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THE SOCIAL CONTEXT AND THE
RELEVANCY OF NURSING CURRICULA

A thesis presented in partial fulfilment
of the requirements for the degree of

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A B S T R A C T

A study based on a perception of nursing as a socially prescribed service, initiated and developed to assist a society to care for members with some inability to maintain self-care. It is argued that, to fulfil its purpose, nursing has an ongoing need to identify and adapt to the changing social realities of a society. 'Social realities' have been defined as the actual conditions, pressures, disabilities and abilities, limitations and resources that exist in the lifespace of people and form the environment within which nursing practises.

A system approach was adopted since it provides for the identification as well as the solution of problems. As a first step a theoretical framework, the 'triadic nursing model' was developed to delineate the key issues nursing has to contend with in contemporary societies. Next, from the operative component of the triadic nursing model an educational tool, with a system approach, named the 'curriculum relevancy process' (CRP) was developed.

CRP, defined as an information-seeking, problem solving, and evaluative process, has three phases. Only the first or information-seeking phase of CRP has been activated, and, moreover, further elaborated to form an information system or process.

Two main activities were undertaken to gain information about contemporary social realities and resultant disorders. To define the social context in which nursing practises an examination was made of:

- dominant trends and problems;
- the effects of contemporary social realities on social institutions, particularly the family;
- changing patterns of ill-health;
- the management of technology; and the clarification of values in an age of degenerative and man-made disease.

From this review it was noted that major issues of today included the problems of rapid and persistent change, and its effects on social institutions and individuals. As well, diseases associated with increasing urbanisation, industrial and technological developments, mobile populations, and the hazards of pollution were found to be prominent. The rapidly escalating costs of health care was also emphasised, and the need to clarify values in order to make optimal choices in the use of available resources. The need for individuals, groups, and societies to have their self-care abilities promoted was also stressed.

The second, and more specific activity, was the use of the information system to focus on the social context in which nursing functions in NZ. For this purpose, information was sought from both voluntary and official sources. The need for broader information about a society's socio-health and nursing needs and problems has been stressed as a basic requirement for maximizing curricular choices. Particular emphasis has been given to the collection of information from the 'mass media' since it provides perceptions of socio-health needs closer to the grass-roots of society.

Characteristics of data collected from the mass media showed that 33% of items were related to specific health problems. Problems of most concern were alcoholism, mental ill-health, inadequate health care knowledge, chronic disorders associated with genetic, pathological, and traumatic incidents, drug addiction, and increasing sexually transmitted disease.

Twenty-six percent of items related to family issues including delinquency in children and adolescents, stress due to psychosocio-economic issues, children-at-risk through abuse, accidents, and marital issues, assaults in the family, and stress due to weakened kinship ties and communication problems.

Twenty-eight and one half % of items affected the community in general. Over 52% of this class related to some concern about inadequate and/or inappropriate health services. Alienation, reduced social exchange, particularly for the elderly, and suicide incidents were also of considerable concern.

Twelve and one half % of items dealt with environmental problems such as exploitation of natural resources, industrial/technological hazards, traffic congestion and accidents.

Based on the priority of socio-health needs shown above relevant curricula for NZ nurses would be concerned with:

- the degenerative disorders of an ageing population in an increasingly industrial society;
- behavioural disorders such as alcoholism, drug dependency, smoking, wrong dietary habits, and trauma associated with behavioural and other 'life-style disease';
- the problems of the basic social unit, the family;
- the care of the frail elderly;
- the physically/mentally disabled (genetic and pathological).
- and the changing social patterns of relationships.

For the consumers of nursing curricula - clients, students, and society-one implication drawn is that there is urgent need to increase the level of responsibility for health care. And amongst the recommendations it is stressed that, as the use of the 'self' in relating to and caring for others is so vital, the development of good interpersonal skills is essential.

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GLOSSARY

BROKER'S SERVICE

This refers to available sources of information from which data can be obtained on request.

CENTRAL PLACE

This term refers to those factors which are central or dominant in the lifespace and wellbeing of an individual, group, or society. The dimensions of 'central place' differ depending on whether it is used for an individual or individuals collectively. The difference is described in the text (see p. 16).

CRITERIA OF VALUE

These are criteria related to the making of judgements that necessarily accompany the selection of actions in nursing and curricular development. For instance, as emphasised in the text, when making curricular choices one has to judge the relevance of alternative choices to the actual health and nursing needs and problems of a society.

CONTEMPORARY SOCIAL REALITIES

The most prevalent conditions or state of order and disorder found in a society.

CURRICULUM

This term refers to the organisation, content, and learning experiences selected to assist with human development in a specific field of learning, and to bring about changes in behaviour. In this context, the curriculum is planned and developed to bring about changes in behaviour in nursing students. It is designed to enable them to develop desirable nursing skills appropriate to a society's requirements for health and nursing care.

CURRICULUM RELEVANCY PROCESS

This is a specific adaptation of the 'integrative process' designed to focus directly on the interrelationship between curricular choices and the socio-health and nursing needs and problems of a society. It can be described as an information-seeking, problem-solving and evaluative process.

INFORMATION SYSTEM (PROCESS)

This is an elaboration of the first phase of the 'curriculum relevancy process'. It is designed for the systematic collection, analysis, and interpretation of information for, in this instance, the purposes of nursing education.

OFFICIAL (FORMAL) AGENCIES

These are governmental (or government related), have legal health responsibilities (government or professional) and, mainly, are tax-supported.

INTEGRATIVE PROCESS

This is a problem-solving, evaluative, and decision-making process designed to draw together all relevant variables involved in the provision of nursing care appropriate to a society's needs.

MASS MEDIA

This is used to refer, in general, to large scale popular forms of communication such as radio, television, cinema, press, periodicals, and records. In this thesis its use is confined, mainly, to the press, radio and television.

NEED

The measurable discrepancy (or gap) between outcomes and desired or required outcomes (Kaufman, 1976).

SOCIALLY PRESCRIBED SERVICE

This term is used to refer to the nature of nursing. Nursing is perceived to be a social institution initiated and developed by a society's need to care for those of its members with some inability to maintain self-care.

SOCIAL REALITIES

The actual conditions, pressures, disabilities and abilities, limitations and resources that exist in the lifespace of people and form the environment within which nursing functions.

SOCIO-HEALTH DISORDERS

This term is used to refer to any loss of balance or adaptation that an individual experiences within and between himself and his total environment. In recognition that the genesis of ill-health lies in the realities of social life, the concept of 'socio-health' is preferred to a separate defining of disorders as, primarily, 'social' or 'health'.

SYSTEM APPROACH

As defined by Kaufman (1974), this is a process by which needs are identified, problems selected, requirements for problem solution are identified, solutions are chosen from alternatives, methods and means are obtained and implemented, results are evaluated, and required revisions to all or part of the system are made so that the needs are eliminated.

SYSTEMS APPROACH

This is closely allied to the concept 'system approach', and is commonly described as a tool for selection of optimal alternative actions based on resource costs and benefits within an area of uncertainty.

Note The main distinction between a 'system' and a 'systems' approach is that the latter commences with a number of assumptions and then goes forward to include the actual selection of methods-means. But the various tools or models inclusive in a 'system approach', are (Kaufman, 1976) planning tools which first identify needs and then delineate requirements, along with a determination of possible methods-means, including feasibility studies to assess the likely outcomes of alternative solutions.

VOLUNTARY (INFORMAL AGENCIES)

These are non-governmental, that is, not part of government structure, are not responsible for carrying out health laws, and are supported by voluntary contributions. Some voluntary agencies, of course, work in conjunction with governmental agencies, may receive some governmental support, and, according to their purpose, may have to maintain standards set by health laws.

CHAPTER ONE

INTRODUCTION: FORMULATION OF THE PROBLEM

NEED AND BACKGROUND FOR THE STUDY

The argument presented in this thesis is particularly concerned with the need for nursing to identify and adapt to changing 'social realities' in order to remain a viable and relevant social institution. As a general concept, social realities are defined here as the commonalities of human life and experience shared by all humanity though with varying emphasis according to all the characteristics of a society. Common to all societies in this latter part of the 20TH Century are the problems associated with rapid and continuous change. Although continuous and widespread social change is not a new phenomenon the rapidity with which change presently occurs poses many problems for society.

A major problem for nursing is the maintenance of relevance in nursing curricula in order to prepare oncoming nurses with skills pertinent to a society's needs. There is a growing awareness among nurses that nursing has come to another turning point in its history which requires some radical reshaping of its services and education. In company with other social institutions - and education is a good case in point at present - nursing is experiencing a sense of urgency about the need to clarify and update the ways through which it mediates its purpose.

Essentially, nursing's purpose throughout history has been simply to assist a society to care for those members with some inability to maintain self-care. From some obscure beginning when neighbourly responses were first made to human need to the skilled profession of today this remains nursing's basic purpose. Henderson (1978) provides an elaboration of the above definition when she states that the universal factor in nursing is providing care throughout the day with any essential

activity that individuals cannot manage with their own strength, knowledge, or will.

Seers (1979) comments that nursing today is too fluid, dynamic, and responsive to changing needs to be pinned down by a single definition. But one needs to distinguish between nursing's purpose and the various roles through which it is expressed. Nursing's roles do vary according to social requirements for nursing assistance, but the essential purpose stays unchanged.

Nevertheless, there is a need for nursing to be flexible, dynamic and responsive to changing social needs in ways appropriate to the socio-cultural context in which it is practised. Moreover, as the realities of social life form the environment in which nursing practises, a continuous updating of information about the 'social realities' must form the basis for changes made in nursing practice and nursing education.

Since the genesis of ill-health lies in the realities of social life it is in the community that nursing needs to commence its efforts to promote health, and to prevent, cure, or relieve ill-health. As a socially prescribed function arising from a society's needs for health and nursing care, nursing activities should always be expressed in terms of social and community needs. The 'social realities' and resultant outcomes provide the best determinants for nursing policy at central, regional, and local levels. In addition, a society's perceptions of its socio-health needs should be ascertained. Although nursing does show an increased responsiveness to the health and nursing needs of a society, it has yet to give society an effective degree of participation in the selection of health and nursing services provided.

Many new demands are placed on nurses due to 'contemporary social realities', which can be described as the most prevalent conditions or states of order and disorder in a society. One response has been an

expansion and diversity of nursing roles. The predominant theme of the 1970's has been nursing in the community, with the community, and within an ever expanding health team (Donaghue, 1975). At the same time advances in medical technology have required specialist preparations for nurses to become proficient in very skilled technical roles. Nursing expertise in both areas is reliant upon nurses with an aptitude for working autonomously and as team members.

A distillation of experiences in diverse socio-cultural environments, impressions gained from the reporting of the mass media, and the solutions advocated in current literature suggest that, in response to the many demands placed on nurses by contemporary social realities, certain issues hold priority for nursing education. As these issues form part of the background for the argument advanced in this thesis they warrant a brief mention at this point.

The first issue is related to policies for the organisation of nursing education. Nursing education requires an organisational structure that can be adapted readily to changing conditions. In addition, the current 'knowledge explosion' means that no basic course can supply what a nurse will need to know for skilled performance throughout a lifetime career. As a consequence, continuing education must be planned with an overall organisation of nursing education programmes. Further, re-entry must also be provided for those who have had a period of interruption. (Abdellah et al., 1973; Briggs, 1972; Cooper & Hornback, 1973; Katz & Fülöp, 1978; Harre, 1976; Hastings & Murray, 1976; CERI, 1975; Steele, 1978; Toffler, 1974; and Warcaba, 1976).

A second issue is the need to ensure that curricular choices are optimal for student learning outcomes in relation to the social context in which they will practise. A 'person-centred' curriculum with a problem-saving approach is thought to be the most appropriate one.

(Abdellah et al., 1973; Clark, 1978; Conley, 1973; ICN, 1974; Jacobs, 1976; Longway, 1972; Simms & Lindberg, 1978; Toffler, 1974; Williamson, 1976; and Woolley, 1974).

Another issue of importance is the location of learning experiences. As the genesis of ill-health is in the community the primary location of learning should be in the community, and the concentration of learning experiences in health care institutions modified (Katz & Felton, 1965; Abel-Leiserson, 1978; CERI, 1975; Dawson & Doornkamp, 1973; Hastings & Murray, 1976; Milio, 1975; Skeet & Elliot, 1978).

Then, in an increasingly complex society, the development of the 'nurse person' (to use Simms & Lindberg's term, 1978) is especially important. Students' learning experiences must, therefore, enable them to acquire a positive self-regard, and an ability to use the 'self' more effectively in personal relationships (Altman & Taylor, 1973; Burgess, 1978; Flaskerud et al., 1979; Maclean, 1974; Orlando, 1961; Reilly, 1978; Rogers, C., 1971; Schneider, 1979; and Simms & Lindberg, 1978).

A further important issue relates to identification of the skills required in oncoming nurses to enable them to cope with current socio-health disabilities. To define a society's or client's nursing requirements, to outline alternative solutions, and to persuade other to collaborate and/or participate for optimal outcomes can be seen to require problem-solving, deciding, communicative, and affective skills.

Priority must also be given to the preparation of oncoming nurses who are able to practise autonomously, accept responsibility for the decisions they make, and can participate in shared, collaborative health team activities (Clark, 1978; Claus & Bailey, 1977; Donaghue, 1975; Johnson, 1968; Peterson, 1973; Putillo, 1973; and Orem, 1971).

As well, the acquisition of coping strategies to manage change

and uncertainty, and to be able to make judgements of value as well as of skills is essential (Auld, 1979; Glover, 1978; Peplau, 1977; Reilly, 1978; Simms & Lindberg, 1978; Steele & Harmon, 1979; and Toffler, 1974).

Finally, to remain relevant to the foremost social realities, there is an obvious need for nursing education to formulate curriculum processes that continually update information about the social realities. And, subsequently, to use the information as a basis for curricular choices, and to amend or enlarge curricula as necessary.

In brief, it can be said that the resilience of nursing to keep on initiating effective systems of nursing care, appropriate to the social context, is dependent on the preparation of oncoming nurses who can apply knowledge and skills to different clients and situations. The self-growth and maturity of the nurse is believed to be vital if nursing curricula are to have successful outcomes.

Nursing has also to consider whether its philosophy of action, and its values, are relevant to a society's condition. There is a need to ask not only what should the nurse know but what kind of a person she should be to be acceptable to a society and to practise effectively.

Reflection upon contemporary needs for nursing care led to this study of the relevance of nursing education to social realities that confront societies today. It is clear that nursing roles will continue to change as social requirements for nursing assistance alter over time. Ongoing knowledge about the 'social realities' and resultant outcomes is seen to be essential for any changes made in nursing education to be relevant to a society's socio-health and nursing needs.

PROBLEM STATEMENT

This thesis focuses on the problem of maintaining relevancy in nursing curricula in relation to the social realities confronting societies in a time of rapid and persistent change. It is particularly concerned with the problem of preparing oncoming nurses with skills relevant to the social context in which they will practice.

The basic questions asked in this thesis are:

1. how can nursing maintain a close relationship between the social realities of a society and the decisions made in curriculum development and planning;
2. what is the best method(s) for the identification and documentation of the dominant social realities and resultant socio-health and nursing needs and problems;
3. what nursing skills are desirable in oncoming nurses; and
4. after evaluation of nursing curricula, particularly of their relevance to the social context in which nursing is practised, what changes are required for problem(s) solution?

APPROACH TO THE STUDY

What Kaufman (1976) calls a useful educational tool, a 'system approach', has been adopted for the study since it provides for the identification as well as the solution of problems. (Definitions of the concepts 'system' and 'systems' approach, and the distinction between the two can be found in the glossary.) As will be apparent later, the identification and documentation of socio-health and nursing needs and problems is placed first in the development of relevant curricula. In the last ten to twenty years, it has been increasingly recognised that there is a marked discrepancy between desirable and actual health and nursing

services.

It is believed that a 'system approach' helps to reduce this discrepancy since it uses from the start a process that identifies and then plans to meet documented needs. It is true, as Kaufman (1976) points out, that such an approach can be arbitrary and mechanistic. But a thorough appraisal of socio-health and nursing needs, as the first step in curriculum development, has a humanizing effect and avoids such faults. It also avoids the error of simply trying to find more effective ways of maintaining present nursing services and educational strategies.

There are a number of 'system approach' tools currently available to promote, and evaluate, educational processes and outcomes. Grouped by Kaufman (1976) into three main types, they include:

1. the 'descriptive mode', which seeks for some understanding of the realities around one and then describes them for possible use;
2. the 'solution-implementation mode', which assists one to find and use the best strategies to achieve objectives, always assuming, of course, that the objectives are valid; and
3. the 'design-process mode', which integrates the first two modes and attempts to develop a more holistic approach. Each of the three modes, however, is valid according to what one hopes to achieve.

CURRICULUM RELEVANCY PROCESS

An educational tool, with a system approach (see figure 3.5., p 47), has been developed specifically for this study of the social context and the relevance of nursing curricula. Named the 'curriculum relevancy process' (CRP) it is discussed, in detail, in chapters three and four. But, in brief, it is defined here as an educational tool that enables all the components involved in curriculum development and evaluation to be identified, and problem(s) solutions determined.

CRP belongs to the group of system approach models classified as 'design-process mode', and provides for all the steps necessary:

1. to identify and document the foremost 'social realities' and resultant social disorders;
2. for evaluation of the relevance and effectiveness of nursing curricula and their outcomes; and
3. to determine the requirements for problem(s) solution and the making of optimal curricular choices, based on feasibility studies.

Basically, like all system approach tools, it provides for the independent and interdependent functioning of all components, so that problem solution is based on documented need. Through the identification of needs, the selection of dominant socio-health and nursing problems, and the choice of optimal problem solution, changes can be made to nursing curricula to eliminate irrelevant and ineffective curricular strategies.

The use of a 'system approach' is believed to increase the likelihood of achieving planned change as it requires a thorough assessment of needs as a first step. It is a demanding approach, as is evident later in the thesis, but its results justify the demands it makes. Through its use the efforts made, and the use of resources, are more responsive to actual need.

To validate the approach taken requires that all the activities delineated in CRP (see figure 3.5., p 47) are undertaken. But as this requires resources beyond the limits of this thesis and, in fact, would require a team effort, only the first stage of CRP is made operational. Even so, the use of a system approach, with a tool such as CRP, is considered essential if nursing is to fulfil its social purpose.

Later in the thesis the social context in which nursing practises is examined at some length, since it is from the social context that the information required for optimal curricular choices is to be obtained.

Moreover, a specific application of the first phase of CRP is made to identify and document the foremost socio-health disorders experienced by New Zealand society during 1979.

This demonstrates, in part, the validity of the approach taken, but an important long-term goal, for later study, is to relate the findings obtained from defining the social context of a society to the characteristics and outcomes of nursing curricula.

PURPOSE OF THE STUDY

1. To develop a way of achieving a closer relationship between the social realities of a society and the choices made in curriculum development and planning.
2. To identify the dominant 'social realities' and resultant socio-health disorders in order to determine broad and specific curriculum objectives for nursing curricula.
3. To determine criteria of value, such as the criteria of relevance and flexibility, to assist in the making of optimal curricula choices. Values are implicit in the very nature of nursing but they need to be articulated.

BASIC POSITION UNDERLYING THE STUDY

In keeping with the perception of nursing as a socially prescribed institution the basic position held is that, for optimal outcomes, curricular choices must be relevant to the social context of a society. In regard to this basic position it is believed, therefore, that:

1. nursing is a socially prescribed service fulfilled through autonomous nursing action, through shared collaborative action, and through assistive or dependent action on behalf of others;
2. the disorders associated with the social realities vary according to

- socio-economic and cultural characteristics, and require, therefore, continuing updating by the systematic capture of information;
3. the social realities of communities and resultant disorders and commonalities provide the most appropriate determinants for curricular choices;
 4. for each individual there is a particular priority of needs, and, consequently, the planning and giving of nursing care should be 'person-centred' and not 'task-centred';
 5. nursing is a process and should be planned systematically with an iterative feedback that provides for modification of care as a society's or individual's condition alters;
 6. to be a 'nurse' involves more than the concept of 'nursing' implies, and, therefore, that a nurse needs certain qualities of mind, of person, and of purpose as well as cognitive and technical skills;
 7. for a student to develop the qualities inherent in the concept 'nurse' the learning climate must be one of mutual trust, support, acceptance, respect, and positive warm regard;
 8. the teaching/learning strategies for nursing students should facilitate the growth of sensitive, adaptive, autonomous, innovative responses to human need;
 9. nurses must be prepared to function effectively both within a team and independently; and
 10. the capacity to accept role ambiguity and uncertainty, associated with changing conditions and needs, is both nursing's most singular quality and challenge.

THEORETICAL FRAMEWORK FOR THE STUDY

A theoretical framework, underpinning the approach and position taken in this thesis, is discussed fully in chapter two. Called the

'triadic nursing model' (see figure 2.1., p 15) it is designed to aid curriculum construction. Based on a perception of nursing as a socially prescribed institution, initiated and developed by societies for the care of those members with some inability to maintain self-care, it consists of three main structural components.

In conjunction, they bind together all the issues implicit in the nature of nursing and its purpose, and in the strategies required to ensure that nursing curricula are relevant to the social context. The structural components of the 'triadic nursing model' are termed:

1. a 'socially prescribed service';
2. the 'central place' of an individual, group, or society; and
3. an 'integrative process'.

Through using theoretical frameworks, such as the 'triadic nursing model', as a basis for curriculum construction all the relevant factors can be clearly delineated, and the relationships between them grasped. The real promise for bringing about effective change in nursing is seen to rest in the recognition of nursing as a 'socially prescribed service'. As a sequence to that recognition, nursing has then to develop strategies for a continuing understanding of the 'central place' of an individual or for individuals collectively. The third component of the triadic nursing model, from which an educational tool with a system approach, the 'curriculum relevancy process', is developed, provides one such strategy.

By emphasising the nature of nursing as a socially prescribed service one establishes a basis for optimal curricular choices. On this basis, decision-making in nursing education commences with a thorough appraisal of the social realities of a society. And, subsequently, with an assessment of a society's requirements for health and nursing care.

ORGANISATION OF THE STUDY

This thesis is concerned with the relevance of nursing education to the social realities of contemporary societies. Chapter one has formulated the problem and provided an introduction to the main issues dealt with in the thesis. Chapter two discusses a theoretical framework which is designed specifically as a basis for curriculum construction. Chapter three, after an initial discussion of the use of conceptual frameworks in nursing education, describes CRP. In chapter four, the first phase of CRP, concerned with the gathering, analysis, and interpretation of information, is further elaborated. In chapter five an extensive review of contemporary social realities is made in order to define the social context in which nursing practices. Divided into five main sections it examines:

1. contemporary social realities - trends and problems;
2. social institutions - contemporary social realities;
3. social realities - changing patterns of disease;
4. social realities - the management of technology; and
5. clarifying values in an "Age of Degenerative and Man-Made Disease".

Chapter six gives an account of the application of an information system to the social realities of New Zealand (NZ) society. Chapter seven reports on the characteristics of the information collected. In chapter eight, the final chapter, the summary, conclusions, implications, and recommendations for nursing education are presented.

CHAPTER TWO

THEORETICAL FRAMEWORK FOR THE STUDY

Along with the professional growth of nursing in the last 40 - 50 years there has been a steady advance in the development of nursing theory and knowledge. But there is still considerable argument about the nature of, and the need for, nursing theory and knowledge. What nurses primarily do for the sick are largely what would be done by women in the home. And, Peplau (1974) notes, this is one reason why society is seen to question the need for nursing to be an academic discipline.

One of the best contributions for clarifying the nature of nursing knowledge has been that of Johnson (1959, 1975, 1968 and 1974). In an analysis of the nature of the knowledge required by nursing Johnson (1968) describes it as consisting of three parts, viz.:

1. knowledge of order, which could be interpreted as 'wholeness' - of man as an organised and integrated whole;
2. knowledge of disorder, which provides the means to recognize it or its potentiality; and
3. knowledge of control, which provides the means to either prevent disorder or to convert disorder into order. Knowledge of control can be better interpreted as 'caring' and 'curing' activities.

It is within the area of disorder that Johnson (1968) believes nursing should establish its own theory. In addition, nursing must ask which of the possible classes of disorders is its primary concern. Is it biological, psychological, or social disorders, or selected classes of disorders? What is seen as unique to nursing, however, is the way in which nursing knowledge is applied to ease stress and to assist recovery of behavioural stability.

Although different conceptual frameworks have been used by nurse theorists to determine the nature of nursing, they are, basically, centred

on the effects of illness and wellness in daily life (King, 1971; Norris, 1964; Orem, 1971; Orlando, 1961; Rogers, M., 1970; and Roy, 1976).

In general, the genesis of socio-health and nursing needs and problems in the social realities of a society is only briefly discussed. Although it has been acknowledged, or implied, from an early period in nursing.

Longway (1972) provides examples, from the writings of Fenwick and Dock, of an early recognition that socio-health disorders have their genesis in the social realities of a society. Fenwick described the work of nursing as one of humanity all the world over, and in 1909 Dock stated that the International Council of Nurses (ICN) desired the full development of the human being and citizen in every nurse so that her professional knowledge and skill could be applied to the many needs of modern society. At the same time, Fenwick noted that nursing in the future will not be restricted to a few years in hospital with a restricted area of influence, but, under a more comprehensive curriculum defined by state authority, will have a specific value to the community.

Recognition of the need for more comprehensive and relevant curricula has, as noted already, resulted in the construction of theoretical frameworks to guide practice. Developing a theoretical framework for nursing, Pervin (1975) comments, is an economical device for binding together many facts. Chin (1961) describes it more graphically by using the term 'mind-holds' for the models practitioners use to manage and co-ordinate the components of practice.

As a basis for the argument presented in this thesis, a theoretical framework, composed of three 'mind-holds' has been formulated to manage and co-ordinate the components of nursing practice and nursing education. Collectively they form a model (introduced briefly in chapter one) which is called the 'triadic nursing model' (see figure 2.1., p 15).

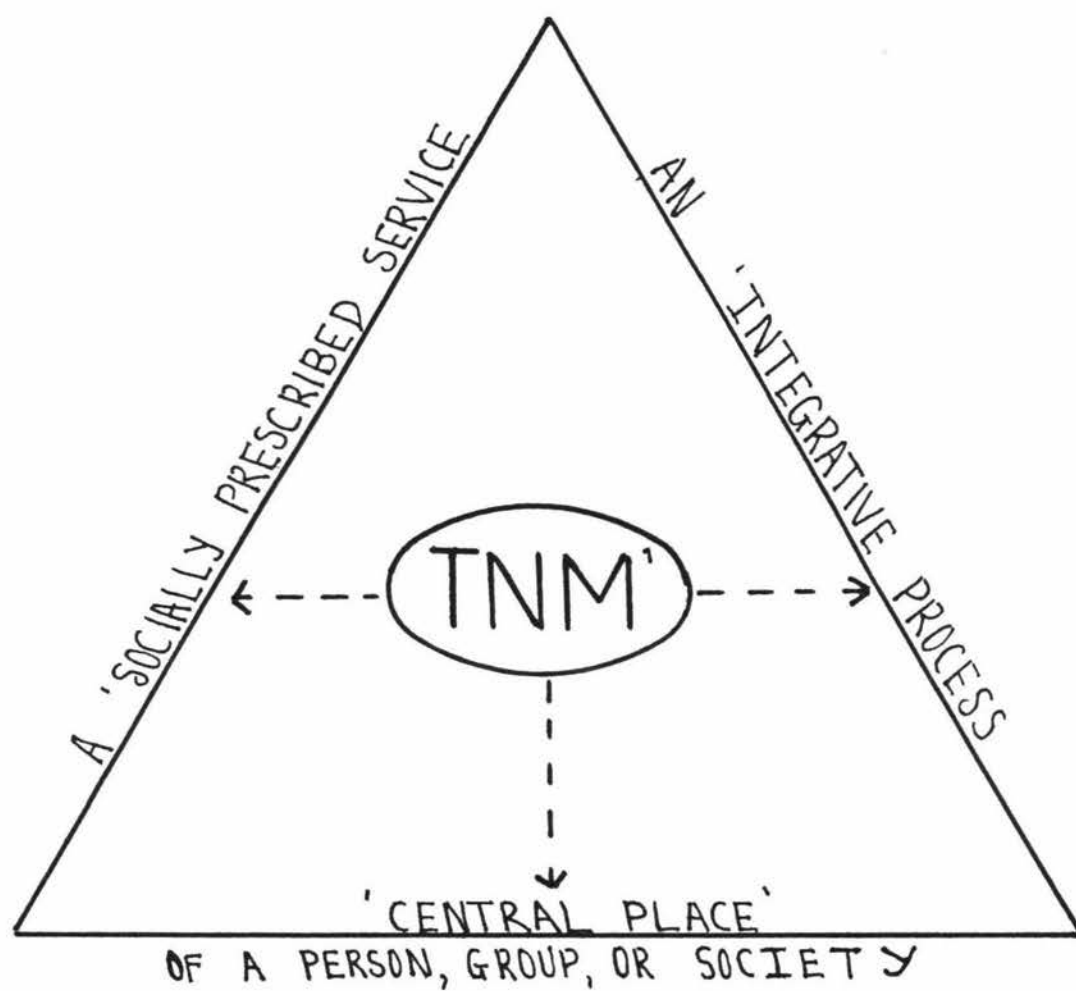


Figure 2.1. Dimensions of a Triadic Nursing Model

1 'TNM' (Triadic Nursing Model)

(Fodor, M. 1980)

TRIADIC NURSING MODEL

The 'triadic nursing model' (TNM) is formed by three 'mind-holds' or structural components which, on elaboration, display the dimensions implicit in nursing. In keeping with the primary focus of concern in this thesis, the first mind-hold draws together all that is implied in a perception of nursing as a social institution. Since nursing has been initiated and developed by collective and individual need for assistance with some aspect of self-care, the first mind-hold is termed a 'socially prescribed service'.

The second mind-hold, termed the 'central place' is used in reference to those factors which are central or dominant in the lifespace and wellbeing of an individual, group, or society. The concept, of course has different dimensions depending as to whether it is used for an individual or for individuals collectively. For a society, central or dominant issues are influenced by the socio-cultural determinants which primarily motivate a society's perception of its needs. But for an individual the dimensions of 'central place' relate to a core or fusion of psycho-social, mental, and spiritual energies. Together these energies form the 'central place' and the development of a unique personality construct. Behaviour to maintain inner balance and harmony with the environment is seen to be the result of activity in the 'central place'.

The third mind-hold, termed the 'integrative process' is the operational tool of the 'triadic nursing model'. It is from the 'integrative process' that a system approach tool to monitor curriculum relevancy is developed. Known as the 'curriculum relevancy process' it has been described briefly in chapter one, but, in detail, in chapters three and four. The function of the 'integrative process' is to maintain relevancy between the actions of nursing and the requirements of a society for

nursing care.

To know what educational preparation oncoming nurses require it is believed that nursing must first establish what it is that nursing is asked to do to satisfy the socio-health and nursing needs of a society. The structural components of the triadic nursing model, discussed fully below, are focussed on this need. For it is only when one knows what a society's nursing requirements are that optimal curricular choices can be made. Defining the social context for which nursing curricula are prepared provides an insight into health and nursing needs as part of the total needs of a society.

NURSING AS A 'SOCIALLY PRESCRIBED SERVICE'

The nature of nursing as a social service varies according to the socio-cultural determinants of a society at a particular point in its life-history. It has been stated already that nursing's purpose is to help society to care for those of its members with some inability to maintain self-care. But nursing activities to achieve this purpose differ according to societal expectations based on socio-cultural and economic factors.

There are a number of recent studies which pay particular attention to the need to relate health services to the socio-cultural and economic determinants of a society. In addition, the need to relate health services, and the education of health professionals, to the specific health needs of people in different locations is stressed. In some of the studies the nurse is reported to play a major role in providing more accessible and effective health care, in others a much more limited role, and in yet others is hardly mentioned (Skeet & Elliott, 1978; King, 1966; Storlie, 1970; Newell, 1975; Brockington, 1975; Wostenholme & O'Connor, 1967; Levin et al., 1977; and Katz & Fülöp, 1978).

It is clear that the concepts of 'nursing' and 'nurse' conjure up very different pictures according to where one lives or what one can afford. Storlie (1970) pleads with some passion for nurses to enlarge their concern from the hospital sick to the social sick... to those who are powerless, feeble, old, troubled, alienated, and hopelessly poor. "Nursing" she writes, "was born to relieve pain and soften human ills" and social institutions must be more involved in the social issues of the day if they are to remain relevant to the society they serve.

Storlie (1970), and Wostenholme & O'Connor (1971), refer to Nightingale and the strong social concern which motivated her interest in nursing and other social issues such as poverty and oppression. The impetus for the development of nursing came from the needs of the poor and powerless, and the ill. As the founder of modern nursing Nightingale waged war on what might be called socio-biological pollution - insanitary conditions and lack of basic necessities such as an adequate diet. In this second half of the 20TH century a 'Nightingale' would undoubtedly wage war against the disorders generated by what Papanek (1971) calls 'psychosocial pollution', and its potentially destructive effect on individual, group, and societal integrity.

The social ills of poverty and oppression still exist, to a varying degree, in most societies, but in the 'global village' (Mead, 1970) of today the basis of individual and societal wellbeing is most seriously impaired by a loss of strong and enduring interrelationships and of a unifying belief. The ability to achieve sustained recovery, when it is a reasonable expectation, is impaired because too often the individual is returned to, or remains in, an overall environment which lacks meaning and a sense of belonging and togetherness with others.

To help restore individual and societal integrity is a major task for nursing today, as it adjusts to the needs of the time. It

involves coping with environmental pollution - physical, biological and psychosocial - as well as an understanding of health, illness, and the nature of nursing care. It also has to be undertaken in a rapidly changing era in which universally rising demands and needs have to be responded to with a finite amount of resources which are generally unequally distributed between and within societies.

To fulfil its social purpose nursing, in company with other health and health related professions, must continually update its information about the physical and psychosocial hazards that confront societies today. Lambo (1967) is emphatic that any realistic attempt to assess the health of people must include identifying, describing and assessing the effect of behavioural disorders on a society as a whole. Nursing has also to take account of the effects that societal attitudes and conditions have on the individual. Consequently, effective nursing practice must be based on an understanding of all the factors in the environment that influence the health status of an individual and a society. Figure 2.2.* depicts the components in the environment which are interdependent and the basis of health in the individual and society.

As a 'socially prescribed service' nursing is necessarily involved in the complex social issues existent in most societies today. It has to develop more understanding of all the interdependent components in the human environment that affect the health of people.

Since the nature of nursing as a 'socially prescribed service' has too many dimensions to be fully dealt with here, this section of the triadic nursing model (TNM) will conclude with a brief look at some of the more important concepts with which it is concerned. The way these concepts are understood influences the sensitivity and response of nursing to a society's requirements for socio-health and nursing care.

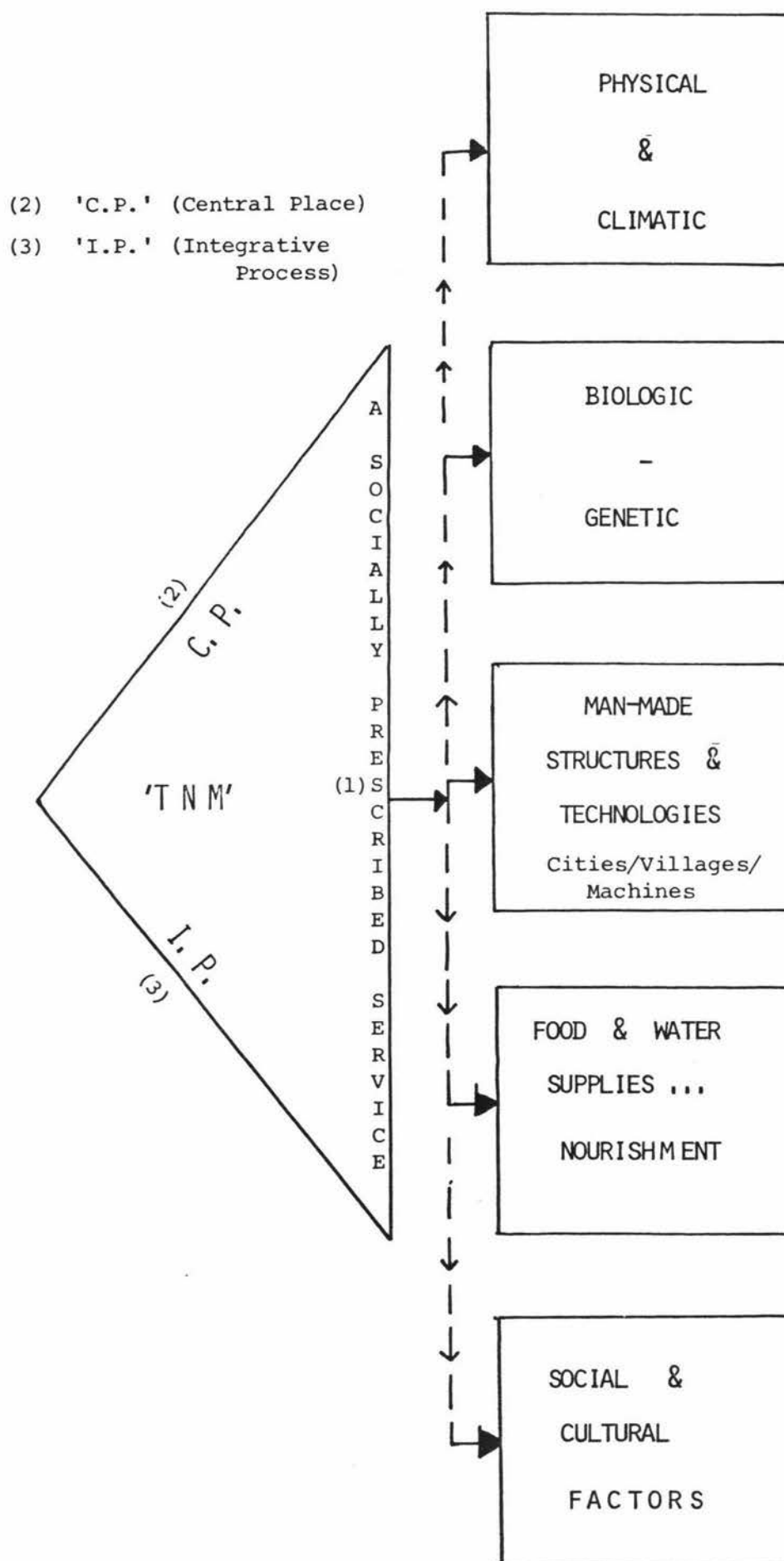


Figure 2.2. Interdependent Components In The
Human Environment That Affect Health

(Idour, M. 1980)

'Health'

There are many definitions of health, but the essential meaning of most is related to the degree with which an individual can effectively adapt to the total environment and function autonomously in healthy interrelationships with other members of his society. In this sense, as Vickers (1965) notes, health is a norm not to be attained once and for all but necessitating continuous renewal and adaptation. Vickers (1965) also comments that few would disagree with the WHO definition of health as a form of individual excellence, but wonders who can define for each person his state of individual excellence. What is needed, he suggests, is a concept of health that allows for the individual's ability to cope with societal pressures without breakdown.

