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### **Legislation for Registration**

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Fellow Nurses, Colleagues

Over many years now, veritable mountains of material have been produced in relation to whether or not nursing may be justifiably deemed to be a profession. Undoubtedly those who argue in favour of the proposition have no difficulty in relating nursing to such concepts and ideals as

- altruism,
- having a recognised body of specialist knowledge
- self regulation
- control of portal of entry
- ethical behaviours and standards
- independence of thought and outlook,

to name but some.

Might I ask you, in the privacy and honesty of your own minds, to consider where Irish nursing stands in relation to its claim for professional status?

Deliberately, not provocatively, I use the term “nurse” to address each and everyone of you, since the current Nurses Act clearly states that the term “nurse means a woman or man whose name is entered in the register and includes a midwife and “nursing” includes “midwifery”. (1)

The final report of the Commission on Nursing has recommended many amendments for that Act, but until such time as those amendments are enacted, the statutory basis upon which registration is built stands. And so as we share this time together, our statutory registration is granted to us, in particular through the enactment of Part III of the Nurses Act 1985, and various parts of the Nurses Rules 1988, made under the act and the amendments which have been made to those rules.

This afternoon I have been asked to briefly address the issue of Legislation for Registration and the first point I will make is one which was succinctly made by the historian Brian Abel Smith almost four decades ago when he reminded us that our statutory registration as nurses was granted to us in 1919, even though much older professions – namely the church and the law – had never felt it necessary to seek such registration! (2) Those professions and others, still have not sought statutory registration. Even if one believes in the absolute centrality of statutory registration per se, it is worth remembering that not alone did the very first General Nursing Council for England and Wales have to create committees to deal with,

- Registration,
- Finance,
- Education and Examinations

- and Disciplinary and Penal issues, (3)

An Bord Altranais to this very day is obligated under the Nurses Act 1985, to concern itself with those very same issues – the words may have changed – the central functions have not.

To say that we eventually took to the idea of statutory registration is indeed an understatement. While our colleagues in England and Wales attended a packed service of celebration in St Martin's in the Fields on January 23rd 1920 to mark the passing of the Nurses Act (4) in this country, we expanded the range of registers at a truly phenomenal rate.

Thus while the initial legislation provided for the creation of a Register of Nurses consisting of five parts

**Table A**

(a) a general part containing the names of all nurses who satisfy the conditions of admission to that part of the Register:

(b) a supplementary part containing the names of male nurses;

(c) a supplementary part containing the names of nurses trained in the nursing and care of persons suffering from mental diseases;

(d) a supplementary part containing the names of nurses trained in the nursing of sick children;

(e) any other prescribed part. (5)

we eventually arrived at a situation whereby we had no fewer than 15 divisions in that Register! (Table B)

<b>Table B</b>		
<b>A Register for the</b>		
1.	General Nurse	R.G.N.
2.	Mental Handicap Nurse	R.M.H.N. (Registered Nurse of the Mentally Subnormal)
3.	Psychiatric Nurse	R.P.N. (Registered Mental Nurse)
4.	Sick Children's Nurse	R.S.C.N.
5.	Fever Nurse	R.F.N.
6.	Infectious Disease Nurse	R.I.D.N.
7.	Male Nurse	R.G.N. (M)
8.	Sanatorium Nurse	R.S.N.
9.	Tuberculosis Nurse	R.T.N.
10.	Orthopaedic Nurse	R.O.N.
11.	Public Health Nurse	R.P.H.N.
12.	Nurse Tutor	R.N.T.
13.	Advanced Psychiatric Nurse	R.A.P.N.
14.	Clinical Teacher	R.C.T.
15.	Midwife	R.M. (1902)

All of these survived the passing of the 1985 Act.

Statutory Registration had a long and difficult gestation period – one writer describing our internal dissensions as a thirty year war! Again, referring back to Brian Abel Smith, Chapter 5 of his book is actually entitled – **The Battle for Registration. (6)**

Those nurses who have gone before us were bitterly divided over the issue of statutory registration as were our medical colleagues of yesteryear. Just as Sidney Holland, Chairman of the London Hospital – the biggest in England (7) not alone opposed the idea of a nursing examination prior to registration

“A nursing examination is so childishly simple that you cannot invent a difficult one” he said (8) he was so convinced that it was a nurse’s character which was of central importance, that he argued

“You would not take a cook from a registry; you would want to know that she had a good character and you would apply to her late employer.” (8.1)

In equally trenchant terms, Nightingale herself maintained a fierce opposition to the concept of statutory registration right up to her death in 1910. Two comments of hers adequately display the vehemence and depth of that opposition; referring to the advocates of statutory registration as “the new-fangled people”

who were aiming to establish an examination system prior to such registration, the Lady with the Lamp said –

