from overseas must have 4 GCE O'Levels, Test D was unnecessary.

In all but one Training School applicants direct from overseas took Test D at the request of the Training School; in NTS10 they took it at their own request. NTS47 was involved in validation tests of Test D and therefore applicants took it at the request of the Training School.

It is officially permitted that the Test be taken twice (see 1.3.9. ii) but of the 19 Training Schools in which overseas applicants took it, 4 allowed a second attempt conditionally and 4 unconditionally:

NTS30 and 37 allowed it "sometimes", the latter
particularly in cases where State Enrolled nurses were contemplating student-nurse training or if the candidate had not been in the UK very long before taking the Test for the first time. NTS2, while maintaining a policy of once only, did allow a second attempt after six months if the candidate could show evidence of study. NTS32 allowed a second attempt on rare occasions.

Of the 4 Training Schools which allowed an unconditional second attempt, NTS22 commented that scores changed little at the second attempt and NTS29 observed that few overseas learners took the Test twice and then usually only after a course in English.

6 Training Schools used Test D as a measure of ability for pupil-nurse training, though pass-marks were considerably lower than those required for student-nurse training, being usually at the 50-60 level.

The suggested pass-mark for student-nurse training is 75 (see 1.3.9.ii) but many Training Schools set it much higher.

Of the 19 Training Schools concerned, 9 set the pass-mark at the officially recommended 75 and 1 set it at 76. The remaining 9 Schools had pass-marks ranging from 80-100, though one, NTS18, did not give the actual figure. NTS30 set it at 90 if the candidate already had GCE O'Levels and at 100 if acceptance was to be based on Test D alone.

Comments concerning the optimal pass-mark varied but the consensus of opinion was that a mark in the region of 100 was necessary for student-nurse training. NTS28 put it as high as 110-120. NTS22 suggested that any candidate achieving a score of less than 90 was not likely to succeed in student-nurse training, 85 was doubtful and scores less than this meant certain failure.

NTS22 also intimated that there were differences in performance between national groups. Malaysians did well at the beginning and end of the Test but poorly in the middle, whereas Africans did well in the first half, then performance deteriorated.

The failure-rate in Test D is, generally speaking, high. 10 Training Schools were not able to give exact
figures but 4 Schools rated it as "high" and 1 School "very high". NTS15 and 51 stated that their failure-rates were "not high" because candidates were "weeded" and "sifted" beforehand.

NTS7, where the pass-mark was 75, observed that if candidates took Test D immediately on arrival and were unselected, the failure-rate was about 20%. If they waited six months before taking the Test, the failure-rate fell to 1 - 7%. However, any overseas learner showing "ability to pass" did not have to wait the full six months.

In the other 10 Training Schools, where approximate failure-rates were quoted, they varied from 33% - 94%; 8 figures being 50% or more and 6 being 75% or more, giving an average failure-rate of 61.1%.

NTS47, which, because of validation testing, was unable to quote a failure-rate, suggested nevertheless that the bulk of scores fell between 50-75 and that only Malaysians usually achieved scores suitable for student-training.

8 Training Schools made specific comments on the use and efficiency of Test D, in 7 of which the Test was used; in the 8th, NTS45, it was not; NTS45 and 51 suggested that the test was unsuitable for overseas candidates.

NTS28 observed that it was a test of non-success rather than success. NTS16 and 30 intimated that it was used more as a means of elimination than as a prediction of success. NTS20 and 37 stated that there was little or no correlation between Test D scores and future performance, NTS37 adding that it was never used in isolation. NTS26 thought that Test D was "adequate" but only as a secondary means of judging suitability for student-training, adding that it was not used very much.

When asked whether a more useful test for overseas learners would be helpful, 17 Training Schools gave an unqualified affirmative; 3 gave an unqualified negative. 7 gave no opinion, 5 Schools in this group either not using Test D at all or for UK-recruited learners only.

NTS15 observed that acceptance of a new test would
depend upon its nature. NTS28 and 52 were doubtful whether a more useful test would be of any value. NTS53, giving an unqualified affirmative, suggested that such a test would be particularly useful for overseas learners entering Psychiatric Training. NTS18, giving an unqualified negative, suggested that "any test should be indicative of literacy and numeracy. It should reflect educability, not training potential".

5.1.5. **Availability of Orientation Programmes, with or without language tuition.**

Table 14 (Vol.2, A.47) summarises the findings relating to the availability of orientation programmes, their length and whether or not help with language was included.

15 Training Schools stated that orientation programmes were held, 12 run by the Schools themselves and 3 by or in conjunction with outside agencies; NTS10 had only one day's programme but stated that the local population was a well-established one and that the people welcomed new nurses. Furthermore, since many overseas learners had relatives in the UK orientation was not really a problem. Language classes had once been held but were no longer run because they were not popular with overseas learners. Moreover, there were difficulties with off-duty times and the local College of Further Education, which ran the courses, was inflexible with its timetable.

NTS18 stated that a two-week course was held at the local College of Further Education, during which time a test-battery was administered. (This test has already been discussed under Recruitment and Selection). The two-week course included remedial English.

NTS47 had organised a hospitality scheme with local churches, including a two-day orientation programme. Language classes were also held for overseas pupil-nurses during their Introductory Block.

The 12 internally-run courses ranged from 1-14 days. One, that of NTS29, included language classes involving the use of a tape-recorder for learner self-assessment.
NTS53, where the course was said to be in its "teething" stages, intended to include a language component later, once the course was well-established. NTS32 had also only recently set up its one-day course and plans were being made to increase it to one week. NTS26 held a course specifically for learners in Psychiatric Training, though not for learners in General or Mental Subnormality Training. NTS52, which did not have an orientation course, stated that one with a language component had been organised by the local College of Further Education but "...the nurses didn't want to know. They thought they knew it all already ..." The course had therefore been abandoned.

5 of the Training Schools which held orientation courses provided data or commented on content: NTS16 stated that its course was "socio-cultural" without giving further detail. NTS7, 11, 29 and 47 all held courses containing practical information, such as banking, the police, the Post Office and shopping. Otherwise topics ranged from environmental studies and visits, to the British educational system and from the use of leisure, to the community and race relations. (1).

15 Training Schools had no such provision. Reasons given varied: NTS59 had stopped recruitment direct from overseas. NTS40, 43 and 51 had too few overseas learners to warrant such a course, NTS51 adding that unless overseas learners' English was good enough initially they were not accepted. NTS37 and 54 stated that new overseas learners were put under the wing of their compatriots. NTS36 pointed out the difficulties of arranging orientation programmes where overseas recruitment was mixed UK/direct. NTS30 had too few staff. NTS45 had established a scheme whereby local families "adopted" overseas learners. NTS23 hoped to have a course of one month's duration once "immediate problems" had been solved. NTS36 commented that attempts to organise language classes had been made but that students were not interested. NTS2, 8, 22 and 49 gave no reason.

5.1.6. Extra-nursing education/language activities.
Responses to this question showed the following:
Of the 17 Training Schools in which overseas learners attended outside classes, 6 mentioned English classes specifically. In this connection 3 stated that overseas learners seldom completed the courses because of their irrelevancy to the learners' needs.

NTS52 commented that English classes were to be offered on one night per week in the School itself. NTS16 stated that the local College of Further Education conducted a special course dealing with the problems of communication but that only some overseas learners chose to attend it. NTS49 pointed out the difficulties of attending classes elsewhere because of problems with off-duty times.

3 other Training Schools mentioned Colleges of Further Education, one of these, NTS8 specifying that overseas learners were following GCE O'Level courses.

6 Training Schools commented that "some" or "a few" learners attended classes, without further specification, and one observed "not now".

5.1.7. Educational and Language Difficulties.

a) Educational Difficulties of overseas learners.

Table 15 (Vol.2, A.48) shows the findings related to the use of educational equipment and techniques in Schools of Nursing and overseas learners' observed difficulties in this respect.

All 30 Training Schools stated that audio-visual aids were used by them, 29 observing no difficulties in their use. NTS11 commented that overseas learners
"... don't seem to gather much from tapes".

All 30 Training Schools stated that Group Discussion was used as an educational technique: NTS23, 36 and 45 did not observe any overseas learner-difficulty. NTS52 commented that general subjects were used at first to acclimatise learners to the technique and that this had led to eradication of earlier problems. NTS51 observed that Group Discussion caused less difficulty now that overseas learners had become accustomed to it. Previously they had felt cheated and thought that the tutor was not doing his or her job properly.

The remaining 25 Training Schools all stated that overseas learners had difficulties with Group Discussion, manifested by their non-participation or their reluctance to take part. Several Training Schools put forward reasons for this: NTS18, 29 and 53: because learners are afraid of losing face. NTS49: because they customarily only speak when spoken to. NTS16 and 54 supported this, specifying South East Asians. NTS15, 20, 28 and 45: because they prefer being given material to learn/didactic methods. NTS15 and 20: because they feel cheated; the tutor is not doing his or her job properly. NTS42: because they are shy, the men even more than the women. NTS47 offered several reasons: because the technique is foreign to their previous teaching; because of the necessity to translate and retranslate; because Malaysians are basically more polite than indigenes and other overseas learners and feel it would be rude to state their own opinion; because Mauritians and Filipinos are afraid that participation is a form of provocation and will therefore be held against them if they express an opinion. NTS37 suggested that an important factor involved was the number of compatriots in the group. If the number was large enough it introduced a competitive element and overseas learners were therefore more likely to participate. NTS7 commented that overseas learners were more willing to express their own ideas on more general topics, as witnessed in the orientation course. They were much less responsive in a more formal situation. NTS26 made the same observation, adding that reluctance to participate in the formal
situation was probably due to overseas learners' feeling that they had to "fit in with the jargon". NTS26 also observed that the willingness to participate depended, to some extent, on the length of time learners had been in the UK. NTS49 corroborated this by commenting that it usually took "until the second year" of training before overseas learners took a more freely active part in discussions. NTS43 suggested that overseas learners were puzzled by the technique of group discussion - that they thought it was a vague way of teaching. NTS40 found that indigenes were as reluctant to participate as overseas learners.

Regarding nurse education in general, several comments were made about the effect of overseas learners' educational background on their ability to cope with their studies.

In addition to the observations made concerning the preference for or expectation of didactic methods vis-à-vis group discussion, NTS10 and 36 suggested that earlier educational training gave rise to problems for overseas learners of changing to the methods of self-teaching and of thinking for themselves that modern nurse education demanded.

NTS7 observed that the tendency to rote-learning persisted with medical/nursing data. NTS49 mentioned the difficulties which overseas learners have, particularly in their first year, of understanding how to cope with project-work and the writing of nursing care studies. NTS28 substantiated this by an observation that initial difficulties in the School of Nursing were a question of format rather than language. NTS9, however, mentioned that indigenes had difficulties similar to those of overseas learners in the transference of knowledge and the correlation of information.

b) Language Difficulties of overseas learners.

i) Spoken.

Table 16 (Vol.2, A.49) summarises the language difficulties of overseas learners as observed by PNOE's.

24 Training Schools commented that overseas learners had difficulties with understanding because of the various
accents and dialects encountered and 26 Training Schools observed difficulties in ability to converse freely in English. 15 Training Schools observed difficulties with telephoning.

Regarding Spoken English NTS29 and 51 considered that careful selection had minimised problems. NTS20 considered Spoken English to be the main problem. There was improvement, however, after the first six months. NTS11 made the same observation vis-à-vis the time-factor. NTS30 suggested that difficulties in Spoken English led to problems in the Communication Section of the ward assessment. (see 1.3.5.)

NTS23 felt that it was the speed of speech which was the problem, though difficulties existed overall. NTS8 and 32 commented on the archaic nature of the English of overseas learners, NTS32 adding that they had difficulty with colloquial English. NTS43 observed that words were often used in the wrong context. NTS22 commented that even when overseas learners seemed to understand, instructions were not always carried out. NTS8 alluded to frequent comments on ward reports concerning the language difficulties of overseas learners.

Accent and dialect were felt to be contributing factors, though few Training Schools commented further, 3 supporting or qualifying comments being made. NTS29 and 47 agreed that accent and dialect were problems, though NTS 29 suggested that overseas learners quickly became accustomed to both. NTS26 thought that they were contributing factors "to some extent".

Regarding telephoning, again few comments were made. NTS47 thought that the difficulty was due to intonation. NTS11 and 32 both recognised the difficulty but stated that overseas learners were taught how to use the telephone in the Introductory Block. NTS48, on the other hand, suggested that overseas learners had no more difficulty than indigenes. NTS37 found that they were better than indigenes and usually answered more correctly.

ii) Written.

Table 16 (A.49) shows that half of the 30 Training Schools observed difficulties with written work, both in
c) Differences in level of competence between national groups.

Table 17 (Vol.2, A.50) shows the findings concerning differences in the level of language competence between the three areas as observed by PNOE's. Totals in the final row add up to more than 30 due to multiple responses in Cols. 1-4.

2 Training Schools, NTS15 and 23, found no differences between national groups, NTS15 suggesting that what differences existed were more individual than a national tendency. If Table 8 (Vol.2, A.40) is consulted it will be seen that both Training Schools had a sufficient number of overseas learners from two or all three of the area groups to make comparisons.

In 2 Training Schools, NTS7 and 10, the question was not applicable. NTS7 recruited Mauritians only and NTS10 recruited mainly Malaysians.

NTS42 gave a qualified negative by commenting that differences were not marked, though Malaysians were...
"perhaps better", NTS40, 51 and 52 were not prepared to comment since they had too few learners to make comparisons. Figures in Table 8 (A.40) confirm this.

The remaining 22 Training Schools gave a definite affirmative. Of these, 12 either isolated or compared particular national groups. (Table 17, Cols. 1-4, A.50). Since many Training Schools responding in this way used the terms "best" and "worst", these were adopted for categorisation and therefore include such comments as "greatest difficulty", which were used by one or two.

9 Training Schools considered that Malaysians were "best". Of these, NTS8, 22, 36, 43 and 53 were clearly still in a position to make comparisons. Of the other 4, NTS9's figures were low because overseas recruitment had stopped and NTS49 recruited Malaysians only. It must therefore be assumed that their assessment of Malaysians as "best" was based on previous experience. NTS48 had supplied neither list nor numbers. NTS36 did not divide its overseas learners into countries, though the accompanying letter stated that they came from all three areas.

Of the 9 Training Schools which rated Malaysians as "best", 4 added further comment about them: NTS36 observed that they "seemed better" but thought this might be due to their higher level of entry. NTS43 stated that they both spoke and understood better. NTS49 stated that they were "much the best". NTS53 observed that they were "easiest to understand".

4 Training Schools rated Africans "worst". Of these, NTS20 and 22 had overseas learners from all three areas; NTS11 had Malaysians only - or virtually so - and NTS48 had supplied neither list nor numbers. Of these 4, 2 added further comment about Africans: NTS11 observed that they showed the least ability to communicate but suggested that the reason was probably more attitudinal than linguistic. NTS20 stated that they had the most difficulty in understanding and being understood and that their failure in examinations was often due to unintelligibility.

4 Training Schools rated Filipinos "worst". Of these; NTS8 had 16 Filipinos; NTS9 had 1 and NTS36 had 10. (2) NTS30 did not divide learners into countries. None of
these added further comment about Filipinos.

4 Training Schools rated Mauritians "worst". Of these: NTS43 had a considerable number though tending towards recruitment of East/West Africans and Malaysians. NTS37 had few Mauritians, only accepting them if officially sponsored. NTS26 and 32 had not divided learners into countries.

Of the 4 Training Schools which rated Mauritians "worst", 2 added further comment about them: NTS37 observed that they had the greatest problems, both in spoken and written English: "particularly if they have a French background". NTS43 commented that they not only had the greatest difficulty but were less comprehensible than other national groups.

6 Training Schools made comments about one or two of the three area groups without rating them "best" or "worst".

NTS2 observed that Africans and Mauritians were "not very forthcoming". NTS8 commented that Mauritians were either "very good" or "very bad". NTS53 found Mauritians less easy to understand than Malaysians but suggested that they were "getting better". NTS20 observed that Malaysians understood better than they were understood; with Mauritians it was vice versa. NTS16 commented that Africans used language more freely but imperfectly, and vice versa with Malaysians. NTS28 found exactly the reverse of NTS16.

d) Tutorial Difficulties.

Table 18 (Vol.2, A.51) summarises responses to the question whether difficulties arise from teaching mixed national groups.

18 Training Schools had no difficulties with teaching mixed national groups and 1 Training School - NTS49 - gave a qualified negative, commenting that there were not really any difficulties because entry requirements were high (being 6 GCE O'Levels in academic subjects).

Of the 18 Training Schools, 6 added further comment: NTS10 stated that care was taken by tutors with their use of English, adding that this was also beneficial to
indigene learners and that therefore no difficulties arose. NTS23 stated that there were no difficulties but that a problem existed of knowing whether South East Asians had understood. NTS32 found no difficulties from the tutorial point of view but added that learners had problems of understanding amongst themselves. NTS36, 53 and 54 stated that difficulties were no greater than with any group, though NTS36 commented that it was often difficult to know whether overseas learners had understood. NTS54 added that "culture patterns" were a source of difficulty. NTS48 stated that it was hard to tell whether difficulties existed in teaching mixed national groups, though rote-learning was mentioned as a possible source of difficulty.

In 5 Training Schools the question was "not applicable": NTS7 and 18 had overseas learners from one area only. NTS40, 51 and 53 had too few to comment.

6 Training Schools found difficulty in teaching mixed national groups. 5 added further comment: NTS28 observed that Malaysians were too polite to imply failure on the tutor's part by admitting that they had not understood. It was therefore not always possible to know how much they had understood. NTS30 found the non-participation a problem and stated that overseas nurses did not seek clarification. There was also difficulty in getting a point across because overseas learners became discouraged if they were misunderstood. NTS45 commented that it was sometimes necessary to have a "multiple approach" to ensure understanding by all national groups adding that the situation improved with increased confidence in social interaction and with increased professional knowledge. NTS47 stated that one difficulty was the need to avoid giving offence. NTS11 found that the main difficulty lay in that indigene learners were usually lagging behind overseas learners and suggested as a cause that indigenes usually had fewer GCE O'Levels than overseas learners. NTS11 also mentioned that a problem existed with overseas medical lecturers.
5.1.8. **Use of the mother tongue and its effect on progress in English.**

26 Training Schools stated that overseas learners used their mother tongue amongst themselves; 21 felt that it affected their progress in English. Table 19 (Vol.2, A.52) summarises the responses.

Of the 26 Training Schools which stated that the mother tongue was spoken, 15 added further comment: NTS11, 29, 32, 37 and 49 stated that its use was actively discouraged in the hospitals and/or in the School of Nursing. NTS11 added that the practice was becoming less frequent now with the increase in UK recruitment. NTS49 added that an effort was made to put compatriots in the same Nurses' Home. NTS43 commented that Mauritian, in particular tended to speak their mother tongue. NTS2 observed that "some" overseas learners did. NTS8 observed no real difference in progress in English between learners who did and those who did not use their mother tongue amongst themselves. NTS48 found that the practice had no effect on overseas students' progress in English because their English was "good enough already". NTS16 commented that it affected "the poorer ones". NTS15 stated that there was "an observable falling back after days off". NTS36 felt that improvement in English was not as rapid as might be expected in proportion to the length of time in training. NTS22 felt that the use of the mother tongue was the greatest obstacle to progress. NTS40 assumed rather than observed any effect on progress in English but added that "any detriment to progress in English was far outweighed by the benefits of free communication; otherwise the isolation was very great". Similarly NTS52, while observing effect on progress in English, considered that it was important, for psychological reasons, that overseas learners should use their mother tongue.

5.1.9. **The case for simplified textbooks and/or a purpose-designed course.**

Table 20 (Vol.2, A.53) summarises the responses to these two questions.

With regard to the case for simplified textbooks, 5
Training Schools felt that they might be useful. 1 Training School, NTS8, gave a qualified affirmative by commenting that perhaps they would be useful — or a glossary at the end of each chapter of existing textbooks.

4 Training Schools considered that simplified textbooks were not applicable in their case since overseas learner numbers were too small.

10 Training Schools offered no comment, either because they had too few overseas learners or because they did not feel qualified to comment.

Of the 5 Training Schools which considered that simplified textbooks would be useful, 3 added further comment: NTS7 suggested either simplified textbooks or a glossary. NTS20 felt that they would be useful for pupil-nurses. NTS18 thought they would be useful "right across the subject board".

Of the 10 Training Schools which answered in the negative, 1 added further comment: NTS43 considered that overseas learners "should be able to cope with the language as presented".

Reaction to the suggestion of a purpose-designed course was almost unanimously affirmative. 1 Training School, NTS29, thought such a course unnecessary since "overseas learners cope as well as indigenes. They are usually better educated than indigenes". NTS53, while answering in the affirmative, was concerned about how such a course would be financed.

Of the 28 Training Schools which gave an unqualified affirmative, 8 added further comment: NTS42, 45 and 49 all stressed that it should emphasize Spoken English, NTS42 suggesting also "an element of written" and NTS49 suggesting précis and telephoning. NTS22 considered that the course should be one of "social orientation". NTS43 wanted a course "on a national basis". NTS11 felt that it would be helpful to those overseas learners who had the general ability to proceed with student-nurse training. NTS51 thought it would help those applicants who were not accepted, adding that some applicants were sent on language courses before being accepted. NTS36 thought that a course would be
useful for indigenes as well as overseas learners.

5.1.10. **Further participation in the research.**

All 30 Training Schools stated their willingness to participate in the later stages of the project; namely:-- to furnish lists of overseas learners; to distribute the questionnaires to them wherever they might be at the time and, if called upon, to offer facilities for participant observation.

5.1.11. **Unclassifiable comments by PNOE's.**

Comments were made by several Training Schools which were not readily classifiable under the preceding headings, but which, nevertheless, had considerable bearing on, for example, attitudes to and practices adopted in recruitment and selection and are therefore added here:

NTS51 suggested that there was need for more stringent preselection because Training Schools were now so large that there was no longer any time to give individual attention and therefore no possibility of help with individual difficulties, language or otherwise.

NTS28 stated that the GNC was unwilling to take responsibility for reducing the number of unsuitable candidates by raising the standard of entry requirements and therefore the onus fell on the individual Training School. NTS28 further commented that as a PNOE's salary was based on the number of learners plus the number of statutory courses run in the School, and as any increase in standard of entry requirements led to an immediate fall in numbers, it was difficult to take the initiative. Moreover, many PNOE's were married and could therefore probably not afford the drop in salary which such an initiative would entail.

NTS22 felt that the GNC should be more concerned with fixing the grade of certificate rather than specifying subjects since grades in whatever subject were often much more indicative of intellectual ability than were particular subjects.

NTS11 considered that if general ability only allowed for pupil-nurse training in the first instance, a learner was unlikely to go on to student-nurse training.
NTS28 felt that while overseas pupils undoubtedly had problems during their training, these arose more from a lack of general ability than from language difficulties.

NTS10, on the other hand, considered that the chief problem was a lack of knowledge of the euphemisms, evasions and allusions used in connection with the body and its functions, illness and death, and of colloquial English in general.

NTS47 suggested that local idiom sometimes offended overseas learners, such as, for example, being called "love".

NTS7 suggested that there was a tendency in Schools of Nursing to move away from Latinised English in favour of "simpler" English.

NTS11 and 28 observed that overseas learners did not talk to patients except on a purely professional level—such as telling the patient what was about to happen—but this was as true of indigene learners as of overseas trainees. Although "talking to patients" was no longer frowned upon by senior staff it was not done and the failure to do so was not generally recognised.

NTS51 commented on the loneliness of indigene and overseas learner alike in the large Training Schools and their disorientation, particularly if from a rural area.

NTS7 observed that while different national groups mixed willingly and well during the [2-week] orientation course, they regrouped nationally as soon as it was over. There was also a "sense of abandonment" once the course was over, overseas learners feeling that they needed support for a longer period.

NTS15 commented that a problem arose within the Group hospitals because patients preferred to go to the hospitals in which the proportion of indigene learners was high.

NTS7 observed that many overseas learners took pupil-nurse training in Psychiatric or Mental Subnormality Schools and left for General student-nurse training immediately on becoming State Enrolled rather than seek Registration in either of these two fields. According to NTS28, some SEN's went from School to School trying to obtain a place in student-nurse training (General), though they often failed two, three or four times because they were not
capable of doing training for Registration.

There was also a certain amount of comment concerning overseas candidates who attempted to queue-jump either by applying from Europe or by first coming on a Visitor's Permit to the UK and then applying through the Training School for a student-visa. NTS23 mentioned Mauritians in particular in this context.

5.1.12. General comment.

During the interviews every effort was made not to induce PNOE's to make statements which did not occur to them spontaneously once the question was put. In addition, it was not always possible to make full notes of comments offered in discussion since, in some cases, it seemed to inhibit free speech. Comments included in this chapter therefore are those which were recorded and are not necessarily the only ones which were made. There was, for example, a very strong and widely held feeling that the level of entry requirements should be raised but that the higher standard should be set by the GNC and not left to individual Training Schools.

The opinion was also frequently expressed that there should be some kind of central admissions system where all overseas applications could be processed, since the current practice adopted by overseas learners of applying to any number of hospitals - the highest figure mentioned was 40 - was a drain on National Health Service resources. The amount of duplication was felt to be very great and the cost to the NHS commensurate; the cost to individual Training Schools was high and made serious inroads on their budgets. Furthermore, the practice of applying to several Training Schools often led to acceptance of an overseas learner by two or more Schools. Since overseas learners often did not cancel applications in Training Schools which offered them a place, the said Training School might begin an Introductory Block two, three or even more learners short without prior warning and therefore without the opportunity of offering the places to other applicants.

Another opinion, also frequently expressed was that
the Immigration Act was not as rigorously applied in the case of overseas candidates for nursing as it was for other students or immigrants and that therefore it was not always easy to refuse overseas applicants entry to the nursing profession, particularly if - as described earlier (see 1.3.9a) - indigene recruitment was low. (3).

There was also a certain amount of apprehension, particularly if individual Training Schools wished to raise their level of entry requirements, concerning the Race Relations Board, since raising the level of entry often excluded certain if not all overseas applicants. This had, in fact, happened in one or two instances, leading to complaints of racial discrimination.
REFERENCES AND NOTES.

1. Since the few orientation courses in existence are quite well known in the nursing profession any more detailed information might lead to identification of individual Training Schools.

2. These figures were taken from the lists of individually named overseas learners submitted for questionnaire sampling.

3. Because of the current economic situation and its concomitant unemployment problem, the situation has altered drastically. Indigene recruitment is high and the Immigration Act is now being strictly applied to overseas candidates for nursing.
5.2. Results of the Questionnaires.

Of the 488 questionnaires sent out to overseas learners, 225 answers were received, being 46.1% of the total sample and 2.5% of the total research population. Since the visits to the 30 Training Schools spanned a period of five months, it was felt that many of the subjects to whom questionnaires were sent might well have left their employment before the arrival of the questionnaires. All PNOE's were therefore sent a list of names of their student/pupil-nurses included in the sample and asked to state whether they were still in employment as at July 31st, 1974. A copy of this letter is included in Vol.2 as Appendix X (A.53).

Table 21A shows that of the 28 Training Schools approached, 4 did not reply. From the remaining 24 it was learnt that 26 subjects had left their Training Schools before the questionnaires were received, this being 5.3% of the total sample. Thus 51.4% of the total sample was accounted for.

Six of the completed questionnaires were discarded for the following reasons:

4 were not members of the three area groups:--
   1 was French
   2 were Guyanese
   1 was Indian

1 gave no nationality.
1 gave nonsense answers throughout.
219 questionnaires were recorded and analysed.

Of the 67 questionnaires distributed or sent to indigene learners, 59 answers were received, being 88.1% of the total sample.

Figure 5 (Vol.2, A.55) shows numbers by area and status, there being 164 student-nurses and 55 pupil-nurses from the three areas combined, with 47 student-nurses and 12 pupil-nurses in the control group. Although the number of student-nurses from South East Asia is disproportionate to all other groups, this is a reflection of the actual nurse-trainee population rather than an imbalance due to sampling since student-nurses from South East Asia account for 44.4% of the total research group, 52.4% of the total
student-nurse population from all overseas countries (as defined in Table 4, Vol.2, A.5) and 35.6% of the total nurse-trainee population from all overseas countries. In terms of percentage representation of their respective area groups the figures are more comparable. (cf. Tables 22a and b, Vol.2, A.56).

Table 23 shows the distribution of the subjects by area, sex and status in the three main fields of training. Three students and one pupil were following a combined training and these have been recorded separately throughout in the manner indicated in Table 23.

The Control Group included 5 Irish subjects: 1 male pupil, 3 female students and 1 female pupil, and 4 Welsh subjects: 1 male student, 2 female students and 1 female pupil. It had been the original intention to record Welsh and Irish responses separately but numbers are clearly too small. Moreover, Thomas and Williams in their survey of English and overseas nurses (1), in which Irish responses were recorded separately, showed that Irish nurses' responses approximated much more closely to those of English nurses than to those of the overseas sample.

Analysis of the figures shows that there are many fewer males, both student and pupil, in General Training than in Psychiatric and Mental Subnormality. This follows the national trend:

<table>
<thead>
<tr>
<th>General</th>
<th>Psychiatric</th>
<th>Mental Subnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.6</td>
<td>48.0</td>
<td>53.0</td>
</tr>
</tbody>
</table>

(GNC Statistics, 1975 (2)).

and is therefore not necessarily a consequence of being an overseas learner.

Part I of the questionnaire was concerned with background information.

5.2.1. **Social Class and Nursing Status.**

Table 24a (Vol.2, A.59) shows the social class of learners, based on the Registrar General's classification (3), by area and nursing status. The Registrar General's criteria for coding (3, p.xvi) were used throughout. For instance, where father's occupation was given as "engineer" without further definition, it was assumed to be
non-professional, and therefore classified as Social Class III (M).  

136 overseas and 40 control group learners were classifiable, being 62.1% and 67.8% respectively of the total sample groups. Of the overseas learners, 106 were students and 30 were pupils; of the control group, 31 were students and 9 were pupils. Table 24b (Vol. 2, A.60), shows these figures as percentages of their respective groups by social class.

Chi-square tests (4) show that there is no relationship between social class and nursing status, either for overseas learners or for the control group. The latter equation was corrected for continuity (5, p.286) since in one cell - control group working-class pupils - the expected frequency was below 5.

However, chi-square tests show that overseas learners are more likely to be from a middle-class background than indigene learners. For students and pupils combined p = <.001; for students p = <.01 and for pupils p = <.05, the latter equation again being corrected for continuity.

5.2.2. Educational Background and Nursing Status.

Table 25 (Vol. A.61) compares the primary and secondary educational background of students and pupils in order to examine whether a relationship exists between length of schooling and nursing status.

With respect to primary schooling six years was taken as the expected norm since this was the average length of primary education for all groups.

94.5% of overseas student-nurses and 87.3% of pupils completed 6 years or more, and of the 16 subjects who completed less than 6 years, 9 were students and 7 were pupils. In the control group 89.1% of students and 55.6% of pupils completed 6 years or more and of the 9 subjects who completed less than 6 years, 5 were students and 4 were pupils.

Regarding secondary education, five years was taken as the expected norm since this was the average length of secondary education for all groups, with the exception of control-group pupils, where it was 4.5. Five years is also
the minimum acceptable length of secondary education as an entry requirement for training for the Register as opposed to the Roll. (See Vol.2, Appendix I, A.6). 1 student and 2 pupils did not answer the question.

87.1% of overseas students and 63.6% of pupils completed 5 or more years and of the 41 subjects who completed less than 5 years, 21 were students and 20 were pupils. In the control group, 87.0% of students and 54.5% of pupils completed 5 or more years and of the 11 subjects who completed less than 5 years, 6 were students and 5 were pupils. 1 student did not answer the question.