Health can also be described as a quality of wholeness, of life as evolving at a satisfying level in physical, psychosocial, and spiritual dimensions, and with adequate capacity to adapt to the changes that occur with each stage of development. The health of individuals is interdependent with those who are close to them and those who are remote. They are also affected by the choices made by the polity and other social institutions in their society. Health, therefore, requires the co-operation of all sectors of a society. Figure 2.3. (p 22) is a flow diagram which depicts the various sectors required to co-operate to maintain individual and societal health.

Finally, Meads description of the Navaho's conception of health (as quoted by Wilson, 1975, p.6), is given since it is a simple, but comprehensive viewpoint of health.

"For the Navaho health is symptomatic of a correct relationship between man and his environment, the world around him, and his fellow man. It is associated with good, blessing, and beauty... all that is positively valued in life. Illness, on the other hand, bears evidence that one has fallen out of this

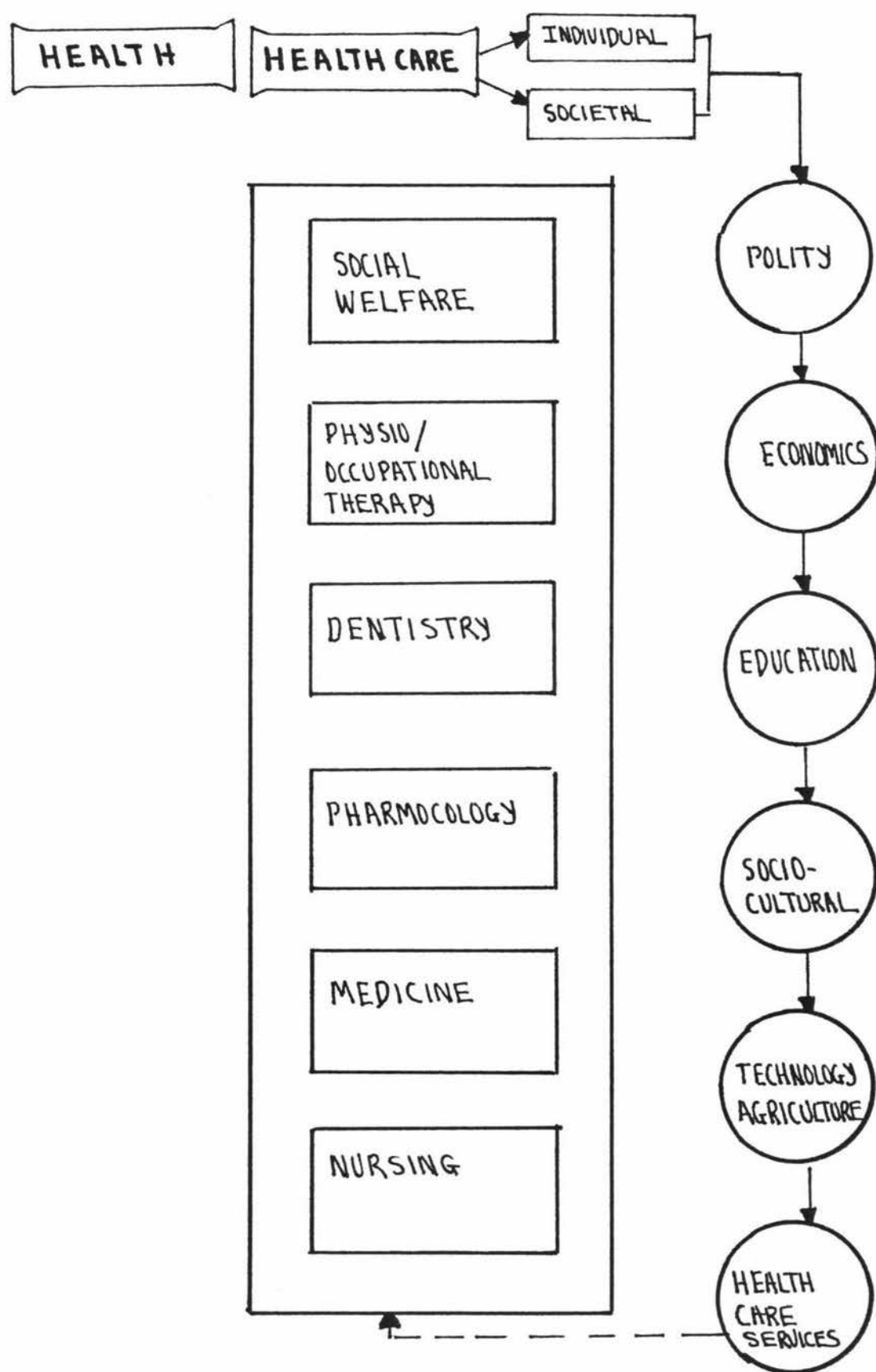


Figure 2.3. 'Health' - A Total Community Effort

delicate balance...."

'Disease'

The concept of disease is used here, in a generic sense, to refer to any loss of the 'delicate balance' the Navaho perceives an individual to have within and between himself and his total environment. Francis (1965) expresses a similar view when he notes that disease is a reaction to a stress which extends beyond the bounds of individual reserve and adaptability - and this can be extended to refer to a group or a society.

Disease can also be defined as a diminishing quality of life, a lack of wholeness or integrity, a loss of values: a developing, destructive process with external and internal causations as depicted in figure 2.4. (p 24). A systems approach would see it in relation to intrapersonal and interpersonal conflict as well as in relation to physical disease and trauma.

One way of avoiding the health/disease or health/illness dichotomy is to make use of Cornillot's concept of 'relative health'. Cornillot (1975) perceives 'relative health' to be a condition of equilibrium which moves towards or away from a level of peak wellness. The value of such a flexible concept is that it covers a condition of being which is in a constant state of adaptation. Further, it also allows for socio-cultural differences and the subsequent perceptions of health and disease/illness that a society may hold.

'Nursing Care'

Nursing care is a response to the needs and demands of individuals and societies with their health/nursing problems. Nursing as a 'social service' has been discussed, but the characteristics of nursing

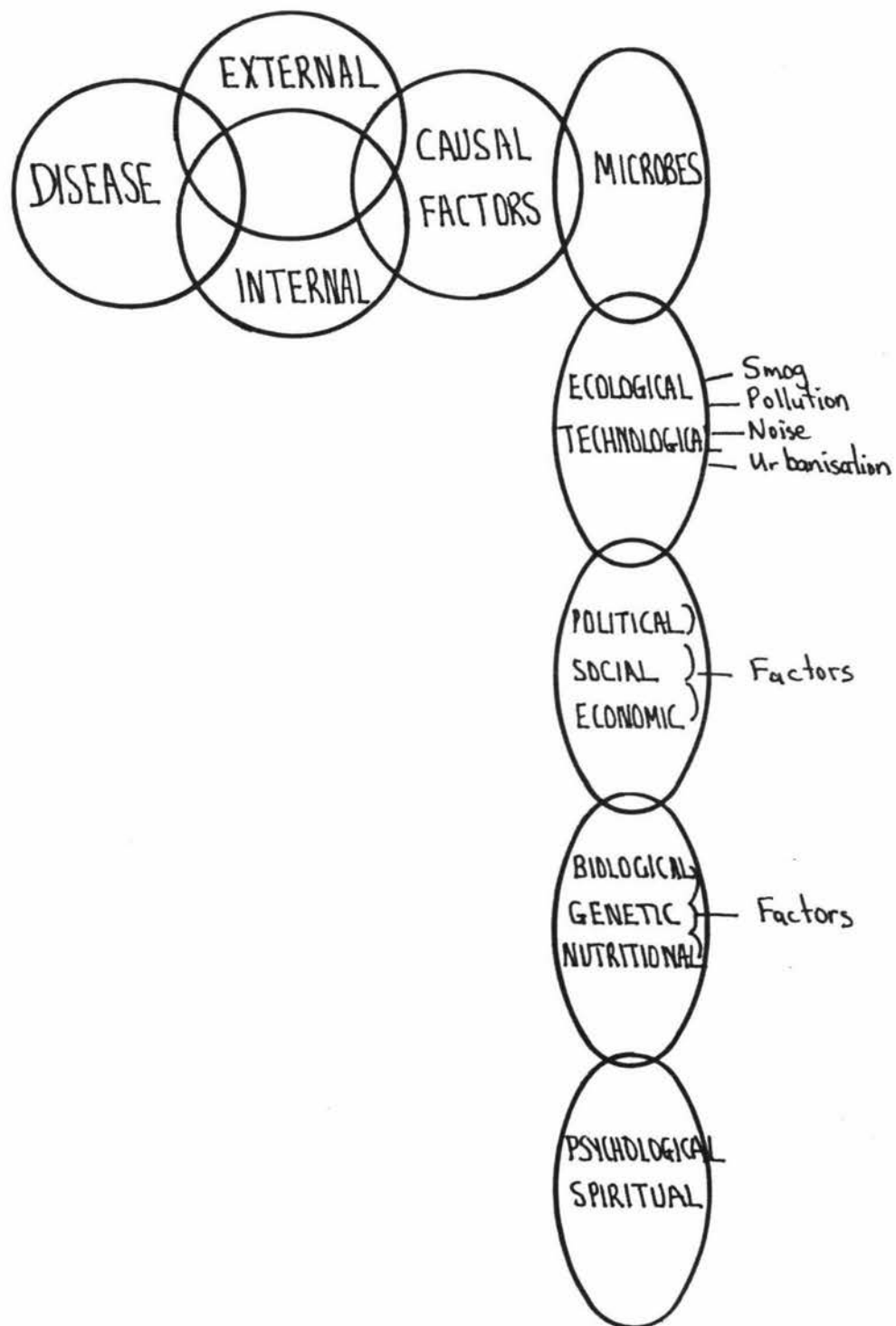


Figure 2.4. 'Disease' - A Multi-Causal Condition
 (Idour, M. 1980)

care need further description.

Nursing care is perceived to be a compassionate, caring, creative, conserving activity. The precise nature of care will vary according to the illness, the individual's coping abilities, and the supports they have available to them. Each one's care, therefore, needs individual planning, and, to be effective, must involve the person as fully as possible in the decisions made on her or his behalf.

The initial activity must be that of identification of the problems that affect the person's ability to maintain health. This entails acquiring knowledge of the total environment of the person, at a particular point of time, since neither the environment, nor the ability to interact with that environment, is constant over time.

Identification and assistance with health problems requires knowledge of the state of what Johnson (1968) calls the 'behavioural system' and any imbalance between its sub-systems, viz., affiliation, aggression, dependence, achievement, ingestion, elimination, sex, and restorative. Nursing care is seen to involve intervention by the nurse, to assist in the regulation and control of the sub-systems as necessary, in order to promote balance and stability of the entire behavioural system. The emphasis for nursing is on the person who is ill and not the illness. When the individual's resources or energies are deficient nursing care is planned to promote ability to hold, regain, or enhance coping strategies and thus recovery.

Nursing care is applied to gaps in self-care abilities, but must be designed to primarily assist the person's movements back toward self-care or management. It is essential that nursing care includes helping people to clarify and obtain the health goals that are optimal for them.

Whatever the nature of the nursing care required there are two key qualities which are perceived by both nursing and society to be, a

priori, essential for the ordering of the activities engaged in. These are the qualities of compassion and competence.

'Compassion' may be variously described as an activity, a process, or a component of value and quality which allows for, meets the needs of, and is an essential part of all nursing activities. It is defined in the OXFORD ENGLISH DICTIONARY (OED) as fellow-feeling or pity for the disabilities of others and the will to be prepared to do something about it. 'Competence' is an essential partner to 'compassion' for it implies the will to do something about it effectively and with sufficient knowledge. To act with 'competence' according to the OED means to be 'sufficiently qualified' to provide the requisite care.

Henderson (1978) stresses that if there is a universal concept of nursing it is that of a constant, comforting, intimate service. Nursing education must prepare oncoming nurses to provide continuing care over twenty four hours. A care that Johnson (1974) found, through personal experience, requires to be planned and organised by one nurse though administered by several. A nurse from whom the patient may receive encouragement, information, skilled assistance, and understanding. And a nurse who meets the patient's needs, for example, for dependency or independency as they arise; and who helps to augment the energies of the patient as necessary.

Finally, in relation to nursing care reference can be made to Mayeroff's (1971) study 'on caring'. He reminds one that, important as it is to have anticipated goals and general aims which contribute direction and meaning in the present, it is the process which is primary for it is only in the present that one can attend to the other. As Mayeroff notes one has to respond to the need which is present, and to act with what one has and at the level which one has reached. Oncoming nurses must be provided with learning experiences that, while helping them to benefit

from past experience, and to plan ahead for direction and achievement of optimal goals, prepares them to respond and act according to present realities and needs.

THE CONCEPT OF 'CENTRAL PLACE'

This is the second of the 'mind-holds' which form the conceptual framework for the study. To achieve its social purpose of comforting, consoling, and assisting people to overcome or to manage self-care deficiencies, nursing care must be formulated around that which is central or dominant in an individual's, group's, or society's socio-health status. Until the socio-health problems which dominate individual or societal concern are recognized and attended to, little sustained progress will be achieved in assisting movement toward recovery or enhancement of wellbeing. This will involve activities designed to aid adaptation to the external environment and adjustment to re-establish or gain internal balance.

The 'Central Place' of a Society

For a society the notion of 'central place' has different dimensions to that which exist for the individual. Essentially it is linked to the perceptions and beliefs a society holds about survival, unity, and order. Further, it is qualified by differing perspectives about the value of the individual in relation to societal groups such as the family, and to the entire society itself.

One could debate, at exhaustive length, the relative placings of unity, survival, and order in society. But only one point will be stressed here. In the preparation of oncoming nurses there is a universal requirement, applicable to all societies, that they learn how to recognize what does primarily motivate those they care for. One should explore with, and provide learning experiences for students about the nature of social

illness - what Katz (1971) describes as a loss of a society's capacity to re-establish its own dynamic balance. Social ills that plague most societies today include the incidence of mental and behavioural disorders, injuries due to environmental pollution and man-made structures, and inadequate and unevenly distributed resources and accessible health services.

To determine what is central to a society, and to explore with it what adjustments may be needed to ensure social wellbeing for all its members, requires interpersonal skills of high quality. The nurse has to start by communicating; listening, gathering and exchanging information, and seeking explanations. Further, nursing has to accept that the solutions to health problems are interdependent with all aspects of the social and physical environment. For example, intestinal infections respond to medical and nursing care, but, for sustained recovery, preventive measures include safe and adequate water supplies, and socially responsible attitudes towards disposal of waste.

In some societies the extended family - a valuable institution in most ways - is the centre of planning, goals, and activities. But some adaptations are needed to promote wellbeing which may be seriously impaired by attitudes and habits of those outside of the family. Integrity of the extended family necessarily involves mutual planning with all relevant others to ensure a safe physical and social environment. In such a society the nurse has to act as educator, interpreter, and provoke participation in social and self-care activities which benefit the wider community as well as the family.

In contemporary industrial, technological societies the nurse has, amongst other roles, to act as a resource person for the lonely, the powerless, and the inadequate. Providing, treating, teaching self-care, and coping strategies to deal with change and interrelationships are

increasingly important nursing activities. Initiating nursing care relevant to contemporary need for assistance with self-care implies the need to know what socio-health problems are dominant or central to a society. It also implies an active role in society's reappraisal of its priorities and values in relation to its total environment and the well-being of its people.

Furthermore, in reappraisal of its own policies nursing must note that the illnesses that prevail are increasingly of a chronic nature and require long-term and sustained assistance outside of health institutions. Katz (1971) discusses some of the chronic disorders that have to be dealt with at home, such as rheumatoid arthritis, diabetes, hypertension, coronary disease, and various forms of paralyses. Long-term illness in the family places a number of stresses on its members. Support is required in different ways and the need for nurses to practice in the community grows.

Sometimes nursing in the community involves giving regular physical and psychosocial support. In other instances it involves knowledge of where other official or voluntary assistance may be obtained. Finally, the nurse must be able to work with other members of society - professional and lay - to determine central needs and priorities, and how best to adapt to changing conditions and needs.

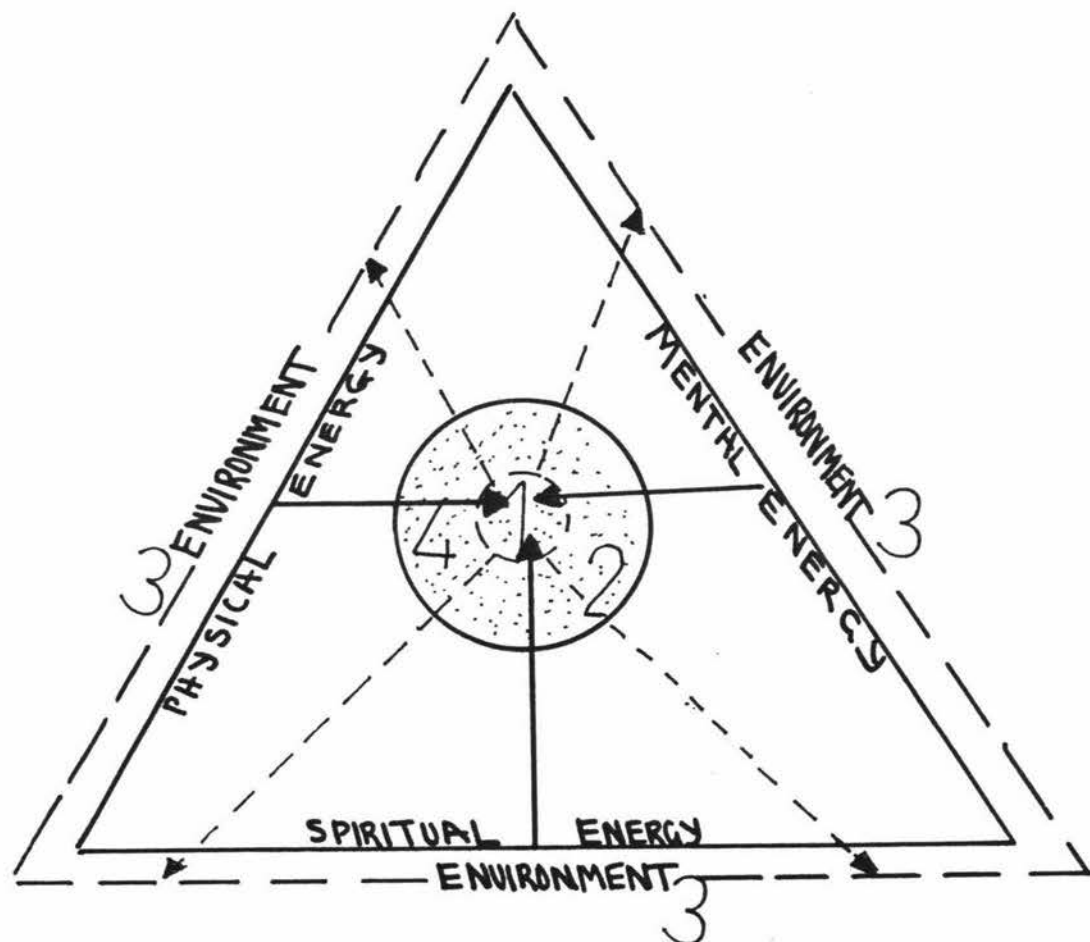
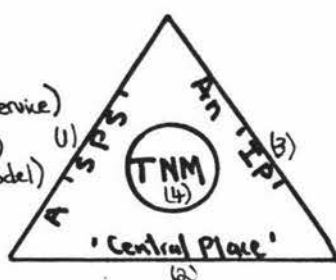
The community or society is not only a unit of organisation, but it is a unit of living, interdependent individuals. Each individual influences and contributes both positively and negatively to his or her society. The experiences the individual undergoes form his or her characteristic ways of managing interrelationships and daily activities.

The 'Central Place' of a Person

In relation to the individual the concept of 'central place' is used here to refer to a core or nucleus in which is concentrated the main energies, concerns, and motivators of action in daily living and interrelationships. There are many personality theories that aim to analyse the human uniqueness of man. Amongst them are the studies of Rogers, C. (1971), Maslow (1968), Lewin (1970), Sullivan (1953), Allport (1963), Kelly (1955), and Altman & Taylor (1973). But for the purposes of this study the concept of 'central place' is confined to perception of it as a 'force' or 'power' centre in the individual that is a composite of physical, mental, and spiritual energies. Social behaviour is seen to result from, and be determined by, the status of these energies fused into one. In figure 2.5. (p31) the 'central place' can be visualized as being formed by the three energies, physical, mental and spiritual. They merge into one in the nucleus of the structure, and, from this 'central place' comes a social dimension which interacts with the environment or all that is exterior to the person.

In addition to the social dimension, which interacts with the total environment of the person, there is also an intrapersonal dimension which qualifies the status of social interaction. Interaction between the 'I' and 'Me', as Mead (1934) notes, or private conversations or conflicts are an important part of the development of the self. The distinctive quality of the self is that "it is an object to itself" and through rehearsal the individual learns to anticipate what others may do or expect. There are times when these interpersonal and/or intrapersonal interactions are unsatisfactory. This can lead to behavioural disorders and displacement of energies which form occasions for nursing interventions.

- (1.) 'SPS' (Socially Prescribed Service)
 (3.) 'IP' (Integrative Process)
 (4.) 'TNM' (Triadic Nursing Model)



- 1 'Central Place' of a person - a fusion of Physical, Mental & Spiritual Energies
- 2 Social Dimension
- 3 Environment with which the Social Dimension interacts.
- 4 Intrapersonal dimension - represented by

Figure 2.5. The Dimensions of 'Central Place'

Argyris (1957), discussing some properties of human personality, notes that the individual seeks internal balance and external harmony. Internal balance requiring constant fine tuning or adjustment and external harmony frequent adaptation to changes in the environment.

Much significant activity occurs within this intrapersonal dimension, which influences the development of the individual and his or her interactions with the total environment in which life is lived.

Social interaction or behaviour is an important indicator of health status, and whether all is well or not with the individual as a whole. The National Development Conference Group (NDCG, 1973) note that for the nurse, preferred solutions for those who seek assistance with self-care, vary with the total life context of the individual or group. Therefore, the preferred system must be discovered in each individual context. Part of this discovery is dependent upon the level of the interactions and communication between the nurse and client(s).

In Carl Roger's view of man (1971), the individual is judged to be the one best able to help him or herself. Intervention is directed toward assisting the person to recognize and manage the solutions that are optimal for him or her. Similarly, Kelly (1955) views the individual as a scientist who can construct his own reality, but having done so must accept the natural consequences of the choices made. However, the ability to construct is a continuing one, and adaptation, which may require assistance, is a strategy available to all.

Pronshansky and his associates (1970) also consider the 'constructs' of the individual. They emphasise the need to conceptualize the human environment, and the relationships between the person's physical world and the world he constructs from it. It is possible to view this construction from the focus of a 'central place' in the individual, in which his or her physical, mental, and spiritual energies

form a fusion of power for adjustment of inner needs, and adaptation to achieve harmony with the external environment.

The concept of 'central place' will not be examined further here, but further study would consider the nature of the social processes and intrapersonal mechanisms affecting behavioural system organisation as perceived by Johnson (1968, 1974). Another appropriate study is that of Abdellah and associates, and their conceptualization of the patient as a conjunction of three systems, central, proximal, and distal. Finally, the models of Orlando (1961), and Peplau (1952), which are dominated by interactionist concepts, are a fruitful source of study in relation to the concept of 'central place'.

THE CONCEPT OF AN 'INTEGRATIVE PROCESS'

The third major component or 'mind-hold' of the 'triadic nursing model' is a process which is considered to act as an integrative thread throughout the practice of nursing. Both in the development of a nursing curriculum, and in the establishment of a mode of nursing practice which is readily adaptable to that which is central in a society's or individual's lifespace at a particular point of time, the process is seen to monitor, evaluate, and provide a basis for decision-making. It acts, it could be said, as both the administrative and functional component of the model. The concept of a 'central place' provides a framework on which to base nursing action, and the 'integrative process', is used to evaluate and assesses how well nursing functions in relation to the dynamics of the 'central place' in their clients.

The 'integrative process' runs similarly to the nursing process, the research process, a decision-making process, and a management process, but it emphasizes that decisions require the making of judgements of value. It is regarded, therefore, as potentially the most effective process for

nursing since, whatever conceptual model may be preferred for nursing as a practice discipline, it necessarily involves the continuous selection of actions in providing care.

Orlando (1961) wrote that nursing is focussed on the process of care in an immediate experience, and is concerned with giving assistance in whatever way the individual needs it at that time. It is clear that a nursing model must have a component that facilitates the making of optimal choices, and that this process be taught to students for application as practitioners. It provides a tool by which effectiveness and efficiency in nursing situations, and in educational strategies used by nursing, can be planned and evaluated.

The nature of an integrative process is discussed further in chapter 3, but in conclusion it can be described as an evaluative, problem-solving process which ensures that nursing fulfils its socially prescribed role and does so by understanding the nature of the person and the state of the 'central place' from which social interaction or behaviour proceeds.

The 'integrative process' acts similarly for monitoring the nursing needs of a society. It identifies and assesses needs, and the problems underlying the needs. This provides a rationale, for example, for determining broad objectives for a community health programme. Decisions to be made include the locations to be covered, the degrees of community participation to be developed, and the methods to be used to define and solve problems. It is also concerned with the implementation and refining of plans and, finally, must assess the programme's effectiveness and viability.

CHAPTER 3

CONCEPTUAL FRAMEWORKS: TOOLS FOR NURSING EDUCATION

The development of conceptual frameworks for the ongoing construction and implementation of nursing curricula has progressed rapidly in the last two decades. This is evidenced by a number of recent studies including those of Conley, 1973; Orem, 1971; Notter & Robey, 1975; Graham, 1977; Pepler, 1977; NDCG, 1973; Johnson, 1968; and Rogers, 1971.

Conceptual frameworks may be organised around system, adaptation, developmental, and interactionist theories, for example, or they may be eclectic and combine theoretical constructs as a basis for curriculum construction and implementation. Rodgers (1976) finds that there is a need for a clear conceptual framework to reduce the chaos from the 'multiple generic programmes' preparing nurses.

But others, such as Johnson (1968), question if any one model could possibly be adequate for all practice situations, or, for that matter, necessary or desirable. Graham (1977) believes that the test of the usefulness and applicability of any conceptual framework comes when one attempts to apply it to the development of all types and level of learning experiences. Oliver (1970) is quoted by Graham (1977) as stating that a conceptual framework should identify the range of decision points with which a curriculum designer must deal - essentially with what is to be taught and how it is to be taught. And Graham believes this need for identification of decision points is particularly relevant for nursing.

For nursing education a preferred conceptual framework is perceived to be one that:

- (a) provides for an ongoing evaluation, modification, and implementation

of nursing curricula relative to the contemporary social realities of society and its individual members;

- (b) establishes criteria of value on which to base curricular choices in respect of structure, content, and learning modes;
- (c) helps to bridge the gap between theory and practice;
- (d) allows for the continuing preparation and development of staff and students; and
- (e) uses socio-cultural frames of reference to provide a broad and comprehensive perspective of generic human behaviours, and identifies the health/nursing needs of diverse socio-cultural groups.

New approaches are needed, therefore, to evaluate socio-medical conditions such as ageing, chronic illness, and drug abuse in order to relate them to the educational preparation requisite for oncoming nurses. Suitable models for this purpose can be found in the class of curriculum development-evaluation models.

OVERVIEW OF CURRICULUM DEVELOPMENT-EVALUATION MODELS

An initial defining of 'curriculum' and 'evaluation' is necessary since the understanding held of these two concepts influences the structure and use of curriculum development-evaluation models. There are a number of definitions of both concepts but they are defined here according to contemporary viewpoints.

'Curriculum', from this perspective is regarded as being concerned with assisting human development and bringing about changes in behaviour. In this context, in bringing about changes in behaviour in nursing students, so that they develop the requisite skills appropriate to a society's needs for nursing and health care. It also implies that the students are provided with desirable learning experiences according

to predetermined societal, broad educational, and specific behavioural goals.

Since 'curriculum' is not a fixed entity but is linked with development and planning it can, also, be defined as a continuing activity, and the sum of all those activities deliberately planned for, so that changes are brought about in students moving them along in specified directions. Figure 3.1. (p 38) shows a simple curriculum development model that demonstrates the steps to be taken in curriculum development.

It can be seen that evaluation is an integral part of the curriculum development model. "Evaluation" is essentially a judgement of the value of an object, an activity, or a product. With the development of organisational and educational theory and methodology, it has now come to be generally defined as an ongoing activity; a process which is functional in each component of a developmental or planning model. The systematic collection of data about progress in goal attainment and objectives, and the relationships between the various collections of data, provides the feedback necessary to guide the activities of curriculum planners, teachers, and students. Curriculum evaluation establishes the worth of a programme, and this is viewed as essential by, for example, Allen, 1977; Bevis, 1976; Conley, 1973; Reilly, 1975; Steck, 1978; Stufflebeam, 1971; and Worthen & Sanders, 1973.

In different models the type of evaluation emphasised varies, for example, Wagner & Seidel (1978), in a study on 'program evaluation', express a preference for 'transactional evaluation' because it focuses on the perceptions of a programme's participants. In addition, they favour Stufflebeam's (1971) defining of evaluation as the 'process of delineating, obtaining, and providing useful information for deciding among alternative actions'. In Stufflebeam's model, decision-making is

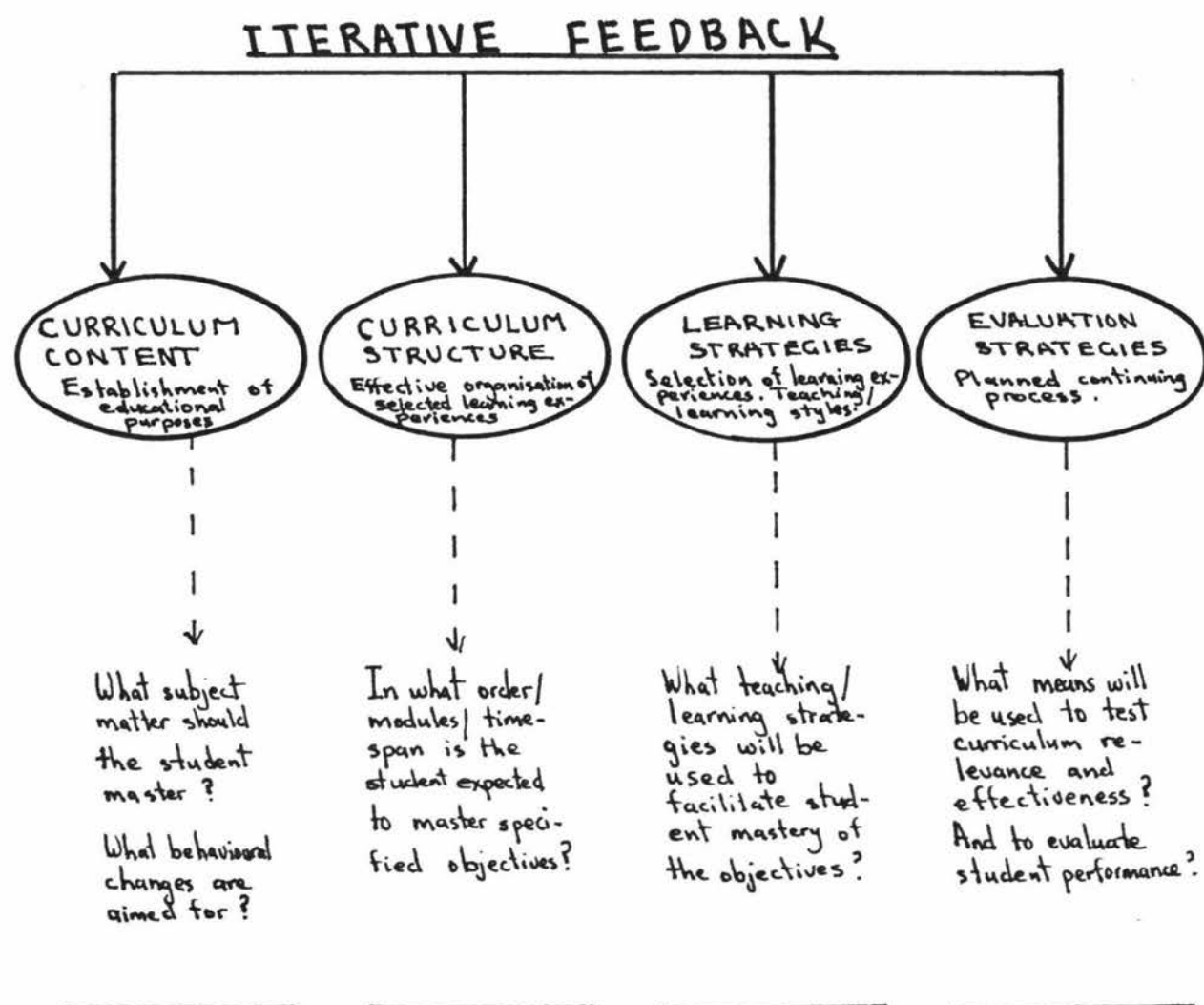


Figure 3.1. A Curriculum Development Model

(Idour, M. 1978)

a central activity which is stressed throughout all stages of the process.

Since a preferred model for curriculum development and evaluation in nursing education also requires criteria of value on which to base curricular choices, Ashley & Labelle's (1976) model of 'value categories in the curriculum designing process' (figure 3.2. p 40) repays study. An important feature of this model is the emphasis given to the integration of educational and learning experiences within the total environment in which they occur. The values considered important are described in relation to freedom, ethics, power, scientific and technical dimensions. In defining the social context in which nursing practices, it has become evident that these are important factors for nursing to attend to.

The phases and activities to which criteria must be applied, to facilitate optimal decision-making, are shown in figure 3.3. (page 41). The criteria are applied by posing questions that need to be asked. For instance, one may ask: - has the programme social relevance, that is, is it relevant to the social realities of a society and its people;

- are the activities related effectively to the learning needs of the individual student;
- has the programme flexibility and can it be adapted readily to changing social realities; and
- do the policies and strategies used, for staff, students and clients, facilitate collaboration, participation, and, where appropriate, innovative solutions to presenting needs?

Wagner & Seidel (1978) emphasise two important characteristics of any evaluative activity of educational programmes. First it must determine the value, merit, or worth of the programme, and secondly, due to its continuing nature it can facilitate the continuous improvement of a programme. Moreover, it should stimulate programme development and not stifle it.