“The idea of the new-fangled people seems to be to put nurses at the level of dictionaries – a dictionary can answer questions.” (9)

And again referring specifically to the idea of a Register she argued;

“Seeking a nurse from a Register is very much like seeking a wife from a Register, as is done in some countries” (9.1)

One of the central arguments used by those who have advocated the cause of statutory registration is that such registration would protect the public interest; a closer examination of this ideal however, reveals that the term “public interest” as used in the early 20th century could be, and was, interpreted in a very narrow sense indeed;

“The public at present (i.e. in pre-registration days) is helpless. It is an important point that this matter (i.e. so called nurses who commit crime) does not affect the poorer classes; they are excellently looked after. They have the Queen’s Jubilee Institution which looks after them in their own homes. If they go to the hospitals they have excellent trained nurses supervised day and night, but the richer classes are perfectly helpless.” (9.2)

Even ignoring – temporarily - George Bernard Shaw’s comment that professions are but conspiracies against the lay man, serious questions have been raised about the validity of the assumption that the public interest is, or indeed can ever be, served by professional groups, or statutory registration (10, 11,12). Indeed the question can be asked whether or not statutory registration was in the best interest of nursing itself.

One of our own historians, Pauline Scanlan believes that,

“The Nurses’ Registration (Ireland) Act 1919, a signpost on the road to the present, was not wholly to the advantage of the public or the nursing profession. In providing for the establishment of the General Nursing Council for Ireland and the registration of nurses it staked a coppice rather than a tree, for it laid down that the Register of the Council should include as well as the part for the registration of general trained nurses **supplementary parts** for the registration of those specialising in the nursing of mental patients and in nursing of sick children, and that additional parts, if prescribed, be provided for.

The recognition in law of fragmented training in nursing was probably largely responsible for the unquestioning acceptance of a perplexing situation.” (13)

Writing in 1969, this author went on to link the inherent deficits of the registration system with our inability as nurses to achieve a place for nursing education within the university system back in the 1940’s.

One cannot but be struck by the historical co-incidence that at exactly the same time in England and Wales, i.e. 1969, nurse historians were arguing that,

“.. The profession – and future General Nursing Councils – must decide what they want; a continuation of the pattern of the past 50 years – or a radical change ...

Certain specific problems must be solved: the educational level of entry; the age of entry; the length of training; the content of training; the size of training schools; and the type of nurse we wish to produce.” (14)

Obviously, statutory registration had ignored and left unanswered many basic questions about nursing and its place in society. Given that the issues of a candidate’s sex and character had been of central importance in determining whether or not one’s name could be included on the statutory register, right from 1919 onwards, it is hardly surprising that the educational level of entry had still not been agreed upon! In this country it wasn’t until 1973 that Rules were drawn up in relation to this issue but then only for those candidates entering General Nursing. (15)

The extension of the minimum standard of educational attainment for the other basic disciplines of nursing in this country did not occur until the 1980’s. (16)

(As an historical aside, it is worth recalling, that it was only in 1986, that An Bord specified that in terms of the training of General, Sick Children’s, Mental Handicap and Psychiatric Nurses that student nurses must have experience of nursing both male and female patients! (17))

But all the time the integrity of a nurse’s character had been attested to as he or she sought registration; and such continues to be the formal situation, today.

The Working Party Report on General Nursing was the spur which led to the introduction of the Nurses Act 1985 (18). Obviously this Act also provided for the statutory registration of Nurses, but it also encompassed a clause for the setting up of what was called the Central Applications Bureau (The CAB).

Debating this issue on the floor of the House, the opposition spokesman on health pointed out that,

“.. The Minister has said that the bureau would incorporate assessment of candidates’ personal suitability for nursing and that educational qualifications on their own will not be the basis of selection. ....

It is important to recognise that training for nursing is not the same as going to university. There is an employer-employee relationship in nurse training schools because these training nurses are employed by the hospitals. It would undermine the hospitals especially since the various hospitals have various disciplines. Some of them are involved in major heart work, others in major brainwork and so on. It is mainly the voluntary hospitals who have developed what one might call the super speciality. There is the factor, also, that voluntary hospitals have their own ethos. These are considerations to be respected because there can hardly be another area in which the question of ethics is more important than in the delivery of medical care.” (19)

Given that statutory registration occurred simultaneously to the growth of the hospital care system and that this system was, from the outset dominated by the members of the medical profession, it becomes very difficult to determine precisely how the public interest was served by this amalgam of events.