Chi-square tests showed the relationship between length of schooling to be significant at the primary level for overseas learners (p = <.05) but not for the control group (p = <.10). The latter equation was corrected for continuity. At the secondary level the relationship was significant for both groups, p = <.001 in both instances.

Although the figures for students and pupils, overseas and control, whose length of schooling fell below the expected norm are approximately equal, the student-groups would, by definition, have obtained school-leaving and/or other certificates acceptable to the GNC in less than five years or by other means (e.g. night school) or have held some other prerequisite qualification, such as a midwifery certificate.

5.2.3. Medium of instruction, nursing status and attitude to a possible specialised course.

Since only 3 Irish and 1 Welsh subject in the control-group were taught in both English and Irish/Welsh, the control group has been omitted. Suffice it to say that all four stated that a special course would be helpful.

Tables 26a, b and c (Vol.2, A.62-63) compare medium of instruction at primary and secondary levels of education with nursing status and with the subjects' attitude to a possible course in hospital communication in order to establish, in the first instance, whether or not a relationship exists between formal linguistic background and nursing status. In the second instance, comparison between formal linguistic background and the subjects' attitude to a possible course seeks to determine whether the educational
medium of instruction has any bearing on the subjects' degree of linguistic ability to cope in the nursing situation as expressed by a need or otherwise for a course.

Table 26a gives the figures for the separate areas; Table 26b combines them and Table 26c gives them as percentages.

**Medium of instruction/Nursing Status.**

At the primary level 93 (56.7%) students and 42 (76.4%) pupils were taught either wholly or partially in the vernacular and/or national language and/or English. 71 (43.3%) students and 13 (23.6%) pupils were taught wholly in English.

At the secondary level 66 (40.2%) students and 34 (61.8%) pupils were taught either wholly or partially in the vernacular and/or national language and/or English. 98 (59.8%) students and 21 (38.2%) pupils were taught wholly in English. It can therefore be seen that a noticeably larger proportion of students than pupils was taught wholly in English at both levels of education.

Chi-square tests showed the relationship between medium of instruction and nursing status to be significant at the 1% level. (For both levels p < .01).

**Medium of Instruction/Linguistic Ability.**

152 (92.7%) students and 53 (96.4%) pupils indicated that a course would be helpful. 12 (7.3%) students and 2 (3.6%) pupils did not want a course. Chi-square tests showed that on the primary level figures the relationship between medium of instruction and attitude to a course was significant at the 5% level (p < .05). At the secondary level, where more subjects were taught wholly in English, there was no relationship. It would seem therefore that although the figures in Table 26b show that subjects taught wholly in English were more likely to reject a course than those for whom the medium of instruction was partially or wholly vernacular, the relationship was not a very strong one since the vast majority indicated that a course would be helpful, regardless of their formal linguistic background.

(For the purpose of analysis the figures in the first and second rows of Table 26b and 26c have been combined).
Informal linguistic background, nursing status and attitude to a course.

The control group have been omitted here also since only 2 Irish subjects spoke a language other than English in informal circumstances.

Tables 27a – d (Vol.2, A.64-7) compare the linguistic background in fields other than education (i.e. informal linguistic background) with nursing status and with the subjects' attitude to a course.

The three fields considered are:- family; friends at home and friends in England.

Tables 27a – c give figures for the separate areas; Table 27d combines them.

Informal linguistic background/nursing status.

family.

110 (67.1%) students and 41 (74.5%) pupils spoke wholly in the vernacular with their families; 50 (30.5%) students and 13 (23.6%) pupils spoke a mixture of vernacular, national language and/or English; 3 (2.4%) students and 1 (1.8%) pupil spoke wholly in English.

friends at home. (i.e. in the country of origin)

61 (37.2%) students and 32 (58.2%) pupils spoke wholly in the vernacular; 80 (48.8%) students and 19 (34.5%) pupils spoke a mixture; 23 (14.0%) students and 4 (7.3%) pupils spoke wholly in English.

friends in England.

5 (3.0%) students and 1 (1.9%) pupil spoke wholly in the vernacular; 87 (53.0%) students and 28 (50.9%) pupils spoke a mixture; 72 (44.0%) students and 26 (47.2%) pupils spoke wholly in English. Chi-square tests showed little or no relationship between informal linguistic background and nursing status.

Informal linguistic background/attitude to course.

family.

Of the 110 students who spoke wholly in the vernacular, 105 (64.0%) indicated that a course would be helpful; 5 (3.0%) did not think so. Of the 41 (74.6%) pupils, all wanted a course. Of those who spoke a mixture of vernacular, national language and/or English, 45 (27.4%) students and 11 (20.0%) pupils wanted a course; 6 (3.7%)
students and 2 (3.6%) pupils did not. The number of those who spoke wholly in English (3 students and 1 pupil) is too small to be statistically important.

friends at home.

Of those who spoke wholly in the vernacular, 56 (34.1%) students and 32 (58.2%) pupils wanted a course; 5 (3.1%) students did not. Of those who spoke a mixture, 74 (45.1%) students and 18 (32.7%) pupils wanted a course; 6 (3.7%) students and 1 (1.8%) pupils did not. Of those who spoke wholly in English, 22 (13.4%) students and 3 (5.5%) pupils wanted a course, 1 (0.6%) student and 1 (1.8%) pupil did not.

friends in England.

Of those who spoke wholly in the vernacular all subjects - 5 (3.0%) students and 1 (1.8%) pupil wanted a course. Of those who spoke a mixture 80 (48.8%) students and 26 (47.3%) pupils wanted a course; 7 (4.3%) students and 2 (3.6%) pupils did not. Of those who spoke wholly in English, 67 (40.9%) students and 26 (47.3%) pupils wanted a course; 5 (3.0%) students did not. Chi-square tests showed no significant relationship between informal linguistic background and attitude to a course.

5.2.5. Educational Achievement and Nursing Status.

Tables 28a and 28b (Vol.2, A.69-70) show the relationship between educational achievement and nursing status as demonstrated by the educational certificates gained. Table 28a shows the number of subjects with single certification; Table 28b those with multiple certification. Some certificates (marked X) are not acceptable to the GNC and/or Nursing Training Schools for student-nurse training. (See Vol.2, Appendix II, A.7-18).

With regard to the Filipino B.Sc. certificates, Nurse Training Schools often use their own discretion, depending on the candidate's general suitability.

Where a number of pupils appear against an acceptable certificate (Table 28a, A.69; Rows 1,4,5,6,9,14 and 15 overseas; Rows 1 and 27 control; Table 28b, A.70: Rows 2, 3,4,6 and 25 overseas), other factors may have influenced their status. They either did not achieve high enough
grades in the compulsory subjects; or they did not hold a certificate in the compulsory subject; or they did not meet the entry requirements, educational or linguistic, of the relevant Training School; or they did not complete the minimum 5 years' secondary education (cf. Table 25, Vol.2, A.61); or, particularly in the case of control subjects, they may be married women who chose pupil-nurse training in preference to student-nurse training because, with home commitments, they did not want the responsibility or the burden of theoretical study which accompanies student-nurse training. (6).

Where students appear against unacceptable certificates or no certification (see Table 28a: Rows 10, 11 and 24 overseas; Row 30 control) either they had taken the GNC Test D; or the certificate in question does not appear on the Schools Council list (Table 28a, Row 24) and is therefore assumed to be unacceptable until the Schools Council rules otherwise but the subjects proved their suitability for student-nurse training in accordance with Training School requirements.

The figures for acceptable and unacceptable certification are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas</td>
<td>161</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>17</td>
</tr>
<tr>
<td>Control</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

It can be seen from these figures that student-nurse status is far less likely to be given to an applicant with unacceptable certification than pupil-nurse status to an applicant with acceptable certification, though overseas learners with acceptable certificates are more likely to be found in the pupil-grade than indigenes, and this is significant at the 0.01% level (p < .001).

Table 29 (Vol.2, A.71) shows the subjects taken for the various certificates gained related to status. Those marked with an asterisk are the three compulsory subjects laid down by the GNC, in at least one of which candidates for student-nurse training must have a Grade I Pass. (see Appendix I, Vol.2, A.6). Otherwise only the number of subjects is laid down, the choice of subjects lying with
the candidate. (see Appendix I, i - ii, A.6).

Nurse Training Schools, as discussed earlier, may ask for any number of subjects and may specify their nature. Some subjects would be considered unsuitable by almost every Training School: (Table 29: Rows, 4,6,8,12, 16,25,30,32,35,39,42, and 46).

Table 29 shows the commonest choice of subjects for GCE O'Level or its equivalent. 11 (6.7%) overseas students and 7 (12.7%) pupils did not specify the subjects taken; 4 (8.5%) control students and 2 (16.7%) pupils did not. 1 control student did not answer the question.

As the Table shows, the three compulsory subjects were popular with both overseas and control subjects, though, with the exception of English Literature, overseas learners were more likely than the control group to have these subjects, chi-square tests showing the following significance levels: English Language: $p = <.05$; History: $p = >.01$. This likelihood, however, is status-related, since chi-square tests show that overseas student-learners were no more likely than the control-group students to have these subjects, while pupil-learners were much more likely to. Chi-square tests, all corrected for continuity, showed the following significance levels: English Language: $p = <.001$; English Literature: $p = <.05$; History: $p = <.01$.

Apart from the mother-tongue/national language, Mathematics and Geography were the most popular non-compulsory subjects for overseas learners and Mathematics and Biology for the control group. With respect to Mathematics, overseas learners were much more likely than the control group to have this subject ($p = <.001$) and this is not status-related since overseas student-learners were much more likely to have Mathematics than the control students ($p = <.001$), as were overseas pupils ($p = <.01$).

5.2.6. Prior knowledge of and acquaintance with Britain.

Tables 30 and 31 (Vol.2, A.72 - 73) show the number of subjects who had prior knowledge either of the training milieu in which they would find themselves (Tables 31a and b); or of the type of training available and entry
requirements for these; or of the structure of that milieu—viz: National Health Service; or of the socio-cultural background (Tables 30a and b).

Tables 30a and 31a give the figures in each category for each area; Tables 30b and 31b show these figures as percentages.

It can be seen from Table 30b that the percentages for each area are fairly close, which suggests that information on the topics included is equally accessible to all three areas. Notwithstanding this, it would seem either that little information is available or that overseas candidates do not avail themselves of it, since only 74 subjects (33.8% of the total overseas sample) had any knowledge of British customs and culture and only 30 (13.7%) subjects had any prior knowledge of the National Health Service.

A rather larger proportion knew the requirements for nurse training, 165 (75.3%) subjects, though fewer knew about the various types of training, 123 (56.2%) subjects. By comparison, 56 (96.6%) control subjects knew the requirements for nurse training and 53 (91.4%) knew about the various types of training. 2 overseas and 1 control subject did not answer the question.

With regard to the milieu—Tables 31a and b—the majority of overseas subjects had a little knowledge, 152 (69.4%) subjects; and several had some knowledge, 47 (21.5%) subjects. Only 6 (2.7%) subjects had a more extensive knowledge of this field and 9 (4.1%) had no knowledge at all. By comparison 23 (39.0%) control subjects had a little knowledge, the same number having some knowledge. 12 (20.3%) subjects had a lot of knowledge. No control subject had no knowledge. 5 overseas and 1 control subject did not answer the question.

5.2.7. Prior contacts in the UK and their current whereabouts.

Table 32 (Vol.2, A.74) shows how many subjects knew someone in Britain prior to his or her arrival in the country and whether or not that person was associated in any way with medicine or nursing. It can be seen that of
of the 219 subjects 146 (66.7%) subjects had either a relative or friend in the U.K. or knew someone - the friend of a relative, friend of a friend etc. - before arrival and 43 (19.6%) knew more than one person. 28 (12.8%) subjects knew no-one at all and 2 (0.9%) subjects did not answer the question. Thus 189 (86.3%) of all subjects knew one or more persons in the U.K. prior to his or her arrival.

Of these 189, a large majority of the subjects, 162 (85.7%) had their contacts in nursing or medicine or both; the remaining 27 (14.3%) subjects having their contacts in universities, colleges of education, businesses, trades or industries. Of the 189 subjects who had had contacts prior to arrival, in 157 (83.1%) cases the contacts were still here; in 32 (16.9%) cases they had left by the time the subject completed the questionnaire.

The control group were asked if they had any prior contacts in medicine or nursing and responses were as follows:

<table>
<thead>
<tr>
<th>FRIENDS</th>
<th>RELATIVES</th>
<th>FRIENDS/RELATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>NURSING/MEDICINE</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>NOT SPECIFIED</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Thus 40 (67.8%) control subjects had contacts in nursing and/or medicine, compared with 85.7% of overseas subjects.

5.2.8. Pre-nursing occupation. (7).

Subjects were asked to say how long they had been in the United Kingdom before starting their nursing training and whether they had had a job prior to nursing. Table 33a (Vol.2, A.75) shows the length of time in the U.K. and Table 33b (Vol.2, A.76) shows the occupation, if any. The time spent in the U.K. is counted in days until 14 days or more.

Table 33a shows that just over half the subjects, 120 (54.8%), were here for a few days only. 48 (21.9%) subjects were here for two or three weeks; 38 (17.4%) were here for a few months and 13 (5.9%) had spent one or more years here.
The 37 subjects who did not specify the actual number of days, weeks etc. had all indicated the relevant category.

Table 33b shows how the time was spent. Direct comments are included as quotations. (Rows 3, 12, 13, 14, 15, 17 and 19). 61 subjects did not specify how they spent their time; 1 did not answer the question. Of the 157 subjects who specified how the time was spent, 87 (55.4%) went straight to their nurse-training schools, either to take up work immediately, or to take part in special orientation programmes, or to wait for the date of commencement of the School. (Rows 3, 5, 6, 9, 15 and 22). The remainder either had occupations unconnected with nursing or were not gainfully employed.

5.2.9. Nursing Background.

1. Selection of Training School, choice of training and status.

The distribution of subjects by area, type of training and status was given in Table 23 (Vol.2, A.58).

Table 34, (Vol.2, A.77), shows whether or not a subject chose his or her own Training School and the source of information regarding it.

It can be seen from Table 34 that 140 (85.4%) overseas students and 41 (74.5%) pupils chose their own Training Schools; 22 (13.4%) students and 11 (20.0%) pupils did not. By contrast 45 (91.8%) control students and 10 (83.3%) pupils chose their own Training Schools; 1 (2.1%) student and 1 (8.3%) pupil did not. 2 students and 3 pupils (overseas) and 1 student and 1 pupil (control) did not answer the question. Chi-square tests show that there is little or no relationship between status and choosing of Training School. However, indigenes are much more likely to choose their own Training School than are overseas learners (p = < .01).

As regards the source of information concerning the Training Schools, 187 (87.4%) overseas subjects and 57 (96.6%) control subjects specified the origin of their information; 27 (12.6%) overseas and 2 (3.4%) control subjects did not. 2 (3.4%) control subjects did not answer the question. Of the 187 overseas subjects who
specified the source, 111 (59.4%) relied on friends or relatives, probably already in the U.K. 34 (18.2%) sought advice from official British sources (Table 34, Rows: 4, 5, 13 and 15); 6 (3.2%) acquired their information either from school or from the Education Office in the country of origin; 35 (18.7%) got it from an advertisement; 1 (0.5%) acquired it from a Travel Agency. It would seem, therefore, that the most popular source of information is friends or relatives already employed in nursing or medicine in the U.K. (cf. Table 32, A.74), since, in addition to the 111 subjects who relied solely on friends or relatives, 6 of the 34 subjects who acquired information from official British sources also asked advice of friends or relatives.

With respect to control subjects, of the 57 who specified the source, 19 (33.3%) relied on friends or relatives; 18 (31.6%) sought advice from official sources, (Table 34, Rows: 8, 11, 13, 14 and 16) 5 of these approaching the Training School in question personally (Row 16). 17 (29.8%) acquired their information from an advertisement, 4 of these seeking advice also from friends.

These figures would suggest that overseas applicants rely more heavily on information supplied by friends and relatives than indigenes and a chi-square test shows a level of significance for this sample of 1% (p = < .01).

2. Learners' own choice of training.

Table 35 (Vol. 2, A.78) shows whether or not the subjects chose their own type of training. For the purposes of analysis the 4 overseas subjects who were following a combined training have been omitted: 3 students and 1 pupil. Likewise those who did not specify the type of training: 7 students and 1 pupil. (see Table 23a, A.57). 2 overseas subjects did not answer the question.

With regard to overseas subjects, 92 (96.8%) students and 28 (84.8%) pupils in General Training chose their own training; 3 (3.2%) students and 5 (15.2%) pupils did not. In Psychiatric Training, 44 (89.8%) students and 10 (100.0%) pupils chose their own training; 5 (10.2%) students did not. In Mental Subnormality Training, subjects, both students and pupils, were equally divided between those who did and those who did not. Chi-square
tests (8) show that students in General Training were more likely to have chosen their training than students in Psychiatric and Mental Subnormality Training (p = <.01) but for pupils there was no relationship between type of training and choice. The second equation was corrected for continuity. Students in General Training were more likely to have chosen their type of training than pupils (p = <.05) but in Psychiatric and Mental Subnormality students were no more likely to choose their own training than pupils. These two equations were corrected for continuity. Taken as a whole, however, there is a strong relationship between type of training and the learner's choice, significant at the 1% level. Learners in General Training are more likely to have chosen their own training than learners in Psychiatric and Mental Subnormality Training.

With regard to control subjects, all learners in all categories chose their own type of training except one student in Psychiatric Training. Thus, the control sample subjects were more likely to have chosen their own training than overseas learners and this was shown to be significant at the 5% level. (p = <.05).

3. Learners' own choice of status.

Table 36 (Vol.2, A.79) shows whether or not learners chose their own status. Those following a combined training and those who did not specify training have again been omitted. 4 overseas subjects did not answer the question.

With regard to overseas learners, 92 (96.8%) students and 20 (60.6%) pupils in General Training chose their own status. 3 (3.2%) students and 13 (39.4%) pupils did not. In Psychiatric Training 43 (87.8%) students and 7 (77.8%) pupils chose their own status; 6 (12.2%) students and 2 (22.2%) pupils did not. In Mental Subnormality Training, 6 (60.0%) students and 3 (42.9%) pupils chose their own status; 4 (40.0%) students and 4 (57.1%) pupils did not. Chi-square tests show that students were much more likely to have chosen their own status than pupils (p = <.001). Students in General Training were more likely to have chosen their status than students in Psychiatric and Mental Subnormality Training (p = <.01) but pupils in General
Training were no more likely to have chosen their status than those in Psychiatric and Mental Subnormality Training.

With regard to control subjects, all subjects chose their own status with the exception of 2 pupils in Psychiatric Training. Pupils were therefore no less likely to have chosen their status than students.

Compared with overseas learners, the control sample shows that indigene students were no more likely to have chosen their status than overseas students. Indigene pupils, however, were more likely to have done so than overseas pupils, the level of significance being somewhat greater than 2% ($p => .02$). The last two equations were corrected for continuity.

4. The GNC Test D.

Table 37 (Vol.2, A.80) shows the number of students and pupils who took the GNC Test D, at whose request they took it and how often. 2 control subjects in General Training who took Test D did not specify either at whose request or the number of times they took it.

With respect to overseas learners, 48 (29.3%) students and 25 (45.5%) pupils took Test D. Of these, 17 (35.4%) students and 10 (40.0%) pupils took it at their own request; 31 (64.6%) students and 15 (60.0%) pupils took it at the request of their Training School. 41 (85.4%) students and 24 (96.0%) pupils took Test D once only; 7 (14.6%) students and 1 (4.0%) pupil took it twice.

Regarding the control group, 25 (53.2%) students and 9 (75.0%) pupils took Test D. 1 control student in Psychiatric Training did not specify at whose request the Test was taken. Of these, 8 (32.0%) students and 1 (11.1%) pupil took it at their own request; 17 (68.0%) students and 8 (88.9%) pupils took it at the request of their Training School. All control subjects took Test D once only.

A chi-square test shows that overseas learners were no more or less likely to take Test D at their own request than were the control group. Nor was there any significant relationship between the overseas and control sample as regards the number of times Test D was taken. However, indigenes were much more likely to have gained admission to student-nurse training via Test D than were overseas
students, the level of significance being somewhat greater than 0.1% (p = >.001).

Assuming that pupils who took the Test failed it, chi-square tests show that overseas candidates were no more likely to fail than indigenes.

5. Pupils intending to train for the Register.

Table 38 (Vol.2, A.81) shows the number of pupils who intended to proceed to student-nurse training on completion of State Enrolment.

Of the 55 overseas pupils in the sample, 51 (92.7%) intended to proceed; 2 subjects did not. 1 did not know and 1 did not answer the question. It is clear, therefore, that the vast majority wanted to go on to student-nurse training.

Of the 12 control-group pupils, 4 (33.3%) intended to train for the Register, 6 (50.0%) did not. 2 were not sure.

Overseas learners were clearly much more likely to want to proceed to student-nurse training (p = <.001).

5.2.10. Extra-nursing educational/language activities.

Table 39a (Vol.2, A.82) shows the number of subjects following courses outside the Training School and Table 39b (A.83) gives the courses followed.

Of the overseas subjects, 24 (11.0%) attended some kind of course, of which 13 were students and 11 were pupils, being 7.9% of the total overseas student group and 20.0% of the total pupil-group respectively.

Of the control subjects, 16 (27.1%) attended some kind of course, of which 15 were students and 1 was a pupil, being 31.9% of the total student sample and 8.3% of the total pupil sample respectively.

It is clear from Table 39a that nurse-learners who attend extra-nursing educational activities are in the minority, whether indigene or overseas, though a higher percentage of indigenes than overseas from the sample were engaged in such activities, being more than twice that of the overseas group. These figures would suggest that indigenes are more likely to pursue extra-nursing courses than overseas learners. A chi-square test shows
the level of significance for the sample groups to be somewhat greater than 0.1\% (p \rightarrow .001).

Table 39b shows that of the 24 overseas learners, 15 (62.5\%) were studying English in one form or another, while 5 (31.3\%) - exactly half the overseas percentage - control group subjects were. 5 from each group were pursuing studies in biology, human or otherwise. For the rest, subjects were following a variety of courses.

Part 2 of the questionnaire was concerned with current training, possible difficulties and possible criteria for a specialised course.

5.2.11. Audio-visual Aids and Teaching Techniques.

For the purpose of comparing the likely educational background with the likely situation in nurse education with respect to the use of audio-visual aids (AVA) and teaching techniques, subjects were asked to say whether or not certain audio-visual aids and/or teaching techniques were used in their schools and/or in their Nurse-Training Schools. In both instances the question was confined to those aids and techniques known to be used in nurse education. Any qualifying remarks such as: "very few times", "only seldom", were counted as negative responses.

Tables 40a and b (Vol.2, A.84) summarise the responses of the overseas and control sample respectively, Y/Y indicates use both in schools and in Nurse Training Schools; Y/N in the former but not the latter; N/Y in Nurse Training Schools but not in schools; N/N in neither.

If these figures are compared (see Table 40c, Vol.2, A.85), it will be seen that, on the whole, indigenes are more likely to have had prior experience of the use of AVA than overseas learners. Comparative figures are as follows:

<table>
<thead>
<tr>
<th>Used in Schools.</th>
<th>Not used in Schools.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas % of sample</td>
<td>Control % of sample</td>
</tr>
<tr>
<td>TR    30.3</td>
<td>54.2</td>
</tr>
<tr>
<td>OP    22.9</td>
<td>47.5</td>
</tr>
<tr>
<td>DG    81.2</td>
<td>69.5</td>
</tr>
<tr>
<td>CS    33.1</td>
<td>67.8</td>
</tr>
<tr>
<td>F     56.4</td>
<td>83.1</td>
</tr>
</tbody>
</table>
In all instances except Discussion Groups the control sample had considerably more experience of teaching aids than the overseas group. As regards Discussion Groups, the overseas sample had more prior experience than the control group.

The most important category, however, with respect to possible educational difficulties is the N/Y category; namely, those learners without prior experience and therefore meeting AVA or Discussion Groups for the first time in their nursing studies. The Y/Y category suggests that, with prior experience, there would be no difficulties concerning their use in nurse education. The Y/N and N/N categories are irrelevant in this particular context.

Tables 4la and b (Vol. 2, A. 86) summarise the responses in the N/Y category; Table 4la gives the overseas sample by area and Table 4lb gives the combined overseas sample and the control sample.

The figures in Table 4la would suggest that Mauritians have least prior experience overall and that South East Asians have most. If these figures are compared with the Y/Y and Y/N responses, indicating use in General education, it will be seen that the N/Y category reflects the general trend.

<table>
<thead>
<tr>
<th>Used in Schools</th>
<th>E/WA</th>
<th>SEA</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>TR</td>
<td>22.7</td>
<td>34.0</td>
<td>21.7</td>
</tr>
<tr>
<td>OP</td>
<td>18.2</td>
<td>24.7</td>
<td>19.6</td>
</tr>
<tr>
<td>DG</td>
<td>81.8</td>
<td>80.0</td>
<td>84.8</td>
</tr>
<tr>
<td>CS</td>
<td>27.3</td>
<td>38.0</td>
<td>19.6</td>
</tr>
<tr>
<td>F</td>
<td>63.6</td>
<td>56.7</td>
<td>52.2</td>
</tr>
<tr>
<td>(N = 22)</td>
<td>(N = 150) (N = 46)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1 E/WA pupil did not answer the question)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The figures in Table 4lb show that a substantial minority of overseas learners were experiencing the use of AVA for the first time, though the number expected to participate in Group Discussions for the first time was relatively small. The proportion of indigenes unacquainted with the use of the tape-recorder, colour slides and films was considerably lower, though the proportion
meeting the overhead projector for the first time was more comparable with that of overseas learners. As regards Group Discussion, the proportion of indigenes encountering this technique for the first time was appreciably higher than for overseas learners.

It would seem, therefore, that, on the whole, overseas learners might have more difficulty with AVA than indigenes but less difficulty with Group Discussions.

5.2.12. **Study: organisation and guidance.**

Subjects were asked to estimate how many hours approximately they spent per week on private study and whether or not they were given specific tasks to do. They were also asked whether they preferred to organise their own study or whether they preferred to be told what to do.

Table 42a (Vol.2, A.87) shows the number of hours spent per week on private study. 2 overseas and 4 control subjects said that they did no private study at all. 5 overseas subjects did not answer the question. 15 overseas and 8 control subjects did not specify the number of hours. 25 overseas and 7 control subjects stated that the pattern was irregular. 7 overseas subjects studied only during study-blocks.

Of the 165 overseas subjects who stated their study-hours, the majority (150 = 90.9%) spent from 1-15 hours per week on private study and the greater part of that majority (128 = 77.6%) spent from 1-10 hours.

Of the 40 control subjects who specified their study-hours, all except one spent from 1-15 hours per week on private study and the greater part of that number (36 = 90.0%) spent from 1-10 hours.

Chi-square tests show that overseas learners were no more likely to study longer hours than indigenes.

Table 42b (Vol.2, A.88) shows whether subjects were told what to do in their study-time or whether they chose for themselves.

As the figures for both overseas and control samples show, almost 70% chose for themselves, almost 25% both chose and were told what to do. Very few were guided entirely by the tutorial staff. 6 overseas subjects did
not answer the question.

It is clear, therefore, that nurse trainees are largely expected to organise their own study-time.

Table 42c (Vol.2, A.89) shows whether or not subjects preferred to choose for themselves or whether they would rather be told what to do.

Of the overseas sample, 133 (88.7%) students and 44 (89.8%) pupils said that they would prefer to be told what to do; 17 (11.3%) students and 5 (10.2%) pupils said that they would not. 14 students and 6 pupils did not answer the question.

Of the control sample, 28 (63.6%) students and 7 (77.8%) pupils preferred to be told what to do; 16 (36.4%) students and 2 (22.2%) pupils said that they would not. 3 students and 3 pupils did not answer the question.

These figures show that the vast majority of overseas learners would prefer to be told what to do and, though the proportion of control learners is smaller, a substantial majority of these would also prefer to be told. There is no significant difference in attitude between students and pupils, nor between type of training and preference.

However, a chi-square test shows that overseas learners were much more likely to want to be told what to do than were the control group (p = <.001).

5.2.13. Difference between medical and everyday language.

Subjects were asked to say whether or not they found medical language very different from everyday language, the assumption being that if they did, specialised assistance in this area might be useful.

Table 43 (Vol.2, A.90) summarises the responses. Of the overseas sample, 102 (63.8%) students and 36 (66.7%) pupils indicated that they did find a difference; 58 (36.2%) students and 18 (33.3%) pupils did not. 4 students and 1 pupil did not answer the question.

Of the control group, 23 (50.0%) students and 4 (33.3%) pupils found a difference; 23 (50.0%) students and 8 (66.7%) pupils did not. 1 student did not answer the question.
There is no significant difference between the findings of students and pupils in either sample group. However, a chi-square test shows that overseas learners were more likely to find a difference between medical and everyday language than were control learners, the level of significance being somewhat greater than 1% \( (p = > .01) \).

5.2.14. **Areas of linguistic difficulty.**

In order to attempt to establish whether and in what fields overseas nurse trainees might have linguistic difficulties, subjects were asked several categorised questions. First, they were asked to say whether they had any difficulty in understanding a) patients; b) students in their own trainee-groups; c) senior staff; d) teaching staff. Secondly, they were asked whether they had any difficulties in speaking to anyone in these four categories. Thirdly, they were asked whether they had any difficulty with reading and/or writing. The answers to these questions are contained in a series of Tables, 44a-n, though only the main findings are discussed here since there are so many permutations of types and areas of difficulty that the numbers involved in this study are not sufficiently large to make an intra-category analysis.

**No difficulties/No answer.**

Table 44a (Vol.2, A.91) shows the number of subjects who had no difficulties at all and also those who did not answer the question.

10 overseas and 1 control student, and 3 overseas and 1 control pupil did not answer the question.

Of the overseas subjects, 45 (21.8%) stated that they had no difficulties at all. Of these, 38 (84.4%) were students and 7 (15.6%) were pupils.

Of the control subjects, 20 (35.1%) stated that they had no difficulties. Of these, 16 (80.0%) were students and 4 (20.0%) were pupils.

**Areas of Difficulty.**

161 (78.2%) overseas subjects and 37 (64.9%) control subjects stated that they had some kind of difficulty. Percentages for the overall figures in the sub-groups are based on these figures.

Of the 161 overseas subjects, 119 (73.9%) were students.
and 42 (26.1%) were pupils. Of the 37 control subjects, 30 (81.1%) were students and 7 (18.9%) were pupils.

**Difficulties in Understanding only.**

Subjects in this group were divided into two sections:

a) those who had difficulty in one category only
   (Table 44b, Vol.2, A.92.)

b) those who had difficulty in more than one category.
   (Table 44c, Vol.2, A.93).

Of the overseas sample, 37 (23.0%) subjects had difficulty in understanding only. Of these, 18 were in the single-category section and 19 in the multiple-category section. Of the 37, 27 were students and 10 were pupils.

Of the control sample, 13 (35.1%) had difficulty in understanding. Of these, 7 were in the single-category section and 6 in the multiple-category section. Of the 13, 9 were students and 4 were pupils.

**Difficulties in Speaking only.**

Subjects in this group were divided as above. Table 44d (Vol.2, A.94) gives the single-category responses; Table 44e (Vol.2, A.95) the multi-category responses.

Of the overseas sample, 9 (5.5%) subjects had difficulty in speaking only. Of these, 4 were in the single-category and 5 in the multiple-category section. Of the 9, 7 were students and 2 were pupils.

Of the control sample, 3 (8.1%) had difficulty in speaking. Of these, 2 were in the single-category and 1 was in the multiple-category section. 2 were students and 1 was a pupil.