INTEGRATED VIEW

REFERENCES

SOURCE OF CONCEPTS

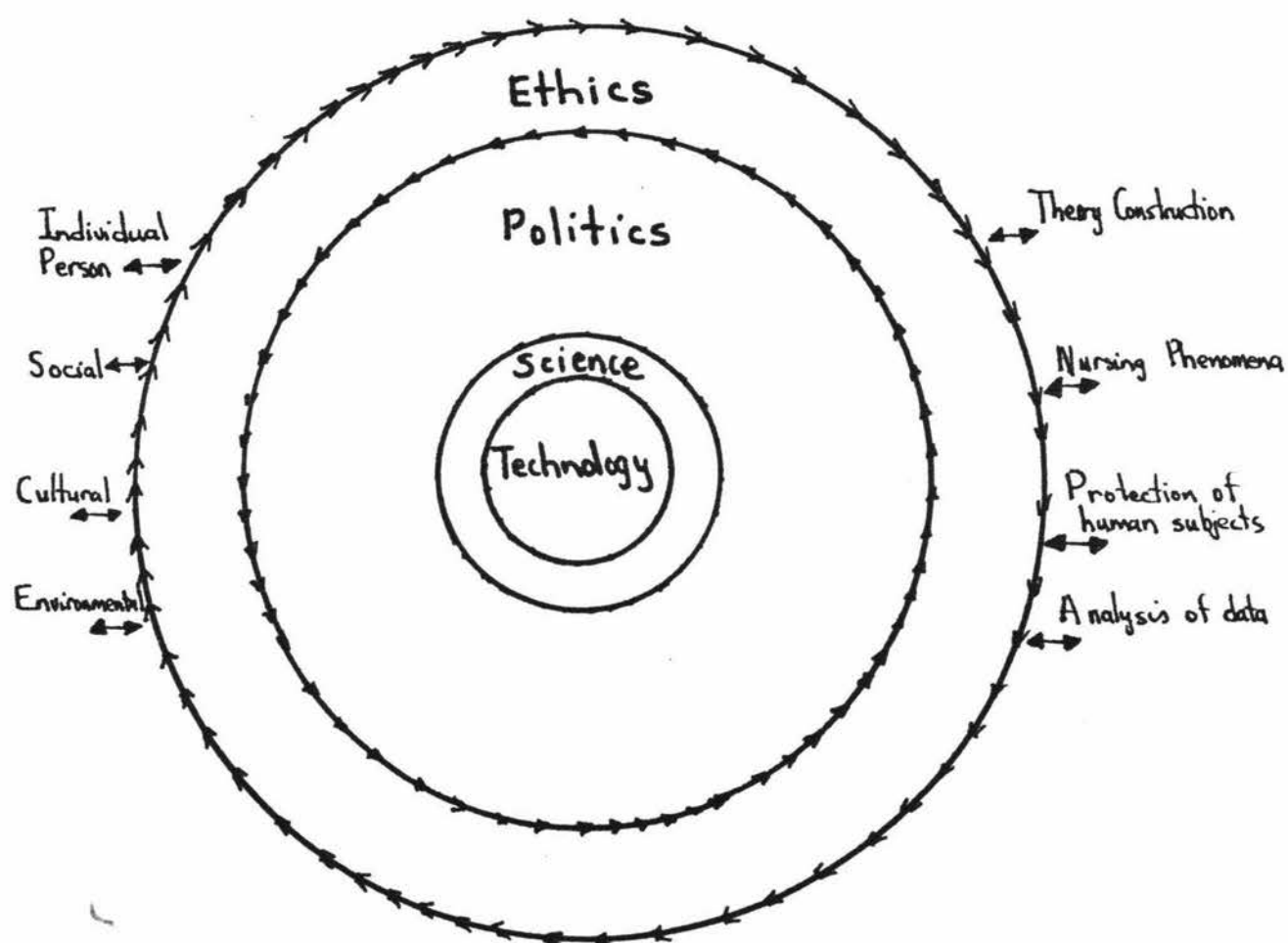


Figure 3.2. Value Categories in the Curriculum Designing Process

(Ashley & Labelle, 1976, p.56)

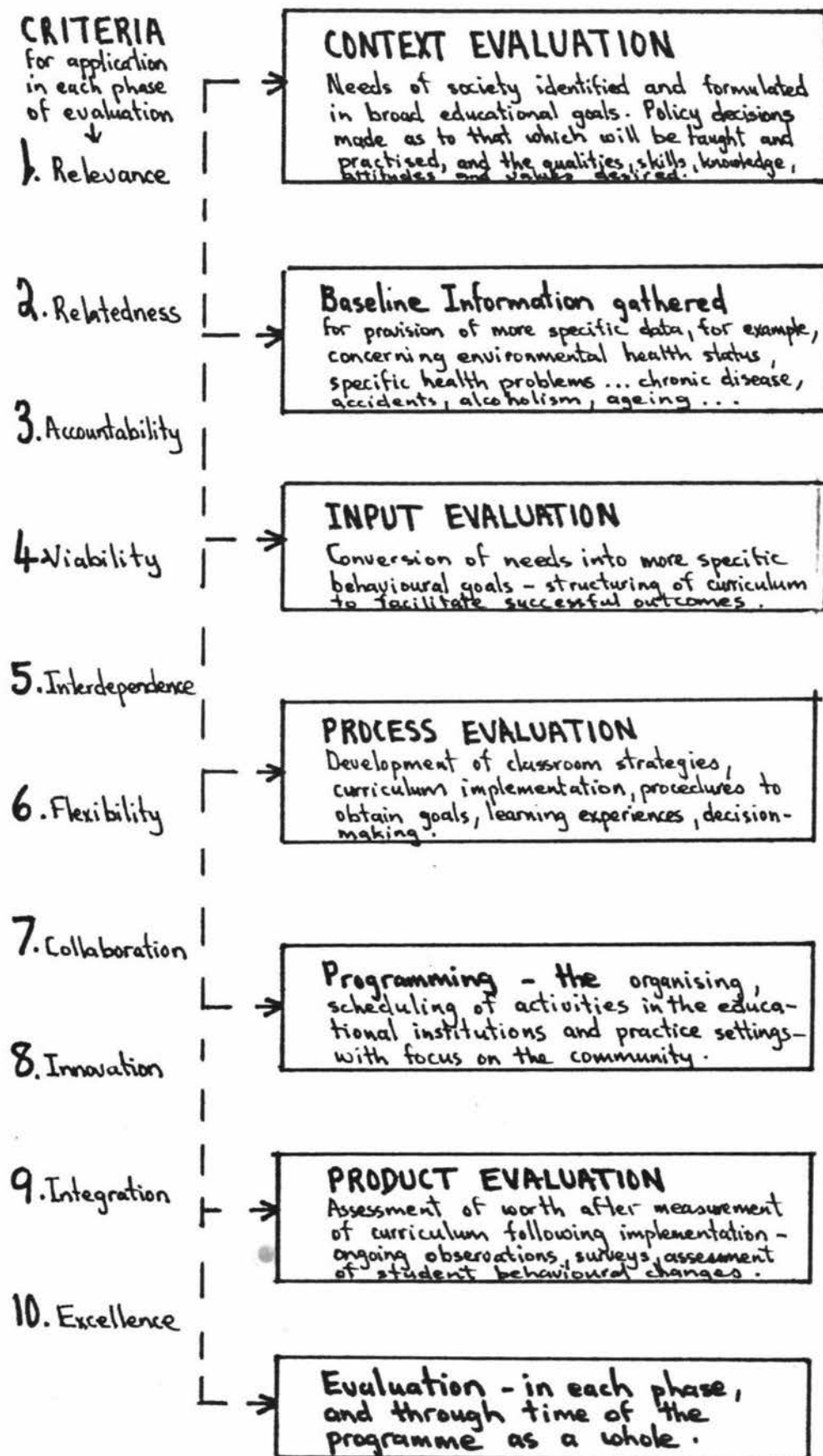


Figure 3.3. A Curriculum Development-Evaluation Model

(Jalour, M. 1980)

SUMMARIZATION OF CURRICULUM DEVELOPMENT-EVALUATION MODELS

Allen (1977) describes three broad and fundamental issues for evaluation that can be used profitably by any nursing education programme planners - or any other educational institution personnel.

- (a) What is the relevance of the programme goals and purposes to the particular community or country?
- (b) What is the relationship between processes and developments in the programme and programme purposes and goals?
- (c) What are the factors tending to support and further the development of the programme, or to hinder it?

But, as Steele (1978) notes, an evaluation cannot focus on all the variables that affect or influence the educational process in one way or another. Consequently, the evaluator must make a decision to study certain variables and not others. In this respect the criteria of value can also help the evaluator to, hopefully, choose those variables which most influence the accountability and effectiveness of the programme. The decision-making structures formulated by Stufflebeam, 1971; Steele, 1978; Claus & Bailey, 1975; and Bower, 1972, present a number of methods that can be used to ensure this. Additionally, the value of collaborative and interdependent approaches in finding solutions to problems can be utilized with benefit to all concerned.

A curriculum development-evaluation process (figure 3.4. p. 43), which delineates most of the variables to be considered in developing and evaluating curricula, shows just how necessary it is to select some variables and exclude others. At the same time, it is essential to delineate all variables in order to determine priorities. The use of a process, similar to the one displayed in figure 3.4. p 43, which outlines all the variables, makes it possible to select those variables which need immediate study. But those which are excluded can be dealt with later, or examined by

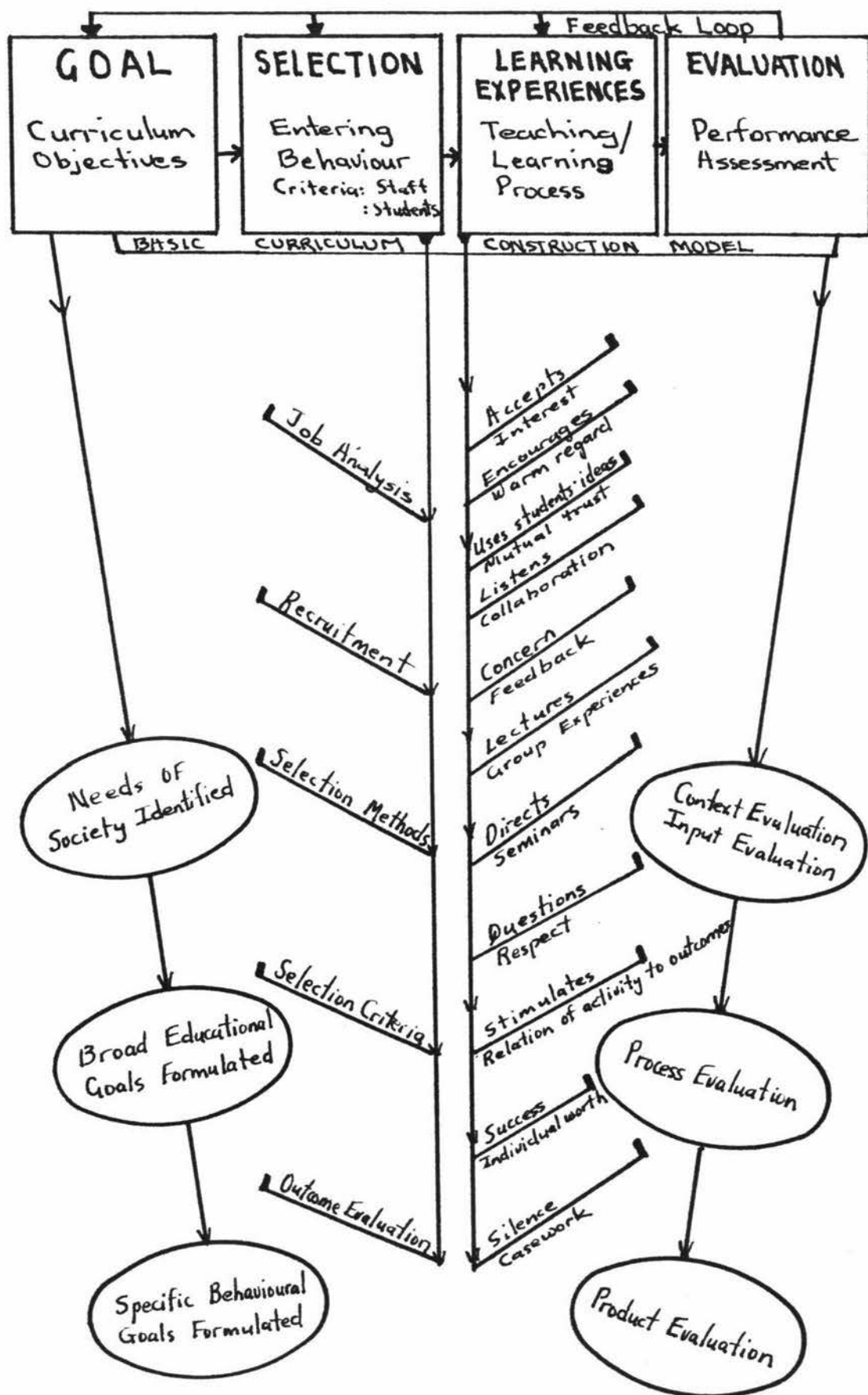


Figure 3.4. Curriculum Development-Evaluation Process

(Idour, M. 1980)

by others concurrently, or reviewed and analysed from other studies.

The curriculum development-evaluation process shown in figure 3.4., though very comprehensive, does commence with a basic curriculum construction model (after Glaser, 1964). Subsequently, the four components of the basic model are elaborated in order to delineate all the activities or variables implicit in each one. 'Learning experiences', in box 3 of the basic structure, for example, requires elaboration to indicate the interactions that occur in the teaching/learning process. For this purpose, in addition to specifying motivational variables, use was made of Flander's (1965) interaction model.

As Pochly (1973) finds, the chief problem or concern in evaluation is what to evaluate, though, as he also notes, specification of goals in terms of direct, observable and measurable goals brings some solution to the problem. Furthermore, as elaboration of box 1 demonstrates, this problem can largely be overcome by first identifying the needs of society, and formulating broad education goals, before specifying desirable behavioural goals. In fact, unless these steps are first taken, one must question how it is possible to determine desirable behavioural goals.

THE INTEGRATIVE PROCESS

Since an evaluation cannot focus on all the variables, that affect or influence the educational process in one way or another, it is necessary to use a process that facilitates identification of the most relevant variables.

The 'integrative process' is believed to be an effective tool for this purpose. It draws together all the relevant variables in order to relate nursing education to the requirements of a society, and, also, to present nursing settings.

In Chapter two the 'integrative process' has been described as the administrative and functional component of the TNM (the 'triadic nursing model'). It monitors, evaluates, and provides a basis for decision-making. In many ways it acts similarly to the nursing process, the research process, decision-making processes, and a management process. But its chief significance lies in the emphasis given to the solution of society's socio-health problems, as the main variable to be considered in making curricular choices in nursing education.

It has this function for nursing generally and, therefore, in policies related to nursing practice, nursing education, and nursing research the main question posed is 'how does this policy, or programme, or teaching/learning strategy, or conceptual approach relate to the social realities of a society and the actual or potential needs for health and nursing care.

It is essential that nursing curricula reflect changing social realities as they begin to emerge to ensure that oncoming nurses acquire skills appropriate to a society's needs. To achieve that goal, the 'integrative process' can be used to focus on the interrelationships between curricular choices in nursing education, and the social realities of a society. But to maximize its effectiveness, the 'integrative process' is further developed to form an educational tool, which uses a system approach, and is named the 'curriculum relevancy process'.

THE CURRICULUM RELEVANCY PROCESS

Definition and Description

The 'curriculum relevancy process' (CRP), is best defined as an information-seeking, problem-solving, and evaluative process. 'CRP' is integrative in nature, and provides for an ongoing correlation of

information about changing social realities with the characteristics of nursing curricula. Essentially, it allows for the continuing collection and analysis of information about the social realities of a society, from which the essence of present and potential needs can be extracted, and applied to choices made in nursing education.

Figure 3.5* outlines the phases and activities of CRP as it is used to initiate and make use of data collection, analysis, and interpretation; and its subsequent application to curricular choices in nursing education. As an information-seeking, problem-solving, and evaluative tool it draws together all the variables that require study for optimal decisions in nursing education. It allows for the gathering, over a period of time, of data on nursing education programmes that is appropriate to their context.

The application of CRP makes it possible to see how well nursing fulfils its socially prescribed role. It does this by the gathering of data which leads to an understanding of what is central or dominant in a society's or an individual's lifespace at a particular point of time. Knowledge and understanding of the socio-health and nursing problems of a society provides the basis for identification of desirable nursing skills.

Since a nursing education programme is perceived to be a system arising within a society, in response to need for health and nursing care, CRP, or a similar process, is considered to be an essential basis for action in nursing education. CRP's overall goal is the enhancement of nursing's role as it participates in the search for a solution of a society's socio-health problems. Subsequently, the preparation of oncoming nurses is orientated towards the development of nursing skills that enable nursing to achieve that goal.

Toffler (1974) states that the nature of a problem defines

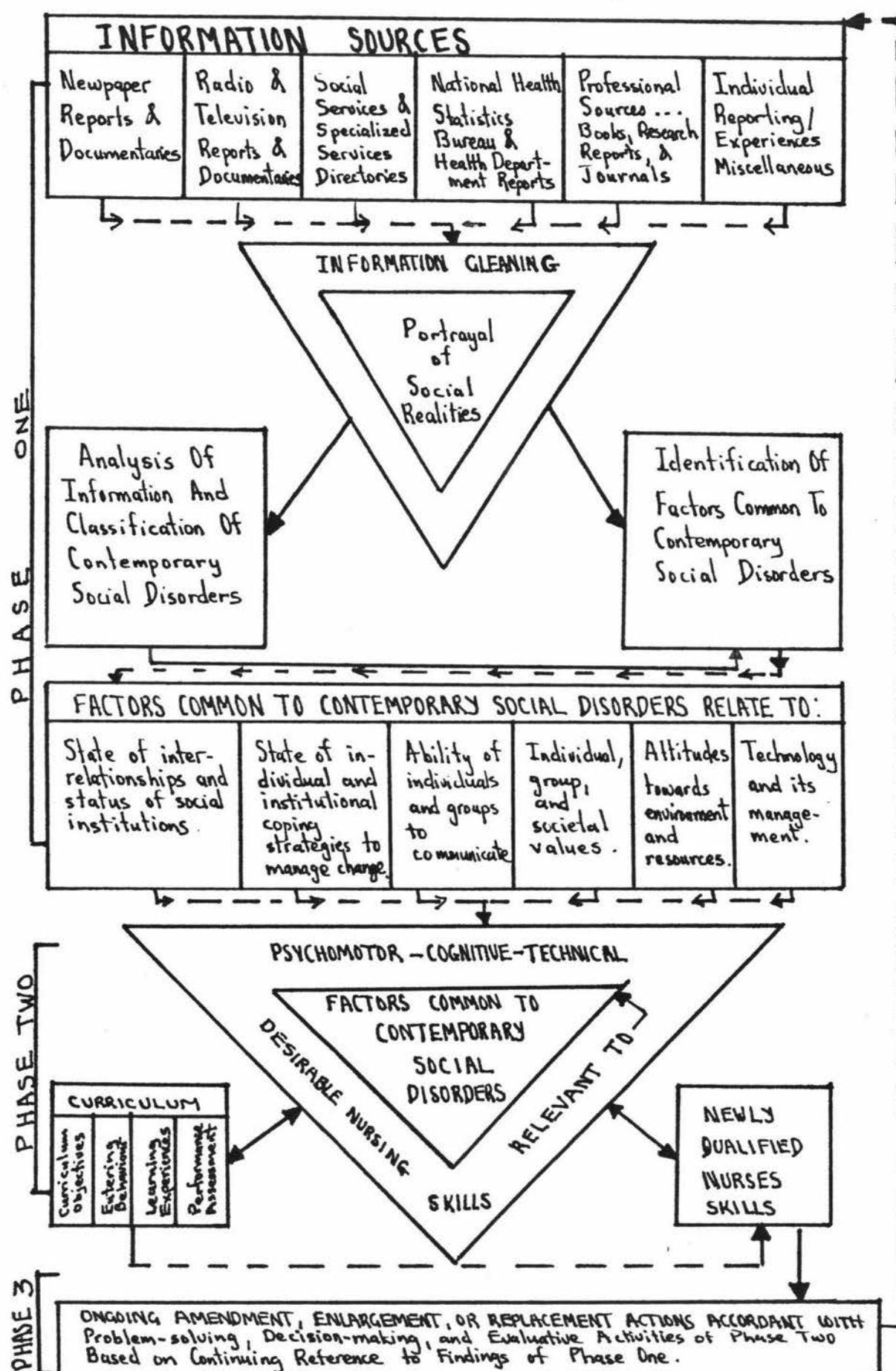


Figure 3.5. 'Curriculum Relevancy Process'

(Idowu, M. 1980)

the nature of the learning required, so that the definition of relevance is created by the real situation rather than by the instructions of the teacher. The identification of socio-health and nursing problems, associated with the social realities of a society, is a core function of CRP since it is the nature of the nursing problems that defines the nature of the learning required. Thus, in delineating the real situations requiring nursing care, the use of CRP helps to define or determine the relevance of curricular choices.

Objectives related to the overall goal of identifying and seeking solutions to a society's socio-health and nursing problems include:

- (a) the establishment of criteria of value to ensure accountable, interdependent use of a society's resources, people and material, in conjunction with other social institutions and professionals;
- (b) optimal outcomes for oncoming nurses from the programmes;
- (c) the provision of a tool(s) by which effectiveness in learning situations, and a programme's relevance and viability, can be evaluated.

Rodgers (1976) believes that, in the final analysis, a nurse's ability depends on her skill in solving problems and, that without this ability, she will fall victim to 'technological and informational explosions'. Further, as Steele and Harmon (1979) emphasise, another important outcome is that of possessing the skill of decision-making, and being able to choose the most appropriate decision among a number of alternatives.

As has been already noted, a conceptual framework for curriculum construction must facilitate identification of the range of decision points with which a curriculum designer must deal. CRP is especially concerned with facilitating this skill to determine curriculum priorities. For the curriculum designer the issue is essentially with what is to be

taught. As well, new approaches are essential to identify, evaluate, and relate to nursing education programmes, the kind of conditions seen to predominate in contemporary societies.

Historically, nurses have been evaluated on the giving of care rather than on whether it actually made a difference that the care was delivered (Steele, 1978; Phaneuf, 1975; Kinross, 1977). But the use of a conceptual framework, such as CRP, allows nursing, not only to evaluate whether care has made a difference, but also, to select and use new curricular approaches and learning strategies, and so ensure that nursing continues to be effective as changes occur.

PHASES AND ACTIVITIES OF THE CURRICULUM RELEVANCY PROCESS

CRP has three main phases and each phase involves a number of activities.

Phase One

This phase is occupied with the gleaning of information about the social realities of a society, and the identification of the socio-health and nursing problems that require nursing care.

Figure 3.6. displays the activities that occur as an information system is evolved to facilitate the making of relevant curricular choices according to the social context in which nursing is practised. Knowledge and understanding of the social realities, existent in the personal milieu of clients and their families, is vital if nursing is to determine what motivates or influences their behaviour, and thus their level of health. Elaboration of this first phase of CRP is dealt with in chapter 4.

Phase Two

The main objective of phase two of CRP is to examine, and

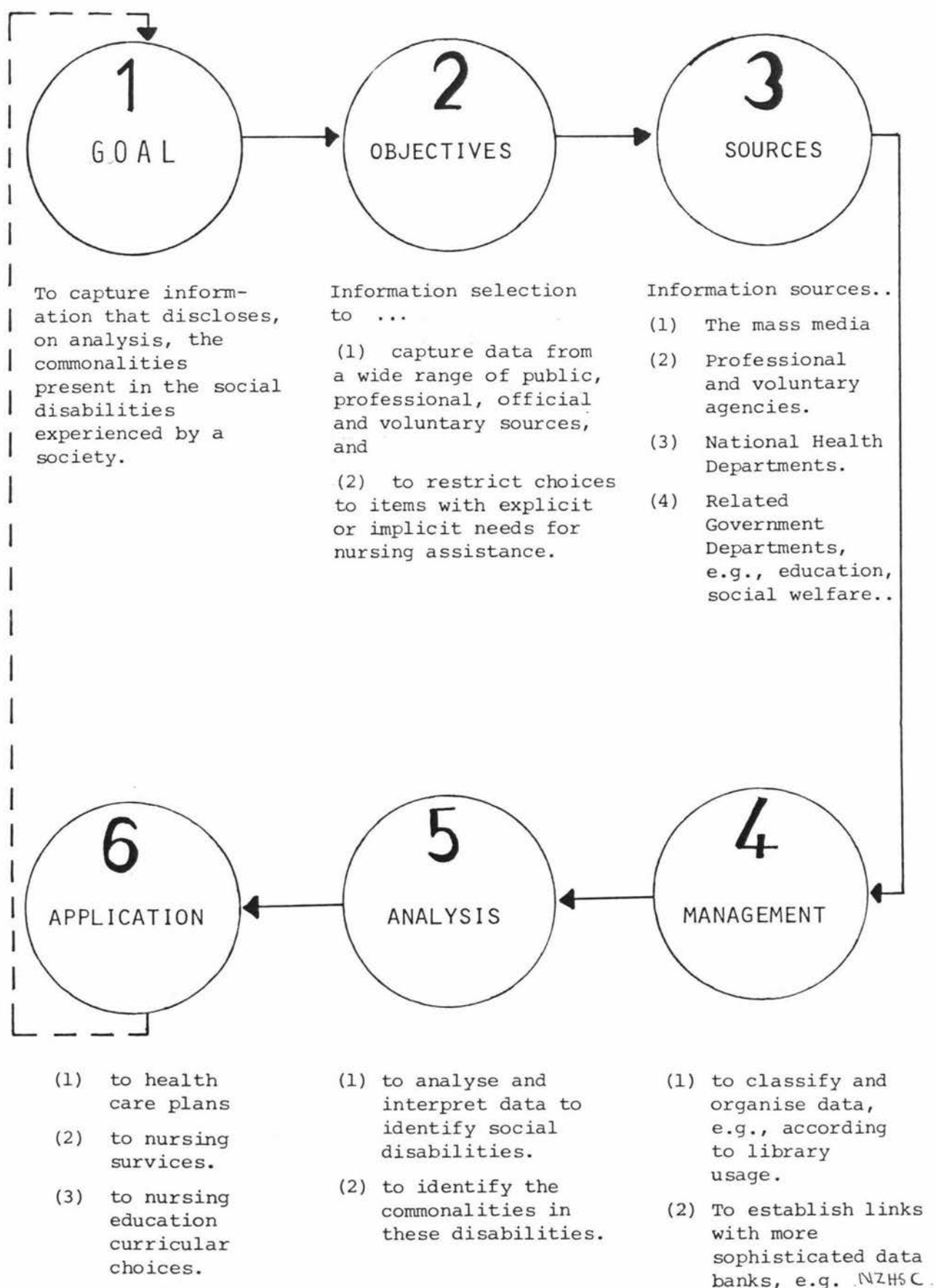


Figure 3.6.

An Evolving Information System

(Idour, M. 1980)

evaluate, how well nursing curricula are orientated towards solution of the socio-health and nursing problems identified in phase one.

Problem-solving and decision-making are important activities in this phase as the characteristics of nursing curricula, and the skills they promote, are reviewed in relation to contemporary social disabilities. A clear profile of contemporary social disabilities provides the basis for curriculum choices that result in oncoming nurses with desirable nursing skills.

As phase two of CRP is executed, the quality and appropriateness of nursing skills, found in newly qualified nurses from the programmes, is evaluated. Further, programme effectiveness is assessed according to how well students have learned what they are intended to learn. Again, the importance of first establishing curriculum objectives can be stressed as vital to successful outcomes.

Programme evaluation encompasses a wider range of data to that required for student evaluation. It also requires a more comprehensive evaluation design which is linked to curriculum development and construction. Figure 3.1. and 3.3. (pages 38 and 41), show a progression from a simple to a more comprehensive curriculum development-evaluation model.

Figure 3.3. is more explicit and detailed and names the criteria of value needed to guide decision-making throughout the process of constructing nursing curricula. Questions must be asked at each stage of curriculum construction and evaluation. For instance, when selecting curriculum content one must question the relevance of material according to the educational purposes of the programme; and not simply rely on circumscribed areas of learning according to tradition.

A realistic statement of curriculum objectives, in conjunction with a thorough appraisal of contemporary social disabilities, helps to

protect the consumer - clients, students, and society, for whom the curriculum is designed - from unrealistic or limited goals. This, also, provides a rationale for determining broad objectives and further use can be made of the criteria of value. In particular, for example for a community health programme, the criteria of relevance, accountability, relatedness, flexibility, collaboration, and interdependence can be utilized to assist decision-making.

The criterion of accountability can be applied to assess how well the oncoming nurse is taught that responsibility is primarily to the patient; or for faculty that the primary responsibility is to the student. At the same time, use of the criterion of relatedness, which is concerned with the interrelationships between the different parts of the programme, will make certain that faculty responsibility towards the student is primarily predetermined by identification of the psychomotor, cognitive, and affective skills the student must acquire to meet the needs of clients.

The most comprehensive curriculum design presented here can be seen in figure 3.4. (page 43). It shows, in detail, the scope of activities which can occur in curriculum development and evaluation. It does, also, display practically all the activities related to phase two of CRP.

In broad terms the activities that occur in phase two are related to:

- (a) the selection and evaluation of staff, students, and the resources required to sustain the programme; and
- (b) evaluation of the overall programme and its outcomes.

More specifically, the activities undertaken in phase two can include:

- (a) consideration of the philosophy and broad educational goals of the

institution and its programmes;

- (b) formulation of specific behavioural goals, that is, of the changes desired in students as they progress through the programme, in order to make clear (i) what they are supposed to learn; and (ii) what skills are desired in oncoming nurses;
- (c) assessment of the qualities, skills, and effectiveness of staff;
- (d) evaluation of the effectiveness of teaching/learning experiences;
- (e) assessment of the learning climate, physical and clinical facilities, and the quality of the interactions in the learning situations;
- (f) appraisal of the facilities and provisions made for staff and students;
- (g) examination of the standards and criteria of programmes in relation to those set by licensing and educational authorities;
- (h) an assessment of the degree of community participation in the programme and in the identification of its educational purposes; and
- (i) evaluation of the methods used to define and solve problems, make decisions, and to undertake self-evaluation studies.

For each society, ongoing evaluation and refinement of nursing curricula is essential to provide a continuing supply of nursing manpower able to function according to contemporary need.

Phase Three

This last phase of CRP is probably the one that is more often implied, than specified clearly, in the majority of curriculum development-evaluation models. It is largely occupied with problem-solving in order to rectify the discrepancies between the desired and actual outcomes of nursing curricula. Constructive responses to the discrepancies found can include:

- (a) appraisal of alternative solutions to the nursing needs associated with contemporary social disabilities;
- (b) reorganisation by adaption and amendment of existing programmes, or

by designing and implementing new educational strategies more likely to achieve relevancy to the social context in which nursing is practised; and

- (c) ongoing evaluation and amendment of changes made as found to be necessary. Feedback, over a period of time, is studied to determine if the actions taken have the desired outcomes for clients and students.

The criteria of value that can be applied in phase three of CRP include those of flexibility to permit adaptation as required, accountability for the actions taken, viability of the actions taken in relation to the resources and support available, and recognition of the need for interdependence with health and other related professionals in planning changes.

Dominating this phase of CRP is ongoing amendment, enlargement, and/or replacement activities of the programme, curriculum objectives, and learning experiences. This necessitates constant feedback from the first two phases of CRP. The 'action process', shown in figure 3.7. (page 55), displays the components of educational change, which, in this instance, is concerned with the achievement and maintenance of relevancy in nursing curricula.

The components of educational change are shown in one dynamic loop and interact to deal with the gaps between prescription and reality. The actions or moves made to modulate change in nursing education programmes, is not simply a closure of gaps between what is and what is required, but a series of balancing measures to keep all parts of the system healthy. However, this part of CRP shows the progression of steps that generally occur with adaptation to change.

Sequence to Activities

The three phases of CRP involve a number of activities which progress logically from one to the other. The conclusions drawn in one

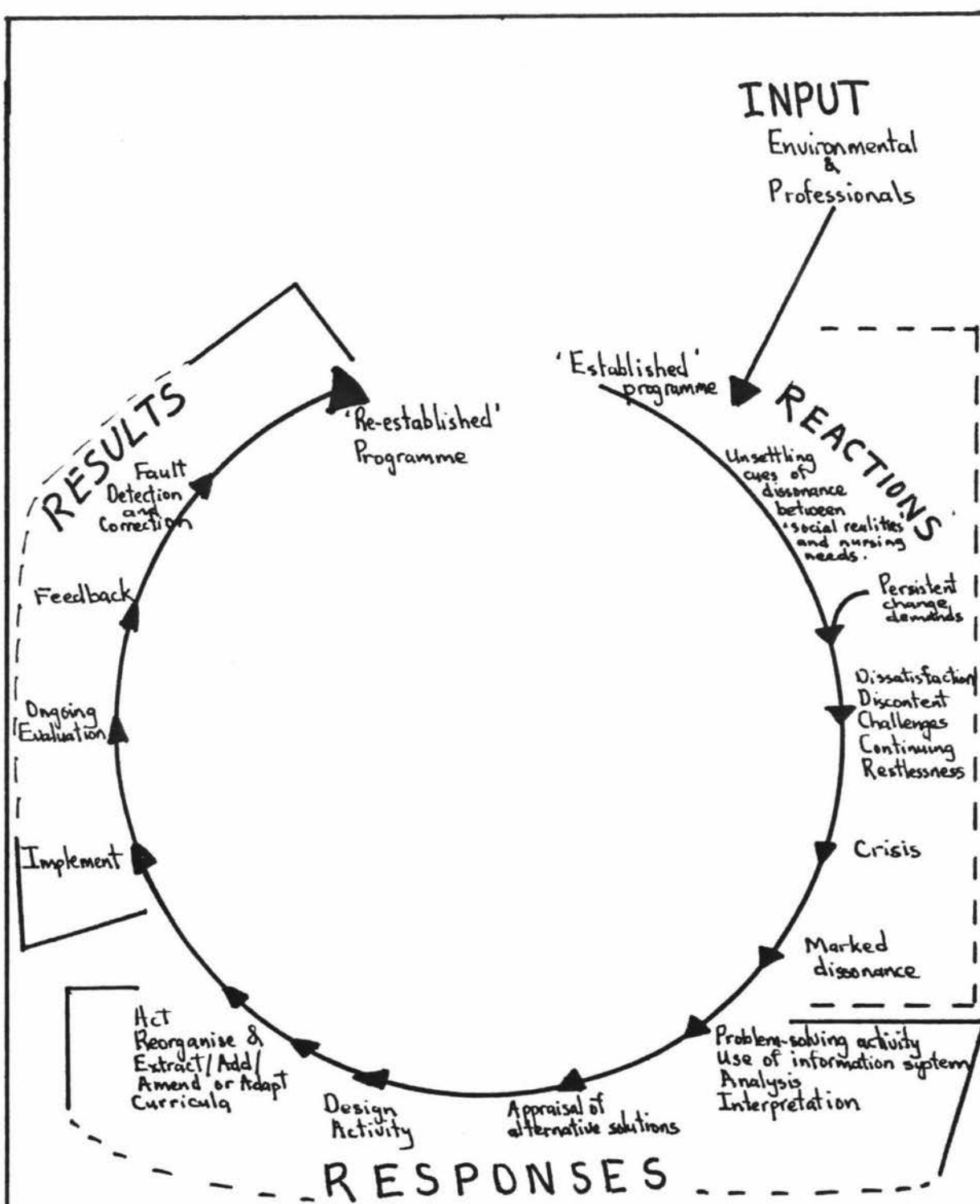


Figure 3.7. Action Process

phase qualify the activities undertaken in the next. For example, if Auld's belief (1979) that the frail elderly require a new nursing model and not a medical one, and need primarily care and companionship and not institutional care is accepted, then it holds important implications that influence the changes that can occur in phase three.

Although, in general, the phases progress logically from one to the other it is also necessary to note that a process, by its very nature, is not a fixed structure and adaptive action can commence at a number of points in the process. It can, for example, start with recognition of the dissatisfaction experienced with an established programme and its outcomes, and then proceed to gather and interpret data about the factors behind this dissatisfaction. As a planned attempt to relate nursing education programmes to a society's socio-health and nursing problems, however, the logical place to activate the process is thought to be the development of an information system to aid decision-making in nursing education.

A system approach has been taken in the development of CRP. As Kaufman (1976) notes, when used 'sensibly', it produces an educational response that is creative and responsive to identified needs, rather than one limited only to historical precedent, or potentially unreliable, if left simply to hunches. Kaufman (1976), as noted earlier, also warns against making an inappropriate start when initiating action, commenting that looking for solutions before identifying problems leads nowhere.

SUMMARY

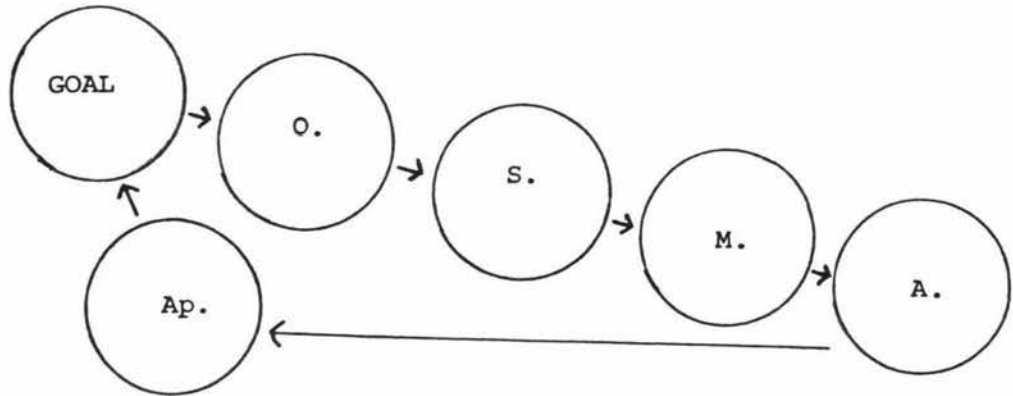
CRP is designed to avoid the inappropriate start Kaufman warns against by commencing with the systematic gathering of information about a society in order to identify the socio-health and nursing problems

that require solution. Further, it involves a thorough appraisal of all the components involved in designing and implementing a nursing curriculum. Finally, it ends with an action process that initiates the steps needed to rectify faults in the system.

Since the gathering and interpretation of information about the social realities and their outcomes is believed to be vital it is further discussed in chapter four.

CHAPTER FOUR

AN EVOLVING INFORMATION SYSTEM: PHASE ONE OF 'CRP'



Legend - see figure 3.6. page 50

The full development of phase one of CRP leads to the evolvement of an information system for the systematic collection, analysis, and interpretation of information about the social realities of a society. An information system facilitates the identification and documentation of the dominant social realities and the resultant socio-health and nursing needs and problems. This is an essential first step in curriculum construction for it provides the basis for determining curriculum objectives.

Additionally, the identification of contemporary socio-health and nursing problems must be accompanied by comparative historical analysis as this provides a deeper perspective for interpreting present realities and emerging trends for the future. If, for example, the findings of epidemiological studies are reviewed in the light of past events before application, it is more likely that the right responses will be made by those concerned. Numerous examples can be cited of plans that have failed due to neglect of this point. For instance, attempts to introduce different foods to overcome nutritional disorders have failed because the reasons for past resistance to similar schemes have not been

studied.

Sometimes, regrettably, the information has not been recorded. As a consequence, previous experiences, which can supply some knowledge of cause/effect and time/location factors, cannot be made use of when planning action to promote or recover health in a people. But it is important to reject the notion that resistance to well-intended plans is unthinking and unreasonable for repetitive patterns of behaviour are usually motivated by some experience, belief, or value. An adequate data base is a reservoir of information that can help to reveal the positive and negative factors that motivate people. Without an information system there is a serious lack of data upon which to base decisions.

THE DEVELOPMENT OF AN INFORMATION SYSTEM AS A BASIS FOR DECISION-MAKING AND PLANNING ACTION

WHO (1972) points out that an increasing demand for health services is paralleled by a need for more and more resources. This underlines the need for improved planning, implementation, and evaluation of health services and their outcomes. In particular, problems associated with evaluatory methods, and the problem of the inadequacy of health information systems, are believed to mar the efficiency and effectiveness of health services.

The need for improved planning, evaluatory methods, and information networks is a subject for frequent discussion through the mass media and other channels of communication. Nurses are amongst those who are increasingly vocal about health and related social issues, but, until recently, they have not generally engaged in the systematic collection and assessment of information to substantiate the perceptions they hold. If, however, their viewpoints are to be taken seriously then they must

develop systems for the capture and management of information.