Politically it has been argued that the very reason that statutory registration was granted in 1919, had more to do with taking the pressure off the Government of the day in relation to the growing threat posed by the suffragettes and the concurrent fear in Westminster that women might even go so far as to consider joining the Trade Union movement or worse still, the Labour Party. (20, 21)

At a practical day to day work level, it has been argued that statutory registration was really the only method of ridding the so called Dickensian shadow and stigma of the Sarah Gamp school of nursing. A more recent analysis of this historical caricature is indeed sobering:

Rafferty has argued that the caricature of Mrs Gamp

“represents a powerful technique in which the weakest features of an individual are exaggerated”

And she goes on to analyse the effect which the institutionalisation of nurse training had on us as nurses;

“...The attraction of institutionalising nurse training was that it provided the means of simultaneously supervising labour and socialising the nurse into conformity with medical orders. The domesticated and hence private and privileged nature of the nurse-patient relationship posed a threat to medical authority. The institutionalisation of training eroded the domiciliary nurse’s contractual, economic and personal independence with patients ... Education provided the means for inculcating the nurse with the rationalist ethos and values of scientific medicine, thus facilitating compliance with medical orders .... Doctors could assert their claims to superiority over nurses since they could exploit moral, social, educational and gender differences at the same time.”

The author then delivers the killer punch!

“It remains one of the paradoxes of professionalism in nursing that it was the unregulated and disparaged Gamp of the pre-reform era who embodied a level of autonomy to which the new professional nurses of the registration debate and their successors would come to aspire. It is as paradoxical as it is poignant that as we wrestle with the brave new world of health care, managed competition, skill mix and the resurrection of community care, we might look back wistfully to a legacy that was lost with the eradication of Mrs Gamp and her like. Indeed it is worth considering, had Mrs Gamp not existed, would reformers not have felt it necessary to invent her? The irony then just might be that history proves Mrs Gamp to be the most enduring of nursing models. Such a twist of fate would surely be the ultimate anomaly of autonomy.” (22)

Before we dismiss Rafferty’s view of history as unreal or scare mongering waffle, let us briefly reflect on our relationship with and understanding of the issues of ethics and psychology in our training in this country.

One might have thought that it was indeed in the public interest that Irish nurses should be encouraged to debate and argue issues of an ethical and indeed psychological nature within their occupation, and that such debate and argument should be conducted within an independent, if not professional, nursing framework. Yet, almost forty years after the introduction of the first Nurses Act, and 7 years after the Nurses Act of 1950, Joe Robins reminds us that An Bord Altranais was obliged to acquiesce to the views of the Irish Hierarchy that only lecturers appointed by the local Roman Catholic Bishop – or in the case of the Adelaide Hospital, by the Protestant Archbishop of Dublin, could address the subjects of ethics and psychology in our training. It was also agreed that An Bord would not carry out any state examination in those subjects. (23)

In similar view, it is worth remembering that it wasn’t until the mid 80’s that our first Code made its appearance in this country. The 1985 Act, in Section 51, subsection 2 provides that

“...It shall be a function of the Board to give guidance to the nursing profession generally on all matters relating to ethical conduct and behaviour”

That clause did not have an easy passage in Dail Eireann.

The opposition spokesperson said on 2nd November 1984,

“ there is a provision where An Bord Altranais will have a function to give guidance to the nursing profession on matters relating to ethical conduct ..... We will oppose with all the powers at our command the section relating to guidance on matters of ethical conduct because we do not think this is a function of the board” (24)

The opposition lived up to that promise.

In relation to my own discipline of nursing – psychiatric – many questions arise as to whether or not statutory registration was in our best interests, or those of the public we serve.

Even though we were allowed enter our names on a **supplementary** part of the statutory register since 1919, one must ask, why it was, and how it was, that Robins could record that by the early 1950’s only “half the members of the staff of Kilkenny hospital were qualified in mental nursing” (25)

Why was it that the Rules made under the 1950 Act only allowed male psychiatric nurses to vote for male candidates in Board elections and female psychiatric nurses only to vote for female candidates? (26)

Perhaps, more importantly and certainly of more immediate interest to present day psychiatric nurses, one has to ask why is it that after the passage of no less than three nurses acts

1919,  
1950,  
1985

why is it that Professor Seamus Cowman and his colleagues are still obliged to admit this year that,

“...Our understanding of psychiatric nursing is far from complete, and our immediate challenge is to become clearer about the knowledge, skills and competencies that will maximise nurses therapeutic interventions. How can nurses be positioned to work best in multidisciplinary and multisectional environments and inculcate change on an on-going basis? ...  
Psychiatric nurses must also be absolute and deliberate in pursuing the necessary education, support and autonomy to engage effectively in mental health services for the patients benefit.”  
(27)

#### **And what of other disciplines?**

Recent public interest in this country has focused on the plight of Mrs Sinnott and her son Jamie. In the historical context of our development since 1919, this issue has reminded me of our collective role and responsibilities in the area of the care of the mentally handicapped. In his portrayal of the origins of what in the UK is now termed learning disability nursing, Duncan Mitchell reminds us that although the first institutions

“developed solely for people with learning disabilities were based firmly on educational principles”,

nonetheless, once the hospitalisation or institutionalisation of this group became a fact of legislative life, he points out that

“a group of workers was needed to staff the institutions, and a number of factors indicated that this group was more likely to be nurses than any other occupational group.”