**Difficulties with Reading and/or Writing only.**

Table 44f (Vol.2, A.96) summarises these responses.

Of the overseas sample, 9 (5.5%) subjects had difficulty in either reading or writing. None had difficulty in both. Of the 9, 1 had difficulty with reading; 8 with writing. 7 were students and 2 were pupils.

Of the control sample, 4 (10.8%) had difficulty in writing. None had difficulty in reading or both. Of the 4, 3 were students and 1 was a pupil.

**Difficulties in Understanding and Speaking.**

52 (32.3%) overseas subjects and 10 (27.0%) control subjects had difficulties in both these areas. Table 44g
(Vol.2, A.97) shows their distribution over the range of combinations.

Of the 52 overseas subjects, 39 were students and 13 were pupils. All 10 control subjects were students.

Table 44g does not show any clustering between the two extremes of difficulty, nor in either area of difficulty. Subjects are fairly evenly distributed throughout the Table.

**Difficulties in Understanding + Reading or Writing.**

11 (6.8%) overseas and 2 (5.4%) control subjects had difficulties in understanding and reading or writing. Table 44h (Vol.2, A.98) shows their distribution.

Of the 11 overseas subjects, 7 were students and 4 were pupils. Both control subjects were students.

**Difficulties with Speaking and Reading or Writing.**

4 (5.2%) overseas subjects had difficulties in these combined areas. No control subjects did. Table 44i (Vol.2, A.99) shows their distribution. Of the 4, 3 had difficulties with speaking and reading and 1 had difficulty with speaking and writing. All 4 were students.

**Difficulties in Understanding, Speaking and Writing.**

20 (12.4%) overseas and 3 (8.1%) control subjects had difficulties in these 3 areas. Table 44j (Vol.2, A.100) gives their distribution.

Of the 20 overseas subjects, 14 were students and 6 were pupils.

Of the 3 control subjects, 2 were students and 1 was a pupil.

**Difficulties in Understanding, Speaking and Reading.**

12 (7.5%) overseas subjects had difficulties in these combined areas. No control subjects did. Table 44k (Vol.2, A.101) gives their distribution. Of the 12, 8 were students and 4 were pupils.

**Difficulties in all areas.**

7 (4.3%) overseas and 2 (5.4%) control subjects had difficulties in all areas. Table 44l (Vol.2,A.102) gives their distribution.

Of the 7 overseas subjects, 6 were students and 1 was a pupil. Both control subjects were students.

Table 44m (Vol.2, A.103) draws all these Tables.
together, showing numbers and percentages for students and pupils in the various areas of difficulty for the purposes of general comparisons.

With regard to the overseas sample, the area in which the highest number of subjects had problems was that of Difficulty in Understanding and Speaking, being about one third of the total number of subjects who had any difficulties. The only other comparable figure was that of Difficulty in Understanding Only, being just under one quarter of the subjects. If the percentage-representation of students and pupils in these two areas are compared with those for the whole sample: (N = 219: S = 164 (74.9%): P = 55 (25.1%), it can be seen that they maintain the ratio very closely. Chi-square tests show that there is, in fact, no relationship between status and likelihood of difficulty in one or more areas.

With regard to the control sample, the area in which the highest number of subjects had problems was that of Difficulty in Understanding Only, being just under one quarter of the total number of subjects who had any difficulties. Likewise, the only other comparable figure was that of Difficulty in Understanding and Speaking, being just over one sixth of the subjects. Although percentage-comparison with the total sample: (N = 59: S = 47 (79.7%): P = 12 (20.3%) is not as close as for the overseas sample, students still predominate and chi-square tests again show no relationship between status and likelihood of difficulties.

Table 44m shows that the majority (20 = 54.1%) of control subjects had single difficulties, while the majority (106 = 65.8%) of overseas subjects had multiple difficulties. Chi-square tests show that overseas subjects are more likely to have difficulties in more than one area, the level of significance being somewhat greater than 2%. (p = >.02).

Table 44n records all instances of particular difficulties by area of difficulty and category.

100 (62.1%) overseas subjects had difficulty in understanding patients and 56 (34.8%) had difficulty in speaking to them, compared with 12 (32.4%) and 3 (8.1%)
control subjects respectively. (Control figures will appear in brackets after overseas figures). 58 (36.0%) overseas subjects had difficulty in understanding students in their trainee groups (21 = 56.8%); 43 (26.7%) had difficulty in speaking to them, (9 = 24.3%). 83 (51.6%) overseas subjects had difficulty in understanding senior staff, (10 = 27.0%); 73 (45.3%) had difficulty in speaking to them, (8 = 21.6%). 44 (27.3%) overseas subjects had difficulty in understanding the teaching staff, (4 = 10.8%); 42 (26.1%) had difficulty in speaking to them, (4 = 10.8%). In the study-field, 29 (18.1%) overseas subjects had difficulty with reading, (2 = 5.4%); 41 (25.5%) with writing, (11 = 29.7%).

With the exception of difficulty in understanding students in the same trainee group and with writing, all overseas figures are higher than the control samples, which would suggest that their difficulties are a function of their being overseas learners. Chi-square tests give the following results:

<table>
<thead>
<tr>
<th></th>
<th>DU</th>
<th>BS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>SS</td>
<td>&gt;.001</td>
<td>&gt;.001</td>
</tr>
<tr>
<td>TS</td>
<td>&gt;.01</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>R</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td>W</td>
<td></td>
<td>no significance</td>
</tr>
</tbody>
</table>

It is clear, therefore, that overseas nurses are much more likely to have difficulties than indigenes.

From the above figures it would seem that the areas of greatest difficulty overall for overseas learners are in understanding patients and senior staff, the area of least difficulty being in the classroom (Teaching Staff). Although the figures for Difficulty in Speaking are not as high as for Difficulty in Understanding, it is also clear that the category which causes most difficulty is that of the Senior Staff. Reading and writing appear to cause relatively few difficulties.

There would also seem to be a considerable degree of non-understanding between learners in the same trainee group and, though less, some measure of difficulty in speaking to each other.
Apart from the control sample's high response-rate in the Student category, both understanding patients and writing were areas of most difficulty. 12 control subjects had difficulty in understanding patients and this is not necessarily a function of the type of training, since 9 respondents were in General Training and 3 in Psychiatric.

**Inadequate Instruction.**

Subjects were asked to say whether they were ever asked to perform services for patients in which they had not been adequately instructed, on the assumption that, if such was the case, it might be a source of difficulty in communication.

Table 45 summarises the responses.

Of the overseas subjects, 149 (70.3%) stated that they were asked to perform such services, 63 (29.7%) were not. 7 subjects did not answer the question. Of these, 3 were students and 4 were pupils.

Of the 149 who were asked to perform such services, 116 were students and 33 were pupils. Of the 63 who were not asked to perform such services, 45 were students and 18 were pupils.

Of the control sample, 42 (71.2%) were asked to perform such services, 17 (28.8%) were not. Of the 42, 36 were students and 6 were pupils. Of the 17, 11 were students and 6 were pupils. Chi-square tests show that being asked to perform services for patients without adequate prior instruction is a function neither of status, nor of the type of training, nor of being an overseas learner.

**Suggested components for a specialised course.**

The list of components in the questionnaire was not intended as a definitive one but as a general indication of the areas in which subjects felt that they would like help.

Of the overseas subjects, 14 (6.4%) subjects did not think that a course was necessary. Of these, 12 were students and 2 were pupils. Of the 205 subjects who thought that a course would be helpful, 152 (74.1%) were students and 53 (25.9%) were pupils. Of these, 5 did not specify which, if any, of the components listed it should
contain. 200 subjects stated their preferences. The figures are listed below, together with those of the control subjects.

Of the control subjects, 22 (38.6%) did not think that a course was necessary. Of these, 15 were students and 7 were pupils. 35 (61.4%) thought a course would be helpful. Of these, 22 were students and 13 were pupils. 2 students did not answer the question. All 35 stated their preferences:-

<table>
<thead>
<tr>
<th>Preferred Components</th>
<th>O/S N</th>
<th>%</th>
<th>Control N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Listening to different English accents.</td>
<td>133</td>
<td>(65.5)</td>
<td>9</td>
<td>(25.7)</td>
</tr>
<tr>
<td>2. Explanation of and practice in using technical terms.</td>
<td>146</td>
<td>(73.5)</td>
<td>27</td>
<td>(77.1)</td>
</tr>
<tr>
<td>3. Information on medical symbols and abbreviations.</td>
<td>138</td>
<td>(69.0)</td>
<td>29</td>
<td>(82.9)</td>
</tr>
<tr>
<td>4. Practice in taking notes.</td>
<td>74</td>
<td>(37.0)</td>
<td>9</td>
<td>(25.7)</td>
</tr>
<tr>
<td>5. Information on the NHS and hospital personnel.</td>
<td>138</td>
<td>(69.0)</td>
<td>15</td>
<td>(42.9)</td>
</tr>
<tr>
<td>6. Language patients use when asking for things or discussing their illnesses.</td>
<td>125</td>
<td>(62.0)</td>
<td>14</td>
<td>(40.0)</td>
</tr>
<tr>
<td>7. Customs of the country where they affect a nurse's care of the patient.</td>
<td>150</td>
<td>(75.0)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Information on the British way of life generally.</td>
<td>147</td>
<td>(73.0)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(Not included in Control).

It can be seen from these figures that, with the exception of Component 4, the greater majority of overseas subjects would welcome assistance in all fields suggested.
particularly concerning the British way of life and customs of the country where they affect patient-care. Control subjects' concern was mainly regarding the technical language and the use of symbols and abbreviations, percentages in both instances being higher than those for overseas subjects. Nevertheless, a substantial minority of control subjects said that information both on the NHS and hospital personnel and on language patients use when asking for things or discussing their illnesses would be useful.

In neither the case of overseas or control subjects was the desire for a course related to status. However, chi-square tests show that overseas subjects were much more likely to want a course than control subjects: \( p = <.001 \).

5.2.15 **General Comment.**

**Response to the Questionnaire.**

Although only 219 questionnaires were analysed, half of the 488 were actually accounted for. Several PNOE's commented: "You're lucky to get so many. Nurses have had so many questionnaires recently that they're fed up with them!" Furthermore, there is a certain amount of suspicion on the part of overseas learners regarding such surveys, as Sen (9, p.8) observed in her study:

"In spite of efforts ... to reassure students that the survey was confidential ... there continued to be some suspicion about the motives of this enquiry. This was corroborated later by the anxious questions put to interviewers ...".

Anderson, in a survey on the role of the nurse (10, p.15), also recorded a high non-response rate for overseas nurses. The extent of the suspicion and fear is somewhat disturbing.

Two other factors may have influenced the response-rate. Firstly, 5 PNOE's wrote to acknowledge receipt of the questionnaires and to confirm that they had been distributed. Thus, while there is no reason to suppose that the other 23 batches were either not received or not delivered, there is no objective evidence that they were. Secondly, as Sen (9, p.161) points out, the questionnaire as a research instrument is known to have major limitations and these are increased when dealing with overseas subjects.
Reluctance to participate, either from suspicion or unwillingness to admit to problems, and unfamiliarity with the genre itself might well have had some bearing on the response-rate.

In this study several subjects did not always fully complete the questionnaires but this could often be attributed to inherent faults in the design of the questionnaire or wording of the questions. With that proviso, however, responses to the questions show a high degree of willingness to co-operate and readiness to admit where difficulties exist.

One question often asked concerning Questionnaires is: Can one be sure that the responses were genuine and honest? Responses to this questionnaire would suggest that, on the whole, they were since 10 overseas subjects added personal comments and 8 wrote letters. (See Appendix XI, Vol.2, A.106-111). Many answers, both overseas and control, carried qualifying remarks or provisos.

Construction of the Questionnaire.

On analysis of the Questionnaires several omissions and faults in design emerged. These could have been put right had a pilot study been conducted but lack of time precluded this. Moreover, the Participant Observation forms the major part of the survey. Notwithstanding this, the following points should be made:

Medium of Instruction in Schools.
The question might have yielded more detailed information had a sub-category: "In which subjects?" been added.

Educational Certificates gained.
Subjects were not asked to state their Grades (though several supplied them). This was partly influenced by the previously-known suspicion of such surveys. Analysis shows that had this question been asked, more accurate information on pupils with otherwise acceptable certificates might have been available.

Audio-Visual Aids/Teaching Techniques.
The use of Radio and Television in schools was not included since it is known not to be used in Schools of Nursing. However, had it been included, more detailed information on familiarity with any type of audio-visual aid would have
been available. Two subjects supplied "Radio", but these were omitted. The question should also have been asked, particularly with reference to Schools of Nursing, as to whether subjects found any difficulties arising from their use. One or two questions should have included a "None" category, particularly Prior Knowledge of Public Health Services. (Table 31a, A.73). This might have obviated the "No Answer" response, though 18 overseas subjects supplied this information themselves.

Some questions could have been open-ended but this does lead to problems of analysis where time is of the essence. The major omission here, however, was in the question relating to Components in a possible Course. As it stands this question is too narrowly based and, to a certain extent, biased towards what it was felt might be useful. For the rest, it was based on what anecdotal evidence suggests would be useful. It was also felt that the responses to the question concerning difficulties with Reading or Writing would indicate whether help with written work would be useful and that the responses to the questions concerning Difficulties in the spoken field, whether help with Spoken English would be useful. As Appendix XI (A.106-111) shows, several subjects, in fact, suggest that help with Spoken English would be useful and other comments made, which will appear later, substantiate this. However, the question itself does not allow for this and the question on Difficulties in Understanding and Speaking do not supply adequate information as to the cause of the difficulties.

Recording of Data.

Although in several instances data have been recorded by area, status and type of training, figures were often too small in any one cell to make meaningful comparisons. However, such comparisons often proved to be unnecessary in the overall analysis, though in the later discussion they have been made wherever this is necessary and possible.

Social Class.

Although "father's occupation" for overseas subjects has been equated with the Registrar General's Classification of Occupation, class-structure as such is not so prevalent in
many developing countries as it is in Britain. Middle-and working-class terminology is not used either in fact or in the literature. "Elite" is usually used in the literature to define the socio-economic "middle" class of developing countries. However, the social prestige attached to particular occupations is roughly equatable and, therefore, for the purposes of comparison, overseas subjects have been divided into "middle" and "working" class.
REFERENCES AND NOTES.


2. Private communication.


4. All chi-squares were computed on raw data. Lowest level of confidence = $p = \leq .05$.


6. This apparently happens frequently with older women whose children are growing up. The woman wants a job which is satisfying but carries no great responsibility. Private GNC communication.

7. Although this question was included in the control-group questionnaire it was irrelevant since the object of the question was to determine how many and to what extent overseas learners had an opportunity to acclimatise to life in Britain before commencing training. Control-group data have therefore been omitted.

8. For chi-square computation, figures for Psychiatric and Mental Subnormality Training were combined.


5.3. Results of the Participant Observation.

5.3.1. The Classroom.

5.3.1.1. Type of activity.

Classroom activities in nurse education may be divided into four categories:

i) lecture. This takes the traditional form and may or may not include learner participation. It is usually used for the introduction of new theoretical material.

ii) demonstration. This is concerned with a particular practical nursing procedure and includes the discussion and handling of the appropriate equipment. The session often begins with a description, in lecture form, of the reasons for the procedure, its execution, its expected effect on the patient and its relationship to the overall pattern of treatment. During this stage a certain amount of revision is usually done regarding the nature of the illness or the circumstances in which such a procedure is or might be necessary, related anatomy and physiology and so on. Nurse learners might volunteer information or ideas at this point. The second stage involves demonstration of the functioning and/or use of the equipment and the execution of the procedure either on a dummy or, where practical, on a volunteer nurse learner. After demonstration and further discussion learners are expected to handle the equipment and to familiarise themselves with its use.

iii) testing. This is concerned mainly with either written tests or with assessment of attainment in practical learning. In the latter the learner is asked to prepare a trolley or tray for a particular procedure and is then tested on his knowledge of the functioning and use of equipment, the purpose, the expected effects and the side-effects of the procedure, the circumstances in which it might be performed and preparation of the patient for it.

iv) other. Under this heading falls anything which does not fit into the above three categories and includes such activities as the allocation of project-work, question and answer (Q/A), revision sessions and practical revision
Table 4b (Vol.2, A.113) summarises the types of activity observed and/or recorded on tape, the type and year of training of the learners (= type of study-block) and their status.

A total of fifteen activities were observed: of these 6 were lectures; 4 were demonstrations; 1 was a testing session (assessment) and 4 were other activities, namely: 3 Q/A revision sessions and 1 allocation of project-work.

Of the learner groups studied, 4 were in General Training, 4 were in Psychiatric and 2 were in Mental Subnormality Training.

Regarding Status, 6 groups were student-nurses and 4 were pupil-nurses. Two groups were observed twice.

With respect to level of training, 2 groups were at the Introductory stage; 5 groups were at the end of their first year of training and 3 groups were at the end of the second year. There were no third-year students or second-year pupils.

Two sessions, a lecture and a Q/A revision session, both involving students in General Training at the Introductory stage, were not recorded. This was inadvertent and was due to the observer's unfamiliarity with the recording machine. Classroom participation was, however, recorded on the data collection sheet.

In the case of the allocation of project-work, involving first-year student-nurses in Mental Subnormality Training, the session was tape-recorded but the learner-participation was not as this proved too difficult. Firstly, the tutor moved from group to group as and when needed; secondly, the learners talked to each other and the tutor at one and the same time and thirdly, the tutor left halfway through the session to interview the Press.

The testing-session was tape-recorded but no attempt was made to record classroom participation on the data collection sheets. Firstly, it was felt that any form of note-taking might upset the candidates and observer and machine were kept as unobtrusive as possible. Secondly, by the nature of the exercise, learner participation was
compulsory.

Table 47 (Vol. 2, A.114) shows the distribution of the learners observed in classroom participation by origin, type and level of training and status.

A total of 146 subjects were involved: of these, 99 (67.8%) were students and 47 (32.2%) were pupils. 70 (49.9%) were indigenes and 76 (50.1%) were overseas learners. 91 (62.3%) were in General Training, 34 (23.3%) were in Psychiatric and 18 (12.3%) were in Mental Subnormality Training. 18 (12.3%) were at the Introductory Stage, 59 (40.4%) were at the end of their first year of training and 69 (46.3%) were at the end of their second year.

Thus, indigenes and overseas learners were almost equally represented. Level, type of training and status were all reasonably well represented, as were classroom activities.

5.3.1.2. Type of learner participation.

Examples. (T = Tutor; L = Learner)

Seeks information.

The learner seeks to establish a fact or acquire information not directly related to the topic:

T: These are the suprarenal glands.
L: That's for hormones, isn't it?

(Topic: Anatomy of the kidney).

Seeks clarification.

The learner seeks clarification of information directly related to the topic:

L: If you wanted to set up a tray for giving oxygen and you were just going to use that Venterial, do you leave the other things off?
T: Yes, you would know your patient, wouldn't you? This is the point.
L: Yes. In the examination, though, if you were told to do oxygen therapy, do you need to put all of these on or just - can we just use that one?

Giving information.

The learner offers information from her own clinical experience or study.

L: Just before you apply the oxygen mask you flush it out with oxygen first.
T: Not necessarily, because you're wasting ...
L: It was done at - Hospital.
T: Was it?

Student idea.
The learner has an idea arising from information given:
T: If somebody was diabetic and the blood sugar was very high, then some of the sugar would be excreted into this liquid which is going to become urine ...
L: So the kidney attempts to cure diabetes on its own - in a way it's trying to fight the effects.
All other categories are self-explanatory.
Table 48 (Vol.2, A.115) shows the total number of learner-participations in the various categories by type of training, status and origin.
Two categories (see Vol.2, Appendix IX, A.38) were not used by learners:
seeks clarification (language) and fails to follow directions.
Follows directions was used in one instance only, during a lecture on Insulin Therapy, where learners were being instructed in the use of a special syringe. The tutor dealt with each learner individually and it was not always possible either to see or hear what passed between the two. This category has therefore been omitted.
Table 48 shows that the most frequent type of participation was the answering of questions and these were much more likely to be put to the class as a whole than to individual learners, the total number of instances being 278 and 109 respectively. Furthermore, when questions were put to specific learners, they were more often addressed to indigenes than to overseas learners, the total number of instances being 73 and 37 respectively. To what extent this bias was created by the presence of an observer is not known, but neither tutor nor learners knew what was being recorded or that a record as such was being kept.
In order to determine to what extent overseas learners participate, either voluntarily or when induced, in relation to indigenes, the figures in each category for both groups were compared.
Tables 49a and b (Vol.2, A.116 and 117) show the expected and actual participation percentage rates, based
on the difference in numbers between indigenes and overseas learners a) overall and b) by type of training and status, where this is possible. The expected percentage assumes that the rate of participation by indigenes and overseas learners would be equal.

Categories aQs and faQs have been omitted from these Tables since participation in aQs is initiated by the tutor, not the learner.

Pupils in Psychiatric Training have been omitted since they were all overseas learners and therefore no comparison could be made. There was no classroom participation recorded for students in Mental Subnormality Training.

As Table 49a shows, overall voluntary participation by overseas learners was well below the level which might have been expected in all categories. Percentages have been omitted from s.i. and g.i. for pupils in Mental Subnormality Training since the numbers of instances of participation were too low for percentages to have much meaning.

Table 49b shows that, on the whole, there was more entirely learner-initiated participation (s.i., s.c., g.i., st.i.) among students than among pupils, though indigene pupils in Mental Subnormality Training sought clarification of content a number of times. Overseas pupil-learner participation in these four categories was negligible.

However, overseas student-learners in General Training sought clarification of content almost as often as indigenes and well up to the expected level (-7.0%) and overseas pupil-learners in General Training were almost as active as indigenes in the aQg category and well up to the expected level (-3.6%). For the rest, Table 49b reflects the overall findings in Table 49a.

As regards the aQs category, participation is induced. Indigenes were asked a total of 73 questions and overseas learners 37. Of the indigenes, 10 (13.7%) failed to answer the question (i.e. by remaining silent) and of the overseas learners, 11 (29.7%). Indigenes are therefore more likely to answer questions put to them specifically than are overseas learners and a chi-square test shows
this to be significant at the 5% level (p = <.05).

Figures for the three types of training were as follows:

<table>
<thead>
<tr>
<th></th>
<th>G</th>
<th></th>
<th>Pm</th>
<th></th>
<th>MS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>aQs</td>
<td>30</td>
<td>17</td>
<td>8</td>
<td>2</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>faQs</td>
<td>7</td>
<td>10</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>

5.3.1.3. Observations from transcripts of tape-recordings relating to classroom activities.

The total number of tutors observed was 13. Of these, 11 were indigenes and 2 were Europeans - one Eastern and one Western.

Of the indigenes, 8 had regional accents. Of these, 4 had marked accents; 4 did not. 5 spoke slowly with clear pronunciation; 3 included glottal stops and dropped initial and/or final consonants. 3 indigenes spoke with Received Pronunciation, clearly and slowly. Both Europeans had marked accents.

a) Tutorial Style.

According to Joos (1, p.11), there are five styles of discourse: frozen, formal, consultative, casual and intimate, each with its own distinguishing features and its particular role in communication. Each style has its own markers, or code-labels as Joos calls them (1,p.27), which serve to identify the style as well as carrying part of the message. Such markers, which carry both social and linguistic implications, are used and recognised automatically and unconsciously by the mother-tongue population.

Consultative Style.

This is a colloquial style and is the base-line for all others. It is the one used most freely and easily by the community.

"... The pronunciation is clear but does not clatter. Its grammar is complete but for an occasional anacoluthon, [a word or sentence lacking grammatical sequence], the semantics is adequate without fussiness". (1, p.33).

Words used have their consultative meanings, which are known to the listeners. If not, information is either supplied or sought. Other styles add to or subtract from this baseline, according to their individual requirements.

The two salient features of the consultative style are:

1. the speaker supplies background information. He does
2. The listener participates fully. Background information is supplied as required, the listener's participation keeping the balance between too little and too much. The speaker, therefore, does not compose more than two or three seconds in advance because the listener's intervention influences the speaker's direction.

E.g. (Learners' contributions are bracketed).

T: "I didn't give you one, I'm afraid I missed it. I'm sorry: a sequestrum. Do you know what a sequestrum is? (Chorus) What is it? (Chorus) Oh yes, you all know about it, then. Do you know how to spell it? (Yes) Well I'm not going to write it on the board for you, then".

Markers for this style include the listener's interjection, use of the all-purpose noun thing, or the all-purpose preposition on and so on. (1, p.28).

E.g.

T: "What other things did we say were good for healing?"

This style is used between strangers with a shared language but whose "... personal stock of information may be different". (1, p.23).

Casual Style.

This style is marked by its wide use of slang and ellipsis, or omission (1, p.24). Joos here is using the word slang in its strict sense, not in the popular and usually pejorative sense. That is, terms which are used widely but which are in vogue for a short time only - usually for a year: For example: "into" (meaning "concerned with" or "engaged in") - or words or phrases used in special senses. Some slang expressions survive to become Standard English. For example: "to be in the know" was slang in the sixteenth century but is now Standard English. (1, p.24).

The use of ellipsis constitutes the main difference between consultative and casual grammar. Ellipsis may involve one or more words or may be merely phonological. For instance, "Any more patients?" is acceptable in casual grammar but: "Are there any more patients?" would be required for consultative. Similarly: "D'you want to?" and "Do you want to?" Ellipsis is stable historically and
some elliptical forms have been promoted. For example: "Thank you", (for: "I thank you"), once casual grammar, is now formal, while "thanks" (for: "many/much thanks") is now consultative.

The salient features of the casual style are:
No background information is given. It is assumed that the hearer will understand without explanation, since the use of slang and ellipsis intimates that the listener is an insider and therefore in possession of all the relevant information. The casual style is used for friends, acquaintances and insiders and by its use it excludes unwanted outsiders.

Intimate Style.
This style is used within an intimate group, usually a pair. Its use indicates total unguardedness, absent in public relations, and this style is therefore not relevant in this context.

Formal Style.
This style is characterised by the absence of ellipsis. The grammar is elaborate and the pronunciation explicit (1, p.37). The semantics is particular, words having technical meanings.

The salient features of the formal style are:
There is no participation. The function of this style is informative and, because of the non-participation, what is to be said must be planned in advance. It is therefore marked by its detachment and cohesion. The tenor is usually impersonal, with no reference to self.

The formal style is used to address a group too large for the consultative style, to open speech with strangers and to overcome or obviate embarrassment in a consultative situation.

The markers used indicate to the listeners that they must wait until invited to participate (1, p.36). For example: "Would anyone like to ask a question?" Another is the rhetorical question: "Now how does this affect the patient? Firstly ...

Frozen Style.
The functions of the frozen style are for print and for declamation. (1, p.39). Good frozen style, according
to Joos, is defined by the absence of any authoritative intonation in the text and by the fact that the reader or listener may not cross-question the author or speaker.

During discourse, according to Joos (1, p.19), a speaker is permitted to move from one style to another but only into a neighbouring style. It is anti-social to move two or more steps in a single shift because such a move may be disconcerting and confusing for the mother-tongue listener and very misleading to the foreigner.

9 of the 12 teaching sessions were examined in the light of Joos's description to determine which style appeared to be most common in Schools of Nursing classrooms. Three sessions were excluded: two because no indigenes were present and this factor, it was felt, might possibly have influenced tutorial style; the third because there were no overseas learners in the group, with a similar possible effect on tutor style.

Of the 9, 2 were wholly in the consultative style, the classroom activities being a demonstration and a Q/A revision session. One session moved from the consultative to the formal, with one or two instances of frozen style, the classroom activity being demonstration. 6 sessions alternated between the consultative and formal styles, with varying length and frequency. The classroom activities were: 1 lecture/demonstration; 4 lectures and 1 discussion.

Thus:

Session 3.
formal: (F) - (introductory) 300 words
Consultative: (C) - (remainder) 3,500 (T) = 3,200
(L) = 360

(Figures relate to the number of words used, being an approximate but careful count).

Session 4.
F (introductory) 90
L answers question 2
F 80
C (T - initiated) 34 (T = 24; L = 10)
F 840
L answers question 1
F 1,880
<table>
<thead>
<tr>
<th>Session</th>
<th>C (L-initiated)</th>
<th>59</th>
<th>(L = 9: T = 50)</th>
<th>F</th>
<th>860</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>324</td>
<td>(T = 310: L = 14)</td>
<td>F</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>418</td>
<td>(T = 400: L = 18⁺)</td>
<td>F</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>1,028</td>
<td>(T = 1,010: L = 18⁺)</td>
<td>F</td>
<td>59</td>
</tr>
<tr>
<td><strong>Session 5.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C (introductory)</td>
<td>480</td>
<td>(T = 400: L = 80)</td>
<td>F</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>C (L-initiated)</td>
<td>155</td>
<td>(L = 115: T = 40)</td>
<td>F</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>C (L-initiated)</td>
<td>11</td>
<td>(L = 5: T = 6)</td>
<td>F</td>
<td>350</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>265</td>
<td>(T = 105: L = 160)</td>
<td>F</td>
<td>340</td>
</tr>
<tr>
<td></td>
<td>C (L-initiated)</td>
<td>55</td>
<td>(L = 30: T = 25)</td>
<td>F</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>C (L-initiated)</td>
<td>35</td>
<td>(L = 30: T = 5)</td>
<td>F</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>C (L-initiated)</td>
<td>770</td>
<td>(L = 220: T = 550)</td>
<td>F</td>
<td>770</td>
</tr>
<tr>
<td><strong>Session 6.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F (introductory)</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>380</td>
<td>(T = 280: L = 100)</td>
<td>F</td>
<td>280</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>47</td>
<td>(T = 40: L = 7)</td>
<td>F</td>
<td>290</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>370</td>
<td>(T = 290: L = 80)</td>
<td>F</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>1,520</td>
<td>(T = 890: L = 630)</td>
<td>F</td>
<td>275</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>460</td>
<td>(T = 380: L = 80)</td>
<td>F</td>
<td>220</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>15</td>
<td>(T = 10: L = 5)</td>
<td>F</td>
<td>15</td>
</tr>
<tr>
<td><strong>Session 7.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C (introductory)</td>
<td>38</td>
<td>(T = 35: L = 3)</td>
<td>F</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>290</td>
<td>(T = 170: L = 120⁺)</td>
<td>F</td>
<td>520</td>
</tr>
<tr>
<td></td>
<td>C (T-initiated)</td>
<td>295</td>
<td>(T = 155: L = 140)</td>
<td>F</td>
<td>110</td>
</tr>
</tbody>
</table>
Table 50 (Vol.2,A.118) shows the percentage of tutor/learner participation for all activities.

As might be expected, lectures (Sessions 4, 5, 6 and 9) were tutor-dominated, the tutor participation levels being 98.8%, 80.0%, 78.1% and 93.2% respectively. On the other hand, during the consultative periods of the discussion (Session 7) learners participated more than the tutor, though tutor participation was higher overall. Session No.3 shows that although the major part of the session was conducted in the consultative style, verbal participation by learners was not great, being 10.3%. There was, however, a considerable amount of non-verbal participation (laughter and giggling) and several tutor-contributions were extended answers to learners' questions. The tutor-domination in Session 8, (93.9%) is somewhat surprising since the session
was a demonstration of a practical procedure and the consultative style might therefore have seemed more appropriate. However, the group was a large one, with 29 learners crowded round one small trolley, and under these circumstances the tutor might have felt that the formal style was preferable.

If the learner participation levels in the two sessions conducted wholly in the consultative style (Sessions 1 and 2) are compared with those for mixed sessions (see Table 50, A.118), it will be seen that they are 5th and 3rd highest respectively. It does not necessarily follow, therefore, that sessions conducted wholly in the consultative style will elicit greater learner participation.

