

# The child first and always: The registered children's nurse over 150 years.

## Part two

In the second part of their paper, Alan Glasper and Imelda Charles-Edwards trace the demise of the single direct entry RSCN and the challenges facing supporters of children's nursing today

**As of** the 31st of March 2001 there were 632,050 people registered as nurses with the UKCC, of which 34,345 (5.43 per cent) hold a children's nursing qualification. It should be appreciated that the majority of these children's nurses hold dual qualifications and are on part 8 of the register. Since the introduction of Project 2000 more than a decade ago only 9,950 students have completed a nursing course leading to part 15 of the UKCC register. Given this small number it is not surprising that children's nurses feel that their branch of the profession is vulnerable.

The primary aim of part two of this paper is to re-evaluate the historical evidence which supports children's nursing as a discrete professional entity and explore the issues facing the NMC in any review of nursing education/registration.

### The early days of the nursing register

Following the 1919 Registration Act, a caretaker General Nursing Council was developed until elections could be conducted from among the registered members. Bendall and Raybould (1969), in their history of the GNC, hardly mention children's nursing but an examination of the membership of the first GNC shows that Miss Agnes



In the 1930s, matrons of sick children's hospitals united to form the Association of Sick Children's Hospital Nurse to help fight the devaluation of their branch

Mary Coulton, Lady Superintendent of The East London Hospital For Children was a member of the important registration committee.

The register was officially opened on the 27th July 1921. The process was slow, with Mrs Bedford Fenwick, the chair of the registration committee, insisting on personally scrutinising the qualifications of all applicants. Fortunately one of the victories of the children's nursing movement was to persuade the Minister for Health Dr Addison to include on the General Nursing Council two nurses who had experience of nursing sick children.

The first sick children's nurse (RSCN no. 1) to be admitted to the supplementary register was Evelyn Margaret Hughes, who trained at the Birmingham Children's Hospital from 1909 to 1912. Evelyn registered on the 28th October 1921 and Agnes Coulton (the member of the caretaker GNC) on the 21st April 1922 (RSCN no. 96), having trained at the Infirmary For Children in Liverpool. Of the initial 119 women who registered as children's nurses on the first published

Table 1. GNC register in 1923

General nurses	10,887
Male nurses	24
Mental nurses	639
Sick children's nurses	191
Fever nurses	356
<b>Total</b>	<b>12,097</b>

(Arton 1987)

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register in 1922, no less than 27 trained at The Hospital For Sick Children Great Ormond Street (UKCC archives). On the 10th January 1923, the electorate for the first election for the GNC comprised the registered nurses in Table 1.

Although a primary aim of the GNC was the creation of a register of nurses, it was also empowered to compile a syllabus of instructions and a syllabus of subjects for examination. Although Bedford Fenwick, an anti-children's nurse protagonist, lost her seat on the GNC after the 1923 election (Baly 1973), the examinations for the RSCN in 1925 demonstrate the continuing generic focus of the council, with no mention of a child within the questions. The Hospital for Sick Children final examinations which students had to pass in addition to the GNC state finals could however be understood and answered by any contemporary child branch nurse (see Table 2).

### The RSCN after 1919

The progress of the sick children's register since 1919 reveals sporadic periods of anxiety among the nursing group holding the qualification. Glasper (1995) discusses the struggle to establish an equitable register where all parties held equal status. The argument by general nurses that children's nurse education is a specialist training and should therefore be at post registration level continued long after the passing of the Act. The inequity among the branches of the register contributed to the decline of the value placed on the RSCN qualification. In the face of this discrimination the matrons of the sick children's hospitals decided in 1937 to form an Association of Sick Children's Hospital Nurses (Duncombe 1970b), presumably on the premise that strength lies in unity. The Association, whose maxim was to further the interests of registered sick children's nurses, became the Association of British Paediatric Nurses (The ABPN) in 1953 in recognition that many members were now working with children outside the confines of children's hospitals.