Whether this served the interests of the handicapped or the nurses who cared for them is a moot point. Mitchell is convinced that nurses were introduced into the area of institutional care of the mentally handicapped because of pressures exerted by the medical profession and he concludes this argument by saying that,

....this “subject was never properly debated and this lack of debate together with the issue of the definition of nurse, set the scene for decades of uncertainty, for learning disability nursing” (28)

#### **And what of general nursing?**

It is many years now since Isabel Menzies with her psychoanalytic approach examined the issue of psychological stress in general nursing and how students and nurses attempted to cope with that stress. Obviously we don't have the time to revisit her findings in total in this regard, but her observations in relation to the issue of competence do bear repeating, especially when we remember that she was writing over 40 years ago!

“An example of a general nursing problem that threatens crisis is the recruitment of nurses. Changes in medical practice have increased the number of highly technical nursing tasks. Consequently, the level of intelligence and competence necessary for a fully trained and efficient (general) nurse is rising. The National Health Service has improved the hospital service and made it necessary to have more nurses. On the other hand, professional opportunities for women are expanding rapidly and other professions are generally more rewarding than nursing in terms

of the opportunity to develop and exercise personal and professional capacities as well as in financial terms. The increasing demand for high level students is therefore meeting increasing competition from other services. In fact, recruiting standards are being forced down in order to keep up numbers. This is no real solution, far too many of the recruits will have difficulty in passing the examinations and be unable to deal with the level of work. Many of them, on the other hand, would make excellent practical nurses on simpler nursing duties. So far, no successful attempt has been made in the general hospitals to deal with this problem, for example, by splitting the role of the nurse into different levels with different training and different professional destinations.

It is unfortunately true of the paranoid – schizoid defence systems that they prevent true insight into the nature of problems and realistic appreciation of their seriousness. Thus, only too often, no action can be taken until a crisis is very near or has actually occurred. This is the eventuality we fear in the British general hospital nursing service. Even if there is no acute crisis, there is undoubtedly a chronic state of reduced effectiveness, which in itself, is serious enough.” (29)

### **Does that ring bells for us?**

Today, the world in which nursing and midwifery exist is changing at an unparalleled rate, and the process of globalisation continues apace, in spite of the type of portrait we have so recently and so sadly seen in Genoa. The introduction of specific European Union Directives for General Nursing and Midwifery is a fait accompli and even the 1985 Act stipulates that,

“The Board shall ensure the requirements relating to the education and training of nurses or of candidates for registration in the register will satisfy the minimum standards in any Directive or Regulation adopted or made by the Council of the European Communities which relates to qualifications required by nurses to secure registration.” Section 37

Interprofessional education has arrived on our doorstep (30(i) 30(ii)); within the area of advanced nursing practice, other countries have made legislative provision for the recognition and development of such practice (31).

The Commission on Nursing has recommended a series of amendments to our existing national legislation, in particular I would draw your attention to recommendation 4.51

“The Commission recommends that the 1985 Act be amended to entitle the Board to require any nurse or midwife to satisfy it as to her or his relevant competencies, failing which the Board could require an up-date on skills and knowledge, as a condition of retention of name on the register, provided the purpose would be for the protection of the public even in the absence of any complaint. .... Rules for the exercise of this power, which are fair and equitable, would have to be drawn up by the Board and monitored to ensure that the concerns expressed about its exercise would not be realised.”

### **Fellow nurses,**

We appear to be on the eve of the introduction of a graduate nursing profession in this country. The issue of our competence as nurses is of critical importance.

Coburn has argued that whereas, in our past, professionalisation was used, by an elite,

“to control nursing and to avoid unionisation”,  
it is,

“now a means whereby nursing can gain autonomy from medicine. Whereas previously the nursing elite suppressed nursing dissent, the professionalising elite now actively seeks to organise nursing discontent in advance of its own ‘professionalisation project’”. (32)

Such an “achievement”, might be no achievement at all.

I sincerely hope that our discussions here in this hotel are but the start of an on-going debate among all of us who care about Irish nursing, what it is, and what it can become.

Those who have gone before us, I have no doubt, acted in good faith and I believe we owe it to them, not just to evaluate what they did, but also, why they did so.

I hope the debate on statutory registration and the debate on nursing competence will converge so that those in need of our care can get it,

- irrespective of their status or wealth
- irrespective of their disease or disability,
- irrespective of our disunited past.

Fellow nurses we have much to learn from each other and from those we care for.

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