Moreover, if the percentage of formal to consultative style for the mixed sessions is compared, it will be observed that consultative more often takes precedence over the formal:

<table>
<thead>
<tr>
<th>Session</th>
<th>F</th>
<th>%</th>
<th>C</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (L/D)</td>
<td>360</td>
<td>7.8</td>
<td>3,500</td>
<td>92.2</td>
</tr>
<tr>
<td>4 (L)</td>
<td>4,000</td>
<td>68.2</td>
<td>1,866</td>
<td>31.8</td>
</tr>
<tr>
<td>5 (L)</td>
<td>1,425</td>
<td>44.6</td>
<td>1,771</td>
<td>55.4</td>
</tr>
<tr>
<td>6 (L)</td>
<td>1,335</td>
<td>32.3</td>
<td>2,792</td>
<td>67.7</td>
</tr>
<tr>
<td>7 (D.G.)</td>
<td>2,320</td>
<td>38.4</td>
<td>3,728</td>
<td>61.6</td>
</tr>
<tr>
<td>8 (D)</td>
<td>1,205</td>
<td>69.7</td>
<td>525</td>
<td>30.3</td>
</tr>
<tr>
<td>9 (L)</td>
<td>730</td>
<td>18.4</td>
<td>3,246</td>
<td>81.6</td>
</tr>
</tbody>
</table>

As these figures show, in only two instances (Sessions 4 and 8) did formal style exceed the level of consultative. It seems evident, therefore, that the style most likely to be adopted by tutors, whatever the classroom activity, is the consultative.

Although figures for learner participation were low (see Table 50, A.118) in relation to tutor participation, the frequency of the former was often greater than the figures would suggest. The cause for this would seem to be that learner-responses tend to be in the casual style, with almost total ellipsis, and tutors often repeat learner responses.

For example:
Session 1. (Learner responses are bracketed).

T: Now what other things did we say were good for encouraging healing? (Cod liver oil). Cod liver oil, yes. (Nicotinic Acid), Nicotinic Acid. (Voice - inaudible on tape) Er - Vitamin B and Pucilline Cream - (Heat and circulation). Yes, what was the last one we mentioned? The rather bizarre one?... (Cicatrin) Cicatrin - that's a good one, Cicatrin. What do you say? (Egg and Complan) Egg and Complan ... why's that? (High protein) High protein compounds, yes.

Session 2.

T: ... two gowns and ... (Gloves) Yeah, if you want gloves you can wear gloves but I never wear gloves. What's the important thing to do to them? (Label them) Label them. Put labels on which won't come off.

Session 5.

T: I'm sure you've all looked out for one before now. (When you're passing a naso-gastric tube?) Yes, when you're passing a naso-gastric tube.

Session 6.


Session 8.

T: How many types of traction do you know? (Er - skin and skeletal) Yes, skin traction and skeletal traction ... if it's skeletal what do we employ? (Bones, skeleton) Yes. The skeleton, yes.

The above examples were all responses from indigene learners. Overseas learners tend to make contributions or give answers in the consultative or formal style:

E.g.

Session 1.

T: Come on, what is important in hearing? That's what I want to know. (It is important in communication). Important in communication, yes. (F)

Session 2.

T: You've got your swabs, your pins - now, procedure. What is the procedure when a patient dies, Nurse - ? (The first procedure - this is assuming that the patient is not of the Jewish or Hindu faith - the first procedure is to lay them out in a reasonable position ...) (F/C)

Session 3.

T: Vaso ... referring to ... (I was thinking about baths. It opens the pores and cleans the skin. But, I mean, the pores close up again, and you still have the dirty water. Are not baths not hygienic?) (C/F)
Session 6.
T: What would cause lots of lacerations, then, or incisions? Give me an example. (Indigene: gravel) (Overseas: A man who hits the windscreen of his car and the windscreen being of laminated glass, it scrapes his face down the front). (C)

Though not always: E.g.

Session 4.
T: What do you think is the composition of urine?
(Indigene: urea) (Overseas: some salt) (Cas)

Nevertheless, examples of the latter were rare for overseas learners.

During the seven sessions where tutorial style shifted from formal to consultative, there was a total of 28 shifts. Of these, 23 were tutor-initiated and 5 were learner-initiated. All 23 tutor-initiated shifts were the result of questions asked, which related to data previously given or learnt and which signalled the end of a formal period. For example, one session was concerned with the First Aid treatment relating to various types of wounds. The session began with a formal recapitulation of the five types of wounds and their possible causes, during which time learners were not expected to participate. The end of the formal period was marked by the question:
T: "Lacerated - another word for laceration is what?"

A period in the consultative style then followed, during which more detailed information regarding wounds was elicited from or offered by learners. Termination of this period was again signalled by the tutor:

And so our principle - our first principle to save life would be concerned with the control of haemorrhage.

Regarding learner-initiated shifts, 2 were caused by the interpolation of a student-idea, 2 by learners seeking clarification and 1 by a learner seeking information, none of the learners involved either requesting or being invited to speak.

For example:

Student idea. (Learner-participation is bracketed).

T: If somebody was diabetic and the blood sugar was very high, then some of the sugar would be excreted into this liquid which is going to become urine once these products have been reabsorbed ... (so the kidney sort of takes over when something else - the 'kidney
attempts to cure diabetes on its own, in a way it's trying to fight the effects) Yes, if - er - that's right.

Seeking clarification.

T: So it's by pressure through the blood capillaries through the - er - walls of this - er - nephron that filtration occurs ... (Are you saying in effect that it kind of squeezes most of the liquid out ...) Yes.

Seeking information.

T: But with sinusitis that is a good thing to do, because then you shrink the mucous membrane and you hope that the opening into the nose will be cleared by the use of these nasal drops ... (Does that apply to hayfever as well?) Yes ...

All learner-initiated shifts were caused by indigenes.

Although the formal and consultative styles were definable by the manner of presentation and the expected or actual participation-level of learners, no tutor used the style corresponding to all the time. There were many instances of consultative being used with the formal presentation and vice versa; casual was often interspersed with consultative during a period of consultation and occasionally formal, consultative and casual all occurred within a few sentences or even within the same sentence.

Thus:

Session 1.

Consultative and casual (3) freely mixed.

E.g.

T: What did you say? Do you remember? Yes/ - You just jumped the gun a bit. /And, yes, cleaning out with an anti-sloughing agent for encouraging the granulation. (C/cas/C)

C Have any of you mentioned about infections? No you haven't. /Wish you would. (C/Cas).

C Come on! Nurse - ? (The organ of hearing). The organ of hearing. All right. /Now you can take up/a bit/now, Nurse - once you get in your/bit/about two parts. (Cas/C/Cas/C/Cas/C).

C And, of course, you know/common or garden/catarrh. (C/Cas/C).

Session 2.

Mainly consultative, with some casual.

E.g.

T: You've got the scissors, you've got the shaving/stuff/, you've got the/stuff/for the head, you've got - there's something missing here. (C/Cas/C/Cas/C).
... so you'll know which patient you've got./Okay?/
C That's quite good. (C/Cas/C).

Well, the first thing you've got to do is use this
C spanner, which is always hanging onto your/oxygen./
You then open it ... (C/Cas/C).

Yes. Well,/hang on/we'll take them off the other
C trolley. (C/Cas/C).

Session 3.

Formal, consultative and casual freely mixed, though
the presentation becomes progressively consultative.
E.g.

T: If you always relate the marks on the syringe to the
F number of units you are going to/com e unstuck/ when
you have to use perhaps one of the ordinary/mill./
syringes. Therefore,you must understand the
principle ... (C/Cas/C/Cas/C).

... the patient has the diet which comes up from the
C kitchen or he collects it. But how do you prevent
him from/toddling/over to the canteen and/stuffing?
That is a problem, isn't it? (C/Cas/C/Cas/C)

...if they [the patient] haven't got a very clean
C mouth - if they are/all gunged up - Ugh! /they lose
their appetite. (C/Cas/C).

It is painful, it causes the individual to walk
C incorrectly, but, more than that, the pressure and
the damage to the diabetic skin does spell danger,
C because the skin is not as healthy, particularly if
the diabetic is a little/dodgy/in his control. It
therefore breaks down. (F/Cas/F).

If you give them a sun-bath, no matter whether you
C expose one inch of toe or a lot of them, you will/
cook them like a lobster. /So they will not be too
C happy. (C/Cas/C).

If you get up suddenly ... your blood-pressure goes
down/into your boots/and you can feel a bit dizzy ...
C (C/Cas/C)

... if you soak in the bath ... then, yes, you get
C all the/gunge - all that mucky stuff/on the top of
the bath ... and you get a/tidemark/(C/Cas/C/Cas)

It's the same with your body. You/dunk/it, soak it,
C scrub it - /hang it out to dry/almost. Don't forget,
you're virtually drip-dry, aren't you?(C/Cas/C/Cas/C)

C Could we please have some essays - a half-hour/
sprint across the paper? (C/Cas)

Session 4.

Mainly formal, with some consultative. Very little
casual,
E.g.

T: ... all the organs are one against the other. In
fact, the left kidney - the right kidney is slightly lower than the left and the liver/sort of/lays over it. (F/Cas/C)

C This one is the renal vein. /O.K.?/ (F/Cas)

F The bladder walls are made up of a serous membrane on the outside. They are situated over the intestines so/you want/the intestines to/sort of/glide over without friction. (F/C/F/Cas/F).

C (... but what happens in the case of peristalsis?)/Peristalsis./ It is an involuntary movement under the control of the autonomic nervous system. (Cas/F)

Session 5.
Mainly formal/consultative mixed, with some casual.

E.g.

T: If the patient starts to swallow, then they may be swallowing blood that's going down the back of the throat. (C)

F Now a cold starts with a/sort of/runny nose. It then goes on to/secondary infection of the mucous membrane and/you get that/awful sort of/thick discharge ... (F/Cas/C/F/Cas/C)

C When the patient wakes up, what instructions must you give him? You know. /Hang on a minute. Someone else?/ What mustn't they do? (C/Cas/C)

F You look in the mirror and there you are, you've got two/black eyes/your nose is/sort of all over the place/and yet this patient is very often - /I must say, they get the/short end. (C/Cas/C/Cas/Cas/C)

Session 6.
Formal and consultative mixed, with a little casual.

E.g.

T: And if it be a punctured wound/as I said, there's very little perhaps sign of haemorrhage on the surface of the wound ... (F/C)

F But you obviously can't apply a pad and bandage over the top of the sliver of glass .../which is penetrating the wound. What, therefore, do you do?/ (Break the arrow and shout!) Break the arrow ... Robin Hood larks, old boy! We've got past bows and arrows. We're/into/other things. (C/F/Cas/C/Cas/C/Cas/C).

F So an incised wound is usually a clean wound, a cut caused by some sharp instrument,/knife, razor blade/that type of thing. (F/Cas/C)

F And they are probably in such a state of anxiety and panic to do the right thing that they tumble words out and the other person at the other end [of the telephone] says ... (C)

Session 7.
Consultative §5 §je throughout, freely mixed with casual.
E.g.

T: It was very rare that we could talk to the female nurses and that sort of thing ... It was all very/
C monastic/and so forth. (C/Cas/C).

C I mean, we wouldn't agree with them to/run the
doctor down/, for instance, would we? (C/Cas/C).

C It was very, very difficult but it was a beautifully
[sic] place, an ideal/set-up/. This is a problem,
Isn't it, to get them to mix. It seems you have a/
bit of a stud-farm/up there. That's what you're
making it sound like ... (C/Cas/C/Cas/C).

F ... and they/concocted some yarn/which, when I
heard about it, nearly made/my hair stand on end/
you know. (C/Cas/C/Cas/C).

C ... getting out of hospital/sausage-machine/into a
therapeutic community. (C/Cas/C).

Session 8.
Mainly formal, with some consultative and a little
frozen. Very little casual.

E.g.

T: Come on!/Tell us. What is it? (Cas/C)

C ... and they don't get any less discomfort when you
come to take off the plaster, when the traction has
either got to be renewed/or at its completion. (C/F).

F This is to support the limb, and we'll show you how
this is used in the demonstration. Also, we will
need means of applying the traction/a force by which
the leg is being drawn towards the bottom of the bed
... and the weights are attached to the lower part
of the limb to cause a counter-traction,/thereby
drawing the fractured ends of the limb outwards, so
that healing is at its optimum fixation; /so that
healing can take place. (C/F/Frozen/F).

... the amount of weight ... is determined by the ...

F surgeon./ Usually, on an average, it's about 7 lbs.
but this can vary ... (F/C).

Session 9.
Formal/consultative mixed. Very little casual.

E.g.

T: Now there is a certain pattern in the examination of
the patient./The doctor doesn't do this haphazardly
and start from any part./There is a certain order.
(F/C/F).

F ... or if the eye remains fixed to one side and the
patient/can see through the other. What's the
condition called? (F/C).

C What is the function of the facial nerve? (It is
sensory to the neck) Not neck (To the face). Not
face./Well, it is mainly motor./It has sensory fibres
supplying the anterior part of the tongue, so this' is tested by putting/with a dropper from a bottle acid solutions ... (F/Cas/C/F/C).

Good./ Are you all quite happy about that?/Facial and auditory nerves./Now we come to Nerves 9 and 10 ... (Cas/C/Cas/C).

From the above examples it can be seen that, on the whole, tutors remained within permitted limits of style-shifting, never moving more than the neighbouring style in one step. The most frequent shift was from consultative to casual and back. Three tutors used nothing but consultative/casual Žty|œ (Sessions 1, 2 and 7). The tutor of Session 9 used formal, consultative and casual Žty|œ and the tutor of Session 8 used casual, consultative, formal and frozen.

The tutors of Sessions 3, 4, 5, 6 and 9 all shifted from formal to casual in one move, though none of them very often: Tutors 3, 6 and 9 once, Tutor 5 four times and Tutor 4 five times.

The tendency of learners to answer in the casual style has already been noted and examples of elliptic responses given. In addition to the near-universal use of ellipsis, at least by indigenes, there were several instances of the use of slang and/or highly allusive language. For example:-

Session 4.
T: If you put a drop of urine on a blue litmus it will turn red. (Flags out!) Pardon?

Session 6.
T: What, therefore, do you do? (Break the arrow and shout!)
T: How desperate would you need to be to use or consider to use a tourniquet? ... (If it's sort of coming out in gallons, which it can do, I mean, if the bloke's cut his thigh ...).
(Yes, you don't sort of say, 'Well, your arm's hanging on by a thread', you know ...)

Session 7.
(You have to bring the conversation to some sort of conclusion. You couldn't disappear, you can't just say 'Hell' and run).
(... if they found you had got one particular favourite ... they might try to get at you because of this favourite).
(... they go running back to the ward with hare-brained ideas ...).
(... You see some chap walking around with a girl and he's got green grass all over his trousers because he fell over and the girl spends two days sobbing her heart out in bed somewhere, you know).

Do you have any of this [the above] trouble on your ward? (I keep trying!)

(That's what we were saying. Some of the staff have more hangups than the patients!)

All these contributions were made by indigenes.

b) Tutor-initiated difficulties.

The quality of learning depends to some extent on the quality of teaching. Since what is taught in Schools of Nursing classrooms has a direct bearing on the nurse learner's understanding of and efficiency in the practical situation, it is of the utmost importance that teaching should be as effective as possible.

The 9 teaching sessions were therefore examined to determine whether any difficulties arose for learners in general and for overseas learners in particular.

Several tutor-initiated difficulties were discovered, some minor and some with more serious implications.

i) Insufficient background information.

There were 6 instances, in 4 sessions, where insufficient background information was supplied, of which 3 were likely to cause difficulty to all learners and 3 to overseas learners only.

Session 1.

T: We didn't mention it, as it were, the curve of the meatus. This must be applied - the knowledge of this must be applied when the ear is being syringed, or if you are putting drops into the ear, you see. What other conditions of the ear did you mention?

No reason is given why knowledge of the curve must be applied. Yet it is of great importance if the syringing of a patient's ear is to be not only effective but safe.

Session 2.

T: ... if there are two nurses you have one nurse who is the dresser and one nurse who is what we call the dirty nurse. Now if you've got a dirty nurse it's much simpler.

Dirty is not explained. Learners are left to draw the inference from the succeeding explanation. As will be seen later, this explanation was inadequate and therefore insufficient data were supplied for learners to make the
necessary inference. Since "dirty nurse" describes a particular role in the performance of aseptic (sterile) procedures, failure to understand that role is serious.

Session 4.

T: ... These are said to be convoluted, convulated tubules.

No explanation of convoluted is given and the correct form is actually replaced by an incorrect form: convulated. As the latter had already been used previously, the incorrect form was thus reinforced. Since nurse learners are expected to use the technical terms both in written and viva voce examinations, they might well use such incorrect terms to their detriment. This instance would suggest a lack of familiarity on the tutor's part with the technical language of the subject.

Session 5.

T: All the keys down the back and the old-fashioned remedies are not half as effective ...

This reference to culture-specific remedies, while not serious, is unlikely to be understood by overseas learners.

T: ... sensitise the mucous membrane of the nose to the decongestant preparation, and when you sensitise it the result is that it becomes boggy and swells, so people that ...

This is technical slang, which is not explained. There is nothing in the text to allow learners to infer its meaning with certainty. Learners would therefore not know whether it was appropriate only in relation to the nose or whether it was transferable. Indigene learners might possibly infer its meaning from other, more general, contexts but it is doubtful whether overseas learners would.

T: Actually, you know that all film stars and folks have their noses bobbed and have them made into the sort of Grecian style and all the rest of it?

This is not essential information and therefore understanding of it is not important. However, it is culture-specific and therefore its lack of significance would not necessarily be understood by overseas learners.

ii) Inadequate explanation/presentation.

5 of the 9 sessions included instances in this category. Only those which should be understandable without background technical knowledge, if the explanation were
adequate, have been offered as examples. Context has been provided where necessary. There were 9 other instances where explanation of highly technical procedures or presentation of theoretical concepts were far from adequate and the degree of inadequacy would have serious implications with regard to effective patient-care.

Session 2.

(Concerned with the giving of oxygen to a patient via a face-mask).

T: You see, if you turn it [the cylinder] off the opposite way to which you turn it on, you never apply this [face-mask] to the patient until you've got it working properly. Don't put the mask on and then start fiddling with it.

Since this was a demonstration and an oxygen cylinder and face-mask were being handled at the time, it is possible that learners could draw the necessary inferences and therefore disregard the inadequate explanation.

(An explanation of the roles of the "dirty"nurse and the dresser).

T: Well, now, there's two ways of doing this. Either you have a - if there are two nurses you have one nurse who is the dresser and one nurse who is what we call the dirty nurse. Now if you've got a dirty nurse it's much simpler. All right? Because she will get the wounds ready whilst you're scrubbing up. She will shoot all your packs out for you, you see. So the patient's prepared, the stuff is, um, put out, she'll pour out your lotions, so all you've got to do is come and open it up and carry on. And then when you've finished, got your wound covered again, she leaves it with just the gauze on, you remove the gauze, carry on with your dressing, then you cover the wound and she can then finish it off strapping up whilst you go on preparing for the next one. Some places they have three people: they'll have one to set the trolleys, one to do the dressings and one as the dirty nurse, and you move on from bed to bed. But if you're alone this is when the problem arises. You've got to prepare your patient, just leave the wound covered, then shoot your stuff out, go and scrub up, then you come back and open it up and proceed as you would do. All right? So unless you can actually see this done it's a bit difficult to explain it, you know, unless there was a wound here. But this you learn with, you know, seeing it done. Have you been on any ward where there's dressings yet?

(Well, not to this extent ...)

Demonstration on a dummy might have made the explanation easier for the tutor and clearer to the learners.
Learners could not use their previous practical experience as reference since, as the learner's reply shows, they had had very little. It is doubtful, therefore, whether they acquired a clear enough concept of either role to function adequately in such a situation without further guidance.

Session 4.

(The anatomy of the kidney)

T: Yes, they produce certain hormones. Right. Now the kidneys themselves are made up of a solid part and a cavity. The solid part is made up - this is the solid part here - is made up of a brown part which is called the cortex - this is the cortex here - this cortex is made up of countless very fine tubules, very fine tubules. These are the kidney unit. It is called nephron, not to be confused with the, er, nerve cells, which is called the neuron. So it's made up of this brown part called the cortex and it's also made of the sort of pur-purplish - that purplish part called the medulla. So the solid part is made up of the cortex and the medulla. This purplish - (coughs) - sorry, purplish part is a collection of the collecting tubules of this nephron and they form sort of a pyramid shape which end up into little apices, little cone shape, which go out to the - into the cavity of the kidney. They are then called the papillas and there are about eight to twelve of these little, you know, at the end of the - the top end of the pyramid of these tubules. You see them? This is for, er, the solid part of the kidneys.

This was a formal lecture and therefore presumably planned in advance. The description, however, lacks the cohesion which advanced planning should give (1, p.37) and it is therefore possible that the tutor knew the subject so well that advance planning was considered unnecessary. It is also possible that since this tutor was from overseas, the difficulties were as much linguistic as organisational. It is doubtful whether learners understood the description very clearly, though a model of the kidney, to which constant reference was made, may have offset this to some extent.

Session 7.

(Explanation of the function of the doctor-patient relationship in a psychiatric setting - Transference).

T: The doctor uses this situation, this relationship, to his advantage to help the patient by going halfway towards the patient to meet them, but not to get, if it becomes very very involved - this is a danger that it can be that the patient places too much emotional love on the doctor and the doctor obviously can't reciprocate it because that is no part of it here -
and he can make use of this in his relationship to help the patient to talk about the past, about these emotional feelings he has towards people and any difficulties that they had which is now affecting their behaviour today.

(and the inherent dangers)

It is possible that the patient might hate the doctor, it is possible that the patient may feel that the doctor is not so good because he is probably probing into their personal lives, and so forth, touching on repressed emotions regarding how they hated someone earlier on in life or were jealous of them or he may cause them to feel hurt or something like this. It is quite possible, if a person who was having for instance an analysis, a full analysis or a very long psychotherapy outside the hospital, if you have got the money and the time to spend on this, very often you read in the paper that they turn up in the doctor's consulting rooms with a gun and want to shoot him. You know, they even go that far, with this transference thing.

This was a formal presentation of the concept of transference which, like the previous example, lacks the cohesion that advance planning might have given it. Some statements are incomplete and the link between ideas is not always clear.

Session 8.

(Explanation of the opposing schools of thought regarding the shaving of a patient's leg before applying [sticking] plaster from knee to ankle on both sides).

T: You will need a tray, a shave tray so that you can get rid of all the hair from the patient's leg. Now some surgeons approve of this, of shaving the leg, before we apply skin traction. Other schools of thought say, well, this isn't particularly good, because if you could make use of the hair, and they will grow anyway, the patient doesn't have any discomfort in the early stage when you apply the plaster to it, and even if they - they don't feel it when we put it on, and when you take it off if you've shaved the leg in first early stages then the hair 'as grown anyway and they don't get any less discomfort when you come to take off the plaster, when the traction has either got to be renewed or at its completion.

No reason is given as to why some surgeons approve of shaving the leg. In the counter-argument no explanation is given as to how the hair might be utilised, nor the nature of the discomfort avoided. The last five lines are incoherent.

Failure to understand the argument for and against shaving the leg has two-fold significance: firstly, the learner is not aware of the relative discomforts to the
patient of both methods; secondly, as patients on "skin traction" are quite common, a learner may well be asked to demonstrate the care of such a patient as part of a ward assessment. (See 1.3.5). In this case, questions would almost certainly be asked regarding the relative merits of shaving or not shaving the leg.

(The presentation of the theory of traction and counter-traction).

T: ... traction, a force by which the leg is being drawn towards the bottom of the bed while the patient is being supported in the bed in the opposite direction, so that the limb is being pulled towards the head of the patient - the head of the bed - and the weights are attached to the lower part of the limb to cause a counter-traction thereby drawing the fractured ends of the limb outwards, so that healing is at its optimum fixation; so that healing can take place.

This is an example of frozen style - though the accompanying grammar is not always in keeping - which is inappropriate in this context. The tutor seems to be attempting to give a textbook definition of the theory. It is doubtful whether learners understood the theory as it was presented and as the session did not include the practical demonstration of it, they were given no opportunity to deduce it for themselves. Since an understanding of this theory is of direct relevance to the efficient care of patients undergoing this type of treatment, lack of such understanding is serious.

Session 9.

(Description of the visual field).

T: Does anybody know what is meant by examine the visual field? (The range of their sight?) That's right. See how a patient can see far, and if he looks straight you will be able to see quite far away on your side. That is the visual field. (Writes on board). All right? And how is this done? Does anybody know?

(and how it is examined)

T: This is done by the doctors confronting the patient and he assess whether the patient can see by moving his fingers, yes. This is called confrontation. Confrontation. Now, also, this can go to a special department and can be made by perimetry - perimetry - (writes on board) ... so if the doctor wants a further investigation of this - if he is not quite sure - this will be done by a special machine.

In the first excerpt the tutor has taken the learner's
reply, dividing range into distance and peripheral vision; but the explanation is inadequate. Neither are confrontation or perimetry adequately described in the second excerpt. However, this tutor was also from overseas and had similar problems to the Tutor of Session 4. Furthermore, linguistic cohesion deteriorated as the lecture proceeded and the instances of incomprehensibility (i.e. heard but not understandable on the tape-recording) increased proportionately.

T: What is papilloedema? (Pause) ... (Papilloedema of the eyeball?) Not eyeball - not the eyeball. Eyeball means the whole eye. (Is it behind the eye?) Yes, it is behind the eye. It is studying all the actual nerve isn't it? Yes - Yes. Well, this is one thing which we will observe.

The question: "What is papilloedema?" is never answered correctly either by a learner or the tutor. The statement: "Yes ... it is studying ..." is misleading, since papilloedema means swelling of the optic disc.

T: ... or if the eye cannot move - it remains fixed to one side - and the patient can see through the other. What's the condition called? Squint.

This is also a misleading statement since it implies that a person with a squint is blind in one eye.

(Description of the method of testing co-ordination).

T: He the patient is asked to touch his shin from one leg and toes and vice versa. You have seen that done? The patient who loses his co-ordination do overshoot, remember. He will do that and come back and touch them. So this does complete the examination of the motor part.

This description is not at all clear.

iii) Confusing rejection of answer.

T: ... what often causes these patients to have cyanosis? (Suffocation). Not necessarily suffocation.(Anoxia). Well, it is in a way (Fits). Well, fits is one thing - what's the other thing? (Asphyxia). Due to what? (Choking). Choking - this is the thing.

It is not clear why the tutor rejected suffocation and accepted asphyxia, since the latter is the technical term for the former. It is evident that the pupils thought there was a difference and it is possible that the tutor thought so too.

iv) Conflict between education and training.

There were two stated instances of this conflict, both occurring in the same session.
Session 2.

(But before you apply it don't you sort of flush it out with oxygen first? I mean, you know, put [the oxygen] right up and flush the whole thing?). Not necessarily, because you're wasting ... (It was done at - Hospital). Was it?

The ward practice was never totally rejected but later comments were dissuasive.

(Addressed to the observer. Referring to the dressing of wounds).

T: Actually, it's very difficult here because we've got no prepacked dressings on the ward so that on the wards they're doing it the old way and yet in the School we've got to teach them the new way. So really it's difficult to make them understand.

These two instances illustrate two different problems. The first is a straight dichotomy between classroom teaching and ward practice, the most frequent bone of contention between Schools of Nursing and hospitals. The second highlights the difficulties of teaching new techniques and procedures in the classroom before wards and departments are equipped to adopt them.

c) Overseas learner difficulties.

Session 2. (Overseas learners' contributions are underlined)

(Overseas learners' contributions are underlined)

Last Offices)

T: And make sure the eyes are closed, tie the toes together, and then just take the pillows away and cover them with just a sheet ... (OS learner: making sure everything is clear first before you tie them up). You what?

The learner knows that the bladder and so on should be empty but has difficulty in expressing the thought in a manner understandable to the tutor.

(Giving of oxygen to a patient)

T: And what do you put into the humidifier? (E: learner: distilled water) Why? (E: it dampens the air) Yes, it dampens but why ... distilled water? (E: You know, it's [got] no chemicals in it). This is the main thing - because it's had the minerals removed ... Why is it necessary to take them out? What can it do if it's inhaled? ... What is the ... respiratory tract lined with? (E: Mucous) Mucous membrane. And what can certain minerals do to mucous membrane? (OS: Take away its properties).

This is a mechanical answer and seems to have been induced by the previous talk on minerals and chemicals. It is suggestive of rote-learning.
Session 6.
(Recapitulation)

T: What, then, is the routine for First Aid treatment of wounds? (E: Stop the bleeding) ... (E: assess the situation). Yes, and what would assessing the situation tell you? (E: The type of wound) ... (E: The seriousness) ... (E: The chance of further injury) ... Yes, good. And from there? (E: Treat the wound). Treat the wound. How would you treat the wound, [aQs, OS]? (OS: In these cases ... try and stop haemorrhage). And that could be done by ...? (same - OS: -contused injury, because, you know, it proved to be that serious a bleeding underneath the skin, um, you know, you could have the patient unconscious or something, suffering from severe shock with a case like that, so there's a chance, you know, you might be treating something else, but you'd be stopping the haemorrhage with most of the others.)

The overseas learner seems to be regurgitating what he can remember of the teaching earlier in the session, without any real reference to the question asked. Again, suggestive of rote-learning.

T: How can you best reassure the patient? What would you do? (E: Talk to him). Have you been to the pictures lately? (E: No, I haven't been to the pictures - I'm sorry, yes. Yes, you don't sort of say ...)

The overseas learner would not have understood the implication of the tutor's question concerning the pictures. The indigene was momentarily non-plussed but realised its import quite quickly.

Session 7.
(Transference)

T: I wonder how it affects us as nurses, this transference of the patient to the doctor? ...(E: Have to observe [the patient's] reactions). Observe their reactions, yes ... What else, do you think? (OS: We can hear from the patient how much he trusts the doctor and how much the doctor is going to say). So the patient discusses it with you.

It is not clear what the overseas learner was trying to say.

(Regarding the difficulties faced by male psychiatric nurse learners vis-à-vis female patients).

T: It is sensible not to go in if girls are dressing in the dormitory and you go in on your own, and so forth. This may lead to stories and that but I don't even find that dreadful to be honest, but the kitchen with a cup of tea, well really!
(OS: Let us say the sister is attending to another patient and you are making tea for all the patients,
some of them are in bed, old ladies. In such a situation, it is just walking into the dormitory and giving that lady who is in bed a cup of tea, you are advised that it is far much better to walk in. You see, there is an old lady lying in bed but they would still advise you to walk in with a female nurse). (Same OS: Some of the patients go through this kind of asking some of the men staff whether they are married. I don't understand why they would be answering as whether you got married or not. So many of them have asked me whether I am married and the only simple answer I use then is I am married already, then that is true. I mean, I'm going to a ...
)

(2nd OS: There is only one talk I have been to, the fact that it has been demonstrated to us in the length of time that I have been here anyway, that how serious this becomes. It isn't just enter either into an award against the Crown Court, you know. I mean that leaves an impression).

The overseas learners were willing to participate from time to time but they had difficulty in remaining linguistically coherent during long utterances.

d) Overseas learner participation.

It was shown earlier (see 5.3.1.2) that overall learner-participation was well below the level which might have been expected in all categories. Having examined both tutorial style and presentation during teaching sessions, it is now possible to enlarge upon the previous statement.