Bergman (1977) considers one of the first concerns of nursing planners is the establishment of an effective information system that systematically collects, analyses, interprets, manages, and disseminates facts about nursing education. But Thomson & Handelman (1978) caution against a tendency in health information systems to develop in a piecemeal fashion with little relationship between the various components of the system. Moreover, they believe that a supreme goal related to the outcome of health services is generally neglected so that information systems have a limited usefulness for evaluatory purposes.

Although, in the context of this study, the primary goal in the development of an information system is to assess the relevancy of nursing curricula, it is also designed to assist achievement of the overall goal of a health system. This can be described as the promotion of the health and wellbeing of people in their societies, and the reduction of disease and suffering inasfar as it is humanly possible to do so.

Since the majority of disorders have their genesis in the social realities a problem-solving approach is best suited to information system development. This offers a flexible framework for the collection of relevant material and reduces the possibility of gathering overlapping and irrelevant material. In addition, information from the total health information system can be added where appropriate.

For example, statistics relating to childhood accidents and their causes can be fed in from a national health information system, and then related to curriculum choices and the type of learning experiences required by nursing students. As Brockington (1975) emphasises, to know what services are needed requires skilful application of health and vital statistics. The capture of information into what might be called a 'minisystem' in comparison with an overall health information system, can supply data for planning, research, and the development of nursing

education programmes.

The communication of health care data is regarded as poorly organised and understood and not very well defined by Thomson & Handelman (1978). This is seen to negate the purpose of data collection systems, which is not, Thomson & Handelman stress, a matter of how it is dealt with, but a means to the best use of personnel and resources for the delivery of effective health/nursing care to people.

CERI (1975) point out that while planning and management require relevant, up-to-date information about what is occurring in present health care systems, the deceptively large amount of statistics generated by such systems, in general, fails to supply this information. They also note something which is particularly emphasised in this study, that is, one must not only assess what is happening within health care systems, but also monitor what is happening in the community, much of which is not in contact with the health system. As defining the social context in which nursing practises in chapter 5 makes clear, information about such factors as lifestyles and behavioural patterns is as vital as data about morbidity and mortality rates.

A systematic capture of information over time provides the necessary baseline data with which to establish the nursing needs of a society. Further, it also offers a basis for determining the kind of nursing curricula best suited to those needs. Without a systematic approach, disclosing all the variables involved and their interrelationships, the best alternative for the optimal organisation of nursing curricula can be missed.

Lundenberg & Goldkhul (1979) present a model, known as 'ISD-ASA', which gives a systematic approach to information system development. In 'ISD-ASA' they describe the work that leads up to information system development as change analyses. Nevertheless, viewing information

system development in a wider context than is considered here, they point out that, if the change analysis indicates the user's needs and problems are other than that provided by an information system, a different approach should be used. In this study, however, change analysis - and action plans - is believed, also, to proceed from the information captured, as has been described in phases two and three of CRP.

Criteria of value, thought to be especially valuable in the development of an information system, include those of collaboration and interdependence. Interdisciplinary and international cooperation in the handling of information about health and social disabilities is essential if nurses and other health professionals are to achieve their goals.

Cornillot (1977) is emphatic that an educational programme (referring to a subject-oriented structure) must serve as a permanent information and analytic instrument for the benefit of the community. Additionally, Cornillot views an impartial attitude as an essential restraint for curriculum planners to ensure that information shared with the society will be objective, irrespective of prevailing political trends in the society.

THE COMPONENTS OF AN INFORMATION SYSTEM

Whatever methods are used for the capture and management of information there are certain constants to be found in the development of an information system. They include:

- (a) the nature of the information to be collected;
- (b) the sources of information to be used; and
- (c) the method(s) to be used to handle the data.

Nature of the Information to be collected

A wide range of information needs to be collected by the health professions as there are many factors which affect the wellbeing of individuals and their societies. For the purposes of nursing education the field is kept wide, but it is restricted to items in which the outcomes of social realities indicate explicit or implicit needs for nursing assistance.

The scope of information considered necessary by nursing depends on the perceptions held on the nature of nursing care. If it is seen as primarily concerned with the ill, especially the institutional ill, the scope is more limited than if it is seen to be required whenever and wherever self-care deficiencies exist in the community. When the wider view of nursing is held then any issue which is constantly reported as harmful, or potentially harmful, to the wellbeing of individuals and their society, must be captured and fed into the information system for analysis and interpretation.

This is important for curriculum development as adequate baseline data is essential to aid curriculum choices. In addition to the accounts of mortality and morbidity provided by national and international health service institutions there is a considerable amount of material to be collected from the community. The need to have access to primary data whenever possible, must be stressed, since it may be necessary to recombine primary data in order to test a specific evaluation hypothesis. For obvious reasons, the level at which information is being collected influences the choice of material being gathered. Moreover, collection at local level, and to a lesser degree at regional level, will be more specific and related directly to the needs of the area. At the same time one can draw on national and regional data banks for information of a

more generalised nature.

Essential characteristics of information gathered at a regional level will be related to geographic, demographic, economic, and socio-cultural issues. Density of the population, physical and transport conditions, likely job opportunities, and the dominant social disabilities of the area are examples of some of the variables that will influence curriculum decisions.

WHO (1972) divides the nature of the information required into five main types. This includes:

- (a) regional or local data covering, for example, population characteristics such as the rate of population growth and age composition, climate, and communications;
- (b) health problems or, more accurately, socio-health problems;
- (c) aetiological factors which can be of a chemical, biochemical, and behavioural nature and have the potentiality to influence the onset of disease;
- (d) health service activities, data ideally including both the quality and quantity of care available; and
- (e) resources available and in use, the information covering personnel, facilities, equipment and finance.

It can be seen that the data required is wider than vital statistics and includes, what Brockington (1975) refers to, as health statistics. These, he notes, measure the state of health, factors affecting health, and items of service. One can also use Omram's (1974) classification or profiles of the socio-health status of societies, in one or other of the three phases of the 'epidemiologic transition', as a means to group types of information. The profiles, presented in table form by Omram, group information into four classes:

- (a) a population profile;

- (b) a social and economic profile;
- (c) a mortality and disease profile; and
- (d) a community health profile.

SOURCES OF INFORMATION

Since the perceptions of social order and disorder vary considerably it is necessary to cast the net wide in order to capture a cross-section of relevant material from public and official sources. Data can be collected from existing records or by the means of specially designed projects.

There are several main sources from which information can be sought for a health information system. Vital and health statistics can be obtained from traditional health service records, for example, hospital discharge records. But dissatisfaction with available material from such sources has led to the establishment of national health information systems which collate material from a much wider field. For example, from cost-accounting statistics, from medical and other professional information sources, and traditional sources of statistics.

Additionally, information can be obtained from ad hoc surveys, from experimental research projects, and from 'expert opinion'. Information from national health information systems and other related sources can provide valuable information about met and unmet health needs and their outcomes. But there are a number of other sources from which information should be sought. Publications from voluntary organisations such as Alcoholics Anonymous, or the Hard of Hearing League supply good material which help to fill gaps left by official records.

Probably the richest source of data closest to the grassroots of society comes from the reporting, letters, documentaries and studies of

the 'mass media'. Kerlinger (1973) notes that newspaper and other magazines do two things in particular for behavioural research. First, they influence the polity and the management of public affairs, and secondly, they mirror the values and positions taken by the public about different issues.

The 'MASS MEDIA'

The open forum provided by the mass media provides a very good avenue for gauging the feeling tone of responses made, or likely to be made, by the public about any issue that has a bearing on their health and wellbeing. In general, 'mass media' is taken to refer to large scale popular forms of communication such as radio, television, cinema, press, periodicals and records. But its use here is mainly in reference to the press, radio and television. For the majority, the 'mass media' are the only regular source of general information about current affairs and socio-health problems. Through the provision of information the 'mass media' can assist a society to make informed choices - though an element of bias must be allowed for.

MANAGEMENT - METHODS USED TO HANDLE DATA

From the inception of an information system it is necessary to choose a method of handling data that offers easy placement, retrieval, and access. When access is needed to only a limited amount of data, or a health information system is well established and functioning effectively and efficiently, its management is simple and requires only minimal organisation. But with the 'knowledge explosion' of today, changes in health care delivery, and increasing flexibility in the structure and content of educational programmes an efficient information system is vital. Data management involves its collection, organisation, and dissemination.

COLLECTION OF DATA

Data can be captured in one of two main ways, that is, either by:

- (a) using what WHO (1972) calls a 'broker's service' and obtaining it on request from others; or
- (b) methodically by experimentations, surveys, research projects, investigations, reported observations, and similar means.

As can be seen later, the application of an information system to determine the social realities of New Zealand society during 1979, information is collected mainly by observation, using either (a) a 'broker's service' or (b) by extraction from a wide range of publications and the mass media.

A 'Broker's Service'

There are a number of difficulties in the initial stages of developing an information service for the health professions since so many categories and sub-categories of information depend critically upon others. The use of a 'broker's service', however, helps to avoid these difficulties for this helps to establish what data are already available, and the terms under which it can be obtained. Once located there should be little difficulty in its retrieval.

Nursing education has ready access to the extensive range of information which circulates through the health system. But one needs to use a systematic approach in the capture of this information to ensure that it does not become blocked at some point in the health system.

Most traditional data is compiled into secondary data from primary sources and then circulated to health institutions as of right. Provision of readily available statistical information is one of the objectives of the NHSB (National Health Statistics Bureau), and NZDH

(1979) report stresses the priority given to the supply of basic information about health and health care in order to assist the formulation of health policies.

Data Collected by Extraction

In addition to the data received on request there is a need for information which portrays the social and health indicators less easily gathered by formal means. Extraction of information from informal sources in a society provides data about occupational, environmental, and socially determined issues which are of increasing concern. The collection of information by extraction from the 'mass media', for example, is more likely to contain the perceptions of a people about their socio-health problems and needs.

Information can also be extracted from the reports of research groups, professional, voluntary, or pressure groups, and be used by nursing education at national, regional, and local or institutional levels. The 'Family Growth Study' (Reinken & Blakey, 1976) is an example of what is available in this area.

The process of collecting data also needs consideration, and this is influenced by the earlier decisions regarding the types of information desired. This is why, in the first phase of CRP, that is, the evolving of an information system (see figure 3.2. page 40), the first steps taken include clarifying the goal, setting objectives, and selecting the sources from which information is to be sought.

Thought must also be given to the amount of information desired, to the points of collection, and to whom responsibility is to be given to capture the information. These are essential decisions for the ongoing collection of information about the socio-health and nursing problems and needs of a society.

THE ORGANISATION OF DATA

The organisation of data occurs automatically in any institution that keeps records or gathers information relevant to its function(s). But this is a limited level of information management unless it is related to wider purposes, analysed, and then fed back into the operational level. Studying the social context in which nursing is practised, for education purposes, is a problem-solving activity requisite at national, regional, and local levels. At each level, however, there is a different emphasis placed on data management.

Nursing education, at a central level, is occupied with the collation, analysis, and interpretation of data. It does this as an adjunct to policy-making, forecasting future manpower and resource needs, and to establish curriculum and standards. For regional authorities there is the dual responsibility of providing information to assist central policy-making, and the interpretation of policy to nursing education under their jurisdiction. A major task is to see that information and feedback flows freely in both directions.

At a local or institutional level, however, the prime emphasis is on the initiation of strategies to operationalise central policy and directives qualified by local requirements. Central directives are essential so that standards and competencies are equitable throughout a country. Nevertheless, health/nursing needs may vary so markedly, even within a region, that operational strategies are best made at local level.

As stated above, information and feedback must flow freely in both directions. It is cost-efficient of personnel and resources to have 'data packages' prepared and supplied from a central level. For instance, providing a profile of the incidence of accidents requires extensive resources and expertise which cannot always be maintained locally. At

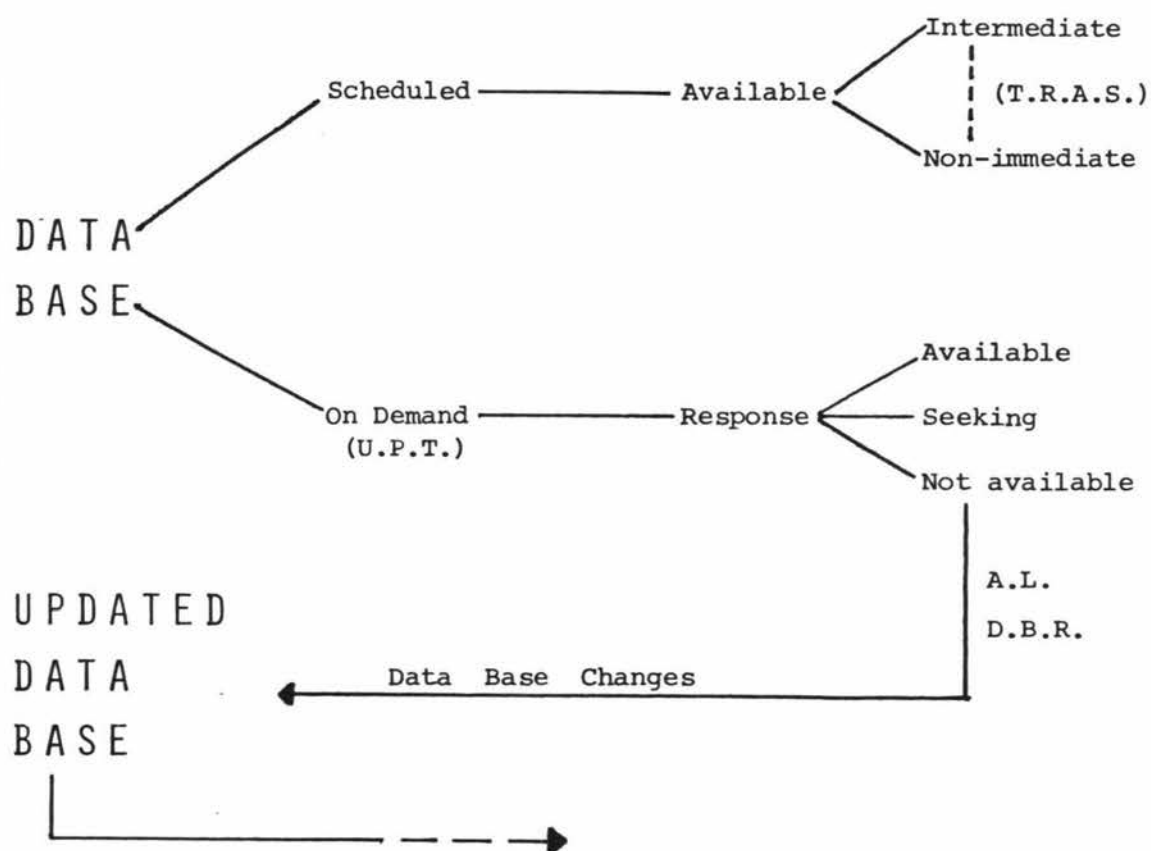
the same time information about local conditions and needs is essential and requires a reverse flow of data from the periphery to centre. An ongoing exchange of information between the policy-makers at the centre and those planning to meet local requirements constitutes an important part of information management.

The criteria of viability, interdependence, collaboration, participation, and innovation are important in the management of data to achieve the goal(s) of the health system and nursing education. Collaboration between the policy-makers at central level and those at regional and local level facilitates the viability of policies and avoids the immobility of policy/location dissonance.

Data organisation begins properly with the formation of a data base. In this thesis, the data base is established with information obtained from the mass media and other publications, and, also, on request from a 'broker's service'. But there are, of course, instances when the information can only be obtained by ad hoc surveys and other research projects.

An effective data base is one that can meet the requirements of scheduled work, or of work which needs to be initiated to meet changing demands or discrepancies between goal, objectives, and outcomes. The information system has to include, therefore, some technique which enables updating of the data base as necessary. Figure 4.1. depicts one way in which a data base may be used. This is constructed after a model prepared by Weinberg (1987, page 86 and 87).

The 'data base usage' model is largely self-explanatory, but some emphasis should be given to the adaptation loop. Without such a facility in the system users become discouraged and use of the data base limited. It also allows for periodic review of the data base and for alterations as necessary. The changes involved may vary from a simple



Legend:

- T.R.A.S. - Time range as specified
- A.L. - Adaptation Loop
- D.B.R. - Data base review
- U.P.T. - Using predefined terminology

Figure 4.1. Data Base Usage

(Idour, M. 1980)
(after Weinberg, 1978)

addition of data to a major recoding of information. Certain problems exist in defining data base requirements and Weinberg (1978) names four of them.

- 1) Users failure to understand the level of precision needed in the statement of specific inquiries and responses.
- 2) Users prediliction to use a limited number of inquiries, and failure to imagine the extent of inquiries that they could make.
- 3) Users failure to realize the time, cost, and space benefits that can ensue from retrieval of data.
- 4) Different users have different requirements in the nature of the information wanted, and in the way in which it is presented.

The adaptation loop and regular data review facility should help to overcome some of these problems. Another important solution to these problems is to educate users in the use of the system. Probably the best solution is the application of problem-solving, analytical strategies in the initial designing of the system.

There are basically two ways of handling data for a health service information system, and this applies equally to setting up an information system for nursing education, though on a much smaller scale. The two main methods generally advocated for the handling of data are (a) a manual, or (b) an automated data processing (ADP) method. For evaluatory purposes both methods have their limitations.

Manual methods can be wasteful of time, material, and space; and the integration of data is more difficult. But there is no reason why classification, coding, and presentation of data prepared manually cannot be rationalised and operated efficiently. One considerable advantage is that observations can be qualified by description, to enhance understanding of the information, in a way which is not possible in an ADP system.

In an ADP system, classification, coding, and placement of

information is quicker, once the terms and usage are defined, and more easily retrieved. Units of information can be recombined in a number of ways, and users with different needs can get the information they want. But there are several reasons, such as cost and limited flexibility in response to change, why ADP is not possible or desirable at local or institutional level. Weinberg (1987) considers, however, that this will lessen as sophisticated computer banks, with terminals in different locations, become more available.

The ideal solution seems to be a combination of ADP and manual methods. As noted, information can be obtained on demand from central and regional computer banks. An efficient manual method to place, retrieve, and provide access for usage of information is one that can be based on a library system. Moreover, as a library system now includes storage of films, tapes, and other audiovisual aids, it can allow a very comprehensive information system to be developed.

GUIDELINES RECOMMENDED FOR THE ORGANISATION OF DATA FOR A NURSING EDUCATION SYSTEM

- 1) The information system can be developed within the library system, but should be the responsibility of the curriculum development and advisory committee.
- 2) Regular meetings should be scheduled with all relevant users to determine data base information requirements and objectives.
- 3) Define the terms of use, and establish codes for scheduled work demands, than can be answered immediately.
- 4) Devise codes that indicate that the adaptation loop and data base review need to be operational. Specify whose responsibility it is to respond to such demands.
- 5) Delineate information that can be obtained from a 'broker's service'

- 4) and detail the sources to apply to for such information.
- 6) As data extracted through the 'mass media' and various other publications is believed to constitute an important source of information for keeping up with contemporary social realities and behavioural problems, a system should be devised to monitor socio-health issues. This permits a broader grasp of human behaviour and can be classified according to a problem-oriented form of recording.
- 7) As advocated by a number of authorities, such as WHO (1972), provision must be made for the public to participate in establishing and maintaining an up-to-date information system.
- 8) As the system develops the data structure needs to be adapted to user requirements.
- 9) Use of the system can be encouraged by involving users in the development of data base objectives and in the specification of information required.
- 10) Identify the range of inquiries that can be made, and the benefits that can accrue, from an information system in order to attain nursing goals.

THE DISSEMINATION OF INFORMATION

As the guidelines given for the organisation of data indicate, to achieve success it is wise to involve users of the system in its development, and in the specification of its objectives and usage. This in itself, helps to ensure that information is transmitted adequately. Integrating collections of information into logical comprehensive systems also helps to achieve better use of the information. Interrelationships can be better grasped, and information exchange flows more freely.

An information system also provides for placement of data which is easily retrieved and to which access can be given - subject to the ethic of confidentiality where applicable - on a regular basis for those who require it.

This is another area where responsibility can be given specifically to a committee member, who is charged with the function of informing users about new inputs or of changes to the data base structure and content.

On a wider basis, information should be exchanged regularly at all levels and also between countries where pertinent. One of the major concerns at the Sixth Regional Consultation Meeting on the APEID (Asian Programme of Educational Innovation for Development) 1979, involved information development and dissemination. This is seen as vital since it provides access to new ideas and comparative experiences. One of the recommendations made was the APEID should support national studies for the transfer and exchange of experience. Nursing education in all countries transmits information through its professional journals, but has some way to go in exchanging information on a formal and informal basis outside its professional field.

SUMMARY

An information system is an integral part of CRP, and it makes it possible to identify and monitor the social realities and their outcomes on a continuing basis. In addition, it makes it possible to monitor their reflection in the curriculum, in the choice of teaching/learning strategies, and in the selection of desirable nursing skills for oncoming nurses.

Knowledge about the social realities, and the socio-health and

nursing problems associated with them, needs to be increased by research, and by systematic ongoing information gathering, analysis, and interpretation.

In chapter 5, an extensive review of the social realities of contemporary societies is carried out in order to define the social context in which nursing practises. In chapter 6, a systematic study of the social realities of New Zealand society for the period of a year - 1979 - demonstrates the use of an information system and identifies the most dominant socio-health and nursing problems. This is seen to offer the most appropriate basis for choices made in the organisation and content of nursing education programmes, and in the selection of optimal learning experiences.

CHAPTER 5

SOCIAL REALITIES: DEFINING THE CONTEXT IN WHICH NURSING PRACTICES

Since defining the context in which nursing functions is a topic of immense dimensions it has been divided into five sections. To begin with, however, the concept of 'social realities' is discussed and defined.

SECTION 1:

CONTEMPORARY SOCIAL REALITIES - TRENDS AND PROBLEMS

SECTION 2:

SOCIAL INSTITUTIONS - CONTEMPORARY SOCIAL REALITIES

SECTION 3:

SOCIAL REALITIES - CHANGING PATTERNS OF ILL HEALTH

SECTION 4:

SOCIAL REALITIES - THE MANAGEMENT OF TECHNOLOGY

SECTION 5:

CLARIFYING VALUES IN AN AGE OF DEGENERATIVE AND MAN-MADE DISEASE

THE CONCEPT OF SOCIAL REALITIES

Discussion of the Concept

As a global concept, 'social realities' has been defined in chapter one as the commonalities of human life and experience shared by all humanity though with varying emphases according to all the characteristics of a society. But, as examination of the words 'social' and 'reality' discloses, a more specific definition is possible, and desirable.

'Social' refers to all that is imputed or attributed to the mutual, interdependent, and communal relations of people. What might be called the basic substance of human societies is the same all over the world. Beliefs and values, lifestyles (work and leisure), individual identity and group belonging, achievement and failure, making and destroying, sharing and withholding, caring and being cared for, are the essence of what moulds people together or separates them.

From this essence, and the common physical and climatic conditions that people must contend with, arise the factors which promote or demote the wellbeing of people. As well, processes develop which affect and motivate the behaviour of people; especially their behaviour in social groups. Obviously an immense field to consider, and one, therefore, that will be confined to those aspects which hold some explicit or implicit relation to a society's need for nursing care.

'Reality', as defined by the OXFORD ENGLISH DICTIONARY, is the nature of something or some object. The actual which underlines appearances and is not distorted by extraneous or subjective factors, but has defining characteristics and possesses consistency. To define 'reality' is much simpler than to determine it, as a nurse attempting to define nursing needs can affirm, but when the two concepts 'social' and 'reality' are used in conjunction the meaning of both is extended and qualified.

'Social realities' implies, therefore, all the real or actual conditions and happenings that exist in the shared human environment of a society. As figure 2.2.* demonstrates, the environment is perceived as consisting of a number of interdependent components. Various linkages between these components determine the nature of the social realities of a society. Individuals both influence and are influenced by the environment in which they live, and interactions between the two establish the socio-health status of individuals. Consequently, the social realities are not a static, passive entity but a changing, evolving set of conditions affecting a society and its members.

'Social realities' are more than just a listing of conditions such as, employment figures, accidents associated with alcoholism, and health and vital statistics. They refer to all conditions which affect the organisation or ordering of a society, its unity, and its survival. The whole range of psychosocial, cognitive, and physical adjustments

and/or maladjustments that a society and individuals may make in response to existent conditions are inferred in the concept. Powerlessness, alienation, job limitations, withdrawal of the right to work, socio-economic factors which limit or promote health status and educational opportunities, the authority power structure of a society, and continuing changes in the environment are some of the current social realities that confront people.

Redefining the Concept of 'Social Realities'

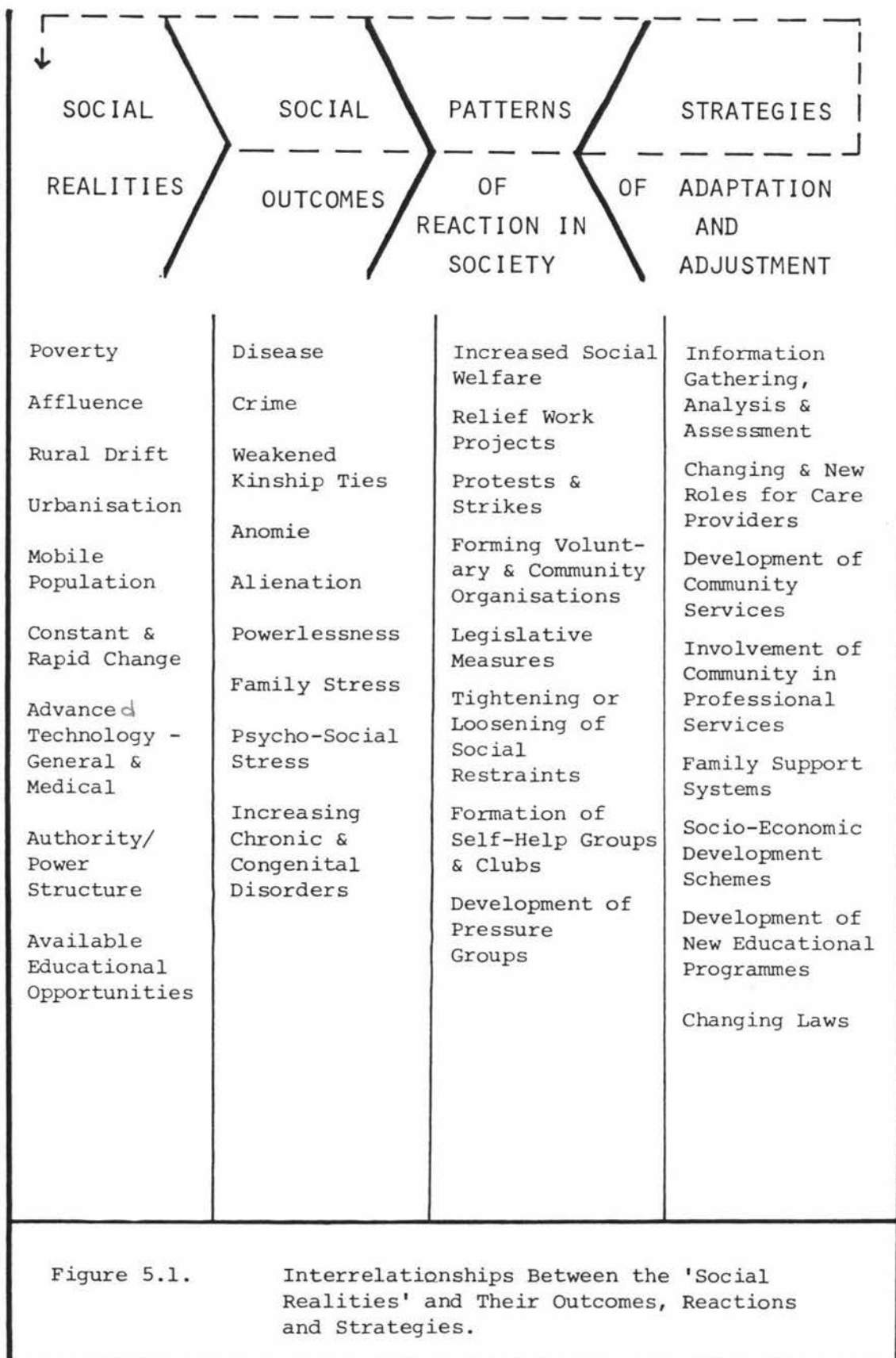
'Social Realities'

In the context of this thesis, 'social realities' are defined as the actual conditions, pressures, disabilities and abilities, limitations and resources that exist in the lifespace of people and form the environment within which nursing functions.

'Contemporary Social Realities'

This term refers to the most prevalent conditions, or state of order and disorder found in a society. Figure 5.1. names some of the most common and universal social realities and their outcomes, patterns of reaction that may occur in response to them, and, finally, some of the strategies of adaptation and adjustment that may be adopted to deal with them.

Nursing care is applied, therefore, to people living in more or less favourable environments according to the prevalent social realities of their society. Johnson (1965) urges nurses to pay renewed attention to the significance of nursing practice, not just for the application of nursing knowledge, but also as its primary location. With slight modification one can urge that the location of nursing practice, that is, its social context, determine, not just the nature of nursing practice,



(Idour, M. 1980)

but also act as the primary source of nursing knowledge.

SECTION 1

CONTEMPORARY SOCIAL REALITIES - TRENDS AND PROBLEMS

As the conditions or states listed under 'social realities' in figure 5.1. (p 81) indicate, many of the factors which influence the quality of contemporary life are associated with material resources and man-made structures. The extent to which they exert control, however, depends also upon the socio-cultural customs and mores of a society.

'Social beliefs' claimed Peters (1975) "father social realities". Different cultures form their own views about the ends and purpose of human existence, about what individuals may expect from significant and generalized others, and about what is satisfying or frustrating. Just how close individuals remain to the general tenor and state of being of their society depends upon the characteristics of their culture. They are also very much influenced by those who socialize them into the ways of their society in their early years. Overall it can be said that the manner in which a society negotiates the events of daily life for its members reflects both its culture and the realities of its situation in time and place.

It is equally true that a society is affected by realities outside its own borders. Modern ease of travel and communications has made it virtually impossible for a society to remain closed to outside influences. Additionally, pathological and social disorders spread more rapidly, and the experiences of individuals are less confined to the social structure into which they were born. As a consequence there is less acceptance of the traditional roles of social institutions, and internal and external pressures on a society are less easily handled.

Prominent amongst the complex problems associated with modern

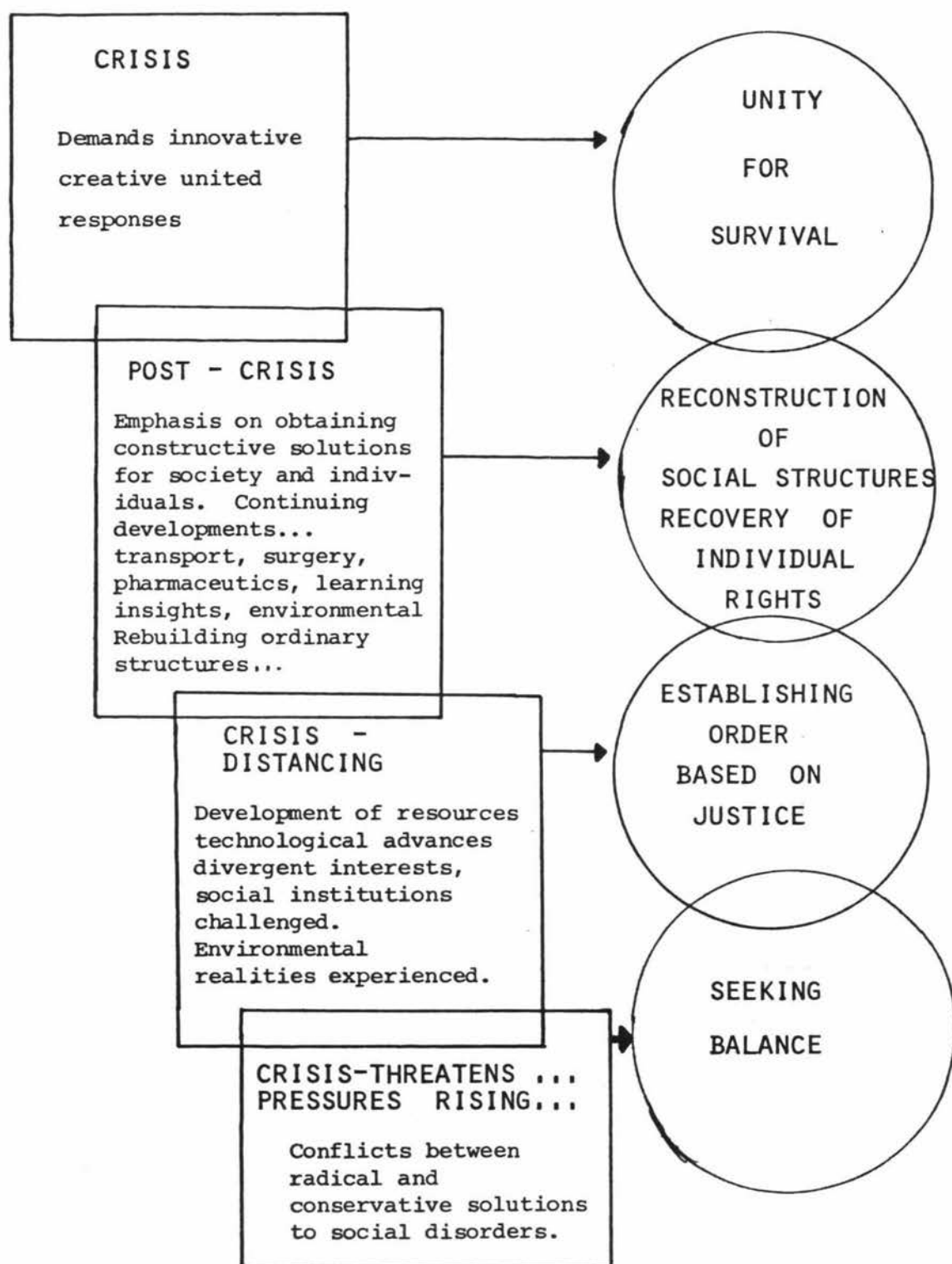
technology since the onset of the atomic age is the knowledge that the extinction of the species is now a distinct possibility. How much this knowledge, consciously or unconsciously, has fed the various problems that have mushroomed since world war two is hard to evaluate. But it is less difficult to form conclusions concerning the strains they have placed on society and its institutions.

In broad terms the health of a society depends upon its stage of development, available resources and attitudes towards them, and the effectiveness of its social institutions. Development has been a feature of societal life ever since human settlements first formed, but the rapidity of present developments does have adverse effects on health. Smith (1966) points out that stress is a marked feature of modern life because social adaptation has not kept pace with technological developments.

Crises of security or social conflict are a feature of most societies today. Lambo (1967) is adamant that any study of peoples health must attend to the critical level of mental and behavioural disorders which have an effect on the entire society. Violence, crime, alcoholism, delinquency and inadequacy are, he notes, as important indices of health as mortality and morbidity figures.

Patterns of Reaction

As a society faces its problems a certain pattern usually emerges which characterizes the ways it seeks to solve them. Some reactions common in contemporary societies are listed in figure 5.1.* For instance, the inadequacy of official services and resources is reflected in the increasing number of voluntary, self-help, and pressure groups, that are being formed. Moreover crises develop periodically in a society and can be an opportunity for growth, retreat, or closure as

Stages of CrisisSupreme GoalsFigure 5.2.Pattern of Reaction In A Crisis

(Idour, M. 1980)

common patterns of reaction. One common hope or expectation of both developed and developing societies is that education will help to solve many of its problems. A panacea increasingly stressed as societies fail to transmit a unifying belief for their members which gives meaning and value to their activities and relationships.

In a crisis situation such as world war two, or when disorders such as those listed above reach intolerable levels, a pattern of reaction as depicted in figure 5.2.* may develop. In the first stage of crisis, initial reactions are oriented towards the maintenance or recovery of unity. At the height of the crisis the greatest need is to protect the survival and freedom of a society. Unity is therefore stressed to ensure survival, and order is organised in the society towards that purpose.

Certain restraints on individual rights are accepted during this period but disruptions of ordinary social structures can later be dysfunctional for a society's wellbeing. Nevertheless, innovative and creative responses during a crisis can lead to continuing developments which benefit a society. For instance, a considerable amount of beneficial medical and general technology began in this way.

Crisis is followed by a stage of post-crisis which is generally a time of reconstruction and return to normality. The overriding goal is to overcome imbalances between societal and individual rights formed during the crisis. The goal is, therefore, a mixture of consolidating the social structures of a society, rebuilding its resources, and the recovery of individual freedoms and rewards. As the crisis recedes more diversity is allowed, although this depends upon a society's stage of development, and its socio-political character.

In the third stage of crisis-distancing social injustices and discord become more evident. Subsequently, social disorders intensify and seriously tax the resources and abilities of social institutions. At

* p. 84

present the social realities that predominate involve a serious disparity between the resources available and the amount required to maintain the wellbeing of all a society's members. The overriding goal is one of establishing order based on justice which is more a matter of treating adequately according to need than to treating all equally.

The fourth and final stage is that of seeking balance between conservative and radical solutions for establishing societal and individual wellbeing. The three main issues for a society of unity, survival, and order now need reviewing. All the components of the human environment (shown in figure 2.2^{*}) must be considered in reviewing a society's priorities, and all social institutions must participate in this task. Figure 5.3⁺ displays how one social institution, nursing, using the crisis construct of unity, survival, and order can participate and assist a society and individuals to establish priorities for recovery and enhancement of health. * P.20 + P.86

In a crisis or time of stress unity necessitates a pooling or strengthening of energies to deal with the situation. For survival, priorities must be established regarding the use of resources and the environment, and the urgencies and basic needs of the situation must be analysed and managed with care. Order is required and obtained by planning and problem solving strategies. The decisions made must be optimal for society if the crisis involves the community as a whole. Even if the decisions relate primarily to an individual there must still be study of all that is involved in the personal environment of the person.