Although the seeds of the devaluation of the sick children's part of the register were sown even before the supplementary register was ratified, it was perhaps the activities of what became the Royal College of Nursing that drove more nails into the coffin of the beleaguered RSCN qualification. An RCN-commissioned report chaired by Lord Horder MD (RCN 1943) recommended that children's nursing become a post registration

qualification. Although the Horder committee recommendations were never implemented, there was a threat to the continuation of the direct entry RSCN, which was not eased when the RCN refused to allow them membership. The impending threat of the Horder proposals was sufficient to galvanise the Association of Sick Children's Hospital Nurses towards proactive lobbying. Hence, at the annual general meeting, held ironically at the Royal College of Nursing, on Saturday the 29th April 1944 (the Association was affiliated to the College in 1941) the invited guest lecturer was the well known Great Ormond Street paediatrician Alan Moncrieff who gave a paper entitled 'The Future of The Nursing of Sick Children' (Moncrieff 1944).

The central thrust of Moncrieff's lecture, that 'paediatric nursing is not a speciality but general care at a special age period' has stood the test of time and remains a potent rebuff to those who argue that children's nursing should be undertaken only as a post registration activity. Moncrieff's lecture was designed to influence the RCN's Horder committee's deliberations and was a deliberate attempt by The Association of Sick Children's Hospitals Nurses to mitigate any attempt to undermine the value of the RSCN.

Of interest is the membership of the Horder Committee, which included a Miss A Coulton of The Association of Sick Children's Hospital Nurses, the same Miss Coulton who was a member of the original caretaker GNC. There is no doubt that the children's nurse representatives strongly opposed the suggestion that this branch of nursing become a post-certificate qualification. Cited in the report as if it were written yesterday is the assertion by the children's nurse lobbyists that, 'The nursing of sick children is a self-contained form of general nursing though limited to a definite age group.'

### End of direct entry

Despite this, the damage to the single RSCN qualification was profound and sustained. This resulted in a gradual phasing out of the direct entry RSCN in all but Scotland, with Saxton (1978) reporting the cessation of the three-year single RSCN training at Great Ormond Street in 1964. (N.B. Wales never had a three-year RSCN programme and the programme in Northern Ireland was abolished in September 1978 (Love 1998).) Many children's nurses pursuing active nursing careers opted to undertake further training to acquire a general

**Table 2. Sample examination questions**

#### The GNC, RSCN paper 1925 (Arton 1992)

1. Describe a case of acute nephritis. How would you nurse such a case? Mention diet and nursing that might be ordered.
2. Describe the nursing of a case of peritonitis.

#### The (GOS) Hospital Final Examination paper 1931

1. A child of five has developed an acute attack of asthma. Give the symptoms and nursing care of the immediate attack. What general steps would you take to prevent occurrences?
2. Give in detail the treatment of a child of four years suffering from:
  - (a) scabies;
  - (b) threadworms.



The 1960s: Nurses working in the new library of Charles West School of Nursing, Great Ormond Street

nursing qualification. Without this extra training, children's nurses found it hard to secure senior positions.

Although beyond the scope of this paper the value of oral history (Church and Johnson 1995) in understanding the origins of past events is well documented. Such primary sources of information enable the acquisition of undocumented material pertinent to the period in question. One of the authors (EAG) was able to interview a number of sick children's nurses who had undertaken the single RSCN qualification during the 1940s at the Hospital For Sick Children, Great Ormond Street during the 150th birthday celebrations at London's Guildhall on the 14th February 2002.

All had led successful careers within children's nursing but had found that discrimination towards the single RSCN qualification required them to undertake further training in general nursing. This they had accomplished in two years but Duncombe (1970a) reports that some general hospitals insisted on a further year of service as a staff nurse before allowing the children's nurse to undertake the 'shortened course'.

Perhaps in recognition that qualified children's nurses were having to leave the environment of sick children's nursing to undertake further training, the large children's hospitals counterattacked by introducing the four-year combined SRN/RSCN courses. Saxton (1978) reports

that a combined children's and general nursing course was commenced at Great Ormond Street in 1954. It is important to stress that these courses were combined with the student taking the SRN qualification at the end of the third year followed by 18 months' experience with adult patients. On return to the host children's hospital the RSCN qualification was taken after a further year of study (Duncombe 1970a).

There was clearly an attrition rate, with some students opting to leave at the end of the third year. This haemorrhage of potential children's nurses was stemmed with the introduction of the integrated three-year and eight-month scheme in which the dual RSCN/SRN qualification was awarded after one joint examination. The decision to introduce these new combined courses, and subsequently the post registration 13-month RSCN courses for SRNs, was also influenced by official publications such as the much-heralded report now almost universally known as The Platt report (Ministry of Health 1959).