Table 51 (Vol.2, A.119) shows the learner participation level per session. Below are the figures per session for the frequency of the use of casual expressions as defined earlier and the number of tutor-initiated difficulties. Type of classroom activity and tutor accent are included:

<table>
<thead>
<tr>
<th>Session No.</th>
<th>Type of Activity</th>
<th>Tutor Accent</th>
<th>Casual Expressions</th>
<th>Tutor-initiated Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Q/A</td>
<td>Regional + glottal stops and dropped initial and final consonants.</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>D</td>
<td>as above.</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>L/D</td>
<td>RP -</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>L</td>
<td>Europ.-marked</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>L</td>
<td>RP -</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>L</td>
<td>&quot;</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>D/G</td>
<td>Regional</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>D</td>
<td>&quot;</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>L</td>
<td>Europ.-marked</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Sessions 1 and 8 were recorded in the same School of Nursing but with different learner-groups. Sessions 4 and 6 were recorded with the same group; likewise Sessions 5 and 9. These Sessions will therefore be discussed in pairs.

Session 1 and 8.

A tutor said (4) of overseas learners in this School of Nursing that they "hardly open their mouths". However, this statement is not entirely supported by the evidence. In Session 1 tutor-initiated (sc.voluntary) participation (aQg) was almost equally divided between indigene and overseas learners, though learner-initiated participation was almost entirely indigene. It should perhaps be said that this was a revision session, which might have influenced overseas learners' aQg participation-level. The tutor's accent did not appear to have adversely affected overseas learners and the use of casual expressions and tutor-initiated difficulties were minimal.

In Session 8 indigene and overseas learner contributions were equal, both in learner-initiated and tutor-initiated participation. For much of the session the tutor's use of formal and frozen styles precluded participation from any learner, in spite of serious tutor-initiated difficulties.

Session 2.

Although there were only two overseas learners in this group, their contribution was higher than that of indigenes in learner-initiated participation and in the aQg their contribution was almost equal. However, one was a West Indian and the other a Mauritian and the tutor's comment prior to the session was: "The West Indian is quite ready to talk and answer. The Mauritian hardly opens his mouth". This was substantiated during the session, the majority of questions (10) being answered, and all overseas learner-initiated participation being contributed by the West Indian. However, the tutor's accent was regional, the use of casual expressions was quite high (9) and there were 4 instances of tutor-initiated difficulties. It is therefore possible that the West Indian was linguistically better able to cope with these than the Mauritian.

Session 3.

Indigene learner participation in this session was
virtually absent, the majority of aQs and all learner-initiated participation being contributed by the overseas learners. There were no tutor-initiated difficulties, though the use of casual expressions was frequent (17).

Sessions 4 and 6.

In both these sessions overseas learner participation was minimal. This was not necessarily due to difficulties in understanding accent for, while the tutor of Session 4 had a marked European accent which was sometimes difficult to understand, the tutor of Session 6 spoke with RP and clearly and slowly. Nor was it necessarily caused by tutor-initiated difficulties for, though in Session 4 there were 6 other tutor-initiated difficulties, similar to the one quoted in the examples, there were no tutor-initiated difficulties in Session 6. The use of casual expressions in either session was minimal. However, indigene learners in Session 6 used casual expressions to a certain extent and the overseas learner had difficulties both with understanding and speaking. (See examples quoted previously). More than this, the indigene learners were very articulate and answered questions so smoothly and promptly that the overseas learner may not have had time to formulate an answer quickly enough to contribute.

Sessions 5 and 9.

Of this group a tutor commented: "Malaysians don't like to speak up in class - they're afraid of making mistakes". It was also stated that since entry requirements were now high for this Training School, language problems had been considerably reduced. All overseas learners in this group were, in fact, Malaysians. Their participation in either session was small and in Session 9 they failed to answer 5 of the 7 aQs. Failure to participate was not necessarily a function of tutor accent since, although the tutor of Session 9 had a marked European accent, sometimes difficult to understand, the tutor of Session 5 spoke with RP and clearly and slowly. Nor was it necessarily due to tutor-initiated difficulties for, although in Session 9 there were 5 instances of these, there was only one minor one in Session 5. However, the tutor of Session 5 used casual expressions quite frequently (10). Nevertheless,
apart from these instances and a few ellipses, this tutor used a good consultative style with the corresponding grammar.

It is possible, therefore, that the tutor's statement was true.

**Session 7.**

This was a group discussion which was, at least in part, dominated by the learners. Overseas learner participation was, nevertheless, relatively low. There were two instances of serious tutor-initiated difficulties and both tutor and indigene learners used casual expressions and/or highly allusive language on several occasions. (See examples quoted previously). In addition, some overseas learners had difficulty in remaining linguistically coherent during long utterances.

It would seem then that where overseas learners fail to participate during teaching sessions, the cause is partly linguistic (Sessions 2, 4, 6 and 7) and partly cultural (Sessions 5 and 9). Nevertheless, the effect of tutors and indigene learners cannot be overlooked (Sessions 2, 4, 6 and 7).

**5.3.1.4 Discussion.**

None of the sessions observed were specially arranged, nor were particular tutors selected. They were all sessions which would have taken place had no observer been present. All tutors agreed willingly to take part, though one or two manifested apprehension about being recorded. To what extent the presence of an observer and tape-recorder affected tutors and/or learners cannot be ascertained, though it is likely that all participants were affected to some degree. Two tutors indicated their apprehension: the tutor of Session 1 asked for the tape-recorder to be turned off halfway through the session and recording would not have continued had the tutor not indicated that it might do so. The tutor of Session 8 asked that the session should begin without being recorded and indicated that recording could start once the session was well under way. It should be noted that most of the learner-participation in this session occurred before recording began and it is
therefore possible that the progressively formal/frozen style of the tutor was a direct result of recording.

During teaching sessions learners seemed to recognise and generally acknowledged signals indicating a period of formal style, usually waiting for the tutor to signal a shift from formal to consultative. In the 9 sessions studied, overseas learners adhered absolutely to the code but indigenes were slightly less willing to wait for the style-shift marker: (Are there) any questions?

It has already been stated that the style most often used by all tutors was the consultative, with frequent shifts to the casual and that indigene learners tend to answer questions with almost total ellipsis. Overseas learners, on the other hand, tend to answer in the formal or consultative styles.

It would appear from this that there is, in fact, very little opportunity for learners to use spoken language very extensively in the classroom and, from the figures quoted above, what interchange there is seems to be indigene-dominated, particularly in the field of voluntary, learner-initiated participation.

Since four sessions revealed evidence of language difficulties for overseas learners, both in understanding and speaking, the level of language competence obviously plays a part. It would appear, however, that presentation and methodology in the classroom also plays a significant role in learners' difficulties since both were inadequate in several instances, often seriously so.
REFERENCES AND NOTES


2. + indicates that a few words were inaudible on tape.

3. Here "casual" also includes expressions which do not have their consultative or technical meanings - e.g. "jump the gun" and therefore might exclude the outsider.

4. No comments were sought from tutors during the period of observation. Any comments made were entirely unsolicited.
5.3.2. The Clinical Situation.

It was intended to visit 9 hospitals, 3 in each type of training, and to work with 2 students and 2 pupils in each hospital, recording the nurse-patient communication. As stated earlier, however, (4.2.6) only 8 hospitals were visited, 3 General, 3 Psychiatric and 2 Mental Subnormality. These visits should have yielded 32 subjects, 12 in General Training, 12 in Psychiatric and 8 in Mental Subnormality, with 16 students and 16 pupils. In the event 25 subjects only were observed, since 2 went off sick at the last minute and 5 were outside the scope of the research. Of the 2 who were sick, one did not report for duty in the morning, the Sister commenting that it was almost certainly genuine as the subject had readily agreed to participate when asked. The second subject reported for duty but had developed laryngitis overnight and though she offered to participate if the observer so wished, the offer was declined. Of the five who were outside the scope of the research, 3 were Singhalese, 1 was South African and 1 was West Indian, although when hospitals were asked to provide subjects, the relevant areas were stated. In the light of the five unsuitable subjects, it would, perhaps, have been better to state the countries. The schedule was such that there was no time to find replacements.

Table 52 (Vol.2, A.120) shows the distribution of subjects by country of origin, status, type and year of training. Of the 25 subjects observed, 11 were in General Training, \((S = 6: P = 5)\), 8 were in Psychiatric Training, \((S = 5: P = 3)\) and 6 were in Mental Subnormality Training, \((S = 3: P = 3)\). 1 was from West Africa, 10 were from South East Asia and 14 were from Mauritius.

Two unforeseen problems arose with regard to participant observation in Psychiatric and Mental Subnormality Hospitals. Firstly, there were seldom patients on the wards in which nurse-patient interaction might have been possible: namely, low-dependency Mental Subnormality wards, where the patients can communicate fairly well. All such patients are usually away from the wards during the day, engaged either in industrial therapy, occupational therapy, sheltered employment or socialisation programmes,
such as shopping. In high-dependency Mental Subnormality wards the patients, severely mentally handicapped as they are, are unlikely to be able to communicate. In Psychiatric hospitals the situation is similar, the major difference being that where patients are present they are usually new admissions, often acutely disturbed or depressed, or they are severely mentally ill - psychotic or schizophrenic - and therefore cannot be observed. The introduction of a stranger, particularly one with a tape-recorder, would be almost certain to create or increase hostility, aggression or paranoia. Since these eventualities had not been foreseen, no structured interview had been prepared. Moreover, any reference to a written document might well have made overseas learners suspicious of the observer's motives. In any case, the prime object of the observation was to study learners' level of competence in the use of English and their ability to communicate with patients. Therefore, whenever patients were available they were included and took precedence over discussion. If none were present the learners were encouraged to discuss various topics. In order to profit as much as possible from the interviews, the topics introduced related to those previously researched in the PNOE interviews and the questionnaires. However, if any learner showed disinclination to discuss a particular topic, it was changed immediately - though this was seldom necessary. In view of the precedence given to patients not all subjects were questioned about the topics discussed below but the majority were questioned about most of them.

5.3.2.1. Reasons for coming to the U.K.

The reasons given are listed below:
(Totals exceed 25 due to multiple answers)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Malay</th>
<th>Filli</th>
<th>Ghan</th>
<th>Mauri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanted to travel</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Wanted to come to U.K.</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Nursing</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(contd. overleaf)
4. Better facilities in U.K.:
   nursing more advanced: 2 1 - 1
   better equipment: 2 - - -
5. "Different training". - - - 2
6. Employment. 2 - - 1
7. U.K. nursing "well-known". 1 - - -
8. Poor facilities in C.O.O.:
   poor equipment: 1 - - 1
   too few NTSs 2 1 1 4
   " " psychiatric hospitals: 2 - - 2
   " " mental health services: 1 - - -
   no psychiatric course equal to RMN: - - 1 -
9. Other:
   difficulties with Bahasa Malaysia: 1 - - -
   have to pay for training: - 1 - -
   "expect perfection" (dress/speech etc.): - 1 - -
   higher educational level required in C.O.O.: - - - 1

As can be seen, learners' reasons for wanting to come to the U.K. were mainly political or economic. The four subjects who stated that there were not enough psychiatric hospitals in their countries of origin had come specifically to gain a psychiatric training. Many others came, like Subject 21, because of the high level of unemployment in their own countries, though most were less explicit:

Subject 21.

I think there are - most of them [overseas learners], well really I should be honest, I myself, I never thought of - er - you know, doing nursing as a career, I never thought. I was sort of forced to, you know, because through our - black unemployment in my country.

Four, however, who had wanted to come to the U.K., had given up jobs at home in order to come. Two, a Filipino and a Malaysian, had been nursing, a second Filipino had been a teacher. One Mauritian had been
working in a Government Office. The nurses sought better training and the other two wanted more satisfying jobs.

5.3.2.2 Choice of Training and Status.

This question was not asked of many learners in General Training since nurse-patient interaction usually took precedence. Of the two pupils to whom the question was put both said that they had lacked the necessary O Levels. Both were hoping to proceed to student-training.

6 subjects in Psychiatric and Mental Subnormality Training had not known the type of Training School to which they had applied or been sent, or commented concerning others:

Subject 4. (Psychiatric Student)

They told me to come early, so I came early - a month early, and I started straight away and that was a psychiatric hospital and I was so frightened. Well, I knew, I expected that, you know, what sort of hospital. There were some girls who came who didn't know that it was a psychiatric hospital.

Subject 13. (Psychiatric Student)

You see, actually I was sponsored by the Ministry, so I could not tell what kind of training I would have - any sort.

Subject 20. (Mental Subnormality Student)

Really we don't know all about these kind of hospital, but we know it was for psychiatric ... because we don't meet these kind of people in Mauritius: there is not so many.

Subject 21. (Mental Subnormality Student)

... when I was at home I couldn't find a job. Right? So I thought, um, I'd better go somewhere else, you know, emigrate ... and try to work, you know. And I applied to the Ministry of Employment in my country and ... they ask me whether I wanted to nurse in England. I said I didn't mind, and they arrange an interview, you know, with the nursing board over there. I didn't apply to this hospital, I didn't apply, I think it was through the British, er - the Mauritian High Commission in London. I got the letter from there, you know, telling me that I'd been accepted by this hospital as a student, you know, to follow ... a student or three-year course ... So I came here and I was told that it was mental subnormality, but I had a vague idea what mental illness is but I didn't know what Mental Subnormality is really because in Mauritius we do not have a hospital with a mental handicap.
Subject 23. (Mental Subnormality: Pupil)

(0 = Observer: S = Subject)

O: Why did you decide to come to England to do your training?

S: Well, I wanted to do nursing.

O: But did you know you were going to do mental-

S: No, I thought it was mentally handicapped. I didn't expect it to be -

O: You thought it would be what?

S: Physically handicapped. Well it's all right; once I've come here now ... What I wanted is the class I can talk to, can understand; I mean an average IQ ...

Subject 24. (Mental Subnormality: Pupil)

O: Did you know you were coming to work - to Subnormality?

S: No, I didn't know.

O: Why is this?

S: I thought that it's psychiatric -

O: Psychiatric?

S: Yeah; (incomprehensible) ... also interested because I want to know some human behaviour ...

O: Where does this confusion happen - at home or here?

S: Yeah; in the home, I think. At home they don't specify too much -

3 subjects, 1 in Psychiatric and 2 in Mental Subnormality Training, were prepared to take whatever they could get, though two would have preferred General Training.

Subject 18. (Psychiatric: Pupil)

O: Did you choose to do psychiatry?

S: No, actually, I applied to a few hospitals, a general and psychiatric as well, and I received this one and they called me in for interview and I came here.

Subject 22. (Mental Subnormality: Student)

O: Did you choose to do Mental Subnormality?

S: Not really. I just pick it at random ... I didn't know really what it was ... I just applied to the hospital, I got through, you know? I say: 'Why not try it?'

Subject 25. (Mental Subnormality: Pupil)

I applied for General but I didn't succeed and when I put Subnormality I came up to my tests ... and I was accepted.
2 subjects, both in Psychiatric Training, did not choose their own status:

Subject 17.

O: Did you choose to be a pupil-nurse?

S: I did not. I came here as a student here ... But I did not have a chance because at the beginning they asked me to wait for five months and so then they made up his mind that I should do the pupil nurse instead of the student.

O: And are you going on to do the students' afterwards?

S: Yes, definitely I am going to do it if I pass.

Subject 18.

O: Did you want to be a pupil-nurse?

S: I came here, you know, and I came here for my interview and they told me that a course was going to start for pupil nursing. They told me that if I want to join them so I decided I would do pupil nursing and do my student after when I have finished.

In spite of the initial confusion and the lack of adequate pre-arrival information, the majority were as philosophical as Subject 23 (v. supra), growing accustomed to the work in time. Nevertheless, as with Subject 23's comment, all indicated that a period of adjustment had been necessary. The majority, like Subject 23, implied it; 2 subjects were more explicit:

Subject 21.

... I think when I first started, you know ... I was not very pleased ... seeing all these things that go on ... But then I gradually got used to the work, to the patients, the place, to the staff ... and the way the work is carried on, you know. And after two and what? - two years and nine months I am just used to it now. Yeah. (Laughter) I wouldn't believe it.

Subject 22.

O: And how do you like Mental Subnormality?

S: Well, at first I didn't like it at all, to tell you honestly. Well, things - I got used to it now, or so that - er -

5.3.2.3. Psychiatry, Mental Subnormality and overseas learners' social and psychological background.

In addition to the shock of finding themselves in a Psychiatric or Mental Subnormality Training School when this was neither expected nor sought, overseas learners evinced a certain amount of bewilderment when faced with
differing social mores and attitudes to psychiatry and mental subnormality. Many seemed shocked at the consignment of old people to the geriatric wards of psychiatric hospitals and the hospitalisation and isolation of mentally subnormal people and non-acute ill psychiatric patients.

As Subject 14 put it:

S: You know, we don't have [chronic, long-stay psychiatric] patients like this in the hospital. Suppose this was a patient, we don't send them to hospital or something like that. We generally look after them in the home.

O: I see.

S: I was surprised, you know, because what they [Mauritians] mean by psychiatric hospitals is more or less where people who are driven mad are put. I was at a loss when I came here. There are many patients I think they should not stay here, but they have nowhere to go ... We have in the psychiatric geriatric wards, too, people who are old. They are not on any medication or anything like that. They are here because they are old.

The reasons suggested were:

firstly: the family caring and responsibility in the country of origin and the lack of it in the UK:

Subject 22.

O: And what about mentally subnormal people: what do you do with them in Mauritius?

S: Oh well, they ... a different question altogether, because their parents look after them - most of them - the majority of them.

Subject 21.

So there's fewer, I think, I reckon there are fewer cases of mental subnormality we got at home [in Mauritius]. They are look after in the family, you know ... Then we have only one mental hospital ... Even some of the mentally ill persons in my country they're all looked after in the family.

Subject 18.

No, if I am severely depressed I do not think I would be sent to the hospital I would be kept home. [Mauritius].

Subject 24.

S: I think we don't have this type of [Mental Subnormality] hospital. We have what call mental hospitals, psychiatric, psychopathic -

O: What would you do with people like this in your country then? Or don't you have them?
S: I t'ink we have. But - they might have put in the - one family might have this type of people. They put it in the house and the parents take good care of it instead, because there might be no facilities to offer these people going to care, and the [Filipino] Government of course is quite ... they don't ...

Subject 21.

... we were talking about it in school one day, the clinical tutor and the student ... about us at home [in Mauritius] ... we all live together - parents, grandparents, children, all together, whereas here in England they are all segregated - parents one side and the children married, living far away, somewhere else far away. That's why they can't be looked after I think.

Subject 13.

Yes. This is a very large country and Mauritius is a small one. So a man might stay in one place or move maybe eight or ten miles away. Or he will go to work there and come back at the weekends. We never leave our parents or family alone ... [Talking of the U.K.] ... Some are in from there [the community] and some have to be referred to us ... You see, at that stage it depends upon the environment in which they are living. Say that somebody is old. He has got his or her daughter or son, but they don't look after him or her, so the best way to be is in a psychiatric hospital. The environment factor plays a great role as well.

secondly: the fundamental difference in attitude to psychiatric illness and hospitalisation:

S: I think people in Malaysia they have got different views of mental illness.

0: How do you mean?

S: People don't like to talk about it or show - you know, - show mental illness. If my brother was mentally ill, then the family would keep him in the house and not let him out. We regard it as a shame, really, you know, a shame that someone was ill and ... so everything was done in the house and not, you know ... Yes, I remember I went to a relative's house and they had a mentally subnormal child. I used to feel sorry for them ... but, you know, they always took care of them in the house and didn't allow them to join the other kids and all that sort of thing, really isolated in the house.

0: Oh, I see, yes, so it is the same for mental subnormality as it is with mental illness?

S: Yes.

Subject 16.

... But I think that the basic difference why we don't have so many people in hospitals in [Malaysia]
is because of the stigma, you see... They do have a stigma here... but they tend to overlook it... and once you are out of hospital you're just... they don't bother to look back into your background. Whereas once you came to that hospital, you have had it, you see.

Subject 13.

Schizophrenia? Aah ... I would say that [Mauritians] we don't diagnose it as particular psychiatric illness ... You see, when somebody just gets disturbed or is aggressive we just put them inside. We don't diagnose them as having separate illnesses. All who go there are mentally ill.

Subject 16.

... here, I mean, in comparing the people who are just slightly depressed, they come into hospital. You have all the GPs just telling them to go inside. You see, whereas at home the family is willing to look after them for a short period until they get... It means that they get the extreme cases, you see. Here, whereas we get beginners, in-betweens, before they reach the extremes. You see, we have no real extremes here. But we get the real extremes, you see.

Not only were these factors seen as reasons for what was considered unnecessary hospitalisation but also as a contributing factor in psychiatric illness, along with environmental stress:

Subject 13.

No, I do not think we get depression. Because, you see, we are always close.

Subject 16.

S: There are just two of them [psychiatric hospitals]. We do not have so many patients - I mean, people who become mentally ill. It is probably the environment, I think, that makes ... Like in England they have a different environment compared to other places. The rate of mental illness is much higher here. I think that it is because it's more advanced ... and environment particularly. ... It [drugs] does help them. Like depression, you can pull yourself up. You will be all right. You are bound to go down again. It is all to do, to my mind, with stress. There is no stress there, you see ... We could have a Malaysian girl, you see, here. I think that it is because if she was at home she would not become depressed, you see...

O: Why?

S: It is because of the environment. Look at the difference, you see.

Subject 15.

O: Why have you only got two? [psychiatric hospitals]
Is it just because they haven't built any more yet, or because ...?

S: I think it is because we don't ... In the first place, we haven't built many, and in the other ... the old aged ... are often kept in the house ... You see it is up to the responsibility of the children to take care of their elders, so you don't come across this problem as much as ... it's here.

The loneliness at parting from such close family ties was keenly felt and commented upon by many, though usually not on tape. Their feelings were summed up very simply by

Subject 13:

I think things become a habit. But you see in our country it is not the same. Since we are small you see we grow up amongst our family - grandmother, grand-dad, father, mother, brothers, sisters. So you usually get this family tie which still exists. That is why, when we leave them we feel it. We feel that we have left something behind.

5.3.2.4. General Language difficulties on arrival and continuing.

Of the 23 subjects to whom the question was put, 17 acknowledged that they had had various initial difficulties with the language, 6 of whom admitted continuing difficulties. All 17 said that their problems lay in the field of Spoken English. None had any difficulty with written work, though 2 subjects commented that private study was difficult. However, the latter was more social than linguistic.

The length of time which subjects said it took to overcome their difficulties ranged from a week to a year, though some subjects were less specific.

Subject 4.

S: When I first came I couldn't understand. You should have come interviewing me then! And you know what a bedpan is or commode it is now, but before I didn't know.

Subject 25.

That was - first of all that was very hard for me. I couldn't understand them [the patients] at all. Even the staff too - because the language was very hard for me to understand. So I should be ...

(drowned by music).

Subject 3.

Yes ... but when I first came it was really difficult.
Subject 23.

When I first came ... I thought "My I can't even ..." (incomprehensible). But it's all right. I get used to it. I can understand it. Try to get a bit in it. About "lads", you know, when I first came, and they were talking, and I could never get that. It is hard. You have to listen and listen, and get to know.

Subject 19 took "not more than one week ... once you get use of it there's no problem at all".

Subject 14 took rather longer:

"Oh yes, [I did have difficulty with English]. I suppose I was a bit lost, you see... But after a few weeks it was better. It's all right now".

as did Subjects 12, 15 and 18:

Subject 12.

I was used to English in the school so I didn't find it very difficult. I think I was able to pick it up after about a month or two months here.

Subject 15.

O: Did you find when you came here that you did have any particular problems? [NB. Language was never specified].

S: Yes, I suppose I had problems because I couldn't understand ... I couldn't catch here what they spoke in the first few months, I think.

Subject 18.

In my first year here it was a bit difficult, especially when they spoke colloquial English, you know, which they are accustomed to.

The causes mentioned were various, 9 subjects commenting on difficulties with regional accents or dialect. Some were general comments; others were more specific:

Subject 17.

O: What about the language? Did you find it very difficult when you first came?

S: It was, it was. It was not that difficult, I mean, just because of the dialect, the accent itself. I mean, if English people speak slowly and in such a way that does not mean any problem for me, you see. It is because it is very quick and the accent different, you see. It is not that bookish.

Subject 6.

S: Most of the problems that the girls met with is to get used to the accent the patient is having, especially of the old patients.

O: You have a lot of trouble with that, do you?

S: Oh, yes, I had a lot of trouble the first time with
that ... and I find it very difficult to understand them.

**Subject 20.**

Accent was most difficult to understand really what people was talking about.

**Subject 21.**

When I first came here, I had some problems, yeah, problems in understanding people, you know, the way - the accent, most of them I couldn't understand ...

Some subjects had difficulty with particular accents, notably Irish and Cockney:

**Subject 18.**

... especially Irish people's accent and Scottish people. It is so different finding this, you know.

**Subject 12.**

You see, I found it very difficult to understand the Irish -

**Subject 1.**

S: When I first came here, I couldn't understand this accent here. I mean we speak English, but we speak the Queen's sort of English, and - I was telling our tutor that I couldn't get what they were saying, how the time ... (incomprehensible) ... and she said, "It's all right, you'll soon get used to it".

O: And did you?

S: Yeah. I think the hardest to understand is still the Cockney, the Cockney accent. I went down to London -

O: And you couldn't understand them?

S: Not - I mean, some words, yes, but some, if they say it too fast, you know, you can't get what they are saying very well.

**Subject 5.**

When we came to England for the first time - when we were in London - they speak Cockney, you know. I could hardly catch what they was saying. They was talking all the time and I couldn't even catch what they was talking about.

Some subjects felt that difficulties arose because of the speed with which mother-tongue speakers spoke:

**Subject 4.**

There are some nurses when they first came - I've met some - who couldn't understand English, you know, not just because of the slang. They just don't understand, you know. They could read, but they couldn't understand when they speak. They thought that English people spoke too fast.

**Subject 21.**

... and sometimes I think they speak too fast, too
quickly. I couldn't grasp what they say sometimes.

Subject 1. (already quoted above)

Two subjects felt that lack of practice in using spoken English was a contributing factor:

Subject 20.

Really I may say it was difficult because you see we learn [English] on paper but we don't talk it every day. That's our problem.

Subject 19.

O: And do you use English much in Mauritius - the language?

S: No, we don't. But just - we using it at school, during the English period you talk English, and during the mathematics, English period, history, chemistry, biology, some, I mean different subjects, excluding French, we talk English. But most of the time the teacher kept on talking - but we the pupil, I mean the student, we find it - we want to say something sometime - we say most of the things but we never had a chat like I am having now, you see.

A few subjects commented on the "different" English, colloquial, slang and swearing:

Subject 18.

Especially when I heard some days people saying: 'I am going to spend a penny?' which I did not know. Then I find out and I know what it was. It is a bit difficulty [sic] when you first came, you know.

Subject 15.

Especially when I watched telly, and the jokes and all that, I couldn't catch it because I was not used to it but after the first month it was O.K.

Subject 12.

I think there are some words which are used in the everyday English here which you can't find in the books, and which ... we don't come across in Ghana ... some additions I think they are very wrong, if you come to think about the grammar and all that, things like that, say, "I couldn't care less" ... And then we have a lot of swearing. You get a charge nurse who will start saying "Where have you bloody ..." and end it with "bloody"; they speak in a sentence about 10 "bloodies".

Subject 24.

O: It's a bit tiring isn't it? I found that when I was in France and I didn't understand.

S: Yes, because before I came here I thought that they speak the English which I was taught back home in the school, because we are learning just from the American, from English, so we came here. Then I found that this to my surprise different, because they sound the accents and everything, and some
words which is no the term how they express it, you know. Later on I find it's a dialect.

One or two subjects said that they were reluctant to ask what was meant or to seek too many repetitions:

**Subject 5.**

... I was too shy to and then when I was home - oh, I couldn't be bothered.

**Subject 18.**

... let us say you are working on a ward and you have got a charge nurse who is Irish and has come to you to ask you to go and do something and you do not understand what he meant, you know. So you ask him for the second time and still do not understand what he wanted you to do and you do not ask him for the third time because he might think you are stupid or something like that.

One subject offered a solution to overcoming problems as quickly as possible.

**Subject 19.**

It depends the environment, you know what I mean? If you can keep out with Mauritian you see, you talk your language. But if you are with some other, I mean some foreigners who speak English, so you can have a chat, you can improve yourself you know.

Of the 6 subjects who acknowledged continuing difficulty, 4 made general comments and 4 made specific ones:

**Subject 24.** (2nd Year Pupil)

In the classroom I think ... it is all right because those are tutor, what you call here, so they speak the English which is - no difficulty in that way in understanding. But outside of that I would say that I still have a problem with that, in understanding them.

**Subject 19.** (1st Year Pupil)

I mean for the English, there will be no problem for you. If you've been taught at home English you get a good qualification - not very good qualification, what I mean is, Form 4, something like that, you can come to this country and - you know, you can't read English at all; if you can read English there is no problem. You can't understand what people is talking to you and you are asking for you see. And you will find it a bit difficult - I mean to explain yourself, to express your feeling, that you will get it - I mean you get, you know, if you want. You got to start something very quick, isn't it?

**Subject 5.** (3rd Year Student)

Sometimes it is very hard for us to catch even now what the Staff Nurses - English nurses - are saying.
sometimes we just guess what they are trying to say and hope we're right.

Subject 21. (3rd Year Student)

Even now there are some persons I can't even - I can't understand very well, you know, some of them.

The more specific references were concerned with accent and speed of speech. (Subject 12's comments regarding slang and swearing have already been noted):

Subject 24.

Accent as well, and some people I found out they even don't (incomprehensible) you know. I have to pay much attention to that before I get things, otherwise if they say, if they talk to me or if she talk to me and want to instruct me to do thing I may not get it, I have to say "I beg your pardon", "Pardon", you know.

Subject 5.

Especially in hospital ... though they speak English and they have their accent - can't catch ours, can't catch theirs.

Subject 9. (1st Year Pupil)

But I notice there are some English people, especially - not so much the English people but the Irish - they speak so swiftly that I cannot understand them ... so I have to say: 'I beg your pardon,'

Two subjects commented on the difficulties of studying in their off-duty hours:

Subject 18.

O: Did you find it easy to study there?

S: No, I was a bit ... I had too many friends in the Nurses' Home and they were playing the cassette and the radio and they were playing the record players and one of my friends would come and say "Let's go out to the club", you know ... And you can't study; you just go to the club or something like that.

Subject 19.

Oh it is very hard, because once after having been working one whole day we find ourselves very exhausted say: "Let's go out; expend some more time, you don't want to get socialised ... let's go out down the city or down the town to expend some money ..."

5.3.2.5 Level of Linguistic Competence.

Style.

All subjects used the consultative style, with very few shifts in style overall. Table 53 (Vol.2, A.121).
shows the total number of style-shifts per subject and the total number of instances of total incomprehensibility. An utterance was registered as incomprehensible if the actual words used could not be determined after several replays of the tape-recording.

As Table 53 shows, there was a total of 14 shifts into the formal style and 78 shifts into the casual style. Of the latter, the use of ellipsis accounted for 61 instances and slang for the remaining 17. There were 44 instances of total incomprehensibility, though Subject 3, with 15 instances, and Subject 24, with 8 instances, accounted for almost half the total.

Of the 14 instances of the use of formal grammar, 12 were addressed to the observer and 2 to patients. Its use occurred mainly at the beginning of interviews with the observer (9 instances) and in answer to identifying questions:

Observer: Where are you from?
Subject 6: I am a Malaysian.
Subjects 3, 25: I am from Mauritius.
Subjects 18, 25: I am a pupil-nurse.
Subject 6: I am in the middle of my third year.
Subject 24: I have been here one and a half years.
Subject 7, 16: I beg your pardon?

The other instances occurred during periods of consultation:

Subject 14: I like [psychiatry] for such was my ambition.
Subject 17: Moreover, I am a bachelor ...
Subject 22: I have myself collected a patient who has gone to town and collapsed.

Only two instances occurred with patients:

Subject 8: May I take your blood-pressure, please?
Would you like to stand up for me, please?

Once a subject was involved in discussion or with a patient, the style used was almost entirely consultative, with occasional shifts to the casual.