The role of nursing in the management of social disorders, involves activities related to sharing knowledge and freeing individuals by enhancement of self-care abilities. Another essential activity is creating a healing environment, which facilitates reparation, by allowing time for treating, healing, and renewal of energies. Comforting and

easing pressures relating to individual or environmental malaise is always needed, and, for some, may be all that is possible.

Coping with Change

The present time is one of rapid and pervasive change with widespread effects. It is associated with technological advances which have been beneficial but at a price. Increased mobility, a hastening move from rural to urban life, a 'knowledge explosion', and rapidly increasing populations are accompanied by environmental and psychosocial pollution. (WHO, 1966; Lambo, 1967; Baly, 1973; Folta & Deck, 1966; Boulding, 1965; Bennis, 1966).

Social institutions, and society in general, find it increasingly difficult to adjust to the rapidity of changes in modern complex societies. Swift and continuing change allows little time for the reactions, interactions, and actions that occur, or need to occur, in response to it. For instance, commitment to change is a prerequisite if it is to be coped with effectively. But this requires an underlying understanding of the need for it, which individuals often do not possess, or which they do not accept.

When change is imposed, generally by external pressures, it is rarely successful or lasting. A more positive response is likely if individuals are given an opportunity to participate in planned change. Participation in making choices facilitates the integration of proposals for change into an individual's mental constructs and patterns of activities. That is, of course, if the changes proves to be necessary and desirable.

Social change has led to a general demand for a more active role in decisions which affect wellbeing. Folta & Deck (1966) comment on the complexity of modern society and the development of forces of unrest and

collective behaviour. The prominence of pressure groups and consumer advocates in contemporary society is an instance of this development. The growth and power of such groups has, of course, been helped by the facilities provided by the mass media. Another factor is the trend towards private medical insurance schemes as public services appear to be unable to cope with the demands and expectations for extension and improvement of available health services.

Although change is a natural part of the life process and occurs in all matter over time there are, nevertheless, points of time in social and environmental issues when choices can be made as to the desirability and direction of planned change. As Mechanic (1969) points out it is vital to achieve some balance between mastery of the environment and individual comfort, not only for humanitarian reasons but also to facilitate continuing performance and mastery.

In a study concerned with the dynamics of change Hirschowitz (1977) discusses processes that ease the stress of transition and promote mastery of tasks to be accomplished. What Hirschowitz calls the process of 'interactive engagement' in the planning of change enables energies to be utilized for dealing with changing reality. Realistic discussion is seen as enabling 'anticipatory grief and worry work' to begin. Something that Hirschowitz likens to Toffler's (1975) term for dealing with change in communities, that is 'anticipatory democracy'.

Hirschowitz (1977) finds that the processes which enable adaptive mastery include these factors.

1. Understanding which provides realistic coping and assurance.
2. Involvement resulting from the process of information - sharing, expands self-confidence and mastery of what is done.
3. Support and reassurance which are vital in a period of change and uncertainty. People require assurance that those who activate change recognize these needs

4. Guidance, particularly 'anticipatory guidance' which provides and prepares for new patterns of action and new roles.
5. Proximity of those who direct or lead change for 'contact comfort' and opportunities to express difficulties openly.
6. Interaction to hasten the 'restitution process'. Constructing the new and disengaging from the old in other words.
7. Clarity about new responsibilities to be gained by repeated discussion to clarify and reclarify in order to overcome the 'phenomenon of role clinging' which interferes with the learning of new roles and tasks.
8. Self-respect which needs rebuilding in a time of change when previous competencies no longer suffice.
9. Hope which can be generated in team sharing of common difficulties experienced in a time of change. Hope, states Hirschowitz (1977), is a 'sine qua non' for successfully managing change.

Figure 5.4. is used by Hirschowitz to show how an organisation can move from uncertainty and restlessness to the implementation of an effective strategy to manage change. This coping strategy can be generalized to other situations in society. For instance, it can be used in what Toffler (1975) terms 'anticipatory democracy' in the community. It moves through five steps, which Hirschowitz (1977) states, must be kept in sequence if adaptive stress is to be avoided. The five steps in figure 5.4. are indicated by capital lettering (see page 91).



FIGURE 5.4. Linear representation of the movement from awareness of unsettling cues to the implementation of a corrective strategy.

Hirschowitz, 1977, p.194)

It should be noted that Hirschowitz uses the term 'contracting' in the way used by Levinson (1962), that is, as a 'psychological contract'. Levinson et al. (1962) use the term in reference to the emotional health of work organisations. When the needs for dependency, affection, and coping support are contractually met, commitment occurs. Hirschowitz calls the model an ideal one but cautions against neglect of any one of the five steps because it is thought to be time-consuming. This, he warns, leads to an inability to cope and uses more time when the process has to re-initiated to cover what was neglected.

A second study concerned primarily with the dynamics of change in organisations, but which is generalizable to society at large is that of Bennis (1966). Bennis refers to American society but the instances of change given are also common to many other societies. For instance, he notes that in 1960 half of all Americans were over 33 years but forecast that by 1970 half of all Americans would be under 25. In education one out of every eight Americans had been to high school, but by 1966 one out

of five attended high school. Finally, referring to the momentum of the scientific revolution Bennis noted that science will dominate even more by 1980 when about \$35 billion will be spent on research and development: \$10 billion on arms and arms control, \$7 billion on basic research, and \$18 billion on vast civilian welfare programs and new technology.

After discussing bureaucracy as the dominant form of human organisation currently prevailing, Bennis (1966) makes his main premise, which is that bureaucracy is out of step with contemporary realities and new social systems are needed. He provides two main reasons: (a) the fact of the 'population' and 'knowledge explosion;' and (b) a less easily defined reason - a general spirit of inquiry and analysis. Consequently, there is a trend towards a change in values and outlooks between those who make history and those who provide knowledge. This development is termed 'organisational revitalization'. It is described as a complex social process, involving self-examination of organisational behaviour, and a collaborative relationship between those who manage organisations and those who contribute scientific knowledge.

For Bennis, the steps outlined by Hirschowitz (1977) are expressed by concepts such as collaboration, reciprocity, cooperation, knowledge-sharing, and organisational revitalization.

Amongst the skills presently required by organisations and individuals Bennis includes:

- coping with swift, persistent change;
- coming to terms with temporary work systems and requiring retraining perhaps three times in a lifetime;
- engaging and disengaging in meaningful relations due to current mobility trends;
- learning how to live with ambiguity;
- being able to identify with the adaptive process; and

- managing contingencies constructively.

Coping with change is believed to demand such skills and to require more flexible and responsive organisational and societal structures than a bureaucracy can offer.

In figure 5.5. (p 94) an elaboration of a chart drawn by Bennis (1966) to show the human problems confronting contemporary organisations is presented. It specifies, in particular, how one social institution, nursing, strives to manage these human problems, in a time of change.

Mead (1970), aptly underscores the universality of the current social problems confronting us, in depicting the world as a 'global village'. Due to the rapidity of change Mead concludes that the 'intergenerational gap' is more significant than sociocultural or demographic divisions. Describing cultures in three categories; (a) 'postfigurative' in which children learn primarily from their forebears; (b) 'cofigurative' in which children and adults learn from their peers; and (c) 'prefigurative' in which adults also learn from their children, Mead argues that it is the latter culture that is required by the world of today and tomorrow if man is to cope with the business of living with meaning and purpose (1970).

An incident revealing the 'intergenerational gap' was recounted by Gandhi at a United Nation Conference on the Human Environment (1972). This told how the demands of tribal elders to have their culture left undisturbed was acceded to but later had to be modified when the young objected to being treated as 'museum pieces'. This incident also illustrates the effects of rapid, universal communication systems on what some may consider to be a more static society. The restless young are not just a phenomenon of the west.

Mead's perceptions of socio-cultural developments and priorities

	PROBLEM	BUREAUCRATIC SOLUTIONS	NEW 20TH CENTURY CONDITIONS	NURSING CONDITIONS AND SOLUTIONS
INTEGRATION	The problem of how to integrate individual needs and management/ * institutional and societal goals	No solution because of no problem. Individual vastly oversimplified, regarded as a passive instrument or disregarded.	Emergence of human sciences and understanding of man's complexity (and diversity). Rising aspirations. Humanistic - democratic ethos.	* Growth of health care concept and team approach. Increasing awareness of (a) patient's right to participate in own health care plans, (b) a society's right to choice of services.
SOCIAL INFLUENCE	The problem of the distribution of power and sources of power and authority.	An explicit reliance on legal-rational power, but an implicit usage of coercive power. In any case, a confused, ambiguous shifting complex of competence, coercion and legal code.	Separation of management from ownership. Rise of trade unions and general education. Negative and unintended effects of authoritarian rule.	* Growing disaffection with lack of power to control, plan, and exercise own professional responsibilities within health organisations. Peer-group approach developed.
COLLABORATION	The problem of managing and resolving conflicts. * And of inadequate co-ordination and correlation between nursing service and nursing education.	The 'rule of hierarchy' to resolve conflicts between ranks and the 'rule of co-ordination' to resolve conflict between horizontal groups. 'Loyalty'	'specialization' and professionalism and increased need for interdependence. Leadership too complex for one-man rule or omniscience.	* Current emphasis on group process. Shared leadership functions. Development of new and changing roles. Specialization. Consensus management.
ADAPTATION	The problem of responding appropriately to changes induced by the environment of the firm/ * institution or society.	Environment stable, simple, and predictable; tasks routine. Adapting to change occurs in haphazard and adventitious ways. Unanticipated consequences.	External environment of firm (institution, society) more 'turbulent', less predictable. Unprecedented rate of technological change.	* Awareness of need to adapt to changing societal and individual requirements grows. Development of health care model, and holistic, person-centred approach.
'REVITALIZATION	The problem of growth and decay. * And of ambiguity, uncertainty, divided aims, and apathy of the majority.	* Modification of leadership/management behaviour. Organisation grows taller.	Rapid changes in technologies, tasks, manpower, raw materials, norms and values of society, and goals of enterprise and society will make... constant revision vital.	* Ongoing problem-solving... creative management. More responsive to change. Prepared to effect change. Growth of new educational programmes. Growth of evaluative strategies and nursing theory.
* 'COLLEGIAL' MANAGEMENT	The problem of equality of professional competence minus the power to initiate action.	Specific roles, formal relations, clearly defined status. Professional and administrative functions separated.	Recognition of all workers as colleagues or co-workers and not just as subordinates. Encouragement of participation in decision-making.	Desire for 'flat' structure. Supportive management. Motivation of staff to function both independently and interdependently.
* AUTONOMY	The problem of 'nursing function' being restricted through entrapment in complex bureaucratic solutions.	The 'rule of control' Organisational structure allows limited autonomy within clearly specified boundaries. Security of specified responsibility stressed.	More involvement, participation, and autonomy encouraged and expected. Re-education for new and changing roles.	Reduction of authoritarian management to some extent. More potential than actual. Attention to autonomy of nurse practitioners.

Figure 5.5. Human Problems Confronting the Social Institution of Nursing
[After the Bennis (1966) Model - additions marked by * - Idour, M. 1980]

are supported by a number of other social scientists. For example, both Toffler (1970) and Dubos (1965) stress the universality of problems associated with rapid change. Toffler (1970) is particularly concerned with what happens to people when they are overwhelmed by change and with how they adapt to the future. Dubos (1965) also attends to adaptation, and warns that each adaptive reaction exacts its price.

In Mead's perception of a 'prefigurative culture' the old learn from the young as well as transmit to them their culture and knowledge. It is through education Toffler (1974) writes, that 'future consciousness' is developed so that future events, individual and general, can be anticipated and coped with more adequately.

SECTION 2

SOCIAL INSTITUTIONS - CONTEMPORARY SOCIAL REALITIES

Social institutions can be defined as structures developed within society to carry out specific functions on its behalf. As Folta & Deck (1966) point out, society has a number of essential functions including familial, economic, political, religious, educational, and socio-health to maintain. But as societies have become more complex various institutions have evolved to mediate these functions (Morrish, 1976). In addition to the specific functions entrusted to each institution there are also certain general societal goals. These include the achievement of continuity, cohesion, sufficiency of resources, the transmission of value and meaning systems, and social control.

'Institution' is used in this context to refer to a structure which consists of a number of functionaries who act in prescribed ways at certain points of need (Chinoy, 1968). Nursing, as already noted, has evolved to assist a society to care for those members with some inability to maintain self-care. Education is expected to act for society by

transmitting its culture. Yet, at the same time, it has also to act to prevent 'cultural lag' (Morrish, 1976), to develop 'future consciousness' (Toffler, 1970), and to mediate what Mead (1970) calls the 'intergenerational gap' and a developing 'cognitive culture'.

Although all social institutions are caught up in the crises caused by persistent and rapid change only one - the family - can be considered further to see how it fares in contemporary society. The strength and stability of the family is interdependent with that of society and can, therefore, reflect in many ways the society's wellbeing.

THE FAMILY

In all its different cultural forms the family can provide a prime example of how current dissonance and unrest affects the integrity of social institutions. A decision has been made to examine the family because it is regarded as the basic social unit of society. As such it is paramount in the initiation of stable and close relationships and a secure environment. It is, therefore, a major determinant of a healthy personality and physique and of a person in harmony with his or her environment (Bowlby, 1969; Daniels & Smith, 1979; Etzioni, 1979; Begg, 1976; Hall & Weaver, 1974; Reinhardt & Quinn, 1973; Loring, 1979; Mahler, 1975).

The current rate of social change has had a marked effect on families. Recent New Zealand figures show that incidents of violence have increased by 21% - from 12500 in 1978 to 15200 in 1979. More incidents of violence are said to occur within the family than elsewhere and this is reported to be a worldwide trend causing considerable concern. Brockington (1975) reports that more deaths due to accidents occur to children in the home than do on the roads.

Hall & Weaver (1974) consider that most crises occur within a family context and that it is rare for an individual to experience a crisis alone. They also note that recent studies indicate that it is change rather than stress which precipitates a crisis. Among recent New Zealand studies on the family in contemporary society is one prepared by Begg (1976) for the Plunket Society. Begg draws attention to the Plunket Society's continuing concern about social change in the last decade. And he commences his study with a quote from Miller et al (1974).

"Just as some children are born with physical handicaps others are born with social handicaps and the greatest of these is an unsatisfactory family ... the principal need (now), is for more responsible standards of family behaviour".

Begg stresses that particular concern is felt about the problems arising, and on the increase, in the new housing areas; a trend which has been confirmed by some of the findings of the Joint Survey on Maternal and Infant Care in Wellington (Salmond, 1975). Two other studies Begg mentions are (a) Crime in New Zealand, 1968, and (b) Child Abuse in New Zealand, 1972. Both studies stress the preventive outcomes of good family life which spills over into all aspects of individual growth - physical, mental, moral, educational and social. The importance of parent education, and motivating parents to use the information, is also stressed.

In an assessment of children's needs Begg points out that mortality and morbidity rates have lessened with control of infectious diseases and more knowledge about nutrition, hygiene, and metabolism. The main issues of present concern now include a greater incidence of accidents and injury, and psychosocial disorders. Further, while the effects of gross poverty have eased those of affluence grow. Begg believes that the chief problems now experienced by families are mainly

man-made environmental ones.

An extensive American study (Kenniston, 1977) on the family and its viability, also examines the anxieties, worries, and obstacles that a changing society is creating for parents and their children. Kenniston (1977) reports that the Commission that undertook the study emphasised that 98% of children grow up in families and are likely to do so even if the pattern of the family unit alters. Consequently, it was agreed that, to support and understand the development of children, demanded the support of the family and knowledge and understanding of the lives of their parents. Moreover, it was urged that planners and policy-makers focus on the broad ecological pressures affecting children and their parents, if the policies are to do more than just repair the damage that the environment is constantly reinflicting.

As a consequence, the study moved from an analysis of the needs of individual children to broader issues about the organisation of the economic, social, and technological setting of childhood. In fact, the position adopted moved close to that of Harbison & Myers (1964) who stated that the objectives of a 'human resources development' strategy is to build the skills and knowledge required for economic, social, cultural, and political growth and to provide avenues of participation in the creation of a better society for all who seek them. One can go further and suggest that the 'avenues of participation' be revealed to those whose socio-economic status would preclude them from knowing about it let alone desiring it.

Another study with a similar orientation to Begg's, though it concentrates on the entire family and not only the children, reports the results of a joint Anglo-American Conference on 'Health and the Family'. The two issues primarily dealt with are related to (a) current erosion of the traditional family and existent alternatives; and (b) the dramatic

developments in medical technology.

The earlier chapters set out to increase awareness of the importance of the family. In the first chapter, Daniels & Smith (1979) look particularly at the changing functions of the family and their interrelationships with health and illness. They believe that changes in the 20TH century are qualitatively and quantitatively different.

Some of the selected data they present to support this belief of new realities in a maturing industrial society includes;

- 1) doubling of the divorce rate in the last 10 years which has increased 700% in this century;
- 2) households headed by women have more than doubled in 10 years;
- 3) 2 out of 5 children born this decade will live in single-parent homes for at least part of their youth.
- 4) each year 20% of the population move (12 million families or 40 million people);
- 5) in the 1970 census one-half of the population lived at a different address from five years earlier;
- 6) the suicide rate in children aged 10 to 14 has doubled and in adolescents has tripled in the last 20 years. (A recent news release reports that suicide attempts in the Wellington district were 9 per 1000 of population; and that most commonly attempts were made by the young, unemployed, young women, those who lived in the inner city, and the Maori).

Of the qualitative factors thought to underpin the quantitative data the changing roles of women and men are believed to be critical. Expected behaviours are viewed as more flexible and variable. Occupational choices, especially for women, are greater and marriage occurs at different ages with different overt and covert expectations than before.

The discussion by Etzioni (1979) on the evolution of the family is very clear and cogent as he presents the viewpoints of those who believe the disintegration of the family is all to the good, as opposed to those who regard it as catastrophic for society. Etzioni points out that the consequences of disintegration may be viewed differently, but that there is no disagreement about the phenomenon itself.

Etzioni (1979) makes apt use of Bale's description of group behaviour to apply it to role differentiation in the family. In the traditional family the mother was seen as the 'expressive' leader and the father as the 'instrumental' leader. In effect, between them, they gave the child the emotional security needed and, also, emphasised progress. Whatever the complexity of role changes, Etzioni is affirming that family health requires both expressive and instrumental role playing for survival. This can be viewed as valid for all cultures, although the expressive and instrumental roles are maintained by a variety of family members, and are not necessarily sex-linked.

The interpretation and projection of data into family dynamics is believed by Etzioni to be very complex and ambiguous. He cautions that there are not really any neutral social scientists and places himself firmly on the side of those who are for the family and against its disintegration. His debate on recent theories about family dynamics and counter-arguments to them is produced in table form in figure 5.6. (p 101).

What is really at stake, Etzioni claims, is a definition of satisfaction and happiness. He identifies happiness as a joint enterprise. One can accept this as accordant with the generally accepted belief that human nature is a socially acquired and sustained entity. Etzioni also finds that about half of the healing profession, including nurses, have a tendency to communicate to clients that individual commitment to the family is the true entity and that the full happiness they are entitled to should

THEORY - FAMILY DYNAMICS	ETZIONI'S COUNTER-ARGUMENTS
<p>1. A first marriage is like a dry-run for a second... an equivalent to a high school diploma in comparison to a college diploma.. (Vestoff's conclusions on intervening 20 divorced couples who had remarried).</p> <p>Considered first choice made relatively on impulse and unwisely... generally with high hopes and ideals.</p> <p>Second choice more carefully made... more comfortable... included a process of reduction of expectations.</p>	<p>Only has one counterargument he states</p> <p>37% of first marriages ended in divorce BUT 59% of second marriages ended in divorce.</p> <p>Data based on National Random Samples not just on 20 couples.</p>
<p>2. No need to worry about disintegration of the nuclear family since we have a better alternative - the extended family... that is a network, for example, of siblings, aunts, uncles, grandparents... to discharge expressive and instrumental duties towards children. (Children are especially mentioned because largely agreed that most other functions of the family can be provided elsewhere).</p> <p><u>Main hypothesis</u> - to ask two people to care for children is to overload the relationship</p>	<p><u>Main counter-argument</u>... whatever the validity of the extended family it is not available to most (Americans) - or to other industrial societies.</p> <p>Due to high geographic mobility family members are commonly widely scattered.</p> <p>In answer to suggestion that one should constitute artificial 'extended' families states his 20 years of sociology tell him it is impossible.</p> <p>Baby-sitting arrangements, friendship networks - yes - but an 'extended' family-to-order is somebody's dream or nightmare - not a sociological reality.</p>
<p>3. The traditional family should be a contractual arrangement. At its origin it is argued, the average life expectancy was between 23-27 years. A marriage could last about 8 years and survive.</p> <p><u>Main hypothesis</u> - biological changes have made the old social institution obsolete. Contract offered as a social invention to deal with the problem. For example, simple five year leases with 5 year renewal options. The extended family is necessary only until children 'come of age' - whenever that may be.</p>	<p><u>Only one counter-argument</u> - the essence of a family is not by its nature subject to contractual arrangements. A contract is a rational, utilitarian, calculative arrangement in which one defines the parameters of self-interest.</p> <p>BUT a family relationship, whatever its length, is an emotional, normative, human, affectionate relationship, not possibly subject to contractual conditions.</p> <p>One CANNOT, says Etzioni, say 'You love me on Monday and I will love you on Tuesday... If I get sick will you serve me tea at least 3 times?'</p>

Figure 5.6. Etzioni's Counter-Arguments To Alternatives to the Traditional Family

(Abridgement in Table form. Iglar, M. 1980)

be sought. He believes this to be incompatible with marriage, however, which, by definition, involves some deep confession to each other in order to generate something more than the sum of the two of them.

The calculation of each activity in order to maximize individual happiness is seen as self-destructive. Ultimately, he affirms, the issue is related not just to the nuclear family but to the whole psychological, sociological fabric of sociability. Irrespective of philosophic views, and without being an ascetic, Etzioni comments the consequences of the 'celebration of the self' can be seen in society. It will commence by completing the disintegration of the family and proceed to end by destroying civilization.

'Civilization' obviously means something different to Boulding (1965) who states that he welcomes post-civilization and has little affection for civilization. But an analysis of his paper on 'After Civilization What?' indicates that the family is still an integral part of the society he envisions, which, for survival, has to develop an almost new form of learning in order to cope with learning in rapidly changing systems.

Begg (1976) names a number of factors in the human environment, specifically of New Zealand society, which are potentially disturbing to family wellbeing. The factors named include:

- changing social attitudes, urban drift, new housing areas,
- immigration, industrialization, the motor car,
- confrontation and violence, and limited resources in the face of limitless demands.

Changing Social Attitudes

The family has probably never been quite the ideal entity it is sometimes portrayed to be and its characteristics vary with the culture.

But in one form or another it has been the basic social unit which socializes the young into their society. Children need adults who are attached to them because they have a profound sense of commitment and love (Kenniston, 1977), and not simply from some contractual arrangement which Etzioni (1970) finds quite impossible.

Changes that Begg (1976) considers affect cohesive family life and the health of children include attitudes towards the durability of marriage, the importance of children and family size, earlier marriages, solo mothers, de facto marriages, and the desirability of both parents, or solo parent, working away from home. In a report on nursing (WHO, 1966), it is pointed out that over half of married women already work, and, in some instances, have already done so for many years. Nevertheless, in a number of cultures where women traditionally work, children grow up in extended families with a number of significant adults who exercise a parental role. Moreover, in rural communities the infant has a secure niche on the mother's back as she works and is breast fed on demand.

Clulow (1979) states that in a period of uncertainty and social change it is difficult to know what is fundamental to the wellbeing of individuals and their society. But, central to Begg's concern about the desirability of the mother working, must be associated the alternatives available in a society to provide children with a sustaining, caring substitute. Kenniston (1977) urges that while parental responsibility can, and should be, expected by a society, external barriers such as unemployment or insufficient single wages, must be removed so that parents are in a position to exercise their responsibility. Additionally, families require access to all necessary resources.

The 'myth' of the self-sufficient family is also challenged: by Kenniston (1977). He believes one cannot hope to solve problems by bringing about changes in the parents alone. For parents are also

affected by broad social and economic forces over which they have little control. As societies become more complex family functions alter, and coping abilities become strained. The family role has shrunk as changing social conditions, due to industrial and technological developments, has taken work out of the home. Further, it has not only removed it from the home, but it moves it, increasingly, into urban areas. The family has become smaller and more mobile as a society becomes more industrial.

Changing social attitudes occur due to various group and social pressures. It would be hard to determine what level of individual choice is present in some of the changes that occur to the family and the network of relationships to which it belongs. Kenniston (1977) describes parents as the 'weakened executive'. Their role is seen to be one of choosing, meeting, talking with, and coordinating the experts, the technology, and the institutions that help to bring up their children. It is a crucial role, he believes, for they are usually the world's experts on the needs and reactions of their own particular children.

Baly (1973) also refers to changing social attitudes that have developed as families have become more mobile, and more subject to changes of occupation, as job choices alter with new industrial and technological trends. Family responsibilities fall on a smaller group causing more strain, and the unstable cost of living makes the family budget more difficult to manage. Smaller homes, more married women working, the disappearance of 'maiden aunts', and changes in longevity have made it more difficult for the family to care for elderly relatives.

The adolescent member of the family tends to be a marked focus of concern in most societies today. They are influenced earlier, and more often, by outside adults, the peer group, the mass media, and they spend more time out of home. (Daniels & Smith, 1979; Reinhardt & Quinn, 1973). Some of the hostility and rebellion is most likely due to reduced

employment opportunities, and to a feeling of powerlessness as adolescence is prolonged (Goodman, 1965; Vellekoop, 1969). Smith (1979) finds them a very vulnerable group and refers to their identification by Morton (1969), as the main 'at risk' group because of ignorance of the most basic knowledge and common behaviour habits essential to healthy living. He also refers to an analysis of their behaviour a decade later and concludes that they do not appear to be any wiser.

A marked change in social attitudes is shown by the earlier age at which the majority of the young leave the parental home and set up homes with their peer groups. This causes a number of problems for families. Folta & Deck (1966) state that it is not uncommon for the mother to suffer from some form of psychosomatic illness or depression as a result. They also refer to the increasing prevalence of both sexually transmitted disease and teenage pregnancies. Alcoholism and drugs are also problems that affect youth who adopt the values of their peers and adult role models (Smith, 1979).

Urban Drift

Urban drift is a factor which deprives the family of support from kin and established networks of friends and other primary groups. It also creates service difficulties due to what Seymour (1977) calls a 'minority geographically isolated' in small centres and rural areas, and a 'majority geographically mobile'. Hill (1965) identifies long-term trends due to urbanisation such as changed ways of making a living, decreased self-sufficiency of families, smaller households, increased mobility of families, and changed authority patterns.

Many activities, once centred in the home, are seen to have moved to external sources. For example, the production of food, the

making of clothes, and recreational choices are given as instances of this occurrence. But, it is noted, when conditions become generally difficult for a society - as in a time of recession - and the family is exhorted to be more self-reliant the coping strategies required to deal with change are often lacking. And 'urban drift' makes it that much more difficult when the larger family or established networks of friends and other primary groups are not there to help out.

New Housing Areas

The separation of work and residential locations is one of the components of isolation and psychological stress in 'instant' suburbs and new towns. Aggregations of young families are found to experience feelings of loneliness and isolation. Family problems are, therefore, intensified because a strong, comforting network of family and/or friends is lacking. Begg (1976) notes that families are aware of the need for support and help, and cites the young Porirua parents' pleas for assistance (Salmond, 1975), as an instance of this felt need. A later Porirua health care survey (1976) confirms the earlier findings. It reports a striking amount of mental stress and need for support, company, and practical and economic help, largely due to isolation and transport problems. In summarizing the findings of a research study on 'Health Awareness and Health Actions of Parents' Pybus & Thomson (1979) also refer to parents' awareness of threats to family health.

The avoidance of feelings of distress and frustration are dependent on the degree of participation and personal effectiveness people experience in their personal and overall environment. But in new housing areas it is apparent that parents, and citizens in general, often feel that important changes are beyond their control. This tends to generate apathy, alienation, protest, or violence (Kennedy, 1979).

Ritchie & Ritchie (1973) consider that the real issue involved in isolation is the sense of loneliness, of insecurity and no support that is experienced.

In the new housing areas many important support services for the family are lacking or rudimentary. Levin et al. (1977) direct attention to Pratt's warning that although popular sociological theory suggests that many previous social functions of the family have been eliminated it does not take account of the increasing number of chronically ill being cared for by the family. If there is a child with special needs, or an adult with a chronic, long-term illness such as multiple sclerosis, rheumatoid arthritis or diabetes, the problems of isolation, loneliness and inadequacy are potentially severe problems for the family to manage.

Immigration

The immigrant family is a very diverse entity and may choose to immigrate for reasons of: occupation; or dissatisfaction with life opportunities and a desire for change; in response to immigration policies; or with the encouragement of other family members. A continuing reason throughout history has been for physical, social, and economic survival.

In the last 20 years or so there has been a massive inflow of immigrants into many countries due to repressive policies in their own societies. Almost half a million immigrants entered Britain in the decade prior to 1976 from countries such as Uganda and Pakistan (Smith, 1979). Recent immigrant families include refugees from Vietnam, Kampuchea and Cuba, and a certain number of such families have come to New Zealand on a controlled scale.

There are particular problems for immigrant families whatever reason may have prompted them to immigrate. Unfamiliar socio-cultural environments and possible language barriers require considerable adaptat-

ion. But even for those from similar cultures there can be subtle differences which affect adaptation to a new environment. For the young psychosocial stress can occur as they try to cope with the demands of two cultures. Smith (1979) instances the intergenerational conflict developing as young Asian women challenge traditional beliefs about their place in the family.

Socio-health problems that immigrant families are particularly vulnerable to, include:- overcrowding, conflict, alienation and increasing violence; tuberculosis, sexually transmitted diseases, and alcoholism. These are perhaps the most 'visible' problems associated with socio-economic factors; misery and deprivation, experienced when removed from known and familiar supports, can affect interrelationships and interactions with the environment in many ways.

Nurses must appreciate that they function in a multiracial society and require knowledge and understanding of the religious, cultural and social influences that bear on 'new citizens'. Attitudes to 'overcrowding', for example, must be related to the cultural context and to additional factors which can cause it to be a problem (Cassel, 1979).

Industrialization

Massive pollution resulting from industrial and technological developments is a hazard to families in the land, water, and air that surround them, particularly in the sprawling urban conglomerates of today (Kennedy, 1979). And Walsh (1978) puts the public health hazards associated with industry into four main categories:

- physical; noise, heat, vibration and radiation.
- chemical; dust, fumes, gases, toxic metals and chemicals, and carcinogens which can affect the whole area.
- biological; bacteria, fungi, and insects.

- stress; physical, chemical, ergonomic factors, and occupational strains.

Baly (1973) notes that the search for affluence on a rapid and large scale has brought with it the 'age of effluence'. While Cole (1971) stresses that the development of nuclear energy and petrochemicals has increased the possibility of environmental contamination on an immense - if not global - scale.

The very marked impact that technological innovations can have on the family, and their 'ripple effect' is emphasised by Kenniston (1977). For example, he points out that television now occupies more waking hours of (American) children's lives than either their parents or schools. Kenniston admits that the results can be beneficial, but points out that a growing number of research studies show a connection between violent programming and aggressive behaviour.

Moreover, according to the commercials, if there is a problem, there is a solution to be bought. Kenniston's concern about the adverse effects of television are shared by Daniels & Smith (1979) who write that it has been implicated in causing or accentuating various problems. They quote from Stubblefield (1977) to pose the question - 'How would you like a stranger to babysit for your children?' - to emphasise the part that television can play in the home.

Motor Cars

Begg names the motor car as one of the factors causing special problems for families which may result in death or disability or social disorder. And McGhee (1969) complains that private motor cars clog the transport arteries of the city. Many hold ambivalent attitudes towards the motor car finding it both beneficial and deadly. Figures supplied

by the NZDH, Public Health Report, 1979 show that 36% of deaths from accidents to 1 - 4 year olds involved motor cars; it is the major cause of death among young adults; and the fourth main killer overall.

Illich (1975) supplies some interesting points about the motor car whilst discussing factors which have a marked impact on social structures, freedom and health. As opposed to increasing autonomy, locomotion, beyond a certain level, affects society when more time is spent on it. For example, Illich notes, 25 to 50% of the total waking time of people in developed countries is spent in driving cars, sitting in cars, going to traffic courts, going to jail, to hospitals, and to jobs to earn money to pay for the transportation. 42% of the energy used in the US goes into making cars or building roads or operating them.

It has already been noted that isolation is a problem for families in new housing areas because of loneliness, lack of support, and difficulties with transport. Economically and socially the poor are most disadvantaged by the motor car. Public transport services decrease as private transport makes them a liability to maintain. Families in poor circumstances become, therefore, more dependent and have very few choices about where they can go.

Confrontation and Violence

The actions of militants adversely affect the environment for all. Begg (1976) stresses that urban attacks, hijacking, the taking of hostages, even wild cat strikes, new group aggressiveness, extreme prejudice and profound selfishness (what Etzioni calls the 'celebration of the self') creates an environment detrimental to the family and society. Interpersonal conflict in the family and neighbourhood leaves a long-lasting mark on children especially in the early years.

Limited Resources

Resources in both developed and developing countries are not equal to a limitless demand for social and health services. New, sophisticated and expensive treatment for the severely ill, inflation, economic recession, and changing priorities cause some rationing of services. But Begg (1976) is emphatic that the less overt preventive health measures must be given the priority needed even if they are less obvious, politically compelling, or of less immediacy.

Available Resources

Parents are regarded as key figures in the development of children, although the emphasis in this century has been to build public services for the provision of health, educational, and social services (Begg, 1976: Kenniston, 1977: Young, 1979: Levin et al., 1977). The essential and primary contribution of parents is often forgotten Begg comments, and he refers to a recent plea from Mead that some of the functions of the family be restored to them.

"The welfare state tends to make people helpless... and dependent on social services. And then we professionalise those services ... and the individual (becomes) dependent on the impersonal organised services instead of the human relationships we've had in the past .. We should construct the types of communities where the services that now have to be given by the state can be given by people to each other".

(Mead quoted by Begg, 1976)

But if parents, or significant adults who carry out parental roles, are to have certain family functions restored to them, then the existence or development of supportive resources must be considered. Begg (1976) details some of the resources provided, or being developed, by the Plunket Society, through the facilities and aims of Health Centres, Extramural Hospitals, and the contributions of different members of the

health team.

Adaptation by the Plunket Society to changing social and family needs is shown in the development of Family Support Services, and in the preparation of new educational programmes for Plunket and Karitane nurses.

Parent education to increase and strengthen their capacity to act on behalf of the family as both health advocates and health caretakers (Kenniston, 1977) is of great importance. Begg (1976) points out that from the inception of the Plunket Society mobilization and motivation of parents to improve the health of children has been emphasised. He also states that Truby used the social instrument of participation in getting people to take action in their own families and communities.

The resources now needed by families require an increasing coordination of the services provided by society, and the family care approach being adopted by nursing and allied health and social workers is recognition of this need. The complexity of modern society and the 'knowledge explosion' has resulted in an ever-expanding team of people who care for the wellbeing of the family. If fragmentation and impersonalization of care is to be avoided in the resources made available to the family then the health team must really work together and not just function as individuals carrying out a specific role.

At least a part of their educational preparation should be shared, and, as is the case in health centres, consultation and collaboration should be the essence of team work. Woolley et al. (1974) urge that team members should focus all their activities on identification and solution of the client's problems. They list three key points to further this objective.

1. The provision of integrative care and avoidance of the overuse of the autonomy concept in nursing practice.
2. Clear display of data as a basis for synthesis of the patient's problems so that logic used in determining problems can be followed by others.
3. Auditing of records to assess the outcomes and benefits of this approach.

If the resources in the family are to be strengthened then the resources made available to them must be enabling and supportive, but not supplant them. Young (1979) stresses the importance of obtaining a 'family profile' but also quotes Geyman & Carmichael (1976) who stated 'that caring for the patient in the context of the family.. is by no means the same as turning the family into the object of care'.

Instruction in self-care is necessary, particularly because of the formidable amount of illnesses due to or associated with social behaviour. Many people have concluded that the costly efforts of the health professions can meet only a small part of the total health care needs of society (Mahler, 1977: Katz, 1977: Brockington, 1975). The family, Brockington writes, is the first defence in caring for sickness and in welfare. Education and sharing of knowledge is an important resource that the professional must make available to the family.

Figure 5.3. (p 86) shows that information-sharing is thought to be an important part of nursing's role at a time of crisis. And, one can add, at any time when the family, and its members, require help with self-care. Mahler (1977) is most emphatic that the mystique of professional knowledge must be removed if socio-health needs are to be met and the WHO target of 'Health for all by the year 2000' is to be approached.

Nursing in Relation to the Contemporary Family Profile

Since nursing is increasingly oriented towards a holistic, person-centred approach, which emphasises that optimal outcomes can only be obtained within the total environment of the patient, family participation is essential when planning health measures and family care.

Application of the three components of TNM (triadic nursing model) to the basic social unit of society, the family, can be stated briefly to involve:

- (1) the fulfilling of nursing's social purpose by helping with the recovery or enhancement of family wellbeing and the alleviation of ill health in the family;
- (2) the fulfilling of this purpose requires:
 - (i) establishing of central or dominant factors in the family situation including knowledge and understanding of the socio-cultural orientation of the family, health habits and coping abilities, and interpersonal relationships within the family and with the community;
 - (ii) commitment to the value of freeing the family from disabilities by providing information and understanding of the ways through which they can establish enabling patterns of health behaviour;
 - and (iii) acting as a consultant and coordinator until the family has adequate resources of knowledge, and economic means, and freeing them from dependence as soon as this goal is achieved; and
- (3) finally, the integrative process, operating as an evaluative, problem-solving process, is the means by which the characteristics of the family and the central or dominant issues of concern to the family can be identified and optimal solutions obtained.