Price (1993) reveals that although the Platt report highlighted the need for sick children to be cared for by nurses with a specific qualification in children's nursing, less well known is the recommendation in the same report that paediatric ward sisters should also be State Registered Nurses. This reinforced the contemporary value of the combined courses over the single direct entry RSCN course and was yet another reason for its demise.

### The introduction of the children's nursing part of the UKCC register

The introduction of the UKCC and the four National Boards, following the Nurses Midwives and Health Visitors Act of 1979, led to profound changes in training and registration, which culminated in the advent of *Project 2000*.

The first chief executive of the English National Board was Dr Eve Bendall, a well known children's nurse and previous head of the School of Nursing at the Hospital for Sick Children. Ms Sheila Barlow, the director of nurse education for the newly named Charles West School of Nursing at The Hospital For Sick Children, Great Ormond Street, became a member of the UKCC and vice chair of the Project 2000 working party. Her efforts succeeded in shaping the new register in which children's nursing (part 15) was reintroduced as a separate and discrete entity.

The arrival of the new children's nursing part of the register was widely embraced and paved the way for a number of innovative child branch programmes at Diploma, Advanced Diploma and Honours degree level. All programmes throughout the country were approved by institutes of higher education, and at qualification nurses entered the new parts of the professional register (15 being for children's nurses). In the new curriculum all nurses followed an 18-month common foundation programme irrespective of their chosen branch. The changes were supposed to give all nurses equal status as registered nurses (RNs) and children's nurses were initially euphoric to see their single direct entry register returned to them.

However it was not long before disquiet was again voiced. Although the new parts of the registers were specifically linked to adult, mental health, learning disability or child, the new adult nurse continued to be perceived as a general nurse. This prevented nurses holding part 15 registration from undertaking a shortened midwifery programme or gaining equitable employment overseas. The lack of equity between the branches, to the disadvantage of all but adult nurses, continues to be demonstrated by the adult bias in the CFP (UKCC 1999) and in the power relationships within many universities.

### The current debate

The legacy from the past is one of instability and there is a need to be vigilant in the fight for respect for our registration. While we should not be bound by our history and be unable to change and adapt with confidence, we are justified in reviewing any proposals with a wary eye.

### The NMC

There are a number of factors that should be considered in any debate within the incoming Nursing and Midwifery Council. These relate to the status of children in UK society and the present pattern of development of UK nursing. These factors are central to our ability to continue to uphold the motto of the Hospital for Sick Children: 'The child first and always'.

The first concern is the structure of the Nursing and Midwifery Council (NMC) itself. In the past the number of council members and the voting system allowed children's nurses to vote one of their number onto the council. The requirement for equal representation for nurses, midwives and health visitors from the four countries of the UK implicitly disenfranchises children's nurses and those on the other smaller branch registers. It is unclear so far how the NMC will obtain expert advice about children's nursing or ensure fair representation of children's nurses within its deliberations.

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### Children in society

Reference to the sociological analysis of childhood (Scruton 1997) provides evidence of the ambivalent attitude of the British to children. The way in which children are treated and their rights respected has steadily improved since 1852 – the year the Hospital for Sick Children was established. However, there is still evidence of a lack of respect for children and their specific needs in society in general and in the health service in particular.

The Bristol Inquiry, chaired by Professor Ian Kennedy, (Department of Health 2001) states: 'The specific healthcare needs of babies and young children undergoing open-heart surgery were too readily subordinated to the need to care for adult patients' and 'We argue that children and their healthcare needs should be given greater recognition and higher priority in the health service'.

The feeling of a relative lack of power amongst children's nurses simply reflects the lack of importance placed on children and their lack of power in society. The gradual recognition of children's rights should be grasped as supportive evidence by those speaking on the value of the children's nursing registration, particularly within the debate prompted by the *Fitness for Practice and Purpose* (UKCC 2001) consultation document on the future configuration of the branches.

As has already been suggested, the CFP has tended to become adult nursing focused (UKCC 1999). It is possible to suggest many reasons for this but the most obvious is the numerical superiority of adult nurses in the student population and among university staff. In the authors' experience, the reality of this bias is often invisible to adult nursing lecturers who have become used to the hegemony of general/adult nursing. Many adult nurses do not understand what concerns children's nurses as they have had no experience of being part of a devalued minority in their professional lives.