With regard to the use of the casual style, only 2 subjects (S.12 and 24) used no ellipsis at all but very few subjects used elliptic expressions more than 3 times, the majority (16 subjects) using 2 or 3.

Of the 61 instances of ellipsis, 58 were lexical and
3 phonological. 41 were addressed to the observer and 19 to patients. One was addressed to a colleague. Of the 41 addressed to the observer, 20 occurred in response to identifying questions:

1. Where are you from?
   Subjects 5, 15, 16. Malaysia.
   Subjects 13, 20, 23. Mauritius/from Mauritius.

2. What stage of training are you at?
   Subjects 3, 4. In my third year.

3. How long have you been here?
   Subject 14. Nearly six months.
   Subject 17. A two years.
   Subject 18. In this hospital?
   Subject 23. About two years.

4. When do you take your Finals?
   Subject 4. Next year, February.

5. Are you a student or pupil?
   Subjects 11, 23. A pupil/Pupil-nurse.
   Subject 22. A student nurse.

6. What ward is this? How long have you worked here?
   Subject 5. Casualty.
   Subject 13. Geriatric ward.
   Subject 7. This ward?

Of the remaining 21 instances, 3 were references to patients:

   Subject 5. Got another down the other end.
   Subject 8. Another two down here.
   Subject 11. She [the patient] doesn't want to do anything for herself. (O: [comments]) Bad, very bad.

1 was an instruction to the observer:

   Observer: Which one?
   Subject: The green one.

The rest occurred during discussions. E.g:-

1. And how are you finding it? [Psychiatric nursing].
   Subject 13. Not bad.

2. It seems to be a very progressive ward.
   Subject 14. What, this?

3. Do you have any difficulty with those?
   Subject 17. With the study? No.
Subject 21. At school? The studies?

4. Where would you take [patient] for a walk?

Subject 22. Round the hospital. ... 'Cos we work with them, we know.
Roun'bout - those who go to school - about 12.

3. Do you actually have any instruction on how to do it?

Subject 25. No, with experience.

Of the 19 instances relating to patients, 4 were instructions, 2 were explanations and the remainder occurred during general or professional interchange:

Instructions.

Subject 8. In the middle [= Sit in the middle of the bed].

Subject 10. Careful! Slope. [= the slope in the corridor. The patient was using a walking frame].

Subject 11. Take your time. No rush at all. Good. All right.

Subject 20. Here! [Put the string round this nail here].

Explanation.

Subject 3. Well, Mr. - ; going to have to roll you over.

Subject 4. Do your back now. [= We're going to wash your back].

Professional interchange.

Subject 6. What? Got a sore throat?

Subject 7. (Patient: Could you just ...?) Yes, just going to.

Subject 7. Hello! Not too bad, was it?

Subject 10. What time are you going home?
(Patient: I don't know) Probably 10 o'clock.
Once more. [= Give me another hairpin].

General interchange.

Subject 6. You want the wireless on? Right, in a minute.

Subject 8. (Patient: Yes. [I am expecting visitors]). Your family? ... How many children have you? (Four) All grown up?

Subject 10. You can eat bread, anyway. Same thing.

Regarding the use of slang, 17 expressions were used
by 10 subjects; 9 were addressed to patients and 8 to the observer:

To the patient.

Subject 6.
... when you're going home. O.K.?

Subject 7.
Thank you. O.K.

Subject 8.
O.K. Thanks very much.

Subject 7.
Can you cough now? Good. Hang on! [= wait! Good. Coming: [= the sputum]

Subject 9.
Would you just lift your hip, darling./Are you expecting visitors, lovey? /Could you just lift your but, darling?

Subject 3.
Do you miss your booze? Your booze - your brown ale?

To the observer.

Subject 15.
No, it's [psychiatric nursing] O.K. now.

Subject 19.
... you try to bribe them, say: 'O.K., I'll give you a fag.'

Subject 3.
We've got orthopaedic surgery and medical, then we've got kids'. [= Children's Ward]

Subject 15.
O:
It's not a bad town, I suppose.

S:
No, it's great!

Subject 16.
Once you came to that hospital [= psychiatric hospital in Malaysia] you have had it, you see.

Subject 19.
But half the time they [psychiatric patients] keep asking for fag, you know.

Subject 22.
... when I came, for me, it [Mental Subnormality Hospital] was just a mere dumping place. They are just dump here ...

It had been hoped to compare the amount of casual style used by overseas learners with that used by patients but since many of the patients involved in the participant observation were either old and confused or too ill to talk very much, no meaningful comparison can be made.

Linguistic coherence.

The 25 tape-scripts were examined to determine the level of language competence as measured by: the subjects' ability to remain linguistically coherent during long
utterances; the extent to which, if at all, difficulty in understanding occurred; and the degree of nurse-patient interaction at both professional and general levels. It was also hoped to establish whether there were differences between the national groups with regard to level of language competence.

For the purposes of this discussion a long utterance is defined as one or more sentences, other than simple sentences, uttered consecutively without external interruption. Linguistic coherence is defined as the ability to express sequential thought in appropriate linguistic terms. Grammatical correctness is not necessarily a criterion of coherence. Two examples should suffice to illustrate both definitions:

Example 1.

Long utterance; linguistically coherent.

O: How d'you mean, better scope?

Subject 2.

Could you help me out, Mr. S - Ah!

Subject 1.

Considering the nursing point of view, in fact, when you compare the nursing standards in Malaysia and Britain, you find it's, er, it's much better here, and the - the medical equipment and all the staff used in here are very much advanced when compared to Malaysia, so - it's in fact always better to have training in a proper place rather than having training in under-equipped hospitals really.

Example 2.

Long utterance; linguistically incoherent.

Subject 3.

O: Oh, not by the nurses at all?

S: No, not by the nurses. The nurses were there mostly to do the injections and medicines, and that.

O: The technical things, in fact? They didn't nurse the patients? [In Mauritius].

S: (laughs) I should say that these, but I'm not sure still, you know; because I'm stop with, like you, really, you, if you stop with him for some time - you've been a nurse yourself, you might know how it is - but if I stop there for one or two days, you know, I might know more what's going on there.

Him in L.8 refers to a friend of the subject, whom the latter had visited in hospital in Mauritius; like you, really refers to the observer and equates the length of
time the latter spent with the subject with that of hospital visiting time.

The data below show ability or otherwise to maintain linguistic coherence in relation to nationality, status and year of training:

\[(S = \text{student}; \ P = \text{pupil}; \ 1,2,3 = \text{year of training})\]

\[
\begin{array}{|c|c|c|c|c|c|c|c|c|}
\hline
\text{Years} & \text{S} & & & \text{P} & & & \\
\hline
\text{Malaysian} & 2 & 1 & 3 & 1 & - & - & - & - \\
\text{Filipino} & - & - & - & - & - & 1 & 2 & - & 1 \\
\text{Ghanaian} & - & - & - & 1 & - & - & - & - \\
\text{Mauritian} & 2 & 1 & - & 1 & 1 & - & 2 & - & 5 \\
\hline
\end{array}
\]

As can be seen, of the 25 subjects, 10 were able to maintain linguistic coherence throughout the period of observation during long utterances; 15 were not. Of the 10, 9 were students and 1 was a pupil. Of the students, 5 were Malaysian, 1 was Ghanaian and 3 were Mauritian. The pupil was Filipino.

Example of coherence.

\textbf{Subject 1: (Malaysian: 2nd year student)}

\textit{Er - oh, not really. If I'm given the choice, I think I would prefer medical. It's quite interesting.}

\textbf{Subject 4. (Malaysian: 3rd year student)}

\textit{Well, I felt it was a better country than Malaysia, because before I came it was difficult to get a job in Malaysia after I left school. I went to do shorthand and typing and all that for two years.}

\textbf{Subject 5. (Malaysian: 2nd year student)}

\textit{S: And then I've heard that the training here is a bit advanced compared to our training back home. I mean, we don't have as much facilities and all that.}

\textit{O: You mean actual hospital space or equipment in the hospitals?}

\textit{S: Equipment and everything else, yes. Another thing is most of the medical terms that we use are in our language, which is Bahasa Malaysia, and as we are brought up in an English school it is quite difficult to speak in our own national language.}
Subject 6. (Malaysian: 3rd year student).

Patient: mumbles: Go home today.

S: Well, you are not going home today, dear. We'll see how much you are eating and how much you can keep down before we send you home, dear. You haven't been feeling very well.

Subject 13. (Mauritian: 1st year student).

(Discussing why so many old people are in geriatric wards in psychiatric hospitals)

O: I suppose it is just that there are no beds in the general hospitals.

S: You see, I think there is one or two things in it. Older people, I think, get confused more easily, that's why. They get confused so they are under a psychiatric illness and they are put in psychiatric hospitals. I think that is the main difficulty.

Subject 14. (Mauritian: 1st year student).

After that, about 2, if the weather is all right, we take them for a walk, or else they stay in the ward, you know. Then we have tea, and suppertime.

Subject 15. (Malaysian: 3rd year student).

We have already improved the health service now, because I remember when I was in primary school we used to have every month when each student was to be allocated, you know, time, and he could see the dentist so that the truck would come along and pick us up.

Subject 12. (Ghanaian: 3rd year student).

O: What are the nursing facilities like in Ghana? Have you got many training schools?

S: No, for psychiatry I know of only one or two I think. You see, the course here, the three-year course, after which you get the RMN, is not done in Ghana. I don't know whether it has been done now, but before I left it wasn't done. I mean, they were doing a course which is - well I would say a bit higher than the SEN course here.

Subject 9. (Filipino: 1st year pupil)

So I have to say, "May I beg your pardon?" I don't feel much difficulty in language communication because I can express myself freely, but it's just my accent, I think, which is a bit defective.

Subject 21. (Mauritian: 3rd year student)

S: No well, they asked me whether I wanted to do nursing -

O: Yeah, And you -

S: - because that was the only prospect apparently. So I said I didn't mind, because I couldn't find a job, you know. It was about time I started work. So I said I didn't mind, and they said "Well, you can go to England to study nursing because - there is a
school of nursing in Mauritius, but they can't take too many, you know".

Of the 15 who were unable to maintain linguistic coherence, 5 were students and 10 were pupils. Of the 5 students, 2 were Malaysian and 3 were Mauritian. Of the 10 pupils, 3 were Fillipino and 7 were Mauritians:

Examples of incoherence:

**Subject 2.** (Malaysian: 3rd year student).

(Discussing cardiac massage in cases of cardiac arrest).

You mean do the...(O: Yeah) Well, depends; if I happen to be here I got to do it, an' then I press for the buzzer, somebody else, Staff or who to do.

**Subject 3.** (Mauritian: 3rd year student).

O: But what happens if you're a pupil nurse and you go back to Mauritius? Would you have any status?

S: I should think so. I'm not sure ...

O: Because in some countries they don't accept it.

S: Because ... Well, I'm aware all the time that they are male or female nurses; to them you will wear just a white coat, and no white trousers ... just their own, you know. They wear their own; or else, if they've got uniform, probably they get the money to buy it or ... a little bit ... they've got ladies to go with trousers. It depends on the hospital.

**Subject 7.** (Mauritian: 1st year pupil)

Actually, it was my ambition to be a nurse, so ze only way I found I thought I could that I'd better apply in a hospital in England.

**Subject 8.** (Mauritian: 2nd year pupil)

You mean, er, which sort of nursing I like? Well, for me, I think its general I like it more. Psychotic - I might do part of training - not really to stick ... I'd rather stick on, er, general.

**Subject 10.** (Fillipino: 1st year pupil)

O: What are the facilities like in the Phillipines for nursing?

S: Oh, I think you're more advanced. I don't know ... I think it's just the same, but in spite of them ... you know, new inventions, it's just the same.

**Subject 11.** (Fillipino: 1st year pupil)

Usually, what I am always thinking is when I see those old people I think to myself, "Well, put me on their place. How I feel if people treat me badly? Very badly". So I'm sure they will feel the same thing. I always put me on the place. You know, "What if I do?" And, I put myself, and I say, "Oh, well, if I do that, people do things like that, how I feel about it?" and I'm sure they will feel the same thing about it, so the point is ...
Subject 16. (Malaysian: 2nd year student)
0: Why does psychiatry interest you in that way?
S: That point is general, whereas comparing general, you know it is there and the disease is there because it is something that you can see. We get different sorts of mental illness. It is so wide.

Subject 17. (Mauritian: 2nd year pupil).
O: Do you find the tutors easy to understand?
S: Yes.
O: They speak more clearly I suppose do they; than people on the ward, because on the ward it is just quick conversation?
S: Yes, just quick, because one thing it is their job, they are professional they have got to make sure that during this time that they are telling you, and you will give them the time.

Subject 18. (Mauritian: 2nd year pupil)
O: What sort of nursing facilities are available in Mauritius?
S: Well, you see, we don't have a lot of hospitals back home there is only a few. Suppose you need a good qualification, you know, like five O'Levels, or something like that, if you are teaching nursing ...
(incomprehensible).

Subject 19. (Mauritian: 1st year pupil)
No. You see what - I mean, my brother was talking about depression, about all this [psychiatric] term, but I was sitting among them one day, so I was completely lost. They were discussing about lumber puncture, cerebral (incomprehensible) ... I can't understand what they're talking about. Once I asked him he say, "Oh; I have a lot to explain to you later; you have to leave the company of where I talk, you see". But once you been taught down the nursing school, so there is no problem at all. You can discuss it with somebody else, you see. But I been here for three months on this ward, but we have a lot to do and a lot to learn.

Subject 20. (Mauritian: 1st year student)
(Instructions to a mentally subnormal woman on how to make a kite pattern on a board by winding cotton round nails in the board).
You know, if you lift them [= cotton] when you move from - to another place you see, you'll have to put it not tight. But if you move it down it will come out easily.

Subject 22. (Mauritian: 2nd year student)
(How to manage a patient having an epileptic fit).
S: Yeah, what to do. Just mere ...
O: What do you do?
S: Well, if your patient goes into fit, you make sure that he doesn't hurt himself; or, if he's in a place of danger we take him out of the danger - or take the danger out of his reach, you know? And just keep him, you know, sometimes they go into a spasm; they can knock their head or anything on the floor. You try to put anything under their head or where it won't hurt them. Elastic over their mattress or anything else - a cushion ... get hold of. And then you unbutton their tight clothing ...

Subject 23. (Mauritian: 2nd year pupil)

No. It is very hard to get them to talk. They might do, once they have been accustomed to that routine of work ... once you tell them. You start for breakfast; they all go to table, things like that.

Subject 24. (Filipino: 2nd year pupil)

S: I thought that it's psychirc --

O: Psychiatric...

S: Yeah; (incomprehensible) ... also interested, because I want to know some human behaviour, which be a good help later to my study in business position dealing with some people. So I said that is all right; I will get more experience from this; so I found out to my surprise much later*, and so I take a chance.

* [that it was Mental Subnormality].

Subject 25. (Mauritian: 2nd year pupil)

(Referring to a crying patient - mentally subnormal).

Like her, if, er - if you, you are - your assessment ... and if the examiner will see that case, she will let you with her, and see how you try to calm her, you see. (Not easily understood).

(The bracketed final comment was inserted by the transcriber).

As these excerpts show, there was a wide range of ability, from near-mother-tongue-speaker competence (Subject 5) to considerable difficulty in remaining coherent (Subject 24), the students in the sample showing a greater tendency towards coherence than pupils. A chi-square test showed this relationship between status and linguistic coherence to be significant at a level somewhat greater than 1% (p = .01). One reservation must be made, however. Those subjects who were assessed as showing a tendency towards incoherence were not necessarily always so. The following examples should be compared with those above for the respective subjects:

Subject 7.

Well, actually I sink zere is a difference between
nursing in Mauritius and nursing in England; as my friends tell me. I have got some friends doing nursing in Mauritius. I have told them how we nurse patients here, and he has, my friend, told me how he nurse the patients there. And I think there is a difference, you see, Ha ha.

Subject 16.

I mean, they [Malaysia] need more [psychiatric] beds as well, you see. I think that the rate of mental illness is going up, in actual fact, because ... (inaudible) ... so I think that mental illness is increasing there as well.

Subject 18.

O: How long will your student nurse training take you?
S: If I do it here it will take me 18 months but if I go and do it somewhere else it might take me 2½ years or two years, something like that. I am not sure.

No subject demonstrated total inability for linguistic coherence throughout the entire period of observation.

If the figures shown earlier are considered from the point of view of nationality and status, it will be seen that there were no Malaysian pupils, no Fillipino students, and that the Mauritians were almost equally divided. From the point of view of linguistic coherence, 5 of the 7 Malaysians, 1 of the 4 Fillipinos and 3 of the 13 Mauritians were able to maintain coherence throughout the period of observation. Group samples were too small for any general statements to be made but the figures would suggest that language competence is related to nationality.

5.3.2.6 Learner-patient Interaction.

Of the 25 subjects, 17 were involved with patients for varying lengths of time. Of these, 11 were subjects in General Training, 1 was in Psychiatric and 5 were in Mental Subnormality Training.

Table 54 (Vol.2, A.122) shows the type and extent of learner-patient interaction and whether the interaction was learner - or patient - initiated. Professional interaction was concerned with matters relating to the patient's well-being, nursing care or treatment: "How are you?"; "We're going to give you a blanket-bath". "Do you want a dressing-gown on?" "Is this your soap?"; "I'm just going to give you an injection". General interaction covered any topic which was not related to the above categories: "Have you
read the paper this morning?" "I used to think lying in bed was lovely - till I came into hospital!"

Each letter P or G represents a change of topic.

E.g:- (Pt: = Patient)

**Subjects 1 and 2.** (working together)

Pt: I got a Ford Escort in the - car, it's the firm's (G) car; I had it ... (F.student giggles)

(P) What did I do, mate?

**Subject 2.**

It's all right, dear.

**Subject 1.**

(P) Just lie on your side. (Pt: On my side?)

That's it.

Pt: Just the turn of Christmas for the firm, there's (G) 31,000 of 'em. That's the way I get around, and that's why I don't get such a sore bum as some of the blokes, like, you know, they do that much sitting. But to get around and see.

All references to patients which were not intended to involve the latter in interaction were omitted:

E.g:-

**Subjects 1 and 2.**

**Subject 2.**

We haven't got any [hair] brushes, Mr. - (To Subject 1)

**Subject 1.**

He hasn't got a comb - oh, yes he has ... The barber has just visited him.

Interaction ranged from one short instruction and response (v. supra) to sustained interaction:

E.g:-

**Subject 3.**

S: Do you want to use the bottle?

Pt: No, I don't want the jug now.

S: What did you call it? (Pt: Jug) Jug! It's a jug!

Pt: You 'ad a good laugh, didn't you?

S: I did, because when you asked me for it this morning, I thought, a jug of water. I was really surprised.

O: I've never heard that.

Pt: First time you laughed like that, I thought you was taking the mickey out of me. (S: Oh! No; I wasn't) (incomprehensible) ... something new (incomprehensible) ...

S: No, no, I don't like to laugh at you, you know that.
He's always jokin' to make fun of me, I mean they all laugh and, you know, we make fun.

As Table 54 shows, there was very little interaction between learners and patients in psychiatric or mental subnormality wards. The difficulties of finding patients has already been discussed. There were, however, further constraints even when patients were present. In the one instance when a patient was present during observation in the psychiatric field, both topic and duration of interaction were determined largely by the patient, who was a long-stay, epileptic.

E.g:-

**Subject 14.**

Pt: [on seeing the tape-recorder] I know about radio and television.

O: Do you?

Pt: Yes, I built my own set.

O: Did you?

S: When did you buy it?

Pt: Eh?

S: When did you buy the set?

Pt: Oh, a long time ago now ... I bought a set and took it to pieces ...

O: You bought a set and you took it to pieces.

Pt: And put it to pieces.

S: Why was that?

Pt: Put it all together.

O: This was a radio set, was it?

Pt: Wait a minute ... (pause)

S: Where is it now?

The patient did not answer this question and remained silent for some time. He re-entered the conversation to point out that the observer's "wireless" was not working:

Pt: That no can work.

His changes of topic were as unpredictable as his agreement to participate.

S: It records - er - on this tape everything you can say and do. It records, that's it.

Pt: Tape recorder ...

S: That's it, tape recorder, got it now?


S: Nowhere to live? But aren't you having letters?
Pt: I got two brothers, and a brother-in-law and a sister.
S: Where are they now?
Pt: Eh?
S: Where are they? Where do they live now?
Pt: One is a bus driver.

This learner was quite capable of pursuing any topic which the patient introduced but the excerpt illustrates the difficulties of interaction in certain psychiatric fields.

5 of the 6 subjects in Mental Subnormality Training were involved with patients to a greater or lesser extent. However, as the Table shows, interaction was minimal, with the exception of Subject 20.

This was largely due to the fact that patients could not talk or that what they said was unrelated to reality:

Subject 22.
S: But really most of them are - can't talk, really.
O: Yeah, that's what I wanted. They just lie here and sunbathe, do they?
S: Uh, well, that one will try to talk to you. Hello, Johnny? How are you?
Pt: I'm dancing.
S: You like dancing?
Pt: Dancing. Mm.

Subject 23.
S: He [a patient] won't be able to answer.
O: I see. It's that difficult, is it?
S: He can only remember his name.
O: I can see the difficulties. They are mostly like that, are they?
S: Yeah; most of them. I would say there are some better.
O: Those are the ones who are on holiday? *
S: Yes; they are the best ones; they can speak a bit.
(* = going away from the ward for the day).

Subject 24.
S: How they talk you know - that the only thing they talk is just like small child.
O: Hello. [To patient].
S: He calls Mr. S - .
O: Are you a boxer?
Pt: ... in the picture ... (rest incomprehensible)
S: Picture, TV.
Pt: She wet me.
O: She did what?
Pt: She wet me.
O: Did she? What did she do that for?
Pt: On the breakfast. She won't let me have that bottle -
S: Where? Inside there?

Subject 25.

O: And how much do they talk? Do they talk enough for you to understand, or do they make noises which you're -
S: No, no: 3 minutes - 2 minutes - that's all. Then they get fed up - and so - they do just like that, you know -

E.g:-
S: Yes, Annie? What are you doing now?
Pt: answers, but incomprehensible.
S: What do you want to do, Annie? Can you tell me what you want to do?
Pt: That lady shit herself and I have to look after her ... I washed 'er and now she's in bed.
S: Where did you put that? Where did you put it? Where did you left it? In your bath? In your locker? In your locker or in the bathroom?
Pt: In the bathroom.
S: In the bathroom. All right.
Pt: Now she's in bed. (Rest is incomprehensible)
Do you know what? A man started talking to me. He was after me ... and he was a married man.

Nevertheless this was not always the case. Subject 20 was instructing a woman in the Occupational Therapy Unit in how to fashion a geometrical design with string, winding it round nails in a board:

Subject 20.

First we'll do here, on the left-hand side, then up on the right, at the top then down here, on the left-hand side. Then we'll begin again the same procedure ... on the second nail ... and again, until it is completely done. In a bit ... You go further in ... Right. Down here now. ... This one ... here ... no ... then come again on the same nail again ...
You have missed that nail. On here first, on here. That's right. You don't come back here. Here. Come down ... down.

The woman made no verbal response to the Subject and
it was assumed by the observer that the woman was unable to communicate verbally. However, this was not so, for in order to test the assumption, the observer intervened after twenty minutes:

S: (to Pt.): Here ... No; you don't come here; up here.
O: M - , would you like a rest for a minute while I talk to you?
Pt: Yes.
O: What did you do before you did this?
Pt: I did sewing work, and I've done basketwork.
O: Did you like that?
Pt: Yes.
O: And did you make some baskets?
Pt: Yes; well one, and a shoe box.
O: I shall have a look when I go out. And what else have you done?
Pt: I've done cards - you know, when they used to have the cards.
O: And do you like working in here?
Pt: Yes.
O: What do you think about this?
Pt: Well, I'm not sure of this.
O: It's a bit complicated, isn't it?
Pt: A bit complicated to me. I can't do owt like that, you know.

It was clear from this exchange that the woman was quite capable of rational communication.

There were long periods of silence, always broken by the observer. It was assumed that the subject was unduly influenced by the tape-recorder but the Sister commented afterwards that though the subject was always willing to answer questions, he never initiated interchange. Since this subject was a first-year student, expecting to find himself in a psychiatric Training School - it is possible that he had not yet recovered from his bewilderment.

Regarding interaction between subjects and patients in the general sector, there were 85 professional interactions and 17 of a general nature initiated by learners.

E.g.:

Professional:

(* indicates change of topic)
Subject 2.
S 2: He hasn't got a plastic thing on his leg -
S 1: Don't think you need a dressing gown, it's so hot. Mm? Do you want a dressing gown on?
Pt: Yes, please ... I had one somewhere, but I don't know where they've put it.
S 2: All right.
Pt: It's an owld one but it'll do.
S 2: I'll get one for you.

Subject 4.
S: Do they speak English?
Pt: Well, they do until you move out of Stockholm and it's nearly all Swedish then - all the older generation. You've got to fling your hands around and everything.
* S: We are going to give you a mouthwash.
Pt: Are you?
S: Yes.
Pt: Good.
* S: When did you come in?
Pt: I came in Monday night.
* S: And what did you have done?

Subject 5.
S: Did you have a fall or something?
Boy: No, somebody jumped on me and hurt me.
* S: I must bring a sponge or a flannel or something to clean you with. (To Observer) In the other hospitals you usually take the bandage off and you bandage them again.

General:

Subject 2.
S: Have you seen the paper this morning?
Pt: Yes, I have; yes.
S: What did they say about Mr. Hill now?
Pt: 'Bout oo?
S: Mr. Hill - that professor in Uganda.

Subject 7.
S: How do you feel, Mr. K - ?
Pt: Oh, much better today, thank you.
* S: Are you expecting any visitors today?
Pt: Oh yes, I hope so, any'ow.
S: You'll be glad to see them, won't you?
Subject 8.
S: Open your mouth - thank you.
Pt: 'kyou.
* S: What book are you reading?

Subject 10.
S: Where's your comb gone?
Pt: In 'ere.
* S: Are you happy that you're going home, Mrs. B - ?
Pt: Yes, I am. I'm pleased to go home. We all are, aren't we?
S: Yes, you are looking forward to it, aren't you?
Pt: Yes, I've got no family but I've got good friends.

Patient-initiated interactions were much more evenly divided, being 21 professional and 25 general topics.
E.g:-

Professional:
To Subject 1. (After pause)
Pt: How long will I stop out here?
S: Till after tea.
Pt: After tea? Once I'm out I don't mind it.

To Subject 6.
Pt: (incomprehensible) ... medicine, is that?
S: Pardon?
Pt: What kind of medicine, is that?
S: No, it's not a medicine. She's been ...
Pt: Not a medicine.
S: He like it. Mr. F - you like it, don't you?

To Subject 6.
S: You are on BBC, you know.
Pt: You want to start up here with this arm.
S: Oh, thanks.

To Subject 9.
S: Oh, that's nice. You seem to be much better than yesterday, aren't you?
* Pt: Yes, I'm still getting a bit of pain.
* S: I'll tell you what I'm going to do. You're going to have a blanket bath today ...

General:
To Subject 2.
Pt: Haircut this morning, yes. Beautiful. No charge neither.
S: No charge, that's good.
Pt: Well, I couldn't have paid one, anyway. Lucky to get seven an' a 'alf a week. That's all it is, seven and a half -

To Subject 4.

S: No, my parents were from China - not my parents, my grandparents.

Pt: Were they? Do you know anything about Ikebana flower-arranging - Chinese, or Japanese?

To Subject 4.

S: You know why, don't you? All the television programmes over there are all American films, American ...

Pt: Yes, so you're from China, are you?

S: No, from Malaysia.

Pt: Malaysia, oh.

To Subject 6.

S: Hello, Bill. Bill. Hello, dear. Wakey, wakey. Just taking your blood pressure, dear. You're drowsy this morning, aren't you?

Pt: I want the ... I want the wireless.

S: You want the what?

Pt: I say I want the wireless on in a minute.

3 of the 11 subjects introduced no general topics at all (Subjects 1, 5 and 11). Of the 23 patients involved, 8 initiated no interaction at all; 3 introduced professional topics only; 7 introduced general topics only and 5 introduced both. From Table 5 it will be seen that the greater part of patient-initiated interaction of either kind was provided by the patients of Subjects 1, 2 and 3 (P = 13; G = 13). It would appear, therefore, that, generally speaking, patients do not initiate interaction, while learners tend to concentrate on interaction of a professional nature. This is understandable, since much of their interaction is concerned with giving instructions or explaining procedures:

E.g:-

Subject 1.

Bend your legs - that's it. Lift your bottom. Dig your heels and lift your bottom.

Subject 4.

We are going to give you a mouthwash.

Subject 2.

Would you like to roll over to me.
Subject 6.
  Just taking your blood pressure, dear.

Subject 7.
  Pt: Can you just - ?
  S: Yes, just going to.

Subject 8.
  Will you open your mouth, please? Can I have your hand? I want to take your temperature. Under your tongue. Close your mouth.

Subject 9.
  Would you just lift your hip? Would you just lift your bottom?

Subject 10.
  You can go in the day-room now if you want. Have you been to the toilet?

Subject 11.
  You take your time. No rushing at all. I will just take you to the toilet and give you a wash. Then I'll take you to the day-room ... That's right. You're doing very well.

As these examples show, much of the language of instruction and explanation is formulaic and therefore repetitious. It will be noted that the examples of linguistic incoherence do not include instances of instruction or explanation to patients, the reason being that none were found. All linguistic incoherence occurred during general conversation, either with the patient or the observer.

5.3.2.7 Difficulties in Understanding: observed and stated.
  There were 4 instances, involving 3 subjects, of observed difficulty in understanding, 3 in which the subject failed to understand the observer and one vice versa:

Subject 8.
  0: Is it - is the Mauritian training rather like the American training?
  S: Well, so far as I know, anyone can train as a nurse in my country.

Subject 7.
  0: And what period of your training are you in?
  S: I beg your pardon?
  0: What period of the training are you in?
  S: Er, two years.
  0: Done two years already, have you?
  S: No, I'm - I am doing my pupil nurse for two years.
O: Oh yes, but what stage of training are you at?
S: I'm doing my pupil nurse training.
O: How much have you done?
S: Sorry - this is my sixth month.

Subject 9.

O: And what stage of your training are you at?
S: What stage?
O: Yes, what stage of training are you at?
S: Ah, this is just my first training.
O: Ah ha, your first year?
S: First year, yes.

It is possible that, although difficulty in understanding the question: What stage of your training ...? seems to be evident, both subjects interpreted it from a different viewpoint than that intended. Since most overseas pupil-nurses intend to proceed to student-nurse training, it may be that these two subjects regarded pupil-training as the first stage and student-training as the second.

Subject 8.

O: Essential hypertension or secondary hypertension? You know, is it because of some illness he's got? Do they know what the cause of it is?
S: I've no idea. Just checking with the top place.

It was not at all clear what the subject meant by: Just checking with the top place. At the time she was entering the patient's blood-pressure recording on the chart.

In addition to the instances cited above - all of which involved the observer - 11 subjects stated that they had difficulty in understanding patients. Of these, 1 was in General, 6 in Psychiatric and 4 in Mental Subnormality Training. Four main reasons were given:

1. The mental confusion of physical or mental illness or of old age. (Subjects 6, 12, 14, 16 and 19).
2. Accent and dialect (v. supra: 5.3.2.4)
3. The idiosyncratic language of the mentally ill. (Subject 14).
4. The inarticulacy of mentally subnormal patients. (Subjects 21, 22 and 24).

One or two of the subject's comments in this respect have
been quoted elsewhere. (v. supra: 5.3.2.4)

**Mental confusion.**

**Subject 6.** (General)

I find it a bit difficult to understand old people.