Figure 5.7. (p115) demonstrates some key points of concern for

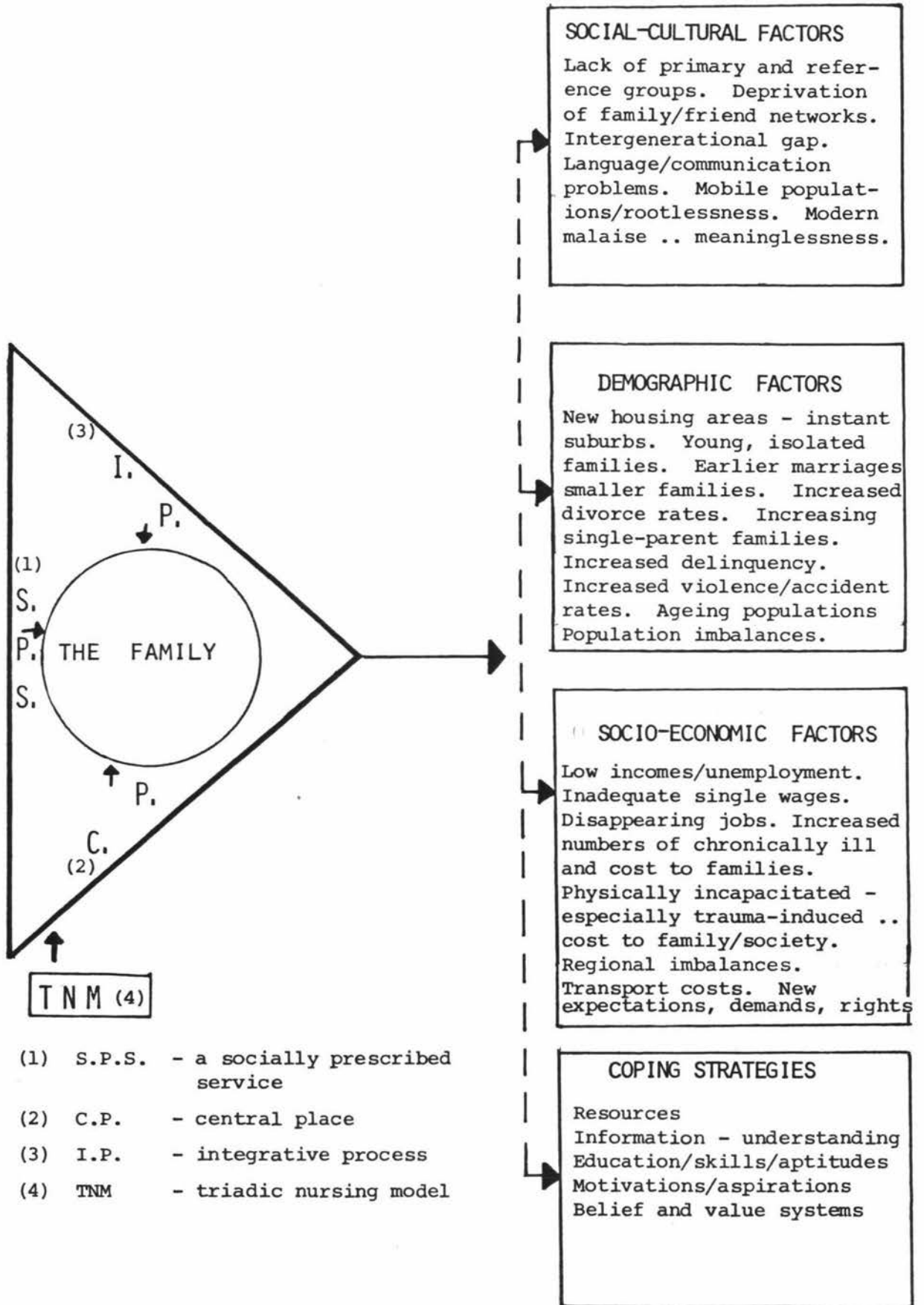


Figure 5.7. Factors and Problem Points in Contemporary Family Profile

a family in relation to the contemporary social realities of an industrial, or post-industrial society.

SECTION 3

SOCIAL REALITIES - CHANGING PATTERNS OF ILL-HEALTH

Altered disease patterns, apparent in most societies, are closely linked to socio-economic considerations and to a society's stage of development (Brockington, 1975; Omram, 1974; Abel-Smith, 1976; Miller, 1972; Baly, 1973; Dreitzel, 1971; Smith, 1979; Wood, 1979; Hinkle & Loring, 1979). Brockington points out that development affects both health and disease to the advantage and disadvantage of a society. Social and technological changes are seen to affect the total environment of people: the machines they make, the chemicals they produce, the homes they live in, the organisation of social life - urban or rural -, and the lifestyles they adopt affect their wellbeing.

The Theory of Epidemiologic Transition

The changes that occur in health and disease as a country develops are portrayed very clearly by Omram (1974) within a theory of 'epidemiologic transition'. He identifies three distinct phases: the Age of Pestilence and Famine, the Age of Receding Pandemics, and the Age of Degenerative and Man-Made Diseases. Omram also identifies three models of the 'epidemiologic transition' process: the classical (Western) model, the accelerated (Japanese) model, and the delayed (developing societies) model.

Figure 5.9* is a condensation of four tables prepared by Omram to show some of the changes that occur in health and disease during the three phases of transition. The tables provide profiles of population, socio-economic, mortality and disease, and community health changes in

* P. 116 a

each phase of the classical (Western) model of the 'epidemiologic transition'.

In the mortality and disease profile changes are identified in selected diseases only. Omram reports that tuberculosis is low but persists in slums, especially in older, disadvantaged individuals, and more so in males. Smallpox is rare and now more a disease in adults. Heart disease is high with a very low rheumatic to arteriosclerotic ratio; starvation is rare; pellagra disappears; and rickets lessens.

In leading community health problems Omram notes that morbidity problems now supersede mortality as an index of health. This is probably related to changes in the population profile, and an increasing life expectancy in developed societies. Degenerative, man-made and chronic disease problems such as atheroma, chronic bronchitis, high blood pressure, mental illness, drug dependency, and pollution increase in this phase. As many occupational hazards are controlled new electrical, chemical, and radiation hazards develop. Transport accidents increase; the cost of medical care becomes a serious problem (Widgery, 1979); maternal and child problems become controlled, but geriatric problems become more severe (Howell, 1979; Young, 1979).

A number of other studies support and add to Omram's analysis of the 'epidemiologic transition'. For instance, Wadsworth et al. (1971) also refer to the ageing trend, but mention the less well known change in the balance between the young and middle aged. Although the 0 - 19 group is larger than the 20 - 30 group it is still not as large as the 40 - 59 group. Reference is also made to the 'onion principle' described by Morris (1967).

The Onion Principle

Morris points out that as infectious diseases and mortality

AGE OF TRANSITION	POPULATION PROFILE OF THE CLASSICAL (WESTERN) MODEL OF THE EPIDEMIOLOGIC TRANSITION	SOCIAL AND ECONOMIC PROFILE OF THE CLASSICAL (WESTERN) MODEL OF THE EPIDEMIOLOGIC TRANSITION	MORTALITY AND DISEASE PROFILE OF THE CLASSICAL (WESTERN) MODEL OF THE EPIDEMIOLOGIC TRANSITION	COMMUNITY HEALTH PROFILE OF THE CLASSICAL (WESTERN) MODEL OF THE EPIDEMIOLOGIC TRANSITION
1 AGE OF PESTILENCE AND FAMINE Pre- and early modern (pre-industrial) society, that is, up to about the middle of the 18TH. Century	POPULATION GROWTH Cyclic until about 1650 with minute net increments Mortality - crude death rates of from 30-50 per 1000 population - with frequent higher peaks Fertility - a high level of 40 or more per 1000 POPULATION COMPOSITION ... predominantly young ... very large young and very small old dependency ratios... slight excess of males Residence - mainly rural... a few crowded, unsanitary, war-torn epidemic ridden cities of small to medium size	SOCIETY ... is traditional... has a fatalistic orientation sustained by rigid, hierarchical sociopolitical structures. FAMILY & WOMEN Clan/extended family structures... large families... multiple-generation households... life is home-centered... women cast in mother role... little rights or responsibilities outside the home LIVING STANDARDS Low standards... public and private sanitary conditions very poor... comforts and luxuries limited to a few NUTRITION Poor quality food for masses... chronic and occasionally acute shortages. Children and women in fertile years most badly affected ECONOMIC PROFILE Subsistence economies characterize mainly agrarian societies dependent on manual labour intensive production methods. Occasional successes... low incentives & cosmic catastrophes	MORTALITY PATTERN Life expectancy around 20... child mortality high... a third of all deaths from 0 to 5... 200 to 300 deaths per 1000... Proportionate mortality for 50+, low because of low life expectancy Females in adolescent and productive years have higher risk of dying than males. Urban rate somewhat higher than rural rate LEADING CAUSES OF DEATH Epidemics of plague, smallpox, cholera & typhus... endemic parasitic and deficiency diseases... the pneumonia diarrhoea malnutrition complex in children, and the tuberculosis-puerperal malnutrition complex in females. Famines occur... severe malnutrition underlies deaths from other causes CHANGING EPIDEMIOLOGY OF SELECTED DISEASES Tuberculosis more virulent in young females Smallpox typically a childhood disease Heart disease ratio low with high rheumatic to arteriosclerotic ratio. Deficiency diseases typical and highly prevalent	LEADING COMMUNITY HEALTH PROBLEMS & PROGRAMMES 1. Frequent devastating epidemics and famines in some areas 2. Endemic infections and parasitic diseases are prevalent 3. Chronic malnutrition & manifest deficiency diseases are common 4. Severe maternal and child health problems 5. Appalling environmental problems... contaminated water supplies, sanitation problems, insects and rodents common sources of infection, poor food and housing hygiene 6. Urban and rural health problems are prevalent 7. Accidents occur mostly in the home HEALTH SYSTEMS & SERVICES 1. Only indigenous systems exist... witchcraft and poor practices most prevalent 2. No decisive therapies are available 3. Immunization not available 4. No environmental sanitation 5. Only effective control for epidemics are isolation and quarantine
2 AGE OF RECEDING PANDEMICS Latter half of 18TH. and almost all of 19TH. Century	POPULATION GROWTH Mortality still high (30-50 per 1000) - peaks less frequently... begins to decline to about 30 per 1000 Fertility remains high (40+ per 1000) Several decades after mortality declines fertility begins to decline Population growth explosive for most of this period POPULATION COMPOSITION Population still young but proportion of older people increases Male/female figure near unity but improved female survival tends towards excess of females Residence... still primarily rural with progressive move from farm to factory Selective migration to new colonies... alters age-sex composition	SOCIETY Traditional outlook persists in lower classes... upper/emerging middle classes of business men adopt faith in reason... rising expectations touches nearly all segments of society FAMILY & WOMEN Extended large-size families still prevail-but nuclear families become more common in urban areas Maternal role begins to allow a little activity outside the home LIVING STANDARDS ... still quite low... hygiene and sanitation gradually improve except in city slums which grow worse NUTRITION Early improvements in agriculture and crop rotation gradually improve food supplies, but women and children still at a disadvantage ECONOMIC PROFILE Pre-conditions for economic "take-off" appear. Better agriculture and land use... modest development of transport-communication networks encourage industrialization... textiles/lumber production emerges	MORTALITY PATTERN Considerable change in level and pattern with recession of pandemics. Life expectancy increases to 30 to 40+. Improved mortality in children under 15 and women in fertility years Infant rates drop below 150 per 1000-births, and neonatal to post-natal ratio increases progressively Proportionate mortality of 50+ ages increases to near 50% LEADING CAUSES OF DEATH Some epidemic diseases start to recede but leading causes of death and disease are endemic, parasitic and deficiency, epidemic scourges, and childhood, maternal complex etc. Successive cholera epidemics affect Europe before disappearing. Industrial & non-infectious diseases increase. Under-nutrition still a problem but less so CHANGING EPIDEMIOLOGY OF SELECTED DISEASES Tuberculosis mortality peaks with industrialization... still more virulent in young females. Smallpox less in children & more in due to vaccination. Heart disease increases... increases in rheumatic to arteriosclerotic ratio. Starvation deaths become rare. Deficiency diseases such as scurvy start to disappear	LEADING COMMUNITY HEALTH PROBLEMS & PROGRAMMES 1. Epidemics and famines still major problems but progressively decline 2. Similar decline in endemic infection and parasitism 3. Occupational health problems arise in industrializing areas 4. Maternal & child health still a problem, especially early in this period 5. Sanitary environmental hazards start to decline towards end of period 6. Urban health problems increase due to migration and crowding under insanitary conditions. With better sanitation urban areas begin to improve 7. Accidents occur in both home and factory HEALTH SYSTEMS & SERVICES 1. Improved nutrition & living standards lead to recession of epidemics and famine 2. Sanitary advances accelerate recession of epidemics, better removal procedures common. Personal hygiene improves 3. More stringent isolation and quarantine measures 4. Medical advances... antiseptics, smallpox vaccination 5. Organised health services started in some countries and progress in quality and quantity occurs
3 AGE OF DEGENERATIVE AND MAN-MADE DISEASE The 20TH. Century... the Modern Epoch	POPULATION GROWTH Mortality declines rapidly to below 20 per 1000 then rate slows Fertility declines to below 20 per 1000 with occasional rises (e.g. post world war 2 baby boom) and becomes chief pace-maker of population Growth fluctuation more by design than by chance. Small but persistent population growth POPULATION COMPOSITION Progressive ageing of population as fertility declines. More people, especially females, survive to middle and old age Male/female ratio continues to decrease High and increasing old dependency ratios... especially for women Urbanisation increases... excessive growth of cities (megalopolitanism)... alarming formation of slums... environmental pollution... unwieldy social and political problems	SOCIETY Rational-purposeful lifestyles prevail; bureaucracy and depersonalization foster anomie groups FAMILY & WOMEN Nuclear families and small family size become norm. Women become increasingly emancipated... better educated and career-oriented LIVING STANDARDS Progressive rises in living conditions enjoyed by large segments of population NUTRITION Becomes increasingly recognised as a vital need, especially that of children and mothers. But tendency to over-nutrition and consumption of rich and high fat foods ECONOMIC PROFILE Spiralling growth initially with scientific and applied technology in economic activities. Stage of high mass consumption... in production growth shift from producer to consumer goods and services... public welfare... leisure spending	MORTALITY PATTERNS Life expectancy rises to 70+... about 3 or more years higher for women than men. Risks for females of all ages decreases. Maternal mortality declines to a minimum Age profile shows reduction in childhood mortality - less than 10% of all deaths. Deaths at 50+ increase to 70% or more of total. Infant mortality less than 25 per 1000. Ratio of neonatal to post-natal deaths is large and increasing LEADING CAUSES OF DEATH Prime killers become heart diseases, cancer, and strokes. Pneumonia, bronchitis, influenza and some viral diseases remain problems. Polio rises and then tapers off. Scarlet fever begins to disappear CHANGING EPIDEMIOLOGY OF SELECTED DISEASES Tuberculosis is low but persists in slums... especially in older, disadvantaged individuals, male more so Smallpox is rare and now more a disease of adults Heart disease is high with a very low rheumatic to arteriosclerotic ratio Starvation rare; pellagra disappears; rickets drops off	LEADING COMMUNITY HEALTH PROBLEMS & PROGRAMMES 1. Morbidity problems supersede mortality as an index of health Degenerative, man-made and chronic diseases e.g. mental illness, drug addiction, radiation and pollution hazards increase 2. Endemic infection and parasitism almost disappear except in certain disadvantaged groups 3. Maternal & child health problems controlled but geriatric problems become more severe 4. Humanitarian worker legislation controls many occupational hazards but new products and methods create new dangers, e.g. electrical, chemical, & radiation hazards 5. Environmental sanitation problems ease, but urban and industrial pollution grows 6. Cost of medical care a serious problem 7. Traffic and transportation - accidents common HEALTH SYSTEMS & SERVICES 1. Modern national health care systems formed with comprehensive, integrated curative and preventive and research measures 2. Special categories developed, maternal & child care, TB, venereal disease control 3. Rigorous sanitary measures more widespread 4. Case-finding and mass screening more widespread 5. Insecticides, chemotherapy and antibiotics increase 6. Health systems and manpower developed and used by enlightened and more demanding societies

Figure 5.8. Changing Patterns of Health & Disease As Shown in Omram's (1974) 3 Phases of 'Epidemiologic Transition'

(Abridgement of 4 tables - Idowu, 1970)

rates decline other diseases become more visible. Physical ills lessen but widespread emotional impoverishment and social incompetence become more obvious. As acute illness, such as lobar pneumonia and mastoiditis, lessens the stresses of affluence increase, for example, alcoholism, anxiety, mental disorders, obesity, bronchitis, and diabetes.

Wadsworth et al. (1971) also warn that although the incidence of disease and the demand for care has increased, it must be related to early detection measures which, in some conditions, show a much greater reservoir of unrecognized ill health than is brought to medical attention. For instance, it is reported that for every 8 persons presenting with diabetes in one year a further 69 will have 'latent diabetes'; and for 5 presenting with ischaemic heart disease a further 15 may be detected on survey.

In addition, emphasis is given to a main lesson of ecology and of social science about the interrelatedness of factors causing ill health. Figure 5.9. is a diagram prepared by Morris (1967) to illustrate the multiple causation to be found in disease.

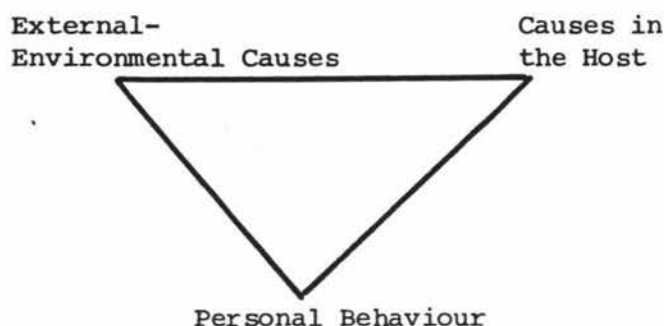


Figure 5.9. The major elements in the causation of disease. (Morris, 1967)

Recognition of the importance of the total life style is a prominent feature of the present analysis of the changing patterns of health and disease. The influence of changing concepts of health and

illness is discussed, among others, by Mechanic, 1968; Dubos, 1960; Parsons, 1965; and in the Ciba studies of 1967, 1971, and 1975. In general, all agree with Morrish (1967), that 'needs have to be felt as such, perceived; then expressed in demand'.

Chronic Illness - the Main Challenge of the 20TH Century

Strauss & Glaser (1975) regard chronic illness as the challenge of - to use Omram's term - the Age of Degenerative and Man-Made Disease. But the debilitating and socio-economic effects of the chronic diarrhoeal, insect-borne, and parasitic diseases that occur in the earlier phases of the 'epidemiologic transition' must also be seen as an equally difficult challenge. The ramifications of chronic illness and its effects on the family and society are of particular concern to Strauss & Glaser (1975).

They emphasise the socio-psychological aspects of living with a chronic illness, and single out for attention rheumatoid arthritis, childhood diabetes, ulcerative colitis, getting around with emphysema, chronic renal failure and the problem of funding. Stress, associated with lessened social contact and considerable social isolation, is perceived to be especially harmful.

A thorough coverage of all factors related to a society's wellbeing is provided by the Ciba studies. The 1967 study 'Health of Mankind' takes a broad look at issues concerning present health; major factors aggravating world health problems; and at manpower and education. Le Riche (1967) for instance, warns that in an ever-changing world each era suffers due to failure to adapt to the new environment.

But this warning has to be heeded along with one given by Illich (1975) who insists that 'health is a process of adaptation' but also, that it must result from individual or group coping and not as a

result of management or engineering. Illich calls upon the support of Dubos and quotes him as saying 'that nothing is more dangerous than man's ability to adapt and now, to be adapted, and in his capacity to survive, with increasingly more commodities, on unspeakably low levels of health, on which he is maintained'.

Le Riche (1967) also notes that the most persistent of infectious diseases are largely respiratory - coryza, influenza, pneumonia, and bronchitis - and diarrhoeal diseases. Various parasitic and insect-borne disease such as malaria also remain problems.

Wolman (1967) writing about pollution of water, air, and food points out that when a community is provided with clean and adequate water, diseases, including non-water-borne diseases, fall markedly. In another paper De Haas (1967) identifies cardiovascular diseases and neoplasms as the major killing diseases in technologically developed regions, accounting for two-thirds of total mortality in both sexes in Western societies, and for 50% in Japan. At the same time, De Haas notes that global epidemiology shows that about the same number die from malaria and tuberculosis. Nearly half of the total deaths in the world (60 million) per annum relate to newborn, infants, and toddlers in Asia, Africa, and Latin America. Further, for young adults and children, especially males, accidents, mainly traffic accidents, account for a similar percentage as cardiovascular diseases and neoplasms do in middle age and old age.

Lambo (1967) reports on the impact of mental and behavioural disorders which he considers to be of critical proportions. Mahler (1977) endorses this belief stating that it has been calculated that two-fifths of all serious disability results from mental disorders, and that at any one time there are more than 40 million people in the world suffering from several functional mental illnesses. Twice as many again

are seriously disabled by drug dependency, alcohol-related problems, mental retardation and organic brain disorders.

The Inhuman City - a major problem of modern urban society

One of the highlights of the Ciba (1967) study is the contribution from Doxiadis on the 'inhuman city'. Doxiadis believes the main problem for health is the 'inhuman city', causing most of its inhabitants to suffer with nervous disorders. Man is seen to be less free to move; he may have gained large dimensions by high speed but is less able to move in the micro-space around him, his children cannot move freely, and many phobias and nervous disorders are probably due to this factor. The inhuman city is not just a place of high density and slums. Doxiadis points out that population density is actually less, but large building complexes separate people and add distance to services; new housing settlements deprive people of family and friends, increase travel and costs, reduce free time and depersonalize.

Nevertheless, Doxiadis considers it impossible for the present-day city, the large contemporary urban human settlements to be eliminated or prevented from expanding. The real challenge is seen to be the creation of human conditions within the inhuman frame of the city. This involves conception of man as sense, mind and soul, as well as of body; and a recognition of the interrelatedness of problems. Otherwise the city will lead to catastrophe - some would say it has already begun - if present trends continue. Doxiadis quotes from Dubos to support his belief '.... eventually half the population would have to be doctors, nurses, or psychiatrists tending to the physical ailments and neuroses of the other half'.

In the latest Ciba study 'Health and Industrial Growth' (1975) Mars presents a valuable perspective on the anthropology of health problems

in developing countries. He is insistent that '... you do not tell people what they want to do but what they need to know'. And Kissick (1975) comments that he now regards 'health' and 'industrial growth' as relative and not absolute concepts. The WHO notwithstanding health alone is not enough, Kissick believes, and there has to be a purpose beyond it for which man can use his health.

It is not possible to do justice to the many other studies which depict health and disease changes. But in brief, one can refer to Kenniston (1977) and his citing of the most pressing child health problems being behavioural and mental health problems, teen-age pregnancy, and child abuse. And to Smith (1979) who focuses on the health problems associated with demographic changes, smoking, alcohol, road accidents, dental decay, mental health and the sexual revolution.

As well, there is Mahler (1977) and his concern with the vicious circle of malnutrition, infection, and further malnutrition in diarrhoeal disease of infants and young children in developing countries. Brockington (1975) in a comprehensive study on 'World Health' provides valuable information, statistics, and discussion about trends in health and disease. And Widgery (1979) concerned particularly about the crisis in health care due to socio-economic restraints. He is emphatic that health and disease trends are aggravated by a system that closes hospitals, places more care to be given at home and in the community, but fails to ensure that the professional and other supports necessary to maintain care are available.

Then there is Abel-Smith (1976) occupied with a search for priorities in health services and noting that they are failing to come to grips with the major causes of ill-health. He believes these to lie deep in the fabric of societies and to include pollution of air, food, and water; over or under consumption of improperly balanced food or

drink; accidents due to natural environment or man-made structures; violence; disabilities which may be congenital, acquired, or due to natural deterioration, ageing or lifestyle and behaviour such as smoking; or climatic factors in the environment.

New Zealand studies dealing with some aspect of changing socio-health needs and disease patterns include those of Begg, 1976; Salmond, 1975; Porirua Health Care Survey, 1976; The Newtown Health Project, 1975-6-7; NZHD, 1979; NERF Manpower Report & Background Papers, 1978; NZCM, 1978; McLauchlan, 1976; Carr & Dodge, 1976; Beaven, 1974. In general, they are concerned with the need to adapt health services to the total context of New Zealand society's health requirements - psychosocial, economic, and biophysical.

Begg (1976) is insistent that an excess proportion of the health vote should not be spent on institutional health services and undue financial restraints imposed on preventive and promotional health measures. And McLauchlan (1976) draws attention to a reliable estimation that of all the ill health treated in New Zealand around 50% stems from emotional or mental problems. He quotes figures from the NSADD (National Society on Alcohol & Drug Dependence) that on an average night in 1971:

- more than 100,000 took a hypnotic or tranquillizer or both;
- and in 1972 106 million doses of tranquillizers at a cost of \$3 million were taken, and 52 million doses of antidepressants at a cost of \$1.5 million were consumed by New Zealanders;
- in 1974, 55 million doses of valium alone were taken, and the NSADD now puts the figure at 80 million doses of valium a year.

McLauchlan also quotes the NSADD President, Johnston as saying '... we live in a chemical society ... the New Zealander ... lives in a state of suspended emotion, ... grappling with trivia, scared at the prospect of commitment to others'.

The extent of voluntary and self-help groups formed in New Zealand belies the exaggeration of this comment, but the figures quoted above certainly indicate a marked degree of social incompetency and inability to cope with the stress which is a feature of this phase of the 'epidemiologic transition' process.

Characteristics of the Changing Patterns of Ill-Health

Current literature about contemporary social realities and their outcomes suggest an alarming increase in the extent of social disorders related to behavioural practices. For instance, deaths associated with alcohol have almost doubled in the 8 years from 1969 and rose by 12% from 1976 to 1977 (NZDH, 1979). Nearly one-third of male deaths were due to accidents, poisoning, and violence, and the most vulnerable age group for these deaths was 15 to 24 years. New cases of mental disorders have increased from 400 per annum prior to 1974 to 1200 since 1978 at one New Zealand hospital.

Bronfenbrunner (1975) has stated that the lifestyle of the next generation will be determined by the physical and natural environment due to its effect on the human, the family, and the child within the family. As already noted, changes affecting the family include:

- more working mothers, fewer adults in families, and more single parent families;
- most children living in single parent homes live alone with that parent of whom more than 70% work;
- the greatest incidence of problems occur in young working families, in new housing settlements, in the lowest income groups, and in immigrant families;
- separation from kin and/or significant others is viewed as damaging as poverty and overcrowding (Bronfenbrunner, 1975; Howell, 1979;

Cassel, 1979; Katz, 1971).

Cassel (1979) has drawn up a classification table of the psychological factors which are potentially related to the level of health (figure 5.10.) and recommends their use as a conceptual frame for measuring the relation of the urban environment to health.

LEVEL OF MEASUREMENT		
	SOCIAL - 'STRUCTURAL'	PERCEPTUAL
DELETERIOUS FACTORS	Indices of Social Disorganization.	Perceived Degree of Control over Environment with Special reference to Relations to Significant Social Groups
	Indices of Status or Role Discrepancy.	
	Degree to which Previous Experience had adequately prepared individual for Current Situation.	Degree to which Expectations of Significant other for Behaviour of Index Case are Conflicting or Ambiguous.
PROTECTIVE FACTORS	Indices of Strength of Affiliative Networks	Perception of Reliability of Others to help in Times of Trouble.

Figure 5.10. Psychological Factors Potentially Related to Health Status.

Cassel, J. (1979, P. 138)

Disorganisation of the family is the real issue of concern according to Bronfenbrunner (1975) for it causes confusion, instability, and particular difficulties for the socialization of the young into their culture, and the attainment of adult roles satisfying to the individual and the society. Auld (1979) also relates the family to the foremost problem of contemporary society - chronic illness.

Auld (1979) stresses the need to ask who is at home to deal with the chronically ill, and, as well, the deviant young, the children, and the frail elderly. Recent studies indicate that there is a marked divergence between the ideal of the nurturing family and the reality of

what is there. The family is there but it is far from intact. How to help the family to restore its integrity and to deal with disabling conditions is possibly the first priority for those living in the third phase of the epidemiologic transition. Katz (1971) comments that although the incidence of illness is largely a social problem the organisation of health and social services is a political one.

This viewpoint gains credence when one considers the responses to illness in different cultures (Skeet & Elliott, 1978; Abel-Smith, 1976; Schaeffer, 1974; Newell, 1975). For the provision of care is provided within a political system and according to the priorities of a society and its developmental phase.

Examination of present social disorders shows that they cut across the boundaries of the social institutions through which the society mediates its culture and ensures unity, survival, and order. For instance, a list of the most common disorders in developed societies can include escalating socio-medical conditions such as problems associated with ageing, chronic illness, mental disorders, drug abuse, alcohol, disorganisation of the family; or with those due to pollution or abuse of the physical environment. The nature of these disorders suggests that the solutions are in the orbit of the economist, the educationalist, the religious, the law, technocrat, and social and health professionals.

White and associates (1976) believe health services develop in ways which reflect social priorities since social values always accompany health values. Mahler (1977) makes a similar point when discussing inequalities in the provision of health throughout the world. While drawing attention to the different connotations social relevance has in different countries and regions Mahler stresses that no society can be complacent about its state of health; that medical affluence is not synonymous with a satisfactory health level, and that double standards

exist which link the malnourished ill of the developing world with the chronically ill and disabled of the most developed countries.

In other words, deprivation is not only due to socio-economic underdevelopment but also results from the inadequacy of society and a faulty set of values and priorities. Mahler (1977) finds it regrettable that many countries still allocate up to three-quarters of their health budget to sophisticated, technical treatments in hospitals while about 70% of populations receive little if any primary health care to promote healthier lifestyles and to control the chronic conditions that increasingly prevail.

SECTION 4

SOCIAL REALITIES - THE MANAGEMENT OF TECHNOLOGY

A close study of contemporary social realities and the ills consequent upon them reveal the futility of relying on science to provide all the solutions required. Although the sciences and their technologies have provided many solutions to society's ills they also appear to have added to the anxieties and stresses that are prolific in modern society. For example, the number of New Zealand children admitted to hospitals with congenital malformations increased from 354 in 1939 to 3309 in 1974. But perhaps it is more accurate to say that it is our uses and reactions to science that cause problems. For instance, our uses and reactions to disposable products is more an indictment of attitude than of availability.

Kenniston (1977) comments that the sophisticated technology of this era offers benefits unthought of by previous generations - from kidney dialysis machines to convenience foods. But along with recognition of the benefits of technology there is an increasing awareness of the harmful side effects it can produce. One has also to ask what are the costs or the risks of continued innovation for future generations. Technological change has already released a number of potentially destructive elements - environmental, socio-health, and economic for

society to manage.

The 'Technological Cradle'

Television is used by Kenniston (1977) to illustrate the mixed blessings of technological change in (American) society for its children. It is seen to offer great educational potential and enrichment as well as entertainment: at the same time it is believed to desensitize by constant exposure to violence, instant solutions, and to undermine family interactions. How to strike a balance between beneficial and harmful effects is one of the dilemmas presented by modern technology. Grossman (1979) urges that in the place of the hysterical reactions to television effort should be expended on improving its quality. He appreciates its ability to effect change and finds one effect of note has been the elimination of a relatively recent phenomenon - adolescence.

Kenniston (1977) also refers to other issues which reflect the mixed blessings of technology such as the changing diet of children, nuclear plants, industrial waste, X rays, and advertising on the mass media. He stresses that bringing to attention the dilemmas associated with technological innovations is not just to indicate the dangers they present. The same technology, he points out, that produces DDT or nuclear power also has the capacity to detect minute quantities of it in food, water or air. Gandhi (1972) is emphatic that pollution is not a technical problem but lies in the sense of values of the contemporary world which ignores the rights of others and is oblivious of the longer perspective.

It is the capacity of technology to assess a wide range of environmental risks which, Kenniston believes (1977), is partly responsible for the sense of danger seen to exist in continuing technological innovations. The benefits of modern technology have increased the aspirations

of people for a better quality of life. But as knowledge of risks has increased so too has the insistence that they be controlled. Additionally, the social costs of production, although harder to assess must be considered. The discharge of waste into a river, for example, has social consequences that must not be ignored. New drugs may destroy bacteria but harm healthy cells. Additives may improve the taste of food but have carcinogenic properties.

Kenniston (1977) states that the technological decisions made now will determine, perhaps irrevocably, the kind of physical and social world inherited by future generations. He considers it essential that business and government organisations exercise social responsibility, and that public vigilance is exerted to regulate and control short and long term risks. Cole (1971) considers man is lucky to have existed for so long when one examines the games he has played with 'biogeochemical' cycles. He is very critical of a failure to recycle materials locally and of industry's encouragement of planned obsolescence which further adds to the accumulation of waste. The environment of man, Cole notes, has now to assimilate synthetic pesticides, plastics, antibiotics, radioisotopes, and detergents.

Advanced technology affects the social and physical environment and Kennedy (1979) states that most people are harnessed to 'social machines' or, to use Galbraith's term, 'techno-structures'. Kennedy quotes from Sapir who, as long ago as 1924, found that the great cultural fallacy of industrialism is that in harnessing machines to our uses it has not known how to avoid harnessing the majority of mankind to its machines. The dominance of the social landscape by large business and government organisations, and their effective control of the dominant values of post-industrial society, is viewed by Kennedy as the central issue of today.

Kennedy (1979) also discusses Etzioni's defining of the present situation and his conclusion that the central characteristic of this era has been a persistent increase in the efficacy of the technology of production at the expense of the very values these means are supposed to serve. Etzioni (1968) cautions that the post-modern period will either see the threat to these values intensify by surging technologies or a reassertion of their normative priority. An active society which is master of itself will, in his view, ensure that the latter alternative prevails.

Ziman (1978), writing of the present superior modern tendency to think that the instruments provided by modern technology will give good results which can be relied upon, points out that good science is never that easy. Science is perceived as an industry grown out of control as it expands beyond a man's comprehension. Etzioni (1968) also refers to the potency of instruments now available and the growth of knowledge. But Etzioni concludes that an active society which enhances man's ability to transform social bonds rather than accept them passively, or simply protest, will control both the instruments and the knowledge of the post-modern period. It will be a society in charge of itself and not one manipulated to suit the logic of the instruments of social patterns that may be encountered.

Dickinson (1975) uses the term 'socially appropriate technology' to refer to the development and use of technology that can be applied to alternative situations with optimal results. A socially appropriate technology would take into account social and economic factors as well as technical. For a developing country Dickinson (1975) considers that a socially appropriate technology should meet certain criteria, for example:

- 1) use readily available local materials and sources of power;
- 2) minimize the content of imported materials;

- 3) use existing or easily transferable manual, technical and professional skills and minimize costly, complicated and time-consuming retraining;
- 4) minimize the displacement of labour or in any other way adding to the pool of unemployed and underemployed;
- 5) minimize social and cultural disruption..... ;
- 6) ensure that capital is used in a manner that is compatible with local, regional and national development plans.

Illich (1975), speaking to the same issue, believes that the relevant question must be what are the hygienic limits of industrial growth and the industrialization of all major sectors, including medicine, and not how man can be programmed to survive in a world which gives priority to industrial growth. In relation to a 'socially appropriate technology' Leonard's comment (1966), that technologically induced changes in the occupational structure eliminates whole sets of jobs leaving large gaps of people unemployable, as the skills they possess are no longer in demand, is also very pertinent. As work becomes more specialized the number of those who become unemployable grows, and this is particularly so for those whose education has been too narrow to help them to adapt to major shifts in technology. It needs to be noted that unemployment is one of the basic factors associated with a number of contemporary health disorders.

As Boulding (1965) points out a number of problems are less those of physical or biologic systems but rather are essentially those of social systems. For instance, he describes the flood as essentially a problem of people and social institutions, of architecture and locating of cities, and not of the river for which a flood is a normal part of its action. That is a rather simplistic description for people traditionally gravitate to such an area because of the fertility of the land. But his point is well made for the technology that produce nuclear energy can also devise ways of river use and flood control that are socially benefic-

ial.

Medical Technology

Leonard (1966) considers that the hospital has become a place to instal expensive diagnostic and treatment equipment that no doctor could purchase by himself. He believes that it is this development which is responsible for the 'care' functions becoming subordinated to the medical diagnostic and treatment functions.

Advanced medical technology, especially from a long-term perspective, raises some very perplexing problems. As Illich (1975) expresses so strongly ... the pain, dysfunction, disability and anguish resulting from technical medical intervention now rivals the morbidity due to traffic and industrial accidents and even war-related activities, and makes the impact of medicine one of the most rapidly spreading epidemics of this era.

Abel-Smith (1976) is also concerned about the expansion of medical knowledge; new pharmaceuticals and new treatment procedures, from transplants to kidney machines, have greatly extended the range of care which physicians can offer to the individual patient. They have, in addition, greatly increased both the staff and equipment needed to treat certain categories of patients. But how much of this increase contributes to the treatment of the patient, Abel-Smith questions, and, further, he adds that certain medical advances leave a progressively more difficult number of problems to be faced.

In reference to changes in the population structure Baly (1973) comments that they are closely linked with technological advances. But like the industrial changes of the 19TH century the advantages they have brought to society have been obtained at a price. Increased mobility has added to the incidence of trauma induced chronic illness, for example,

and Brockington (1975) notes that for all the benefits of technology each problem solved has uncovered another - or as Morris (1967) would say the 'onion principle' becomes operative.

For Maxwell (1976) this is one of the dilemmas of medical technology. The measures which have saved infant lives have also increased the threat of handicap. Renal dialysis changes a latent need into an immediate and continuing demand. Stainton (1979) lists some of the contradictions that arise with the use of technology and pose some very vexing problems, ethical and clinical, for nurses:

- a 400 gram infant exists attached to life support systems;
- a 1000 gram foetus is aborted;
- a newborn infant is welcomed into a family after years of infertility;
- a child is battered and abused.

Stainton (1979) mentions the concern of Scandinavian nurses about the loss of clinical skills with the unnecessary use of technical aids in normal midwifery. But she believes the real issue for nurses in maternal/child health care is the ability to predict and plan for new trends in health care, and to respond in constructive ways to problems associated with technology. The knowledge and skills needed in an era of advanced technology must be determined so that it is used as intended, that is, to help in the provision of care in new ways.