This raises the question of the ability of universities, however committed to the ideal they may be, to deliver a truly general training. The old SRN and RGN were not general, they were adult physical health nursing with a few add-on bits such as mental health and children's nursing. General training should presuppose some sense of equality between adult and child, physical and mental health, hospital and community practice, plus care of people with a learning disability and the care of the mother and the newborn. Equality means equality in practice placements as well as classroom learning. In reality, given the current, and increasing, number of

students, this would be impossible to achieve and children's nurses are justified in suspecting any change to general training will presage the return to an adult physical health dominated curriculum for all.

#### Service expectations

Following the requirements of *Fitness for Practice* (UKCC 1999) the branch part of the programme was lengthened to two years. This change is an acknowledgement of the time that it takes to develop the level of expertise required for registration. The expectations of the service of newly qualified nurses are, of course, critical to this debate. Given the present health economy and the reliance on nurses to offer increasingly specialised and complex care, any diminution of knowledge, skills and attitudes on registration would be politically unacceptable. The political impetus towards a more successful multi-professional service (DoH 2000) does not necessitate a generic initial qualification. It is hard to see how the required level of expertise at registration can be squared with a general education and registration. The phrase 'jack of all trades and master of none' comes to mind.

Relegating children's nursing to a post-registration qualification, with the same breadth and depth of knowledge, would be much more expensive and would further delay any specialist training. Given current financial limitations, it is safe to predict that this would lead to the loss of the wealth of knowledge, skills and attitudes that the current child branch gives (despite its faults).

#### Improving child branch

This does not mean that nurse educators have got the education of children's nurses right and effort should be taken to re-divert the attention that is given to those problems and therefore make children's nursing stronger and more coherent.

The challenges facing Great Ormond Street Hospital now, in some ways, mirror those of the profession itself. GOS is one of the last two stand-alone children's hospitals offering highly specialised tertiary care. While such hospitals are the repository of a huge amount of precious expertise, most health care of children goes on elsewhere and much of it is provided by parents, supported by community children's nurses (if the family are lucky in their geographical location).

Beach (2001) raises one of the many unexamined

Table 3. Entry to the Register 1986 and 2001

	Part 1 General nursing	Part 8 RSCN	Parts 1 & 8 Integrated	Total Part 8/ Children's nursing
1986	11,939	424	323	747 (6.2% of General total)
	Part 12 Adult		Part 15 Child	
2001	8485	111	1557	1668 (19.6% of Adult total)

complexities of children's nursing, namely how students learn within the context of family-centred care. This is an example of one of the serious educational questions needing to be answered in order for children's nurses to continue to claim to be the champions of ill children.

#### Recruitment to the branch

In the authors' experience, many child branch applicants seek a career specifically with children. It should be appreciated that the large numbers of students who currently apply for places on a child branch course might be lost to the profession were there no direct entry courses available. In 2001, for example, the University of Southampton received no less than 234 applicants for only 30 places on its new three-year child branch degree programme, and 618 applicants for 78 places on its diploma/advanced diploma programme. Clearly, the child branch programmes are popular among prospective students who genuinely want to care for children and not adults. A comparison of the ENB completion figures for March

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1986 (pre-Project 2000) and March 2001 graphically shows the popularity of the child branch (ENB Annual Report for 1985-1986 and 2000-2001)(see Table 3).

#### Conclusion

Readers tracing the historical development of the children's nursing register and the contributions to this of the Hospital for Sick Children

might at this point be feeling either depressed or uplifted by the efforts of children's nurses, supported by paediatricians and consumer groups, to uphold the value for children of nurses specifically educated to care for them.

The nursing profession has a tendency for internecine warfare and it is therefore appropriate to cite a line from that famous Pogo paper (Schuster 1952): 'we have met the enemy and he is us'. Although regretful, it seems that each generation of children's nurses has to take up the baton in order to ensure that the needs and rights of children remain 'first and always' **PN**

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This paper is dedicated to the many children's nurses of the past such as 'Sister Mac', formerly of The Hospital For Sick Children, whose contribution to the care of children in society has often gone unrecognised. Without their dedication and service the care of children today might be somewhat different. Photographs: Medical illustration: Great Ormond Street Hospital

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