Example of confused talk:

Pt: *(mumbles).* If I don't have it on. *[his radio]*

S: Speak a bit more clearly, Billy.

Pt: If I don't have it on. If I don't have it on.

S: Have it on?

Pt: No. If I don't have it on. Oh, can't make you understand. If I don't have it on, don't matter, does it? ... I'll put it on now.

S: Put your arm straight, Billy. That's it. There's a good boy.

Pt: Don't matter if I don't have it on. I can lay on me back and get the rest if I lay on me back. I wonder, what if I could go home today.

O: She's listening to your heart.

Pt: I didn't say that about me wireless.

S: You want the wireless?

Pt: No, I said I wonder if I'll go home today.

S: Not yet, dear, not today. You've got to eat properly first before you can go home.

Understanding of this patient was made more difficult by the fact that he had not got his false teeth in.

*(Psychiatric)*

**Subject 12.**

... but it is very difficult to understand some of them, especially the old ones ...  

**Subject 16.**

Like patients who are a bit confused, I mean, for that matter, anybody can't get through to them, you see. Otherwise we can get through to them with no trouble at all.

**Subject 19.**

At first it was a bit confused for me ... What I mean is, you know what they wanted to say you see, but sometimes a word they apply - you can't understand what they are trying to say. Because they are very old; they are a bit confused; sometimes they are restless, agitated. But you try to - I mean, say "Beg your pardon", and they say it again.

**Idiosyncratic language of the mentally ill:**

**Subject 14.**

Yes, we do have patients that talk and it's difficult
to understand them, even for people from this country. We have patients who form their own words ... and speech.

The inarticulacy of mentally subnormal patients:

Subject 21.

S: But most of the time according to the noises they make, they just sort of make a noise and you can't understand them.

O: Well how do you know what they want then?

S: Well, the thing is, um - well most of them are seriously subnormal. They can't talk, they just grunt, so I don't think there is much more communication you can - there is not much, you know, opportunity of communicating with them.

Subject 22.

O: How do you know when there's anything sort of wrong with them? Are they able to tell you in any way?

S: No, the thing is, we've got to observe certain - if there is something goes wrong with them, we will know by the mere observation ... They can't talk really, and so if something goes wrong they won't tell you.

Subject 24.

Yes - you know - because they have to talk like this ... How they talk - you know - that the only thing they talk is like small child.

5.3.2.8 Performance of tasks without adequate instruction.

10 of the 11 subjects observed were engaged in routine nursing care. 5 (Subjects 1, 2, 3, 4, and 9) were giving blanket-baths; 3 (Subjects 6, 7, and 8) were recording vital signs; one (Subject 11) was taking an old lady to the bathroom for a wash and the tenth (Subject 10) was getting an old lady dressed and ready for discharge. The 11th subject (Subject 5) was performing a technical procedure - the application of a figure-of-eight bandage for the support of a fractured clavicle. 9 of the 11 subjects seemed thoroughly familiar with their tasks and evinced no difficulty in performing them.

Subjects 5 and 9, however, were clearly unfamiliar with their tasks and performed them in a manner which suggested that adequate prior instruction had not been received.

Subject 5.

The subject, a 2nd year student, was to apply a
figure-of-eight bandage to a boy of five. It was inadequately applied so a Staff-nurse reapplied it. The procedure took approximately twenty minutes. The tape-script follows in toto. (S/N = Staff-Nurse).

0: I see.

S: When did you do it? Was it a week ago? Eh, Robert? Was it a week ago that you did it? Last week was it? I am going to give it a wash. I'll just go and ask if his father's brought a flannel or a sponge to wash him.

(Gap)

Subject putting on bandage; does not talk to boy.

S: This is not very big room is it?

0: I've seen better.

Another long pause while student is silent.

S: Keep straight. That's it. Is that tight?

Boy: What?

S: Is it tight? [Staff-nurse approaches.]

S/N: It's not tight enough.

S: Which side? This one?

S/N: It's not tight enough.

S: (to boy): Are you sure it's tight?

S/N: No, it isn't.

S: Shall I make it tighter?

S/N: Do it again, otherwise it will be too loose.

S: (to boy): It's not tight enough dear.

S/N: (to boy): Can you come here, pet.

S: (to boy): Come and sit here, Robert.

Long pause while Staff-Nurse reapplies the figure-of-eight bandage, giving no instructions to the student.

* S: Is it equal? Staff, the pulses are equal?

S/N: You have to take ... Both sides have to be equal to make sure the circulation's right.

(to boy): How does it feel, pet?

(to student): How old is he?

S: Five years old. Is that comfortable?

S/N: Put that [the safety-pin] far enough to get at it.

S: O.K. All right, Robert?

S/N: Is Mummy with you?

Boy: No, my Dad.

* At this point, the bandage reapplied, the Staff-Nurse held both the patient's arms down by his side while checking the radial pulses. Note that the subject had to ask
Subject 9. (First year pupil)

This subject was giving a blanket bath to a patient on the day following a major abdominal operation. The patient had an intravenous infusion running into the left arm and was to sit on the commode by the bedside while the bed was made.

Observer's recorded comment at the end of the observation period:

This nurse had no idea how to do a blanket bath for someone so ill, nor how to move a patient who has had such a major operation. She is obviously not used to getting patients up who have an intravenous infusion. This is a good example of someone being asked to do something for which they have been inadequately instructed.

Instructions to the patient on such an occasion, concerning movement, must be detailed and explicit if pain is to be minimised. Otherwise the patient may become frightened and limit all movement thereafter. Clearly, this subject was not aware of this:

S: Would you just roll over to nurse, dear? And I will wash your back.

O: Let me take this arm with me [the one with the intravenous infusion]. Now then, let yourself go loose and just roll. Don't try to raise yourself up. Just roll.

On getting the patient out of bed an attempt was made to draw instructions from the subject:

S: Here we are. Would you take her?
O: Oh, careful! (referring to the intravenous infusion).
S: Sorry, love!
O: Can I sit her up first.
S: ... (Inaudible) ...
O: Do you want me to sit her up first?
S: Yes, please.

When the moment came to get the patient out of bed, it was necessary for the observer to take over as the pupil had clearly forgotten about the intravenous infusion hanging from its stand and was also giving no instructions to the patient:

O: So that it doesn't pull too much. Look, bring your feet back on to the bed and dig your heels in. That's it. So that we can pick you up. All right?
Don't tense up too much if you can help it. Sit forward. This is the most difficult bit. Just lean back a bit, love, will you? Move your left arm back a bit, will you? Sorry, love. (Pause). It's not pulling too much, is it? (Pause).

To S: What about ...? [the intravenous infusion].

S: Sorry! (Pause)

O: What about ...? [Indicating it]

S: Shall I put ...?

O: Give it to me. Keep it up! Keep it up. That's right. (To patient) We don't want to leave your juice behind, do we? (Pause). Bring the stand round. It's not coming too much, is it? (To patient) Gently! Gently! Are you there? All right so far? (Pause).

S: All right now? We'll make your bed.
6. **DISCUSSION OF THE FIELD STUDIES.**

In conducting three field studies it was hoped to establish to what extent problems of communication exist for overseas learners and where the main areas of difficulty lie, as expressed by the learners themselves and their educators and as observed in both classroom and nursing practice. By comparing the three sets of data it was hoped to determine points of agreement or divergence, the extent to which such problems are acknowledged and/or understood and the measures taken to minimise or alleviate them.

With regard to the representation of overseas learners in the three types of training it was suggested (5.1.1.), on the basis of their representation in Nurse Training Schools, that questionnaire (Q - ) responses would show 61.9% in General Training, 23.8% in Psychiatric and 14.3% in Mental Subnormality Training. Actual representation of respondents was: 62.3% in General, 28.5% in Psychiatric and 9.2% in Mental Subnormality Training. Thus, proportionally, Psychiatric learners were slightly over-represented and Mental Subnormality learners slightly under-represented.

6.1. **Recruitment and Selection.**

The literature suggests (3.3. iv) that past practice in recruitment and selection has been a contributing factor in overseas learners' problems by presenting them with a confusing and heterogeneous picture of what is or is not acceptable for entry to nurse training and consequently their suitability for the various types of training.

According to the Principal Nursing Officers for Education (PNOEs) interviewed, this would still appear to be the case. Most Training Schools continued to recruit direct from the country of origin, less than one-third having arrangements for preselection before the prospective candidates leave their home countries. The number of O Level subjects required varied from two to six, the subjects and grades required varied and there was a considerable number of additional provisos and conditions imposed.
on overseas learners over and above those required for indigenes. Since almost 60.0% of overseas learners depended on friends or relatives and approximately 19.0% on advertisement for information regarding Training Schools, it is reasonable to assume that many are not in full possession of the facts before coming to the UK. In fact, three-quarters of the Q-sample said they knew what the requirements were for nurse training before coming, while only 56.0% were aware of the different types of training available, as opposed to 96.6% and 91.4% respectively of indigenes, and many comments made in the questionnaires regarding choice of both training and status reinforce these figures. With reference to choice of training, one student-nurse commented: "Not exactly because I didn't know this was a Mental Subnormality hospital", while one pupil-nurse remarked regarding status: "I didn't know the difference". Many of the comments in Appendix XI (Vol.2, A.106-111) are indicative of this and several subjects in the Participant Observation (PO-) sample corroborated them. Six subjects in the latter in Psychiatric or Mental Subnormality said either that they themselves had not known the difference or that they knew of others. Such lack of knowledge sometimes resulted in overseas learners finding themselves following a training they had not anticipated. Overall figures for the Q-sample showed that learners in General Training were statistically more likely to have chosen their training than those in Psychiatric or Mental Subnormality, this being significant at the 1% level, while indigenes were more likely to have chosen their training than overseas learners, significant at the 5% level.

It is possible, however, that many overseas learners in Psychiatric and Mental Subnormality chose such training because entry was easier (see Table 12, Vol.2, A.45) and certainly three subjects in the PO-sample admitted that they had taken what they could get, though they would have preferred General Training. This factor may well account for the high level of choice in the Q-sample, where almost 90.0% of students and all pupils chose their own training. This would corroborate UKCOSA's findings (1,p.36) that:
"A number of nurses admitted that they came to these hospitals precisely because they were easy to gain admission to."

It is, however, hard to understand why, in the Q-sample in the General field, three students and five pupils said that they did not choose. Since General Training is much sought after by overseas nurse-learners, it may well be that the subjects misinterpreted the question. On the other hand, it is possible that they were among those who either applied to their Ministries for jobs abroad or who were so deployed following a request for recruits by a Training School to such Ministries, since such candidates seem to have no choice where they go.

With regard to status, most overseas student-learners in the Q-sample said that they had chosen their own status, while for pupil-learners figures were much lower, being approximately three-fifths in General, three-quarters in Psychiatric and two-fifths in Mental Subnormality. Two of the PO-sample said they had not chosen. This would appear to be a function of their being from overseas since statistically indigene subjects were much more likely to choose their own status. The cause would appear, in some cases, to be lack of accurate information, since the relationship between length of schooling at secondary level and status was significant. It seems that the General Nursing Council's (GNC) 5-year minimum rule is applied throughout nurse training, except in very special circumstances. This may seem obvious since, although Training Schools may ask for more than the minimum requirements, they may not accept less. However, it is worth stating the obvious since the number of pupil-nurses in the Q-sample who did not have five years' secondary schooling (31.4%) does suggest that they might not have been fully aware of a) the entry requirements themselves and b) their enforcement. This assumption is strengthened by the figures in Table 30a (Vol.2, A.72), where only three-quarters of the subjects had received information concerning entry requirements before coming to the UK. What is somewhat surprising is that, given that 84.0% of subjects in the Q-sample had relatives or friends in the UK
before they came, the overall figures in Table 30 relating to information on the National Health Services, British customs and so on are so low. It might have been expected that they would be much higher, particularly since three-quarters of the total sample had friends or relatives in nursing and/or medicine. It can only be assumed that the contacts had either not been in the UK very long; or that they were infrequent correspondents; or that advice on such matters was neither sought nor given or that the contacts were not very strong.

Whether or not overseas learners chose initially to do Psychiatric or Mental Subnormality Training or to be pupil-nurses, the studies showed that for many the ultimate objective was General student-nurse training. One PNOE remarked that most if not all overseas pupil-nurses in Psychiatric and Mental Subnormality Training in that particular Training School sought General Training as student-nurses - though they were not always capable of it - as soon as their pupil-nurse training was completed, rather than seek student-nurse training in Psychiatric or Mental Subnormality. To this end they went from School to School trying, often unsuccessfully, to find a place. The Q-sample showed a similar pattern, indicating also that indigenes were statistically much less likely to want to change to General Training, and many subjects in the P0-sample stated their intention of trying for General Training and/or student-nurse training.

6.2. Entry Requirements.

Comparison of indigene and overseas applicants' suitability for nurse training, based on secondary school certification vis-à-vis Training Schools' requirements, is interesting. The majority of Schools in the PNOE-sample required English, usually specifying English Language. Of the Q-sample, (Table 29, A.71) almost all overseas learners had English Language compared with just over two-thirds of the control group. In addition, more than half the overseas sample had English Literature, as opposed to two-fifths of the control group. History, Geography, Mathematics and the Sciences were the other subjects which
were held by appreciable numbers of both groups. Again, overseas learners were better represented; approximately two-thirds had History compared with less than a half of the control group. Geography and Mathematics were popular subjects with both groups, though nearly twice the percentage of overseas learners had Geography and more than twice the percentage had Mathematics as the control group. Regarding the Sciences, here again overseas learners held more certificates than the control group, 46.8% having General Science as opposed to 3.8% of the control group; 23.9% having Biology as opposed to 45.3% and 14.9% having Physics compared with 7.6% of the control group. However, as Table 12 (Vol.2, A.45) shows, many Training Schools specified the grades required and this question was purposely not asked in case overseas learners should suspect its motive. No comparison on this basis can therefore be made but one PNOE did suggest that overseas learners were "better educated" than indigenes and that this sometimes caused problems in classroom teaching.

Nevertheless, many Training Schools showed a certain amount of mistrust concerning the "paper qualifications" of overseas learners because of the possibility that they might not be genuine. Two of the PNOE-sample commented that certificates could too easily be acquired at a price and two tutors in the PO-sample remarked upon the difficulties posed by prospective overseas learners offering bribes for places in the School. One tutor added that some overseas candidates wrote to say that they had not got the necessary qualifications and could not afford the bribes for documents. Could the School help? This matter was also the subject of discussion by the Kings Fund Working Party and their report commented (2, p.2) on the possibility of overseas candidates being able to buy GCE O Level certificates. Furthermore, a few years ago one overseas applicant offered the editor of the Nursing Times a ring "... worth at least £500" for a place in a School of Nursing (3). While there seemed to be general agreement that the number of overseas learners with bogus certificates was probably very small, there was no doubt that such a practice called into question the validity of overseas
certificates.

Whatever the reasons, there is no doubt that many overseas applicants with acceptable educational certificates for student-nurse training find themselves in pupil-nurse training, the proportion being far in excess of that of indigenes. The Q-sample showed that 35 overseas pupil nurses had acceptable certificates compared with 4 of the control group and that therefore overseas learners with acceptable certificates were statistically much more likely to be found in pupil-nurse training. Thus while an acceptable certificate is necessary for student-nurse training it does not guarantee it.

One of the PNOE-sample suggested that overseas qualifications were often misleading, since some candidates appeared "properly qualified on paper but on arrival at the School of Nursing, they can't converse with anyone". This statement confuses educational attainment with competence in Spoken English, which are not necessarily interdependent. It does, however, suggest language difficulties in a particular sphere and this was corroborated by another PNOE who stated that many overseas candidates who showed the intellectual ability for student-nurse training could not cope with it from the point of view of language. Consequently, one of these Training Schools asked either that the medium of instruction at school should have been English or for a Grade I - III in English Language at O Level.

Analysis of the Q-sample showed that medium of instruction at school was indeed related to nursing status, this being statistically significant at the 1% level, while there was no relationship between nursing status and the informal use of English in the country of origin. This may also be stating the obvious, as with length of schooling, since if the medium of instruction at school is English, the subject's use of it is at a formal, more intellectual level, and he or she is thus more familiar with using it in this context. On the other hand, if English is used informally it tends to be at the local level of competence and the registers culturally determined (See 2.3.2). This does not necessarily equip such a
person to operate in a milieu other than his own, where accent, dialect and culture are all very different. Notwithstanding this, from informal comments made during the field studies it appears that many people believe that if English is the second or even third language of a country, the relevant national should, by definition, be as competent as a mother-tongue user in the spoken field.

6.3. **Language Difficulties.**

An overseas nurse-learner, as demonstrated in the field studies, has to cope with language in two distinct spheres: the classroom and the clinical situation. Some of their problems are peculiar to one or other sphere; some occur in both, as, for example, the problems of local accent and of lack of knowledge of colloquial English. All three field studies showed that overseas learners' language problems lay mainly in the field of Spoken English, where difficulties in both understanding and speaking were both admitted and observed.

With regard to the Q-sample it was shown that 78.2% of overseas learners had difficulties of some kind, either of understanding or speaking to patients, fellow-learners, senior staff or teaching staff and in reading or writing, compared with 65.0% of the control group. Moreover, overseas learners were statistically more likely than indigenes to have difficulties in more than one area. In neither the overseas nor the control group was the likelihood of difficulty related to status. In the P0-sample, 17 subjects admitted to difficulties - all in the field of Spoken English - 11 with initial and 6 with continuing problems.

The question of understanding local accent was clearly seen by both educators and learners as one of the root causes of many of the overseas learners' problems. Of the PNOE-sample, 24 saw it as a major problem and in the Q-sample, many subjects said that they had difficulty in understanding because of accent. This was substantiated by the 65.5% of overseas subjects who, when specifying course components, said that it would be helpful to listen to different English accents as compared with 25.7% of the control group. In the P0-sample, of the 17 subjects who
admitted to language problems, 9 commented specifically on the difficulties caused by accent.

In the classroom observation it was noted that the majority of tutors had regional or foreign accents and over half of these were marked. It might be said that indigenes have as much difficulty with understanding regional accents other than their own but it should be remembered that regional recruitment of indigenes is usually local (see 1.3.9.a) and that therefore such learners understand and often have the same accent as the tutors. The Q-sample certainly showed that overseas learners were much more likely than the control group to have difficulty in understanding teaching staff; this was statistically significant at the 0.01% level.

Nevertheless, classroom observation suggested other possible reasons for overseas learners' difficulties in understanding teaching staff, one of which was the use of the casual style of discourse by some tutors, particularly the use of slang and the failure to provide background information on it: for example, one tutor's use of the word "dodgy" in an otherwise formal utterance or another tutor's reference to "keys down the back" as a cure for nose-bleed. As Joos remarks (4, p.38) in a slightly different context (referring to false intonation in a formal speech):

"... the fog of confusion which this spreads over the listeners' attention will render approxi-
mately six subsequent words inaudible to them. Meanwhile they must first detect the absurdity of what they plainly heard; forget the pseudo-sentence but retain the list of its words in sequence; third, by trial and error construct a plausible sentence from that list ..."

Since indigene learners also used slang and/or highly allusive language, which would exclude any outsider, it is likely that an overseas learner misses a considerable amount of what is said in the classroom and the fog, at times, must be very dense. In the Q-sample, 8 subjects mentioned slang and/or colloquial English as a source of difficulty, as did 5 subjects in the P0-sample, though neither group related the difficulty specifically to the classroom, and two of the PNOE-sample suggested that "lack of knowledge of colloquial English" was a problem.
It should be noted that the source of difficulties in understanding teaching staff appeared not infrequently to be the tutors themselves. The instances of inappropriate methods of presentation of practical procedures, inadequate explanation of theory and lack of advance organisation of material – which were disturbingly frequent – observed in the classroom would almost certainly compound the initial problems of overseas learners and may well account for the difficulties in understanding experienced by some indigenes.

In addition to difficulty in understanding teaching staff, many learners admitted to difficulty in speaking to them. Two and a half times as many overseas learners as indigenes had this problem, though relatively speaking this was the area of least difficulty in the Spoken field for overseas learners. Nonetheless, overseas learners were statistically more likely than indigenes to have difficulty in this area and 26 of the PNOE-sample said that overseas learners had difficulty with general conversation, adding that a similar comment was frequent on ward reports. Classroom observation tended to corroborate this, since overseas learners were shown to have difficulty in formulating answers and there were several instances which indicated that they had difficulty in remaining linguistically coherent when attempting to answer at length or when joining in discussions.

With respect to the field of Written English, 15 of the PNOE-sample said that overseas learners had difficulties, though all were agreed that they were less marked than in the Spoken field and one PNOE suggested that indigenes probably had difficulties as well. This was substantiated by the Q-sample, particularly with writing, since approximately one quarter of both the overseas and control group said they had difficulty with writing, the control-group figure being slightly higher. Two overseas learners said that they could not write fast enough, two said they had difficulty in expressing themselves and one commented: "Quite, now, due to language deterioration".

As regards reading, 18.0% of overseas learners acknowledged some difficulty, nearly four times as many
as the control group. However, the comments made were sometimes unexpected, since several subjects remarked upon difficulties with pronunciation. This presumably refers to the reading aloud of ward reports, though they were not specifically mentioned. Only one or two comments were concerned with problems relating to text-book reading, such as "big fat words".

In the clinical sphere the number of overseas learners who had difficulty in understanding or speaking or both was much greater. With regard to patients, a substantial majority of the Q-sample - nearly twice the percentage of the control group - had difficulty in understanding. Of the PO-sample, 11 - mainly in Psychiatric and Mental Subnormality Training - said they had such difficulties. Reasons given, both by the Q-sample and PO-sample, were concerned with the patients' illness or incapacity, though two subjects in the Q-sample remarked that "they do not speak good English" and several in both samples considered the speed of speech to be a contributing factor. One Q-sample subject commented: "[No], I don't find any difficulty in understanding patients or friends but I have been through a lot of problems before coming at this stage".

With respect to understanding senior staff, over half the Q-sample overseas learners had difficulty, compared with over a quarter of the control group and three comments were made by PO-sample subjects. Two said that they did not understand instructions and the third that overseas learners "just guessed and hoped they were right".

As regards difficulty in speaking to patients and senior staff, the number of overseas learners was again much greater than the control group in both categories, being twice as high for senior staff and four times as great for patients. Very few comments made by overseas learners regarding these two categories were concerned with actual language difficulties due to lack of fluency or grasp of English. They regarded the problems as more cultural, since three subjects in the Q-sample mentioned racial prejudice and two subjects said that the difficulties arose because of shyness. One South East Asian put it very succinctly: "Yes, because of our shyness and their prejudice against foreigners". Certainly one of the
PNOE-sample remarked that patients preferred to go to hospitals with a high indigene percentage and another observed that overseas learners "take a lot of stick from patients because they can't speak English very well".

Notwithstanding the cultural causes, there was some evidence to suggest that language problems play an equally important part, at least in speaking to patients. Two of the PNOE-sample observed that overseas learners do not talk to patients, except on a professional level. The clinical observation confirmed this, showing that, in general, patients did not initiate interaction and overseas learners tended to concentrate on interaction of a professional nature. This is perhaps because language used in professional interaction is formulaic, repetitious and transferable and therefore easier to learn and produce. Furthermore, professional interaction is circumscribed and utterances are shorter, while general conversation requires greater linguistic reserves and a wider topic-range. This argument is strengthened by the observation that linguistic incoherence was not shown in such interaction, even by the most linguistically incoherent subject in general conversation.

Since the clinical observation was primarily concerned with learner-patient interaction, no such generalisation can be made regarding difficulty in speaking to senior staff. However, the three instances which occurred during observation would suggest a reluctance to engage in such interaction. The failure of the senior member of staff to either instruct or to speak to the learner who applied the figure-of-eight bandage has already been discussed (5.3.2.8). The second instance concerned two visits, during a blanket-bath, of a doctor and senior member of staff. On neither occasion did either address a single word to the learner, either to formally interrupt the procedure, or to give instructions or to formally indicate that the procedure might continue. Such attitudes must surely influence a learner's perception of what is or is not permitted between qualified and learner-staff. The third instance, also already discussed (5.3.2.6) concerned the learner in Mental Subnormality.
who did not converse with the patient and who was said by the Sister never to initiate interaction.

As regards difficulty in understanding or speaking to learners in the same group, one of the PNOE-sample suggested that there were problems of understanding amongst learners themselves and this was corroborated by the number of Q-sample subjects who stated that they had difficulty in this category. Just over one-third of overseas learners said they had difficulty, compared with well over half of the control group. Indeed, difficulty in this category accounted for more than half the total difficulties of the control group. It would seem, therefore, that there is a high rate of mutual misunderstanding between overseas and indigene learners. There is apparently less difficulty in speaking to each other, though approximately a quarter of both groups admitted such difficulty, one overseas subject suggesting that it was because their interests were not the same as those of indigenes. It is possible that these difficulties are perpetuated by the practice in some Training Schools of putting overseas compatriots in the same Nurses' Homes, one of the PNOE-sample commenting that it was a deliberate policy of the Training School in question.

Clearly, such a policy would naturally result in the use of the mother-tongue during off-duty hours but, although 26 of the PNOE-sample said that this was so, only 5 thought that it affected progress in English. One subject in the PO-sample made a similar suggestion, commenting that only by talking to foreigners [sc. English people] could an overseas learner make progress. However, of the Q-sample, very few subjects said they spoke wholly in their respective vernaculars. Approximately a half used a mixture of their mother-tongue and English and almost half spoke wholly in English.

According to two PNOE's improvement in English took approximately six months, though for the 5 PO-sample subjects who specified, the length of time ranged from one week to a year. The other 6 subjects who admitted to initial difficulties did not specify. The remaining 6 subjects who acknowledged language difficulties were still
having serious problems after a year or more.

6.4. **Educational Difficulties.**

When PNOEs were asked whether overseas learners evinced any difficulties with nurse education, two main problems were suggested: firstly, their non-participation in Group Discussions and secondly, their problems with self-teaching.

Regarding non-participation, 25 PNOEs saw this as a major problem, many giving cultural factors as the main causes: namely, that overseas learners have been taught to venerate their teachers and to speak only when spoken to, or that they do not like to lose "face". Only one PNOE suggested that it was due to language difficulties because of the necessity to translate and retranslate and one PNOE commented that indigenes were equally reluctant to participate.

Concerning the translation and retranslation, this is possibly a major factor, since Sen, in her study (5, p.136) found that of 264 overseas learners, only 13.6% thought wholly in English, 42.8% used both the mother-tongue and English and 43.6% thought wholly in the mother-tongue, and that facility of thinking in English was highly significant when related to performance in English. Nevertheless, with respect to the cultural factor, according to Q-sample responses the majority of overseas learners said that they were familiar with Group Discussions since they were used in schools in the countries of origin, and this applied to a greater percentage of overseas learners than it did to the control group. (Table 40c, Vol.2, A.85.) It would be reasonable to suppose, therefore, that overseas learners would have less difficulty with this technique than indigenes. Although few classroom sessions observed involved Group Discussion as such, observation revealed a number of linguistic factors which might well be expected to inhibit overseas learner-participation in this field.

The difficulties posed by local accents and the use of slang, with Joos's consequent "fog of confusion" have already been noted, as has the overseas learners' greater
likelihood of difficulty in understanding the teaching staff. To these difficulties must be added the indigene learner's near-total ellipsis when answering questions and the speed at which they do so. These factors alone would be sufficient to inhibit participation. If, however, as Sen suggests, the majority of overseas learners think in their own language, leading to the necessity to translate and retranslate, it is clear that overseas learners have neither the linguistic facility to make their contribution nor the time in which to do so. One PNOE suggested that the length of time that the overseas learner had been in the UK was an important factor and another commented that it took "about a year" to persuade overseas learners to participate. Certainly, what learner-initiated participation there was in the class-room activities was dominated by indigenes. One PNOE remarked that the number of compatriots per group was important since, if the number was high enough, an element of competition was introduced and overseas learners were then more likely to participate. Since overseas learner-participation was so meagre and few groups had high numbers of compatriots, this statement could be neither substantiated nor challenged.

With respect to overseas learners' difficulties with self-teaching, one or two PNOEs suggested that they were the result of the didactic teaching of many countries. This was substantiated to a certain extent by the Q-sample's response to the question of choosing for themselves or being told what to do in their private study time. The greater majority were expected to organise their own study though an even greater majority of both overseas and indigene learners would have preferred to be told what to do, being nine-tenths and less than three-quarters respectively. Notwithstanding the large majority of indigenes in this category, overseas learners were statistically much more likely to want to be told than the control group. Furthermore, in the classroom observation, the tendency towards rote-memorisation and regurgitation was apparent in some overseas learners' answers, often with little real cognisance of the question asked. These factors were not apparent in indigenes' answers.
6.5. **Differences in language competence between national groups.**

When asked if they perceived any difference in language competence between the various nationalities, most PNOEs gave definite answers. 9 PNOEs considered Malaysians to be most competent. 4 thought that Africans were least competent, 4 felt similarly about Filipinos and 4 felt the same about Mauritians. Clinical observation seemed to uphold these opinions, since 5 out of the 7 Malaysians remained linguistically coherent throughout the period of observation, compared with one out of 4 Filipinos, and 3 out of the 13 Mauritians. Since there was only one African in the sample no comparison can be made. Moreover, all Malaysians were student-nurses, all the Filipinos were pupils and the Mauritians were almost equally divided. While no general statement can be made from so small a sample, within the sample linguistic coherence appeared to be related to both status and nationality.

6.6. **Tutorial Difficulties.**

When PNOEs were asked whether the teaching of mixed national groups caused difficulties for the tutors, the greater majority said that it did not. In view of the acknowledged variation in language competence, this assertion is somewhat surprising since the literature on the teaching of multi-racial groups suggests that, in general education at least, the difficulties are quite considerable. Nevertheless, 3 of the above and 6 other PNOEs remarked that there was a problem in knowing whether overseas learners, particularly Malaysians, have understood. However, classroom observation showed that tutors tend to involve overseas learners less, since only one third of the questions asked of specific learners were put to overseas learners, though the latter were statistically less likely to answer than indigenes if they were.

It was also said that overseas learners do not seek clarification and the classroom observation showed that, on the whole, this was true, except for one group.
Student-nurse learners in General Training sought clarification almost as often as indigenes and well up to the expected level (−7%).

It should be noted, however, that there was evidence to suggest that if tutor-initiated difficulties are serious, as, for example, in Session 8, all learners will cease to participate, even to seek clarification.

6.7. **Orientation programmes and extra-nursing activities.**

Although 15 of the PNOE-sample said that their Training Schools conducted orientation programmes, only 7 Q-sample subjects mentioned them when asked how they spent their time in the UK before starting training. Since six Training Schools had 7-day programmes and two had 14-day courses, this discrepancy is somewhat puzzling, though there are three possible explanations. Firstly, some PNOEs said that their courses had been introduced recently and it is therefore possible that many of the Q-sample had started training before their introduction. Secondly, 61 subjects did not specify how the time was spent and some of these may well have attended such courses without thinking to mention it, or they may have considered it as part of their training. Thirdly, those who did not reply to the questionnaire may have constituted the majority of those who attended orientation courses.

With regard to an English Language component, only two PNOEs said that their courses included one. Most Training Schools had tried but had abandoned them because of lack of interest on the part of overseas learners. It was not easy, however, for learners who wanted to attend courses elsewhere. Although 17 PNOEs said that some learners followed extra-nursing courses, they felt that the number involved was small. Six mentioned English courses but were of the opinion that learners seldom completed them because they were not very helpful. Furthermore, there were difficulties with off-duty. This was confirmed by the Q-sample, which showed that of the overseas group 11% were following courses, the greater majority
studying English, and of the control group 27.1%. Indigenes were statistically more likely to be following courses and the subjects being studied by both groups suggest that overseas learners were furthering their education, while indigenes were pursuing hobbies or interest-subjects. Several of the overseas subjects commented that they would like to follow some course but that they either had no time or that the unpredictable nature of duty-rosters precluded it. It is true that nurse-training, where movement from hospital to School of Nursing and from hospital to hospital - frequently some distance from the parent-hospital - often for up to twelve weeks at a time, makes the pursuit of extra-curricular activities very difficult. Furthermore, nurse-training itself involves private study and compulsory written work which, in the main, must be done in the learner's off-duty time after a hard, and often stressful, period of duty. It is not surprising, therefore, that so few find either the time or the energy.