Widgery (1979) is as adamant as Illich about the need to sharpen the focus of medical science and to take more seriously its implications and application. Each time a new innovation is being considered Widgery believes one should ask whether it enhances medical science or the patient's wellbeing. They are by no means the same thing, he states, and stresses, also, that medicine exists to save life and not to prolong death.

Abdellah (1974) considers that the provision of quality health

care for all who need it poses some very difficult socio-health problems for planners and policy-makers. She finds that there is a wholly inadequate fit between the possession of fine medical technology and the health needs of many people.

The NZDH 1979 report notes that, partly due to the size of New Zealand population, and, in part, to central control of expenditure, it is largely possible to avoid the proliferation of highly specialized units and of sophisticated, expensive technological equipment. Nevertheless, there is a continuing debate in New Zealand on the priorities which guide the use of the health vote. And there are some, like Begg (1976), who would doubt that the objective of preventing undue spread of all that is implied in medical technology is achieved.

SECTION 5

CLARIFYING VALUES IN AN 'AGE OF DEGENERATIVE AND MAN-MADE DISEASE'

'The social future is largely now in man's own hands. If he has only his technology to guide him in how he shapes it, it could be a trivial future - one in which he would skilfully but gradually escape from being man. The hope must be that his education can keep him in touch with the true sources of authority both within and outside himself ... The worthwhileness of new possibilities men perceive is still dependent upon the quality with which they see, feel, and understand. Decision-making is not simply an administrative act, requiring knowledge of human societies and human nature and of how to 'manage' them. For the knowledge that is of most worth is never wholly external to the knower'.

The above quote is taken from a book of considerable depth on 'The Sciences, The Humanities, and the Technological Threat' edited by Niblett (1975). Much of what is written is pertinent to the issues of value and judgement which confront nursing today. One must agree with Niblett that a mutually reinforcing emphasis on both the sciences and the humanities is essential as nursing faces the task of adapting its

educational programmes and nursing practice to suit present requirements for nursing care. Figure 5.11. is a simple diagram in which nursing, as an applied science, is placed about midpoint on 'a continuum of knowledge' that stretches from the humanities at one end to the natural sciences at the other.

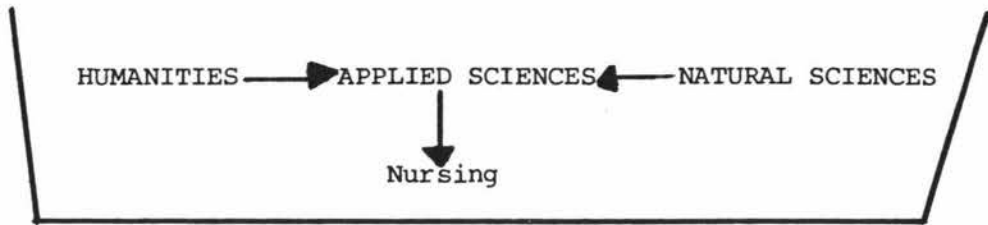


Figure 5.11. A Continuum of Knowledge

(Idour, M. 1980)

It is from the humanities that values and a philosophy for action must be drawn to assist nurses to practice effectively; and to cope with the complex issues related to advanced technology. The importance of the knowledge and insights to be gained from the humanities is that it can provide meaning for nursing action and for the priorities selected in the provision of health care. The humanities, ideally, are always relevant to the condition of people, and to their society.

One can only hope, with Niblett, that education can keep the individual in touch with the true sources of authority both within and outside himself. When one recapitulates some of the comments, reported in the last section, regarding the threats posed to the human environment by the mismanagement of technology, it is clear that it is essential for oncoming nurses to be able to do so. Comments such as those of Widgery (1979) that medicine exists to save life and not to prolong death; or Illich's insistence (1975) that the hygienic limits of industrial growth must be calculated; or the remark made by Leonard (1966) that the 'care' functions of a hospital must not be subordinated to technical care

indicate some of the occasions when the oncoming nurse must have recourse to sources of authority in order to clarify values and make decisions.

Clarification of values is essential as nurses are faced with ethical issues on a dimension not previously experienced. As the values related to health and wellbeing are the concern of the whole of society the establishment of values to guide practice requires a collaborative effort from public and professionals. This is endorsed by Camus (1961) who emphasises the supreme value of increasing the amount of responsibility to be found in people everywhere. And in regard to the preparation of oncoming nurses, and other health professionals, it is clear that the clarification of values must start with helping students to explore their attitudes towards human nature and society; towards the 'self' and towards others.

Cornillot (1977) in a discussion of 'conflicts of ethics', that is conflicts related to a collective or individual conception of the value of life and the cost of health, includes all the arguments about the right to life, the right to death, euthanasia, voluntary abortion, the right of survival for the disabled, the infirm, the aged, and the mentally sick, and about what is normal and what is pathological in the physical, psychological and mental fields. Advanced medical, and for that matter general, technology has introduced new elements into these arguments because it has increased the alternatives available. But again one needs to remember Niblett's comment that 'if man has only his technology to guide him... he could only have a trivial future'. And Cornillot (1977) notes that reference is made, concerning the conflicts listed above, to the contributions of philosophy, religious morals, the right of survival of minorities, and to the mores of a culture.

Priorities, according to Mechanic (1969) always depend on values, and the two paramount values he nominates are (a) the humanistic value of

need, and (b) the notion of gain. The first is founded on the idea that the best services should be made available to those who need them in spite of cost, difficulty in obtaining them, or the pressure on resources. But the second notion of gain is based on the belief that the services should be made available when the result is equal to the investment. Conflict between the two, Mechanic notes, usually involves some marriage, however uncomfortable, between the notions of need and gain.

Niblett (1975) warns that in decision-making a clear-cut, measurable judgement is only likely if covert, or apparently irrelevant factors are ruled out. Moreover, he writes that a decision which has no imagination of the larger social consequences that may result from its implementation or nonimplementation, and does not employ the decision-maker's human understanding or sense of life, is likely to be a bad decision because it does not take account of all the evidence that is available.

While there must be compromise, if a decision is ever to be made, it is important not just to preserve, Niblett (1975) states, but to increase the human heritage into which man may enter. It is only in this way that one can counter the essential technological threat: that of going on and on or accelerating production with little regard for the direction in which one goes. As Steele & Harmon (1979) note, advanced medical technology can complicate rather than simplify (nursing) situations. For instance, the prolongation of life with machines is the result of progress in medical technology. But Gruenberg (1977), as quoted by Steele & Harmon (1979), suggests that emphasis should be placed on the prevention of illness by isolating the causes of health impairment rather than on efforts to prevent death. Nevertheless, this is seen as a dilemma, requiring the collaboration of an entire society, and not one to be left solely to health professionals.

In health care, William & William (1976) declare, almost any decision will affect people in terms of benefits, rights, and just distribution, and it must, therefore, be subject to ethical reflection before action is taken. Currently, health professionals are confronted with a number of ethical decisions about the use of an increasing number of machines and instruments.

Leininger (1974) presents a number of questions that arise in relation to their use. For instance, what are the ethical implications about using equipment which has not undergone testing under variant usage conditions? How long should machines be used to prolong life? And what of the use of technologic equipment in relation to diverse human or socio-cultural values? How can one control technologies so that they do not limit humanistic capabilities? One answer to the last question is to say that the limit of value in technologies is attained when the likelihood of a worthwhile outcome is too precarious to be grasped.

Leff (1978) commenting that 'value' is as hard to define as 'attitude', finds that the discussion of three social scientists helps to clarify its meaning. He notes that Kluckhohn (1951), Williams (1971), and Rokeach (1973) all seem to reach agreement in conceiving of values as conceptions of the desirable that help to guide decision making. In relation to health and physical wellbeing a pro-life society would give high priority to the health of all citizens. Health, Leff implies, is a desirable value, and long-term health needs an ordering of priorities far different from that of many societies' present listing of priorities.

Probably the most thorough study on clarifying values in nursing is that of Steele & Harmon (1979). Values are said 'to represent a way of life ... to give direction ... and to make a difference in living'. They also believe that nursing has a responsibility to assist its members select values through a deliberate decision-making process which allows

for the humanistic qualities inherent in nursing. As the 'integrative process', discussed in chapter 2, emphasises, the making of judgements of value requires a process which allows optimal choices to be made in the planning of health/nursing care.

Several highlights from Steele & Harmon (1979) can be used to conclude this section on clarifying values in an era of technological innovation. First, they note that the issue as to whether the practice of medicine should be regarded as a technical activity with occasional overtones of moral or social emphasis, or a moral and social activity with a technical base is very important. If the former option is chosen then the management of medicine (health care) can be left to the experts. But if the latter alternative is chosen then there are questions of purpose and value which cannot be resolved by the experts alone. A similar choice must be made concerning the nature of nursing care.

Secondly, they refer to Levine's proposal (1977) that the basic ethical challenge to the nursing profession includes the 'ethic of competence and the ethic of compassion'. In an earlier discussion on the nature of nursing care (see page 26) the two key qualities named as central to nursing are 'compassion' and 'competence'. Competence is believed to provide a framework of knowledge and skills through which compassionate care is given effectively.

Steele & Harmon (1979), in their comments on biomedical ethics and values, stress that the time arises when one must question, argue, and challenge. Solving problems, they believe, comes from raising new questions and not giving 'patterned answers' to old questions. To make people think - to arouse essential thinking in oncoming nurses - opportunities must be provided to question and explore problems. A list of ethical rules is not adequate for present practice. The learner must be helped to work through the problems of conflict that occur between

personal and professional values. This is an essential basis for accountable, autonomous practice in an 'Age of Degenerative and Man-Made Disease', marked by a number of conflicts associated with technological innovations.

They also warn that unless nurses are helped to clarify values the resultant conflicts may make a number of situations too emotionally and physically exhausting to handle. For instance, the conflicts may relate to:

- life and death issues;
- disputes between clients, families, and physicians;
- the rights of others;
- the value of technology and its costs relative to overall societal and health needs; and
- attitudes towards research and the consequent developments and outcomes of advanced medical technology. They note that Gruenberg (1977) has summed up the situation well with his comment that life saving technology of the past four decades has outnumbered attempts at producing health preserving technology.

For nursing there is a clear need for an 'integrative process' which, as noted in chapter 2, clearly displays vital relationships and can be used in the many situations which involve ethical or value-laden decisions. An apt ending to this section on the clarification of values comes from a quote that Steele & Harmon (1979) have taken from Levine (1977).

'To be a nurse requires the willing assumption of ethical responsibility in every dimension of practice. The nurse enters a partnership of human experience where sharing moments in time - some trivial and some dramatic - leaves its mark forever on each participant. The willingness to enter with a patient that predicament which she cannot face alone is an expression of moral responsibility: the quality of the moral commitment is a measure of the nurse's excellence'.

SUMMARY

The defining of the social content in which nursing practises, as a touchstone for evaluating the relevance of nursing education programmes, has necessitated an extensive examination of the 'social realities' confronting contemporary society. 'Social realities' has been defined as the actual conditions, pressures, disabilities and abilities, limitations and resources that exist in the lifespace of people and form the environment within which nursing functions. As the genesis of ill-health lies in the linkages between the various realities that exist in the overall environment of people (see figures 2.2., 5.2. and 5.1.) a study of some of the major issues which affect nurses, personally and professionally, has included a consideration of:

- current trends and problems associated with rapidly changing systems and factors related to their management;
- the human problems confronting social institutions such as the family, education, and nursing;
- changing patterns of disease in developed and developing societies, using Omram's theory of 'epidemiologic transition' as a basis for description;
- the characteristics and management of technological innovations, both general and medical; and
- the clarification of values in an 'age of degenerative and man-made disease' and technological innovations, since this is believed to be an essential basis for accountable, autonomous practice, commitment to that practice (Alstchul, 1979; Salmon, 1971), and professional development.

The purpose of this review of 'contemporary social realities' has been to define the social context in which nurses practice in order to establish priorities in nursing education.

Defining the social context in which nursing practices is done at some length since nursing is believed to have originated and developed through societal need. Nursing, as a socially prescribed service, carries out on behalf of a society, those activities which individuals cannot do with their own knowledge, strength, or will (Henderson, 1978). Its purpose is directed towards assisting individuals to maintain, regain, or enhance self-care abilities. Unless nursing engages in a thorough appraisal of the social context in which it practices the preparation of oncoming nurses has limited relevancy.

CHAPTER 6

APPLICATION OF AN INFORMATION SYSTEM TO THE
SOCIAL REALITIES OF NEW ZEALAND (NZ) SOCIETY

A FOCUS ON THE SOCIAL CONTEXT IN WHICH NZ NURSES PRACTISE

PROBLEM

The problem formulated in chapter one is essentially that of maintaining nursing curricula that are relevant to the social context in which nursing is practised. The reduction or elimination of discrepancies between the desired and actual outcomes of nursing curricula is seen as a particularly difficult problem in a time of rapid and persistent change.

TOWARDS PROBLEM SOLUTION

In pursuit of a solution to the problem stated above one has carried out the following steps.

1. Formulated a theoretical framework, TNM, to clarify the nature and purpose of nursing and to underpin the approach and position taken in this thesis.
2. Developed an educational tool with a system approach, CRP, as an operational strategy to find answers to the questions posed in this thesis (see page 47).
3. Further developed phase one of CRP to form an information system for (nursing) education.
4. Defined the social context in which nursing practices by an extensive review of contemporary social realities. This has been done to throw into relief the socio-health and nursing needs and problems of

societies, and subsequently, to establish priorities for nursing education.

As a sequence to reviewing the social realities of contemporary societies an information system has been used to focus on the social context in which NZ nurses practice.

INFORMATION SYSTEM

The 'information system' or tool applied here to the social context of NZ society has been evolved from phase one of CRP. CRP is an educational tool with a system approach which has been defined already as an information-seeking, problem-solving, and evaluative process. For practical reasons, only the first phase of CRP is activated in part answer to the problem stated above. The information system is designed to provide for (a) the information of a data base, and (b) an ongoing collection of information to assist the making of relevant curricular choices.

Note

As the construction and use of an 'information system' has been discussed in chapter four only brief additional comments, in this respect, are made here.

The 'information system' (see figure 3.6., p50) consists of six steps, viz.:

- I. statement of the goal;
- II. specification of the objectives;
- III. selection of sources of information;
- IV. management of the information;
- V. analysis and interpretation of the information; and
- VI. application of the findings to curriculum choices in nursing education.

Step six (VI) of the information system merges, in fact, into the second and third phase of CRP, and, therefore, is only dealt with to a limited degree in the later chapters.

(I) STATEMENT OF THE GOAL

This is the acquisition of sufficient and pertinent information about the social realities of contemporary NZ society in order to:

- (a) identify the dominant socio-health disorders;
- (b) select desirable nursing skills appropriate to the commonalities of socio-health disorders; and
- (c) select learning experiences that will produce the requisite skills.

(II) SPECIFICATION OF OBJECTIVES

The objectives set include:

- (a) the collection and documentation of information about NZ society during, in the main, 1979;
- (b) analysis and classification of the information gathered about contemporary social realities and resultant disorders;
- (c) identification of the commonalities present in the socio-health disorders; and
- (d) determination of desirable nursing skills appropriate to contemporary socio-health disorders.

Primarily, the objectives are set for the collection of information from which the essence of contemporary nursing needs can be abstracted and applied to the choices made in nursing education. Application of the findings to curricular choices first requires, of course, that the problem-solving and curricular activities of phases 2 and 3 of CRP are activated. When CRP is fully activated, and the findings of the information system

are applied to curricular choices, two additional objectives which need to be set are:

- (e) construction of assessment tool(s) to determine the relevance of nursing curricula; and
- (f) recommendation of educational strategies that are likely to maintain ongoing relevance in nursing curricula.

But as noted, it is not possible to activate phases 2 and 3 within the limits of this thesis.

(III) SOURCES OF INFORMATION

A wide variety of sources has been selected since there are many factors which can affect the wellbeing of individuals and their societies. Since the perceptions of social order and disorder vary according to a number of personal and social factors care has been taken to choose both official (formal) and voluntary (informal) agencies (terms defined in glossary).

Official sources, which include the national health information system (NHIS), offer considerable material about met and unmet health needs, and about some of the outcomes provided by the health services. But this still leaves a number of gaps in the information needed to identify NZ socio-health and nursing needs. For this reason, considerable weight is given to the collection and documentation of information from voluntary or informal community sources. For instance, a great deal of material has been gathered from the mass media. Additionally, social services directories (listed in Appendix B3) can also be seen to disclose a considerable degree of unmet needs in NZ society.

Another point relating to the wide sources of information chosen, and the weight given to information from voluntary sources, concerns the

perspective of nursing held in this thesis. As a socially prescribed service nursing is seen to be required whenever and wherever self-care deficiencies exist. And not just as, primarily, the care of the ill, especially the institutional ill. Any issue, therefore, which is constantly reported as detrimental to the wellbeing of individuals has been captured and fed into the information system.

The main sources of information selected are:

- (a) the mass media (as defined on p.66);
- (b) professional journals, periodicals, news releases, conference and research reports, and social services directories;
- (c) traditional (official) health service records such as hospital, regional, and NHIS statistics; and
- (d) miscellaneous, for example, studies from related disciplines or voluntary agencies concerned with some aspect of socio-health and nursing requirements.

An instance of the latter category is a study by Brown (1979), 'Planning for the Disabled', reviewed in the 1979 Planning Research Index and published by the Ministry of Works and Development.

Further details and description of the sources of information used is discussed below under 'collection of data'.

(IV) MANAGEMENT OF INFORMATION

The provision of information and its documentation is an essential part of curriculum development, and evaluation. The management of information involves its (a) collection, (b) organisation, and (c) dissemination.

COLLECTION OF INFORMATION

Data has been collected by observation: either by the use of a 'brokers service' and obtaining it on demand, or by extraction from the mass media and other sources. Extraction of data from the mass media has been favoured because it gives observation of societal and individual behaviour on a continuing basis. This is seen to have a decided advantage over recorded data which is studied retrospectively and may lack pertinent facts.

Collection of Data by Extraction

This has involved:

- (a) scrutiny and extraction of data from NZ newspapers for the period of 1979;
- (b) scrutiny of all issues of the NZ Listener for 1979 with the intention of extracting relevant items broadcast or televised in 1979; and
- (c) scrutiny and extraction of key items from publications such as the WHO technical series, professional journals, social services directories, and similar publications.

COLLECTION OF DATA FROM THE MASS MEDIA

Most items of information extracted from the mass media have been listed and form Appendix A. In appendix A there are, in fact, four collections of data extracted from the mass media.

Appendix A1 contains items from appropriate files in the Dominion newspaper reference library.

Appendix A2 contains items extracted from NZ major daily newspapers for the period of 1979. These items were obtained from appropriate

files in the NZBC reference library.

Appendix A3 contains a list of socio-health and nursing related programmes broadcast over 2ZA in 1979. These items were obtained from the file of the staff member responsible for planning and operating the programmes.

Appendix A4 contains a list of socio-health and nursing related programmes broadcast over the National 'YA's in 1979. These items were extracted from the files of the daily report and documentary programmes.

The object of this collection of data from the mass media has been to gather items of information that, collectively, portray the dominant social realities and resultant disorders at this point of time. Specifically, it is an attempt to form an impression of what ills or disorders, as reflected by the mass media, have been of most concern to NZ society during 1979.

Some reference must be made here to the question of objectivity and bias in the news items. Granted that issues and events are reported as they occur one must allow for an element of selection in what is considered newsworthy. For the degree to which news items provide an adequate, accurate, and intelligible view of current issues is important. Having said this, however, it must be noted that it is not the intention to examine here how items are selected by the mass media. Rather the intention is the collection from the mass media of a wide range of perceptions about NZ society and its socio-health status in 1979.

It is considered that these viewpoints, expressed in articles, reports, documentaries, and letters are closer to the grass-roots of society than that of more formal sources of information.

An ongoing collection of information from the mass media and other voluntary sources, in conjunction with data from official sources, is

thought to provide an adequate data base to assist curricular choices.

Criterion. Only one criterion has been applied to the extraction of information from the mass media. The item had to contain some explicit or implicit requirement for health and nursing care. To some extent, however, the choice of items had been predetermined by those who filed items in the reference libraries.

Information Collected from Newspapers

Three collections of information from newspapers have been made. One collection consists of newspaper clippings taken from the Dominion (Wellington's morning paper) and from Manawatu daily and weekly papers (The Evening Standard, The Tribune, and the Guardian). These clippings have been collected throughout 1979 and form the news-sheets found on pages

Two more collections from (a) the Dominion Reference Library and (b) the NZBC reference library form, as noted already, appendices A1 and A2.

The Dominion Reference Library Files

Since not all issues of the Dominion had been sighted for 1979 a visit to the papers reference library made it possible to scan relevant files and to extract items not obtained from the paper directly.

Covering the period of 1979 the files made available contained clippings on the subjects of social welfare, health, and nursing. Item selection for the above files had been made by the library staff, consisting of two young women of about twenty years of age. Although they had had no

particular training or directives supplied for the task their selection does contribute a non-professional perception of what is relevant about health and related issues.

Newspaper Files - NZBC Reference Library. Scanning of the 1979 Listner issues proved to be of little use as inadequate details of item was supplied. As a consequence, a visit was made to Broadcasting House with the hope of obtaining a record of relevant programmes broadcast or televised during 1979. No such record was obtainable, but access was given to files containing clippings from the main national newspapers of New Zealand.

Appropriate files made available for scrutiny included ones for medical services, nursing, social life and customs, and health. A listing of the items contained in each of the above files is to be found in Appendix A2.

Several headings taken from pertinent newspaper clippings are shown below in order to illustrate just how varied in nature the information collected from newspapers can be.

Age	Trend	Puts	Pressure	On	Welfare	
Average	Kiwi	Older				
They're	Young	But	They're	Not	Children	
Home	Saves	Hospital Beds -	For	Frail	And	Aged
Beds	And	Doctors	Exceed	Demands		
Hospitals	Face	Higher	Demands			
Free	Service	(A&E)	Pushes	Up	Hospital	Use
New-look	Plunket	Stands	Up			
Midwife	Study	Begins				
World	Nurse	Need	Shown	(WHO, 1979)		

To 'at risk' Folk Stay Away
 Emergency Services Are Vital
 Integrating The Young Disabled
 Craft And Care For Stroke Patients
 Street Groups End Stifling Suburban Isolation
 Social Ills: Loneliness Is A Killer
 Drug Education
 Prevent Overdoses, Doctors Advised
 Police - Report Rise In Domestic Violence
 Concern At Incidence Of Excessive Drinking
 Helping To Ease The Pain - Chronic Illness
 Injuries A Worry (Sporting Injuries)
 Foster Care Under Scrutiny
 Many Children At Risk
 Family At Risk
 Booze And Buns May Be New Zealand's Health Ruin
 More To Light Than Meets The Eye (Effect
 on Health and Danger Of Artificial Light)

Collection of Data From Radio and Television

Television. Although, as noted, scanning of the Listener for 1979 proved to be of little use, some data could, by implication, be extracted from the programmes listed. For example, 'Eight is Enough', 'One Day at a Time', and 'Medical Centre', though primarily of an entertainment nature, are constructed around common issues. For instance, the above programmes deal with issues such as the family, the intergenerational gap, and socio-health disorders.

There are, also, certain documentary programmes that enhance understanding of either people or the environment. Instances include

'Friend of Men', 'Primitive Men', and 'Vision On' (an almost totally visual programme designed expressly for children with impaired hearing. Two other features related to societal and individual wellbeing are educational and future oriented. One is 'Stubbing out the Smoking Image ... smoking replaced by jogging'. And, secondly, 'Directions for the Future' presented by the Commission for the Future.

Radio - 2ZA Community. An interview with the staff member responsible for programmes dealing with health and social issues made it possible to collect a list of relevant programmes. Two examples are (a) 'Training for childcare: Family and Marriage Guidance Council' and (b) Report of Conference on Alcohol and Drug Abuse'.

These programmes are listed and presented in Appendid A3.

National Radio YA Programmes. During 1979 a considerable number of daily report programmes and documentaries dealt with the social realities confronting New Zealanders. Issues discussed included a series on handicapped children, one on cancer designed to educate and improve understanding about the disease and its management, and other related to the family and psychosocial stress. A list of socio-health and nursing related programmed are presented in Appendix A4

COLLECTION OF DATA FROM JOURNALS, PERIODICALS AND DIRECTORIES

A collection of items from official and voluntary (excluding the mass media), is contained in Appendix B. The purpose of this collection is the gathering of information from professional and general community sources to augment that provided by the mass media. In some cases the data consist of research findings or the conclusions of experts that supports, rejects, or takes a neutral stance about issues reported through

the mass media.

Collection of Data from Journals

There are many nursing and health related professional journals. Examples of professional journals found to contain a wide variety of information related to dominant socio-health disorders and their actual or potential effect on nursing requirements are listed below.

New Zealand Nurses Journal (NZNJ):
 Nursing Outlook (NO):
 Journal of Nursing Education (JNE):
 Journal of Continuing Education (JCE):
 Journal of Advanced Nursing (JAN):
 Nursing Times (NT):
 Nursing Research (JNR):
 Nursing Forum (NF):
 American Journal of Nursing (AJN):
 Journal of Health and Social Behaviour (JHSB):
 New Zealand Medical Journal (NZMJ):
 Sociological Review (SR):
 Social Science & Medicine (SSM - and international journal):
 International Nursing Review (INR).

In general, these journals provide a wide spectrum of articles dealing with socio-health issues. Moreover, they contain information needed for the making of optimal curricular choices.

The NZNJ, of course, provides, in particular, articles of direct concern to NZ nurses: consequently, a list of relevant articles has been extracted from the NZNJ only. This list forms Appendix B1.

Collection of Data from Periodicals

There are numerous periodicals and amongst these can be included news sheets, pamphlets, and special releases from such organisations as the NZDH and WHO. One of the best sources about contemporary socio-health

issues, in fact, is WHO. A list of periodicals forms Appendix B2. Material from international organisations is included because it has relevance for all contemporary societies, including NZ.

Collection of Data from Directories

Probably one of the clearest indications of the social and health disorders affecting New Zealanders can be inferred from the 'Social Services Directories (SSD). These name and describe the purpose and activities of all official and voluntary organisations that operate in the regions they cover. A telling comment on 'unmet' health and social needs can be inferred from SSD, when one notes the number and range of voluntary groups that have been formed to fill in the gaps not covered by official agencies, or to augment the services available.

A list of New Zealand SSD, and of some similar overseas publications, forms Appendix B3. The inclusion of some overseas directories is done to emphasise the universal character of contemporary social disorders. Appendix B3 also includes a sample of the contents of one of NZ (Dunedin) SSD.

COLLECTION OF DATA FROM OFFICIAL SOURCES

Information from official sources has been readily obtained on request from official (government, central, regional or local governing authorities, and professional organisations). This has been the case, for instance, for most items listed in Appendix C1. Some items of information, however, have been obtained by extraction from primary sources. Appendix C contains four collections of data collected from official sources.

Data Collected from Socio-Health Publications

Information material which has been obtained on request from official sources is presented in Appendix C1. This lists the source of the material, and the topic or subject matter it deals with. The nature of the information contained in the various publications is indicated by the title of each one.

Data Collected from a Hospital Board

One instance of statistics from the Otago Hospital Board is given in Appendix C2. The statistics are for the department of geriatrics and cover the period of 1978 (the most recent period available at the time of collection).

Data Collected from a Hospital Department

The statistics of one class of clients attended to at Dunedin Hospital Accident & Emergency Centre during 1979 are presented in Appendix C3. Clients were those who had suffered some incident of poisoning.

Data Collected by Extraction from Official Publications

A selection of entries have been extracted from (a) the Planning Research Index, 1979 and (b) the Department of Social Welfare Library Catalogues, 1975 to 1979. The items chosen are of direct or indirect relevance to the biopsychosocial needs of people. Recourse to the publications listed in Appendix C4 can, therefore, provide a rich source of data to assist the making of curricular choices.

This collection of items of information, or of the sources of items of information, provides readily available statistical material.

A good deal of the statistics, for example, that provided by the NHSC, has been compiled from primary sources. It is such material, obtained on request from a broker's service, that can be used to form a data base. Its collection and use is economical of time and resources.

It can be said that official material is often received as of right by health institutions. Having said so, however, it is also the case that it is often blocked at some point in the organisational system. Official or traditional information is best collected by a systematic method and not left to chance.

Statistical material obtainable from the sources of data referred to in Appendix C, provide a solid base for more interpretative or conjectural material. Both types of data need to be collected in order to have a supply of basic information about socio-health and nursing needs and problems. The basis of selection has been to gather material that has been reported on in statistical terms, or from professional studies involving research and feasibility studies. This is needed to counter the measure of interpretation and, consequently, the possible bias of some items of information.

COLLECTION OF DATA FROM COMMUNITY SOCIO-HEALTH AND NURSING AGENCIES

A list of some of the health care agencies examined by students of a 'Health Care Systems' paper (Massey University Nursing Studies Unit) in 1979 is presented in Appendix C.

The objective of this final collection of data is to illustrate further the range and extent of voluntary agencies in the community. Not infrequently one hears the viewpoint expressed that "people should do more for themselves and not always rely on the government". But the

majority of agencies listed in Appendix D (and B3) indicate a remarkable degree of people organising themselves, voluntarily, to ease in some way socio-health disorders in the community. 'Self-help' agencies in the community are desirable. But they are already providing services which support official institutions: Or they are covering the gaps where socio-health needs are not met at all by official agencies.

If nursing curricula are to be relevant to socio-health needs information must be systematically collected from voluntary as well as official sources of data. This enables the formation of profiles, such as those described by Omram (1974), including:

- a population profile;
- a social and economic profile;
- a disease and mortality profile; and
- a community health profile.

ORGANISATION OF DATA

Organisation of the considerable amount of data available for an information system for nursing education needs to be considered from two perspectives. First, it must be considered from the perspective of operating and, if necessary, initiating an information system. This demands an operational strategy or process for analysis, classification, coding, storage, retrieval, and availability of data for use. It is important that the system used allows for the updating or removal of data as requisite.

Figure 6.1. (page 159) demonstrates how an information system can be operated.

As the diagram shows the information, after collection, requires scrutiny and analysis. The need for the information must also be consid-

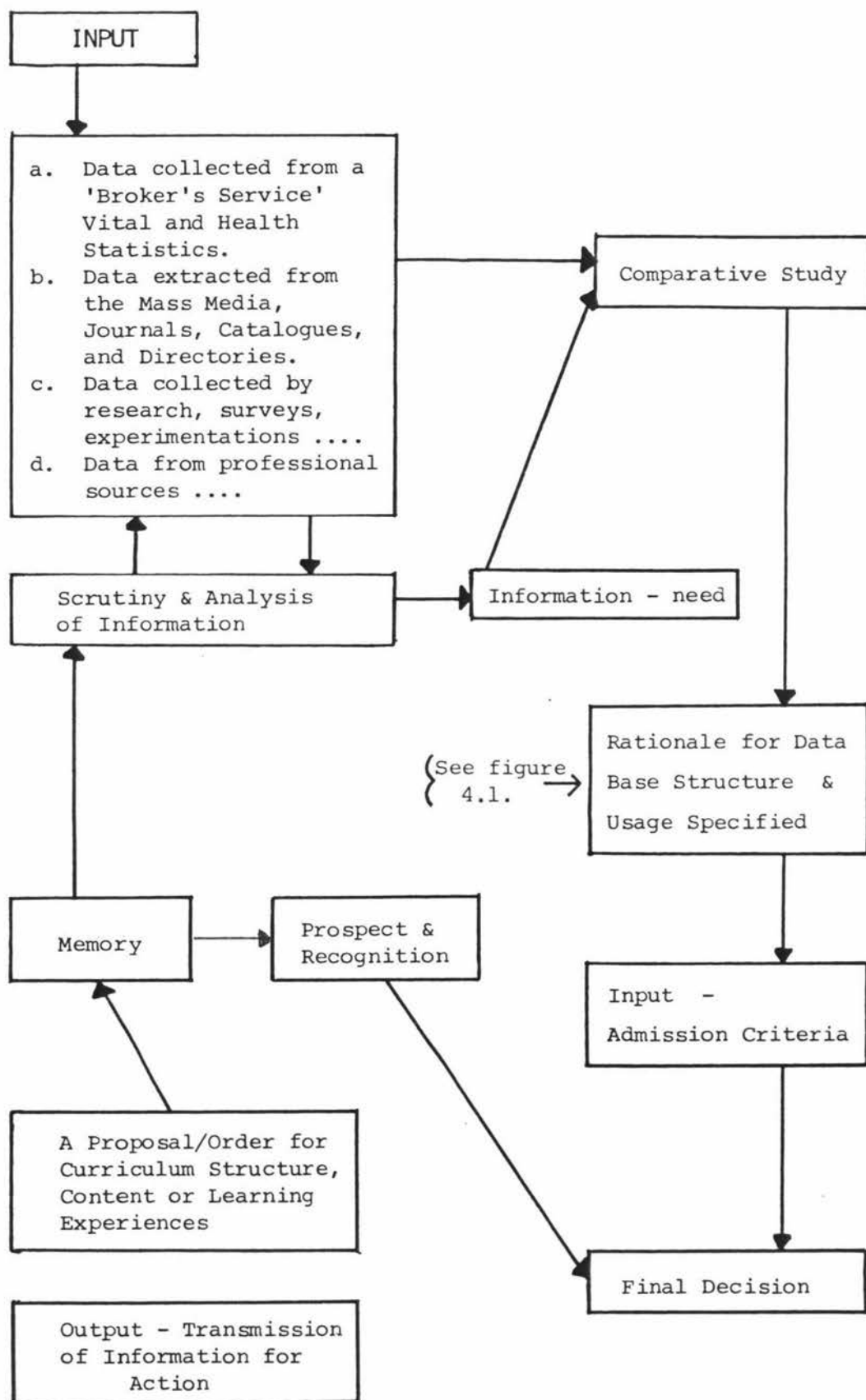


Figure 6.1. Operating An Information System

ered in relation to a comparative study of material already available. Rationale for data base usage must be specified, and, as figure 4.1. (p 71) indicates, the procedures for updating or adding information must be applied systematically. Pre-established admission criteria can be used to aid decision-making for utilization or rejection of the data.

The second perspective relates to the classification of data. An early assessment of data is essential in order to facilitate coding the information into classes and subclasses. This produces a more manageable arrangement of material for analysis, interpretation, and decision-making. Two actions have been taken for this purpose. First, news-sheets have been constructed, and, secondly, data has been coded for placement according to library usage.

CONSTRUCTION OF NEWS SHEETS

From the large collection of newspaper clippings extracted from (a) the Dominion, and (b) the Manawatu daily and weekly newspapers a selection has been taken to form thirteen news sheets. This provides a visual impact of some of the current issues troubling New Zealand society. As a study of items in the newsheets (pages 161 to 173) indicates, social determinants hold a central place in a number of the ills and issues reported in the newspapers during 1979.

In addition, clippings have also been selected that point to future developments and changing needs. For instance, a British survey report (News sheet, page 173, Old Age Dementing) warns that degeneration of the brain in old age will become the most serious single health problem of the future. And the conclusions of a book about future resources 'A small seed takes root' (see News sheet, p 173) finds that individuals are not poor because of meagre natural and human resources, but because

THE FAMILY-CHILDREN AT RISK

Psychologist finds link between crying and baby bashing

UNION
October 10
1979

RESEARCH being done at Massey University could lead to a reduction in baby bashing.

Dr John Kirkland, an infant psychologist of the university's education faculty, who has been researching the subject for some years, feels there is a connection between infant crying and baby bashing.

He is hopeful that his research projects being carried out throughout the world will enable babies who are potential prolonged criers to be identified as soon as they are born.

Once this has been done the parents could be counselled and taught skills that would enable them to deal with the problem.

"Infant crying is a major area of social concern yet in spite of the fact that most babies cry it has been almost completely missed as a worthwhile research investigation," Dr Kirkland says. "Only about 40 people in the world are researching the subject."

tional questionnaire that was answered by about 500 people. All but two of the respondents were women.

The results showed that almost 400 of these people felt like bashing their babies because their infants cried for prolonged periods and a further 50 said they actually hit their babies and eighty said they have never felt like hitting their children.

From the answers of the questionnaire it appears that loneliness, fatigue and a crying baby occurring together bring about a situation primed for violence.

Many women who felt like hitting their children said they were extremely tired at the time.

"Mothers need time away from their babies to be with other adults to regain a sense of well being," Dr Kirkland comments.

"They need adequate sleep. Continually interrupted sleep night after night is a living hell."

Women who answered the questionnaire said one solu-



Reporting for The Dominion in Central Districts:
KARLUM LATTIMORE

tion to the problem was to "get away from it all" if only for a brief time.

"If you are expecting a baby try to find another adult whom you could leave the infant with for brief periods," Dr Kirkland advises.

"And if you want to help a mother with a newborn child then go and baby-sit for a short time to give the mother a break so she can get herself together again."

Dr Kirkland notes that while some babies appear to be "born criers" — particularly low-birth-weight boys, some baby crying can relate to physical health.

Medical research has found that abnormal cries can arise when a baby has chromosomal irregularities, as for example with Down's syndrome. A recent United States study showed there was a considerable difference between a pre-death baby's cries and a normal baby's cries.

Dr Kirkland is presently researching the difference in cries between colic-affected and non-colic infants.

The results of this study are not expected to be known for another year or so.

Further information on baby crying and its effects on parents is still needed, Dr Kirkland says. He would like anyone with views on the subject to write to him care of Box 718 Palmerston North.

Ultimately he would like to publish the full results of the questionnaire with letters from parents in booklet form. He is considering "Try Counting To Ten" as a title for the booklet.

Baby Bashing

Sir.—Your editorial headed, Baby Bashing, September 5 drew my attention to a cause that is to me one of the most distressing, alarming and increasing crimes to be allowed to go, so far, almost undetected here in New Zealand.

To me, it is a sad state of affairs for your paper to state, that, as this is indeed the Year of The Child, it would seem an appropriate time for "an all-out assault" on this major barrier to progress.