Nonetheless, there is a clear need for language tuition for, when asked if a language course specifically designed for nurse-learners would be helpful, the response from both learners and educators was overwhelmingly positive. 29 of the PNOE-sample agreed, one adding that it would also be useful for indigenes. As for learners, almost all from overseas and well over half the indigenes said they would like a course, though, statistically, overseas learners were more likely to want one than indigenes.

It is evident from these field studies that the problems of communication facing overseas learners are considerable in number and serious in nature, often involving the majority and frequently a substantial minority.

If what is learnt in the classroom affects performance in the clinical situation - and it must - the difficulties in understanding for overseas learners and the failure of tutorial staff to elicit to what extent understanding has occurred must be matters of great concern. It is disturbingly clear that while nurse educators
are, to some extent, aware that problems exist, they are seldom conversant either with the nature, the extent or the causes.

In the clinical situation the difficulties are even more severe. Since the majority of overseas learners had difficulty in understanding patients and senior staff, almost half had difficulty in speaking to senior staff and a substantial minority had difficulty in speaking to patients, one must question the quality of both ward teaching and patient-care. Nor do all overseas learners benefit from the moral support and cohesion which, as Hutty (6, p.25) suggests is characteristic of a learner-group, for there is, in many cases, both a lack of understanding and difficulty in communicating between overseas and indigene learners.

Little initial help seems to be given either in acclimatising to their new situation or in coping with language problems and the majority, if the Q-sample's experience is at all representative, go straight to their Training Schools and start training immediately. Current recruitment and selection policy, which, from an overseas learners' point of view, is still confusing and heterogeneous, often results in those Training Schools being other than anticipated, offering a training which is either unwanted or previously unheard of at a status-level which is not recognised in many of the countries from which overseas learners are recruited. The undoubted unhappiness, resentment or disillusion that this causes, and to which the comments in Appendix XI (Vol.2, A.106-111) testify, can only add to an already extremely difficult task.

These, then, are the problems as revealed by comparison of the three field studies. The question remains as to what extent they originate from or are influenced by background factors.
REFERENCES AND NOTES

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7. GENERAL DISCUSSION.

7.1. The influence of social and psychological factors on overseas learners' problems.

It was shown earlier (2.1.) that in many developing countries the ties of kinship are both strong and binding, resulting in a deep sense of caring and of responsibility. The older generation are loved and respected, cared for and protected by the kin-group and it is incumbent upon the successful members of the family to provide for those who are too young, too old or unable to do so for themselves.

It was also seen (2.4.) how, when a person falls ill, acceptance of his entry into the sick-role - particularly in the field of psychiatric disorders - his treatment and his return to full health becomes the responsibility primarily of the kin-group but ultimately of the whole community. The illness of one is regarded as a crisis for all and the kin-group is, in part, held responsible for the sickness of its member. The sufferer is cared for at home, except in very special circumstances, when hospitalisation becomes necessary for the seriously disturbed or violent and the patient is no longer controllable. When hospitalisation does become necessary, it carries a stigma for both patient and family, as the field studies show (5.3.2.3). Beliefs about the origins of sickness determine their beliefs about its nature and treatment and a strong continuity with the dead, coupled with the very great likelihood of dying in infancy or in the early adult years influences their attitude to dying.

All this is very far removed from the nuclear family of England and Wales, the early separation of offspring from their parents and the consignment of old people to either hospitals or Homes. Relatively few ill people, particularly in the case of psychiatric disorder, are cared for at home by their families and death is avoided or staved off as long as possible at almost any cost.

Thus, as suggested in the Kings Fund Report (See 3.3.1), the overseas learner has a considerable adjustment to make to her new milieu and, given the fundamental
dichotomy in attitudes and approach, initial problems of some magnitude might be expected.

As both the literature (3.3.1) and the field studies (5.3.2.3) show, this is indeed the case. Many overseas learners have difficulty in accepting and adjusting to the social mores and attitudes to psychiatric illness and mental subnormality with which they are confronted in such hospitals. They find it particularly hard to understand why so many old people are found in psycho-geriatric wards when, in their opinion, there is nothing wrong with them except old age and uncaring relatives. The consignment of the mentally subnormal and non-acute ill psychiatric patients, such as depressives or neurotics, they find equally shocking, and much of the anxiety and depression they see they consider to have been caused by the lack of family caring. This tends to cause impatience towards the patients, whose entry into the sick-role they clearly do not accept, and lack of sympathy for the relatives who, though responsible for the illness, have abdicated their responsibility. Thus, where codification and evaluation are obviously not shared, overseas learners have great difficulty in correctly interpreting the situation, and of distinguishing the normal from the abnormal, and therefore of communicating effectively with its participants.

It might be argued from the data in the literature (3.2.1.1) that indigenes also have considerable difficulty in adjusting to the abnormal situation - and this is true. They have one great advantage over overseas learners, however, and that is their knowledge of the milieu. When an indigene takes up nursing in England, not only is the language the mother-tongue and the culture part of her heritage, but, as has been described elsewhere (1,p.248), she already has a substantial foundation of knowledge - and this seldom seems to be appreciated - concerning attitudes to birth, sickness and death, the language of the same and much of the vocabulary of the sick-room. Not only has she had the opportunity to acquire firsthand knowledge of the workings of the National Health Service (NHS), with General Practitioners, dentists, School Clinics and so on; she has also had the opportunity to acquire a considerable
amount of secondhand information either from documentary evidence or fiction, through books, journals, films, radio and television. Most overseas learners have little or no exposure to any of this and, as the Q-sample responses showed, although a substantial minority of indigenes had less than an adequate knowledge of the NHS or hospitals, a very large majority of overseas learners had little or none. Furthermore, it is noteworthy that, when asked if they found medical language very different from everyday language, overseas learners were statistically more likely to say that they did than indigenes.

One other factor which, whilst also resented by indigenes (3.2.1.ii), is, to many overseas learners, culturally inexcusable, is the question of public criticism. This is particularly prevalent in the nursing profession and to many overseas learners, particularly Filipinos, with their hyper-sensitivity to criticism, it is extremely upsetting - so much so that, as Sen discovered (3.3.ii), its effects are statistically related to final performance, though more so for Asians than Africans. The latter, on the other hand, are more likely to be upset if called "stupid" or "silly" because of the implied threat of madness. As one PNOE remarked "I told a Nigerian she was a silly girl and she was upset for days. I couldn't make it out at all". It is clear, therefore, that much unnecessary distress is caused by mutual cross-cultural misunderstanding.

7.2. The influence of the educational factor.

The educational background (2.2.) described the lack of educational facilities, the generally poor quality of the teaching, the heavy accentuation on examinations and their function as selection-devices and, as a result of all this, the concentration on academic subjects, favouring the arts at the expense of the sciences. Didactic methods of teaching and rote-memorisation by pupils of subject-matter, while being inevitable in the circumstances, was seen to have a deleterious effect on the development of logical thought-processes and ability to correlate or transfer learning.

The influence of such a background is evident, though
it is not wholly disadvantageous. As demonstrated (6.2), a greater percentage of overseas learners held O Level certificates in English Language and Literature, History, Geography and Mathematics than did indigenes and, given the generally poor showing in science teaching in developing countries, it is surprising that a greater percentage of overseas learners had certificates in a science than did indigenes, particularly among Mauritians, since in Mauritius entries in the sciences are relatively low (2.2.3). Of the 26 Mauritian student-learners in the sample, 4 had biology, 12 had chemistry, 7 had physics and 1 had General Science. Furthermore, with the considerable amount of writing required in arts subjects, writing proved to be the only category in which indigenes were as likely to have difficulty as overseas learners. Although the differences was not statistically significant, it was the only category of difficulty in which indigene figures were higher than overseas.

Nonetheless, many of the disadvantages arising from such an educational background do hinder overseas learners from deriving the maximum benefit from nurse education. The fact that many, even in the top quartile in selection examinations to secondary education do not necessarily gain a place, leads to a preoccupation with achieving high marks and one PNOE commented that many overseas learners, particularly Malaysians, get extremely upset if they get a mark of less than 80.0% in a test-paper. They think they have failed and need a considerable amount of reassurance that a mark of 73.0% is no mean achievement.

The fact that pupils are not encouraged to ask questions at school, in addition to their own unwillingness to be distracted from the business of learning for examination, would be sufficient - without the language problems isolated earlier (6.3) - to discourage overseas learners from participation in classroom activities in Schools of Nursing and the belief that the teacher is always right from asking for clarification, even though classroom observation suggested that the need for the latter might be rather frequent.

Lack of library facilities, or even adequate text-
books, in many developing countries means that pupils were unable to read much for themselves and in the Philippines reading is not encouraged in any case (2.1). The literature showed that overseas nurses were not used to reading round a subject, though this was equally true of indigenes - with less apparent reason, since books are more easily bought or borrowed in the UK.

Failure to participate in group discussions also suggests in part the influence of the dominance of examinations for one PNOE, in a Training School which operated a 14-day orientation course, observed that overseas learners were more willing to participate in general than medical or nursing topics. Once a medical or nursing topic was introduced, overseas learners fell silent. This suggests a weighting by overseas learners as to what is examinable and what is not and, consequently, why they prefer didactic methods with medical and nursing subjects and feel cheated if the discussion technique is used for teaching. This would account for the fact that, although 80.0% of overseas learners in the Q-sample said they were used to group discussions at school, almost all PNOEs said they never took part.

The inability to think for themselves or to organise their own study-time was reflected in the PNOEs' comments that overseas learners have difficulty with project work and by the Q-sample subjects' own admission that they would prefer to be told what to do in their private study-time. While this was shown earlier (6.7), to be at least in part a function of the demands made on time and energy by nursing, overseas learners were much more likely to want to be told than indigenes. Certainly private study would seem to be more essential for overseas learners since they appear to derive less benefit from either classroom or clinical teaching than indigenes. What slight motivation there may be to study is often dissipated by the lack of suitable conditions. For example, one of the Q-sample subjects observed: "No [I don't study] , because of lack of suitable seating in my room" and many subjects in both the Q-sample and P0-sample referred to noise in the Nurses' Homes and interruptions by friends as detrimental to studying.
7.3. The influence of the linguistic factor.

The field studies showed that there were differences in level of language competence between the various national groups, with some evidence that Malaysians were better equipped linguistically than the others. Certainly linguistic coherence seemed to be related to nationality, and both to nursing status, and the Q-sample clearly demonstrated a statistically significant relationship between medium of instruction at school and nursing status.

As the linguistic background shows (2.3.3), the medium of instruction in Africa and Malaysia was predominantly English, until the introduction of Bahasa Malaysia as a national language in Malaysia, whereas in Mauritius English is seldom if ever used. Nonetheless, the language used by teachers in the classroom is formal and any switch from the formal to consultative or, in particular, from consultative to casual, confuses second language learners and causes them much anxiety. (2). They do not realise that the use of styles other than the formal is either illustrative, (for example: film-stars and bobbed noses: 5.3.1.3.b) or light relief. They feel that they must go on taking notes because they are unable to distinguish between what is linguistically and therefore factually important. Thus, overseas learners are bound to have difficulties, particularly when slang is used or culture-specific references made, in separating the wheat from the chaff. They might well assume that a word such as "dodgy" used in an otherwise formal utterance is technical language and they may well adopt it as such, unaware of its linguistic rating.

One FNOE, as noted earlier (6.2), remarked that overseas learners' certificates were often misleading as to their ability to cope with English, but as both Bamgbose and Boadi point out (2.3.5), good grades in English Language O Level do not necessarily guarantee a wide range and use of Spoken English. This reflects more on the undirected and inadequate teaching or use of English in schools than on the authenticity of the certificate. In many countries Spoken English is either not taught or not used at all (2.3.5), to which 3 of the P0-sample testified.
Furthermore, there is often little opportunity for the pupils to use English in the classroom since the teachers usually do all the talking and the use of the formal style inhibits the spontaneous formulation of questions — even if these were not actively discouraged — as observed in the field studies. With particular reference to Mauritius, since the role of English as medium of instruction is so undefined and its use is mainly confined to written work (2.3.3), it is not surprising that the incidence of linguistic incoherence among Mauritians was so high, confirming Clarke's observation that Mauritians' control of English is superficial (2.3.5).

It should be remembered, however, that not all difficulties are related to inadequate teaching of or lack of use of Spoken English. Many influences are sociological. It was demonstrated earlier (2.3.5) how fluctuations during the process of stabilisation and the creation of new norms — which are not yet complete — in the evolution of national forms of Standard English makes the teaching of English both confusing and difficult, even for the best and most conscientious teachers and how this state of affairs affected ultimate proficiency. Moreover, attitudes to the use of English, even where necessary as an official language, are ambivalent. This ambivalence is reflected in the total rejection, particularly by Africans, of Received Pronunciation (RP), the adoption of which by an African is, as both Bamgbose and Boadi observed (2.3.5), considered to be snobbish, affected and artificial. Thus, references to "poor" accent, made by Sen (3.3.iii) and also by many in the PNOE-sample, must be seen in this context. RP is a definite disadvantage in a country in which there is communal resistance to it and any reference therefore to a "poor" accent is a culturally biased value judgement, not a linguistic observation. Such political and social pressures are even harder to withstand than are the influences of vernacular sound-patterns on the imported English (2.3.2), though the accent which results inevitably causes problems of intelligibility in cultures other than their own, as the PEP survey shows (3.3.iii), in which only half of the overseas learners had accents which were easy to understand. It
is noteworthy, in this context, that local English accents, as the field studies demonstrate, cause as much difficulty in understanding for overseas learners.

7.4. **The influence of political and economic factors.**

As Kiev observed (cited in 2.1), if a member of a community in a developing country is ill-equipped to obtain the economic resources necessary for the maintenance of his status and power, he is rejected by his family. He must therefore succeed. Since the economic potential is often lacking in the home country, leading to high unemployment rates - particularly among the 15-24 age-range - (2.5) employment must be sought elsewhere and many countries encourage their nationals to emigrate.

As was shown previously (1.3.9a), the continually low level of indigenous recruitment in England and Wales and the high wastage-rate, led to the influx of large numbers of overseas learners, particularly to Psychiatric and Mental Subnormality Training Schools, in what the PEP Report referred to (3, p.15) as a "marriage of convenience"; overseas applicants wanted employment - England and Wales needed nurses.

As the background shows (2.5), many developing countries have either very few training places or very poor facilities or both. Consequently, although many apply first in their countries of origin, very few are chosen. Many of the rest, in addition to many who just want employment, apply to come to England and Wales. Others emigrate for political reasons as well as economic. For example, Malaysians who come to the UK are either Chinese or Indian - as the Q-sample showed - never Malay. This is due to the current national policy of favouring Malays for employment (2.5) and also the institution of Bahasa Malaysia as the national language. It was also suggested (2.5) that the Chinese and Indian Malaysians who come to the UK are not very competent in Bahasa Malaysia and that therefore their prospects in Malaysia are not good.

The majority, as both the literature (3.3.iv) and the three field studies show, expect to follow General Training as student-nurses when they arrive but a substantial
minority find themselves either in a different type of training or in the pupil-nurse grade or both. This is often the result of educational unsuitability or linguistic difficulties, yet, as a result of lamentably inadequate recruitment and selection procedures, these deficiencies are often not detected until the candidates have arrived— with powerful financial, social and psychological reasons to prevent them from returning to their own country immediately.

So great is the need for employment that some overseas nurses acquire a place in a Training School without due regard as to their suitability or qualification and not all Training Schools are scrupulously honest in their employment techniques. Nevertheless, the vast majority of misplacements or misunderstandings are the result of confusion and misinformation on both sides. There is no doubt, however, that for a substantial minority of overseas learners, their problems of communication arise from unsatisfactory application, recruitment and selection measures.

7.5. **Culture shock.**

As described earlier (2.6.), everyone moving into a culture other than his own experiences some degree of culture shock, sometimes transitory, sometimes longer-lasting. Given the findings of this research, it would be naïve to suppose that overseas learners suffer anything other than profound culture shock. It is accepted that the world-wide average length of time required for an expert in his own field transferring to another culture to recover fully from culture shock and to reach his full potential is one year. It is suggested here that the need to relate to ill people and to come to terms with working almost permanently at a high level of stress, coupled with the demands of concurrently studying in a language which is not the mother-tongue, is likely to both heighten and prolong the culture shock experienced by overseas learners.

Foster states (2.6) that the signs and symptoms of culture shock are: irritability and lack of attention, leading either to annoyance or despondency; frustration
and anger and complaints about the people, the country and the customs.

There is evidence in the literature (3.3.1) to indicate that overseas learners feel much of this and react in such a way, though the hostility and aggression usually take about a year to develop. Homesickness and loneliness are also symptoms, which Foster suggests is relatively short-lived but both the literature (3.3.1) and the field studies indicate that for many overseas learners the homesickness and loneliness are prolonged. Of the PEP and Sen survey samples, many learners confessed to still feeling homesick after a year or more and several subjects in the field studies admitted that homesickness was still keenly felt after 1-2 years.

Many overseas learners in the Sen and PEP studies tended to make their friends among their compatriots, not among indigenes, and several had no close friends at all. Efforts to form the learner-group into a cohesive one and mix the nationalities does not necessarily provide an answer, for in one Training School, which had a very good orientation course, it was found by the staff that as soon as the course was over the national groups re-formed and there was no further mixing. Furthermore, the very excellence of the course, which sought to provide every support for the new overseas recruit, led to a sense of abandonment when the learners started training and went on the wards.

Foster also suggests that the onset of culture shock coincides with the indifference of the host-culture towards the newcomer which follows the period of interest and novelty. If indifference were all that the overseas learner had to contend with, it would be hard enough. Both the literature (3.3.1) and the field studies, however, indicate that a substantial majority of overseas learners claim that they meet with racial prejudice among both colleagues and clients and that indigenes think themselves superior. This contention is supported by one PNOE who commented: "We expect far more when we go abroad than we reckon to give to foreigners in Britain. There's an attitude against foreigners here".
There is also evidence, both in the literature and the field studies, to suggest that there are several intensifying factors. Firstly, the non-acceptance of overseas learners by colleagues and clients and—particularly for pupil-nurses—being regarded as inferior (3.2.3.d) both as foreigners and pupil-nurses. Secondly, the very serious language and cultural difficulties in an abnormal situation, where problems of human relationships are often acute in any case. (3.2.1-3). Thirdly, the fact that the vast majority go straight to their Training Schools and begin training immediately, with no form of orientation whatsoever. Fourthly, for many, finding themselves in an unexpected and often uncongenial training. Fifthly, the absence of the formalised rituals of their own cultures for the release of emotional stress (2.4.).

It is also recognised and accepted (2.6) that the individual does not work effectively until the culture shock is resolved and experts get worried because they know they are not working to their full potential. What then must overseas nurse-learners suffer when, like their indigene fellow-learners, they are expected to perform tasks for patients in which they have been inadequately instructed but when, unlike said fellow-learners, some senior staff expect them to be stupid or fail to understand so do not bother to give them proper instructions? Thus, in spite of their greater difficulties, overseas learners receive even less help than do indigenes.

The recovery from culture shock is dependent upon the degree of adjustment to the new situation and there is no doubt that some overseas learners seem to recover, as judged from comments made by several P0-sample subjects. Nevertheless, in that many still evinced symptoms after one or even two years, the question must surely be asked as to how many never recover at all. It is reasonable to suppose that some do not.
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8. COMMENT AND CONCLUSIONS.


If, as Ruesch and Bateson suggest, (3.1.), correct interpretation of a social situation depends upon the identification of the roles, rules and system of codification and evaluation, such identification must not only be shared but acknowledged and adhered to by all participants. In a work-situation this is important if maximum productivity is to be achieved and this depends on effective communication. The machinery of communication must, therefore, be in good working order, the channels, receivers and transmitters must be used to full capacity without overloading and threshold problems must be avoided. When that work involves the promotion of health, the prevention of illness, the restoration of health and the alleviation of suffering (1.3.1.), education and training of the workers - or the transmission of the organisation's information - is of vital importance. Of equal importance is the quality of education and training for as the International Council of Nurses states (quoted in 1.3.7), education and training are interrelated and the standard of practice is dependent upon the quality of basic education. If that quality is sufficiently high, the end-result will be a competent nurse (1.3.1) clinically efficient through instruction and practice and intellectually capable of interpreting her work through greater understanding (1.3.7).

The most disturbing findings to emerge from this research are the inadequacies in both education and training, with which in some cases all learners are faced, and the conflict between the two. The two main conclusions to be drawn, therefore, are that, in Ruesch and Bateson's terms, communication must frequently be anything but effective and that if many newly-qualified nurses fit the definition of the competent nurse it must often be in spite of rather than because of their education and training. It is not suggested that all problems affect all Training Schools, or to the same degree, though both the literature and the field studies suggest that they are widespread enough to
cause concern. For overseas learners, to the existing problems must be added those arising from language and culture.

Nevertheless, most of the problems are soluble should appropriate action be taken and for overseas learners this should start with a radical reappraisal of recruitment and selection policies and methods. The confusion in this field has been amply demonstrated, though none of it is necessary. Australia, for example, is able to furnish a list of all Training Schools willing to take overseas learners for which type of training and on what conditions, with details of entry requirements over and above the minimum (1, p.48). England and Wales cannot. Consequently, overseas applicants write to several Training Schools, often taking the first place offered regardless of, and often unaware of, the type of training offered. Hence the frequent frustration. Many find themselves as pupil-nurses for whatever reason. Hence the frequent resentment.

Frustration and resentment do not form a good basis on which to start training and should therefore be prevented particularly as the overseas learner cannot leave as easily as the indigene if she finds the work uncongenial. Certain trends were seen to be emerging already: some Training Schools recruited overseas learners only if already resident in the UK and had stopped recruiting direct from overseas altogether; others recruited only for student-training from overseas; others were admitting a controlled percentage. Some were being much more careful about selection, particularly as, with the grouping of hospitals, Training Schools are becoming too big to allow time for the solving of individuals' problems.

It is suggested that improvements in selection procedures should include a test of Spoken English in the country of origin or the proviso - recommended by the GNC in 1972 (1.3.9.b.1) - that the medium of instruction at school should have been English, since the latter was shown to be significantly related to status, while high grades in English Language at O Level do not necessarily guarantee ability in the spoken field.

Many PNOEs felt that the GNC should take an official
stand regarding overseas entry requirements but this is not the prerogative of that body. It is, however, of the Department of Health and Social Security (DHSS) and many recommendations, including that of the Kings Fund Working Party in 1974 (2, pp.16-29), have been made to the DHSS that a Central Clearing House for overseas applications should be instituted. Not only would such an organisation be able to channel applications to those Training Schools willing to receive them and vet the suitability of candidates but it would also be in a position to determine which certificates awarded in England and Wales were acceptable in which countries and advise accordingly. Overseas applicants would therefore not find themselves in unwanted or unsuitable types of training or at pupil-nurse level and the frustration and resentment, common at present, would thus be avoided.

Having removed the problems of communication which originate from the present unsatisfactory situation regarding recruitment and selection, it is suggested that an orientation programme, incorporating a language component, should be available to all overseas learners. Again, many recommendations have been made regarding such programmes, not least by the Briggs Committee (3, para. 326) but few, if any, give more than the suggestion that its content should be geared to local needs. As this research shows, however, much of the content could with benefit apply to all orientation courses, regardless of their location, in the form of a common core, with regional supplementation.

Such a common core might include: on the cultural side: British attitudes and approach to:- family life, old age, sex, illness, death, acceptance of entry into the sick-role, hospitalisation, psychiatric illness and mental subnormality. Although the detail of psychiatry and mental subnormality is taught during training, a general introduction would be useful for all overseas learners, since mild psychiatric disorders and traumatic mental subnormality are not infrequently encountered in general hospitals. Some knowledge of such attitudes would be helpful in cushioning the shock which overseas learners undoubtedly feel when first confronted with them in
hospital wards, and might well help to influence their attitude towards relatives. Fundamental differences in attitude and approach towards such matters can make understanding and conforming difficult enough if working among healthy people but where such differences can directly influence the effectiveness of communication, as when caring for the sick, where beliefs and fears about such things are very much to the fore, understanding of them is vital.

On the language side, the component might include: the teaching of elliptic answering, since this is a function of the question-and-answer technique in Schools of Nursing; intensive conversation, in order to develop linguistic coherence on general topics, particularly when talking to patients. As Stubbs points out (4, p.21), studies show that a speaker's language is a major influence on the impression formed of his or her personality. People judge a speaker's intelligence, character and personal worth on the basis of the language used — and both the literature and the field studies suggest that this is true of both colleagues and patients vis-à-vis overseas learners. Since as discussed earlier (2.3.5), the ability to use the correct variety of English is based on a knowledge of culture and level of proficiency in English, discussion groups, with guided participation for overseas learners, would introduce them to both the cultural aspects and the language of the topics. At present there seems to be little real opportunity for many overseas learners to gain very much practice in the use of English other than the formulaic patterns of professional interchange, either in the classroom, the clinical situation or off-duty. Consequently, it is hardly surprising that it often takes so long before improvement is noticeable.

In view of the considerable degree of lack of understanding and difficulty in speaking between overseas and indigene learners, it would be profitable, both linguistically and from the point of view of human relationships, to include the latter in the orientation course for, clearly, the problems of communication were not entirely
linguistic ones. Furthermore, by encouraging the younger generation to discuss cultural topics, and to share their views, the tutor, the indigene and the overseas learner would all reach a considerably higher degree of understanding about each other than appears to exist at the moment. Overseas learners should be encouraged to ask questions and should be given the time in which to do so, so that by the time their formal studies begin they recognise that to ask questions is a proper procedure in the classroom and they will have had some practice in doing so. Tutors, too, would be more used to involving overseas learners in classroom participation and to eliciting evidence as to whether they have understood what has been said.

In order to improve their ability to carry out project-work and to organise their own study-time, instruction and guided practice could be given on how to use a library and how to collect information.

At the local level, listening to and organised study of the local accent and commoner dialectal forms would ensure at least a degree of understanding of it for overseas learners before they are faced with the necessity of listening to lecturers or having to talk to patients who employ both.

With regard to the comment made by many PNOEs that overseas learners "don't understand colloquial English", few if any developing countries teach or use the casual style and seldom the consultative style. If both were taught and encouraged during the orientation period, this would go a long way to solving the problem.

It is suggested that, in view of the benefit which would accrue to all learners - and ultimately the nursing profession and the patients they care for - from such a course, it should be made an integral part of nurse training and take place in the three weeks preceding the Introductory Block. If close co-operation were established between the local College of Further Education and the School of Nursing, the maximum use could be made of that time and the positive effect it would have on the currently rather bleak picture would be incalculable.
With respect to overseas learners, the sooner such courses are implemented the better for, as noted previously (2.3), the position of English, its role and status, is changing constantly in many of the countries from which the majority of overseas learners are drawn. In Africa it is gradually becoming an optional rather than compulsory subject and in Malaysia and the Phillipines the transition from second to foreign language is almost complete. There are real fears among teachers of English (5) that English Language teaching standards will decline once Bahasa Malaysia as a national language is fully implemented by 1984. The problems, therefore, serious as they currently are, are likely to increase rather than diminish and there will be an ever greater need for positive action on an official and properly organised basis.

If, however, tutors are to fulfill the role outlined above, there is clearly a need to incorporate the learning of such teaching skills in their teacher-training.

Apart from the obvious and urgent need to improve teacher training for nurse educators with regard to methodology and presentation, since the present state of classroom teaching contributes in no small way to the problems of learners, it is suggested that their training should include a component relating specifically to overseas learners' problems. This might comprise: study of the influence of background factors on those problems; their nature and causes; the political and social influences on language policy and use and the levels of correctness acceptable in the countries from which their learners come and any changes which occur in these fields. Furthermore, expert advice and training on the style of classroom discourse and its possible effects on learners' understanding and participation would help to minimise the tutor-initiated difficulties observed in the classroom. Language in the classroom is extremely important in any teaching situation if teaching is to be effective but where what is learnt in the classroom affects the life and health of others it is important beyond measure. Since this research shows that what is not learnt in the classroom will not necessarily be taught effectively in the
clinical situation, improvement in classroom techniques is urgent.

It is clear that nurse educators need professional guidance on such matters since, though a certain amount of awareness of the problems was shown by PNOEs and tutors in the PO-sample, it was evident that that awareness was rudimentary - primarily because of the almost total absence of research. It is therefore suggested that a professional English Language Teaching expert be invited to participate in teacher-training for nurse educators to both advise and train them in linguistic matters.

Last but not least, this component might include a section on the causes, intensifying factors, signs and symptoms of culture shock for, in recognising and understanding it, tutors might well be able to alleviate it to some extent.

Finally, it was evident from the comments of many overseas learners that the period of adjustment was long and it was suggested that some overseas learners never recover from culture shock. Many of their problems of communication, which this research demonstrates to be only partially language-linked, could be overcome if proper counselling were available. For obvious reasons such a person should be independent of both the educational and services sectors. For one thing, such a person must be seen to be completely unbiased towards either learners or trainers. Secondly, if the problems put foward both in letters accompanying some of the questionnaires and during the period of observation are widely symptomatic of the current state of affairs or in any way representative of the whole, the counsellor is likely to be occupied full-time and the need for such a person is pressing. Many institutions of Higher and Further Education already employ such full-time personnel. It is time the nursing profession followed suit, particularly as indigene learners would also benefit.

It must be reiterated that not all problems apply to all overseas learners but many apply to many and the numbers involved are too large to be ignored. Interviews...
the growing concern of nurse educators throughout the country regarding the problems of communication facing both themselves and overseas learners. Most PNOEs were only too well aware that problems existed and were ready to support any move which might lead to a solution. However, little can be done without official recognition of the areas of need and willingness to take action. As Ruesch and Bateson observe (6, p.8):

"Information about the values which people hold enables us to interpret their messages ..."

Since lack of information on either side is conspicuous by its almost total absence, correct interpretation must be minimal and the cost to the nursing profession and their patients is high.

8.2. The wider implications.

There is no reason to suppose that application of the findings of this research, while primarily concerned with overseas nurse-learners, is necessarily confined to nurse-learners, to basic education and training or to England and Wales. Many countries in the developed world include overseas learners in their basic nurse education and training programmes and many countries, including the UK, offer post-basic nurse education or experience to foreign nationals. Furthermore, these countries also conduct medical and para-medical education and training programmes which include overseas participants or send their own nationals to assist with health programmes in developing countries. For all such groups, particularly where theory and practice are so closely interrelated, the need to understand the source, the nature, the extent and the causes of problems of communication and the influence of background factors upon them is of paramount importance if participants are to derive the maximum benefit from the programme and the risks to patients, resulting from failure to communicate effectively, are to be avoided.

In a wider context, in any educational or training programme involving multiracial and multilingual groups, difficulties in both understanding and production of the language used as the medium of instruction and problems of cultural "incommensurability" are likely to occur. If the
The tutor is aware of their origins, their nature and their causes, and of the possibility that many of them may be tutor-initiated, action can be taken to eradicate the avoidable difficulties and to minimise others by careful attention to the style of discourse and teaching methodology and by carefully planned orientation and appropriate language tuition.
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SYLLABUS AND RECORD OF PRACTICAL INSTRUCTION AND EXPERIENCE (PSYCHIATRIC) FOR ADMISSION TO THE ROLL OF NURSES. + GUIDE TO ABOVE.