Why the Year of The Child? Why not a daily "all out assault" to help jog the public conscience. What is going to take the place of the Year of The Child next year?

I was in the United Kingdom in 1977, returning to New Zealand in 1978 — in England at least they are really trying to grapple with this ghastly crime, New Zealand lags far, far behind other countries in their efforts to stay this ever growing horror.

FLEUR GILLESPIE
Paraparaumu.

Common

"It struck me that there was a very common infant behaviour that nobody was looking at from a psychological viewpoint. I decided to do something about this and have been working on it for several years."

One of his approaches was to look at the effects infant crying had on listeners.

In laboratory-based studies he has found evidence to support what many mothers already know — that infant crying is an extremely disruptive sound.

"However few men, particularly fathers, are aware of the problem because they are too busy carrying out careers to spend long periods of time with their babies," Dr Kirkland says.

He points out that independent researchers have reported that men are just as upset as women by crying babies.

To gather preliminary information on the possible relation between infant crying and baby bashing Dr Kirkland formulated a na-



Baby dies in smash

A BABY died and three members of her family were injured when a railcar and car collided in Hamilton yesterday. The child was: Gina Marie Todd, 24, of Greta Street, Hamilton. The railcar hit the car at a level crossing on Kahikatea Drive at 5.30 p.m. The early model car was flung 20 metres clear of the track by the impact of the collision. In the car were a woman and her three children. The motor and seats were flung from the car in the crash. No one on the north-bound railcar was injured. The woman and her children were rushed to Waikato Hospital but the baby died from injuries received in the smash.

Fatally crushed by car

A TEENAGER died when the vehicle he was working under collapsed at his Saddle Hill home near Dunedin early last evening. Police did not issue the dead youth's name immediately as his parents had not been located. The accident happened shortly before 8 p.m. It was thought the jack supporting the vehicle collapsed while the youth was underneath it.

Many children at risk

NEW Zealand children are three times more likely to die in motor car accidents than their counterparts in Sweden, according to the annual report of the Department of Health tabled in Parliament.

But four major areas of concern in relation to child accidents are accidental poisonings, burns, water and road accidents. A 50 percent reduction in accident mortality by 1980 is one of the aims revealed in the report.

Concern is also directed at the drinking drivers and their involvement in road accidents.

"Special consideration made to be given to the PLUNKET - New Zealand Dominion

not at all costs

WOMEN should be encouraged to breastfeed their babies but should not be made to feel inferior if they do not do so, according to the medical director of the Plunket Society Dr David Geddis.

Dr Geddis, who is also a member of the Health Board's child health committee, has just returned from a World Health Organisation meeting in Geneva.

The meeting recognised a need for action to promote health and nutrition of mothers and babies.

Dr Geddis said many of the topics discussed were not relevant to New Zealand, which, on a global scale, had a high standard of child health.

"However," he said, "there is no room for complacency. Many aspects of child health could be improved."

"I'd like to see the number of women breastfeeding their children go much higher."

"There has been a worldwide decline in recent years in the number of mothers breastfeeding. In New Zealand this reached its lowest ebb in 1967. There is now an upward swing, but there is still a long way to go before the peak levels of 1940 are reached again."

To do so information and educational material about the advantages of breastfeeding must be available.

"Women had a right to information and education that would enable them to

Children poisoned

SEVEN children under the age of three swallowed poisons in the Palmerston North Health District last month.

The poisons included medicines, caustic soda, turpentine and lighter fluid.

Altogether eight cases of notifiable poisonings were reported. Hepatitis A continues to be the most frequently notified infectious disease in the district and last month eight cases were reported.

Three people fell ill from leptospirosis — all of these had farm connections.

improve their own health and that of their families.

Dr Geddis said medical authorities in New Zealand fully supported breastfeeding and were trying to let women know of its distinct advantages.

However, women should not be forced to breastfeed their children if they were going to feel uncomfortable doing so.

"All we can do is advise women of the advantages of breastfeeding. We can't force them to do it."

Women who for some reason did not want to breastfeed should not be made to feel inferior or failures.

That would only make the situation worse. Women must feel comfortable in the feeding process, he said.

8 — EVENING STANDARD, THURSDAY, JANUARY 31, 1980.

Unhealthy ears

N.Z. Press Association
WELLINGTON. — Only about one in four young children have normal, healthy ear-drums, according to a survey in Northland.

The survey of 277 children, carried out by Health Department staff in Whangarei, is reported in the latest edition of the New Zealand Medical Journal.

It found that only 65 children — or 23 percent of the group — had clinically normal

tympanic membranes (ear-drums) in both ears.

In children under two years of age 67 percent had normal drums, but this figure dropped to 27 percent between two and five years and to 19 percent in those over five years of age.

The survey found a marked reduction in the number of children with chronic suppurative otitis media — discharge from an inflamed middle ear.

The rest had ruptured, no

translucent or immobile ear-drums.

In 1974, one in 10 children were suffering from this painful condition which causes hearing loss.

In 1978, a similar survey found fewer than one in three children had this condition. The medical journal reported this improvement to a mobile ear clinic's child hearing programme.

THE FAMILY - CHILDREN'S NEEDS

Foster care under scrutiny

A SEMINAR on foster care will be held at Massey University on September 22.

It will mark the beginning of Foster Care Week which runs until September 30.

The guest speaker at the seminar will be Mr Rajen Prasad, a social work lecturer at Massey University. Mr Prasad has considerable experience in foster care and is one of the few people to research the fostering scene in the country.

The seminar will be held in the Social Sciences Building between 9 a.m. and 5 p.m., and will cover these topics:-

- Planning for children in care.
- Loss, grieving and termination.

● Communication.
● Children with special needs.
● Cross cultural fostering.
● Discipline and moral development.
● Teenage foster children.
● Consumers of foster care - the child and the family.

Mr David Burrowes, a social worker with the Palmerston North Social Welfare Department, said Foster Care Week had two major roles - education and recruitment.

"We want to inform the public about fostering, and enlist their assistance. We believe that children in foster care are the community's children and we are in need of the

Tribune
15.9.79

Foster care: The children who need homes

"Tribune" reporter

Rita is a Mongol. She is only three years old.

Although she is lovable, cheerful and anxious to please, she has no family of her own. Rita's parents were so distressed at her birth three years ago that they gave her up for adoption.

Unless a foster or adoptive home can be found, Rita will spend her life in institutions of one sort or another.

She is one of many New Zealand children who need new homes. Their needs will be discussed on Saturday at an all-day seminar at Massey University.

The seminar marks the start of Foster Care Week which runs from September 2 to 30.

Mr David Burrowes, a social worker with the Department of Social Welfare in Palmerston North, is particularly involved in foster care.

His work includes finding suitable foster homes to suit the specific needs of a child; sharing information necessary to develop an understanding of the child's needs; supporting the foster

family in their 24-hour a day caring role, and arranging any family contacts that may be in the child's interests.

Mr Burrowes explained that foster homes were generally ordinary homes where the family provided care for an extra child of any age.

"The addition of a new member of the household will require a period of adjustment for both the child and members of the fostering family," he said.

"It is usually some time before the new arrangement settles down and, as the foster child may have had disturbing experiences, some adjustment difficulties often occur. These sometimes continue and a high level of caring and understanding is required of the foster family.

Some foster homes provide emergency or short-term care only.

"Fostering is seldom a permanent arrangement," he said.

"A successful return of the child to his/her own family is the most desirable outcome to any period of separation. This is sometimes difficult for a fostering family to accept - particularly where strong attachments have been formed, or where the foster parents believe that the child's own home offers 'few opportunities'.

Mr Burrowes said a child's emotional bonds to the parents were often of greater importance to the child than the comfort and security of what could be a more orderly environment in the foster

home. Foster parents who understood the importance of this agreed that continuing contact with the child's own family must be encouraged in a successful return home were to be achieved.

Mr Burrowes pointed out that the Department of Social Welfare paid a weekly board rate in respect of each child, as well as a clothing allowance, pocket-money, and payment for special expenses if needed.

"In addition, the full range of social work resources of the department are available to the foster family and to the child if required," he added.

People wanting to know more about fostering may telephone Mr Burrowes at 67-099, Palmerston North.

Tribune
9.12.79

Festival of children exciting

THE IYC "Childrens Festival" was held last weekend and, although it got off to a slow start, by 5 p.m. on Sunday many hundreds of people had taken the opportunity to find out what children were saying and feeling about a large range of topics.

DOMINION
November
1979

NEW-LOOK Plunket stands up

WITH THE closing of Wellington's Karitane Hospital only three weeks away, the Plunket Society yesterday unveiled the first of its new family centres.

The Minister of Health, Mr Gill, opened the centre in Cannon's Creek, Porirua, at a short informal ceremony on the law in front of the small house at 217 Bedford Street.

Throwing away a prepared speech, Mr Gill remarked to the 40 people present on the new direction the Plunket Society had taken, praising the concept of catering for the whole family and not just the babies.

Short speeches were also made by Porirua mayor Mr Whitford J Brown and Plunket vice-president Mrs J H Andrews.

The Karitane Hospital will close on July 31, and the dozen nurses still completing their training will be based at the new centre.

The babies and young children, mostly in the care of the Social Welfare Department, will be accommodated at homes.

The new family centre, as yet unmarked by a sign-board, sits in an anonymous row of four yellow, wooden houses. Its two storeys contain a living room and dining room downstairs, and bedrooms upstairs with one of the rooms already containing several cots.

The unit will open from 9 am to 5 pm on weekdays, and will serve as an informal place for families to visit as a back-up to the Plunket nurse service.

Another feature will be the bright red station wagon which will transport people to and from the centre.

The Plunket Society aims to establish 40 family centres in all, with at least another two planned for the Wellington region.

When the closure of New Zealand's six Karitane hospitals was announced earlier this year, society president Mrs Joy Reid said Plunket hoped to extend its service into the community by operating the centres. These would be established with money raised from the sale of the hospitals.

Children running show

"THE Child in the World" exhibition which opens this Thursday in the Manawatu Art Gallery will be run entirely by pupils from Intermediate Normal School.

The exhibition features historic and contemporary photographs taken by adults and children, expressing their view

of children, and the way children view the world.

The exhibition opens at 7 p.m.

An opening speech will be made by a pupil from the school. This will be followed by a play from Chaucer, a recorder ensemble and a puppet play, presented by Intermediate Normal school children.

The council is organising the first stage of a promotion to encourage provision and use of family recreation facilities.

Mr Bruce Stokell, the council's recreation promotions officer, said yesterday.

"That's not easy, but it will

Promote Family Life Takes Off

become more difficult if we don't do something now."

The council is organising the first stage of a promotion to encourage provision and use of family recreation facilities.

Mr Stokell said that the word "family" was intended in its widest possible sense to include not only father, mother and children, but also grandparents, aunts, uncles and neighbours.

"The family has been under considerable pressure for many years; it is a fact on which there is general agreement and it is supported by statistical evidence."

different ages, through mixing together, may take a fresh view of some of the traditional values on which our society is based."

Mr Stokell has begun approaching sport and recreation clubs, companies, local bodies and Government departments to enlist their support.

In December the council will begin a campaign to involve members of the public.

The council was aiming to stimulate the provision of permanent facilities and did not want the campaign to be just a flash in the pan.

"So far the idea and the philosophy have been extremely well received, and I can't cope with all the letters I've received," Mr Stokell

M.P.s will hear Plunket's case

Evening Standard
21.5.79

TOP women in the Plunket Society will visit Government M.P.s over the next two weeks to tell them of the society's changing role in the community.

The women, who represent Plunket branches throughout New Zealand, will encourage M.P.s to examine first-hand the work of the society, and in particular the development of the new Plunket-Karitane

THE FAMILY - CHANGES: NEEDS: PROBLEMS

DOMINION, November 1, 1979

Family at Risk - Fears of rapid

change that people's experience of their own upbringing may be of little use to them in rearing their children.

Does this mean the future of the family is at risk?

What is the nature of the risk that face today's family? Is it partial or complete disintegration that we fear? Just what in fact do we fear?

For the past five years the Social Development Council has been helping Government develop a family policy for New Zealand and in this article its chairman J L Robson, looks at threats to the family unit.

"SINCE we began our project, we have not expressed in society about families. Many and its future is uncertain. Since the cornerstone of our society, a threat to the society and our way of life.

Is the family really at risk? Sometimes this fear reflects only a nostalgia for an "ideal" family life which never existed — romanticised as stable, secure and happy.

But an examination of history shows the inaccuracy of this picture. For example, it is forgotten during the economic depression of the nineteenth century, family breakup was widespread in New Zealand. Fathers travelled through the country looking for work, and children drifted away from home looking for money or food — to such an extent that our society began to build industrial schools and other institutions to provide some control and supervision of them.

But of course, if concern about families can be dismissed as nostalgia. Most of it reflects a very real anxiety about the future of the family. The claim the family is at risk is often made on the basis of two observations — that fewer people are having children and that the traditional structure of the family is changing.

Midwifery check starts

THE maternity services committee of the Board of Health is reviewing New Zealand's home midwife scheme, which the New Zealand Home Birth Association considers ineffective.

The committee is to make recommendations to the Minister of Health, Mr Gair, deputy director-general of health Mr Ron Barker said.

He was commenting on criticism from the association that New Zealand's midwifery training is inadequate for the domiciliary role and that domiciliary work is economically unattractive.

An improved programme of midwifery training is being in-

troduced with the transfer of nurse training from hospitals to technical institutes, Dr Barker said.

At Wellington, midwifery training has been lengthened from six months to a full year, and similar moves will be made in the Waikato and at Auckland and Christchurch next year.

"I can't say if the new training programme will take in home midwifery," Dr Barker said, but he felt this was not too important.

"Midwives can work where they please," Dr Barker said. "It would appear most prefer to work in hospitals where they have full back-up services."

number, and proportion, of all married women, are taking on paid employment. Rates of separation and divorce are increasing, and there is a growing number of solo parent families. Many people view those trends with alarm, feeling that they are likely to lead to an unstable environment for children and a greater incidence of child neglect.

Nuke family may give way to extension

THREE or four generations of people may one day live together in a new form of extended family not necessarily based on ties of blood.

This is a future alternative to the two-parent and one-parent families which now predominate, according to a booklet "Societies in Change: A Question of Scale" prepared by the Commission for the Future.

The family has undergone fundamental changes since the industrial revolution. In Western countries it is no longer an extended group of three or four generations built around children, their parents, grandparents and even uncles, aunts and cousins.

Now it is a two-generation unit made up of only of parents and their dependent children.

Since World War II even this nuclear family has undergone tremendous change. In developed societies, as women have gained control over their fertility, child bearing has ceased to be primary focus of their lives. Today nearly 20 percent of married women have no children.

Technological innovations in the home and easily prepared foods have allowed greater freedom from time-consuming home duties but at the same time have fuelled the demand for higher incomes. Like men, women have come to depend on outside employment for finance and self esteem, and the number of women in the work force has increased dramatically.

Values, too, have changed, notes the commission. Many people now believe that there is no moral bond holding a woman to home and husband.

Many men and women have been unable to adapt to these changes in family relationships and there has been a marked trend towards single-parent families. By 1976, 47,917 households in New Zealand, or 7.5 percent of the total, were single-parent families.

The commission believes that the correct figure could be nearer 20 percent as many

from the New Zealand of twenty years ago. Further, increased about the developmental needs means society now has high expectations of parents only just beginning to realise the place on time and energy. Women have performed this continue to do so though a great are also taking on paid

readily women are realising pattern can restrict their in other activities, and can being isolated within the. Often husbands are willing to equal share of the work, but is not flexible enough to allow so. For example, there is little for part-time hours of work, other jobs which carry low pay and low

rents are also restricted by this flexibility in employment.

There are three problems which all are likely to face. But certain may face extra strains and difficulties, due to their special needs, and our society also needs ways of overcoming their problems. For example, our society is a number of migrant families,

including a growing number of Pacific Island migrant families.

Such families are likely to experience stress in adjusting to our way of life, which in many respects will be quite different from the life they have left. Many migrant families have no close friends or kin in New Zealand, and thus no one to call on for help when they are trying to get settled. Often parents face the additional problem of their

one-parent families are boarders among other house-

There are some cautionary Women lose their jobs more and in New Zealand two unemployed in the professional categories are women.

A British psychologist has men in Britain tent to believe should make an equal finan-

tion to the home and that me with the child-rearing and Wellington's Porirua.

With their supremacy in Auckland's Meadowbank under challenge, many men have proved extremely successful second place in the home. Useful and similar units are with the consequent loss of self being opened shortly. Follow-

Much concern has been expressed, six will be established children's future in the chin Auckland West, Tauranga, scene, yet few alternative Palmerston North, Upper ties have been found to replace Hutt, Christchurch and Dun-

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THE Maternity Services Committee is to call for submissions on home midwifery services in New Zealand.

The committee has already considered preliminary papers on the subject and it will be a major topic for consideration by the committee at future meetings, chairman Dr R A Barker, deputy director-general of health, said.

Some interested parties have already made submissions, and as soon as the present project on neonatal care is finished attention will be centred on home midwifery, he said.

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Plunket to Boost Support Services

The Guardian, September 10, 1979

Plunket's move into family support services is poised for a big leap forward, according to a supplied statement.

By the end of the year, the society claims it will be operating 15 support teams throughout New Zealand.

The Plunket-Karitane family support service has been designed to act as an extended "family" for parents, offering helpful advice and practical aid to young parents finding difficulty in coping with infants and toddlers.

The statement describes the service which operates on two levels — fixed units staffed by trained Plunket and Karitane nurses who provide help in friendly, home-like surroundings, or mobile Karitanes who visit mothers at home.

PILOT

"Pilot fixed units in with the child-rearing and Wellington's Porirua. With their supremacy in Auckland's Meadowbank under challenge, many men have proved extremely successful second place in the home. Useful and similar units are with the consequent loss of self being opened shortly. Follow-

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"The advice is friendly and uncritical.

For some tired, over-burdened mothers, the chance to catch up on lost sleep at the unit or at home while her pre-school children are cared for by Plunket and Karitane nurses is all the help they need. Others need to spend time with the nurses to work through their problems — time which the district nurses or family doctor, may not be able to spare because of their workload.

"The mobile Karitanes have quickly established themselves as one of the most successful aspects of Plunket's revitalised community approach to family health.

RANGE

"They call on families from a broad range of socio-economic backgrounds, helping mothers in particular to cope with the everyday problems of raising children and running a house.

"Families in need are generally referred to the Karitane by a Plunket nurse or family doctor who sense mother is under pressure. Sometimes they will look after baby while mother is ill. Or care for an infant while mother manages the new baby.

PINPOINT

"By spending time with parents, the Karitanes can pinpoint where a mother might require advice, or identify other family pressures which might be adversely affecting a mother's capacity to care for her child properly.

"Now that Plunket-Karitane are moving out of hospital situations and into the community as part of the family support service, the Plunket Society has decided that different skills are needed and a training programme for future 'community Karitanes' is being set up, the statement concludes. health workers who are not professionals

Birthright ... Guardian, Palmerston North
Midwife study begins Nov. 14 1979
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There are many subsidiary ways in which Birthright helps in families.

The majority are of limited means and dependent on Social Welfare benefits. There have been times when the benefit has been less than adequate for the average family's needs. Although the situation has improved.

The annual report shows some of the ways in which children are helped. There are holidays and holiday camps for food, clothing, tuition fees and the like. They are helped with furniture, household appliances, educational grants, firewood, help with the section and other forms of practical assistance. A great many people help with the supply and delivery of such articles.

The principal help remains counselling. Many families come and go over a relatively short time and only a proportion receive long-term counselling. The people who Birthright ask to become counsellors offer support and advice to a parent. Branches never seem to have enough counsellors and are always looking for help in this area.

Birthright has constantly looked at its aims and objectives so it can fulfil its

HEALTH SERVICES - TRENDS & FACTS

Nursing base gains priority

DOMINION
November 3,
1979

WELLINGTON Hospital Board members are planning a \$75,000 community nursing base for Miramar.

A special meeting of the board's community health services committee has decided to ask the Health Department to fund the base.

Proposals are for a Lockwood home sited in Miramar Central School grounds.

The meeting decided against pressing for funds for a Salvation Army hostel in Upper Hutt. The committee asked for money for the hostel last year, but was turned down.

Mrs Nan Caldwell, who chairs the committee, said: "We re-thought our priorities."

If approved the base will be a home for about 10 public health and community nurses already servicing Miramar from city bases.

At yesterday's meeting, board members criticised slow progress on extensions to a similar community nursing base in Paraparaumu established some years ago.

About 15 months ago, the committee provided extra space from the next door building, so social workers and district nurses could work under the same roof as community nurses - but the extra space has remained unused because it lacks furniture.

Board member for Kapiti, Mr D J Howard said: "It's a disaster."

"There seems to be a breakdown in liaison with the works department. We're only talking about \$3000 - \$4000 complete cost, and it would save the building sitting there unused," Mr

EXCLUSIVE by LYNETTE COX

THE TRIBUNE
November 25,
1979

Free service pushes up hospital use

MORE and more people are attending the Accident and Emergency department at Palmerston North Hospital - and one of the reasons is the free medical service. Since 1969, the number of people receiving free treatment in the department has risen from 25,000 to 38,000 a year and hospital authorities predict the figures will continue to rise.

Medical superintendent of the hospital, Dr Tony Poynter, told the "Tribune" that the trend was slowed for a time after the introduction of the Accident Compensation Act, but by 1977 another sharp increase was noticed.

This followed the opening of the new Accident and Emergency department (A and E), which enabled the hospital to give an improved service.

"Between 1969 and 1974, we had fewer doctors looking after A and E, people had long waits and conditions were often unpleasant," he said. "Now we have a bright, modern department, more doctors and an improved service, and the waiting time has been reduced."

Dr Poynter attributed the increased attendance to three factors:

- The improved efficiency of the A and E department.
- The roster system introduced by many city doctors, which resulted in patients having to make appointments to see their own general practitioners.
- Economy.

According to Dr Roger Ridley-Smith, the chairman of the New Zealand General Practitioners Society, more and more people throughout the country are making use of casualty departments. He said the "overriding reason" was the free service.

FEES CHEAP

Speaking from his surgery in Wellington, Dr Ridley-Smith said people would continue to use the casualty wards as long as the service was free.

"But when you pour all your resources into a hospital building, what can you expect?" he asked. He said people were "exceedingly deceitful" about the availability of their own doctors, in order to avoid paying for treatment. He said that medical fees charged by general practitioners were still cheap by world standards.

Dr Ridley-Smith said his society had recently met with the Minister of Health on this matter.

Dr Joan McIntosh, head of the A and E department at Palmerston North Hospital, is making attempts to reduce the number of patients who return to the department after the initial treatment.

"But we do bring some patients back," she said. "With cases like injured knees, we cannot always see how bad the injury is the first time, and we like to see them again. But in cases of wounds and burns, which are slow to heal, the patients will have to go back to their general practitioner."

"We don't turn anyone away, but sometimes we do refer patients to their medical practitioner."

On an average Monday, 170 people are examined by the A and E department of Palmerston North Hospital, 20 of whom are admitted. An average day shift is made up of one or two doctors; two registered nurses; two student nurses and one enrolled nurse.

NOTHING TO DO

In emergencies, they can call upon extra staff working in the rest of the hospital.

Dr Poynter said it was difficult to predict the number of patients who would present themselves during the course of a weekend. "A and E can have 50 or 60 people there one Saturday afternoon, and another time, there will be nobody there - while the sisters and doctors are standing around with nothing to do."

He expects this year's figures will show that the number of attendances at the department will have risen to 40,000, and if it had not been for the introduction of the Accident Compensation Act, the figure would have been far higher. Referring to his graph of attendances he said: "The way the graph was rising we could have expected it to have reached 44,000 by now."

"To some extent the use the people make of medical services relates to what is available to them. As a population

Welfare widens role

Political Reporter

MASTERTON will be the testing ground for a Social Welfare Department adolescent support unit.

The Minister of Social Welfare, Mr Gair, last night said the unit introduced a new concept of support for young people leaving the direct care of the department.

The four-unit motel block will be set up at a cost of \$110,000, on a three-hectare property next to an

existing departmental family home.

The aim is to help former members of the "family" to bridge the gap between leaving the home and living independently in the community.

The Masterton family home has been operating for nine years, catering for disturbed children regarded as unsuitable for placement in either foster homes or institutions.

Mr Gair said it had become clear these children face considerable

difficulties in moving from the family home environment, with its close parental care and control, to coping for themselves in a flat once the start working.

Pressures often destroyed the improvements achieved by the youngsters during their family home years.

Mr Gair said the results of the scheme will be carefully monitored for future application round the country.

Beds, doctors exceed demand

DOMINION 30.10.79

NEW Zealand has too many hospital beds and will soon have too many doctors.

This is the view of the editorial in the New Zealand Medical Journal this month.

"The health resources of the country have got out of balance," it says.

"There are 25 per cent too many hospital beds, ranging from a 46 per

cent excess in the maternity field to 18 per cent in psychiatry.

"The long-term prospects are for a surplus of doctors and, at least in 1977, there was no shortage of nurses." The editorial says there has been too much emphasis on hospital treatment and community health services have been partly neglected.

"Better health management at pre-doctor and primary medical

levels will reduce the pressures on institutionalised resources."

The editor of the journal, Professor R G Robinson, Dunedin, yesterday would not comment on the editorial but its views were backed by officers of the Health Department.

The director of the hospitals division, Dr R Dickie, said the excess beds were mainly in rural hospitals and the health system

Plunket's changing emphasis

THE TRIBUNE
December 9,
1979

Hospitals Face Higher Demands

PUBLIC confidence in the ideals and service of the Plunket Society has always been unwavering.

Yet there were genuine misgivings among some staff, former patients and well-wishers when the society decided last year to close its six Karitane hospitals, and replace them with smaller family support units.

It was feared that the special needs of mothers and babies to which the hospitals had catered so well over 71 years, would suffer as a result. Doubters saw it as a withdrawal from the Karitane tradition, rather than a renewal.

However, Auckland's pilot family support unit in Meadowbank is claimed to be a great success. In its first year it has helped more than 900 mothers and well over 1000 children, which is more than used the old Karitane hospital in a year. A State house is now being prepared at New Lynn for a second unit.

By March 1982, the society expects to have 46 units operating throughout New Zealand.

Government disapproval of what it considered unwieldy financial methods in the old Karitane operation, played an important part in the Plunket decision to restyle it.

THE TRIBUNE
November 25, 1979

NOT SURPRISINGLY, c New Zealanders are moving to their general practitioner and emergency department number of people at 38,000, and prediction

Naturally many people accident and emergency cases which cannot be justifiable one - that there because it costs

The chairman of the Ridley-Smith, of Wellington, overriding reason may own general practitioners availability of their own hospital, he said.

Dr Ridley-Smith fundamental reason for "something for nothing" service should be free, not appear to be keep considerable amount

operations, for example Many people feel that pressing put on a burn doctor, and pay more

The number of people seen as an anti-G.P. se looked on highly in the matter to blame them

HEALTH PROBLEMS: CHRONIC CONDITIONS

20,000th alert readied

THE 20,000th New Zealander to get a Medic Alert Foundation bracelet, Mrs Janette Cooper (right) of Lower Hutt, receives it from the Minister of Health, Mr Gair, in a special presentation in his office yesterday.

The Medic Alert Foundation, which began in the United States in 1956, was established in New Zealand in 1962. It is sponsored by the Upper Hutt Lions Club and supported by Lions Clubs throughout New Zealand.

Its bracelets enable people with hidden medical problems to have these communicated to doctors in emergency.

The bracelet can alert a doctor to the special needs of someone who falls unconscious.

It has the condition engraved on it and gives the foundation's 24-hour telephone number which the doctor can ring to get full information about the person, who has a code number, also engraved on the bracelet.

The bracelets are used to indicate more than 200 conditions, among them diabetes, epilepsy, hemophilia and asthma. Allergies to all sorts of things are also



Spotlight on the disabled in our midst

EVENING
STANDARD
September
21,
1979

by JUDITH TUCKER

CRIPPLED Children Week started officially yesterday – and today we start a series of stories on the aims and activities of the Crippled Children Society, the programmes it offers, and the people it helps.

In this International Year of the Child, Crippled Children week centres around the May theme – "The Child in Work and Vocation."

We will look at how disabled people face the problems of work, vocation, and how the society helps them.

Not so long ago a "crippled child" would have been thought of as someone who walked with a limp or had a crooked spine.

Today there is no common image – people suffering a wide range of disabilities live as ordinary members of the community.

This changing image of disability parallels the growth and change of the Crippled Children Society.

In 1935, Sir Alexander Gillies, a noted surgeon, persuaded the Timaru Rotary Club to establish a Crippled Children Society to help children suffering from polio.

In 44 years, the society has expanded to 32 branches and centres throughout New Zealand and the Cook Islands.

It works for children and adults suffering all type of disability – from crippling diseases to emotional disturbances.

Field officers provide the basic service of the society. They counsel disabled people and their families on medical services, schools, recreation, vocational training and all aspects of daily living.

A great part of the society's funds is spent in transport – to school, to medical centres, camps, workshops and on holidays. Without this help a disabled member of a family

would often have to stay home.

Pre-schooling training, specialist care, work placement and assessment schemes are all provided to help the disabled child grow to independence.

But it's not all hard work.

The society supports recreation programmes ranging from leisurely craft work to adventurous activities like riding and skiing. These experiences develop individual skills and instil confidence.

Adults, too, benefit from the society's services. Assistance is provided with such things as car purchase loans or alterations to make a home accessible.

The society is continually changing to meet new needs. A recent development is the first Disabled Living Centre in Lower Hutt. Run by disabled people for disabled people, the centre provides social and practical services not within the scope of the society.

Similar centres are now being sponsored in other areas and it is hoped that one day every New Zealand community will boast one.

Concerned with the care of all crippled children, the society tries:

- To see that every child has the earliest possible treatment of his or her disability, by providing ready access to specialist facilities and ensuring the most effective, co-ordinated care.

- To help parents and the immediate family understand the child's special needs and the physical, mental and behavioural training necessary to his or her welfare. Parents sometimes want to spoil a disabled child but without training for normal behaviour and rehabilitation, physical care is incomplete.

- To ensure that every crippled child has a sound vocational education adapted to individual requirements. This helps children to rise above physical disability to take their rightful places in

society and, where possible, in the economic life of the country.

- To bring both parents and child new hope and confidence through understanding the facilities and services available. At the same time, the society works to remove attitudes which often prevent disabled people from entering the community and force them into "disabled ghettos".

- To promote an attitude among employers which will bring suitable work on a sound economic basis within the reach of every crippled child.

Employment for severely disabled people is generally obtained through sheltered workshops and other schemes. Skilled people with walking disabilities find it difficult to actually get to work and into a place of work.

The society hopes eventually to have work areas for disabled people within factories, organisations and departments – instead of separate from normal life, often in depressing surroundings.

- To rehabilitate physically handicapped people and help them live within the community.

Developed countries all too often shut away their elderly and their handicapped people. These people are citizens and have a rightful place in the community.

The Crippled Children Society is working to make places available for all disabled New Zealanders.

Children can and must learn to cope with their disabilities and to become as independent as possible. This requires special teaching from professional staff and community understanding.

The society believes there is little point in encouraging children to be independent if the outside world prevents them from acting independently.

This happens in many ways – lack of accessible public transport, architectural barriers that prevent access to buildings, misunderstanding of various disabilities, and reluctance to hire disabled people.

If community support is combined with specialist services such as those provided by the society, disabled children will have the chance to take part in the world around them.

There are over 8000 disabled people registered with the society – babies, teenagers, young adults – all of whom have individual desires and ambitions.

Disabled adults are also the society's concern. Many rehabilitation workers, teachers, therapists and counsellors, as well as training facilities, workshops, pre-school training centres and

Kids get



KIDS GET A BREATH

DOMINION November 17, 1979
CYSTIC fibrosis children Paul Walklin (left) and Phillip Jarman, use the respiratory machines donated to the Cystic Fibrosis Association by the Tinsford Lions. The machines are used by the children three times a day, with distilled water or a diluting agent, to thin the mucus in their lungs. Valued at over \$100 each, the machines were presented by Mr Gael Ansell (holding Paul) governor of Lions in Wellington and Mr B.J. Tarpley (holding Phillip), president of Tinsford Lions.

HEALTH PROBLEMS: CHRONIC DISABILITIES

Heart Week

HEART WEEK (October 7-13) is Heart Week and features the theme "Family responsibility for health". The following extracts are from a talk by the medical director of the National Heart Foundation, Dr D R Hay, in Dunedin on September 27.

DOMINION, October 10, 1979

"THE major advance in the prevention of developmental heart disease in the last decade has been immunisation against rubella or German measles, which in early pregnancy can cause congenital defects in the child. Undoubtedly this has led to a reduction in the number of children with congenital heart disease and this has been observed in surgical units in New Zealand and elsewhere. I am not suggesting that rubella is necessarily the major cause of congenital heart disease, but for the present it is the main preventable cause.

Disorder

"Rheumatic fever and its cardiac complications is another disorder in which progress has been made.

"The fact is that salt and hypertension are closely linked and a reduction of intake appeals as a preventive hypothesis.

"Like many issues in cardiology we don't have proof that intervention will succeed, though trials on the salt reduction theory are in progress. I believe reducing dietary salt to half our usual quantities would cause no adverse effects, would be acceptable to most of us — much more so than a low fat diet, and may help to keep blood pressure at lower levels.

"Trials justify an aggressive attitude toward drug treatment of mild blood pressure but they are not sufficiently clear cut or spectacular to warrant hunting out every hypertensive in the community to get them on to drug treatment.

Correction

"For now I advocate a conservative screening and case-finding policy, and for the milder cases, a return to simpler management with correction of food and salt excesses, a more relaxed way of life, and positive approach to physical fitness and non-smoking. These measures take first priority for the milder case.

"New Zealanders eat too much. Their diet is very high in fat which for most adults is the largest source of energy. Cholesterol intake is very high, the medium intake for men in their twenties is 670 mg per day, while women consume about 390-440 mg on average.

"To put these figures in perspective, the so-called 'prudent' diet in the USA contains about 300mg of cholesterol per day, so we are well above this 'prudent' intake.

"This results in a diet which is higher in energy content than the values recorded for most other countries. And because our energy expenditure has become less with urbanisation and less physical activity, obesity is a common problem. 14.6 per cent of men aged 20-29 were 20 per cent overweight and 5.3 per cent were 40 per cent overweight. Women reached their peak obesity figures in the 50-64 age group, of which 17 per cent were 20 per cent, and 6 per cent were 40 per cent overweight.

"What this report is saying is that our diet, like that of most other so-called affluent nations — but more so — is precisely the sort which leads to a high level of coronary disease, and this is what we have. It is too high in calories for our energy expenditure, very high in fat, cholesterol, sugar, and alcohol.

Sickening

"We are a fat nation, we admire fat babies and if you are not overweight you have little chance of All Black selection as a forward, or for that matter the local school rugby team. Someone should do a follow-up of ex-All Blacks forwards and see how they have fared with their health in later life — I wouldn't mind betting that they have had more than their fair share of arterial, diabetic and arthritic problems. Our young people wallow in alcohol and our beer intake at 131 litres or over 30 gallons per annum for every man, woman and child in the country is sickeningly high.

"We need to condition ourselves and particularly our children, to less 'sweetness' in our diet. Secondly, fat consumption must be reduced and this means less meat and dairy products. Producers should be breeding leaner animals and excess fat should be trimmed off meat before cooking. Rich fatty gravies should be avoided. A reduced intake of beef and dairy products will reduce the already high level of saturated fats.

"We agree that there should be an increase in consumption of grains, starches, fruit and vegetables, and we support policies such as giving a lower priority to beef and mutton on the menu, with inclusion of more chicken and fish products.

Pride

"The question of the sale of food in schools is under study and we

"Exercise is not totally protective and some exercise fanatics do no service to preventive medicine when they overstate the case and talk for example, of marathon runners never suffering coronary attacks and having almost complete immunity from them. I believe that the benefits of exercise are derived partly from the pleasure and relaxation which it induces, and because the person who takes a pride in fitness also looks after other aspects of his health. When the exercise ceases to be fun but becomes more a punishment and a grim ritual, then I doubt whether it is achieving its objectives.

Staggering

"You may have seen President Carter, already beset with popularity problems, staggering to an undignified end in a community jog held recently. This sort of thing worries me because although the President, I understand, does carry out daily exercises, he was clearly not fit for what he was trying to do on the particular day. We see the same problem in some of the community jogs in New Zealand and every time one is held, I feel concern that someone is going to come to grief because he or she should not have attempted it.

Maoris

"Maoris smoke very heavily and in almost all age groups more Maori women smoke than men. Over two thirds of Maori women aged between 20 and 35 are smokers which I suspect is one of the highest rates in the world.

"We are faced with some obvious target groups — the Maori population, younger women, those in less skilled occupations, but social attitudes have changed and this is in our favour.

"Life expectancy for those over 40 or over 60, that is, in the years when heart disease takes its main toll, has changed relatively little over the last 80 years. The gain for men aged 40 is only 2 years with no significant change at all since 1955. Men aged 60 can now expect to live another 16.17 years, whereas in 1900 it was 15.33 years, hardly a great gain. Women have done better, the corresponding figures being 16.34 years in 1900 and 20.55 years in 1977. Indeed, if we knew why women were tougher and got less heart disease, we might be a lot

THE TRIBUNE, November 11, 1979

Craft & Care for Stroke Patients

CROCHET is the only handicraft that "stroke" patients cannot learn to master, claims Elsie Downing, one of the most dedicated Community Volunteers in this city.

For the past 15 months, Elsie has run three care and craft groups in the suburbs, teaching people of all ages, including the disabled, a wide range of skills.

She also teaches them the value of friendship, and fosters an atmosphere of care and understanding among the people who attend the groups.

The groups are held in Takaro, Hokowhitu and Wood Street for two-to-four-hour sessions.

They are run in church halls and community centres, and include solo mothers, housewives, widows and widowers and disabled people.

"It's good for the disabled

Injuries a Vvorry

PARAPLEGICS are worried by the number of spinal injuries caused at rugby and soccer games in the southern North Island. At the annual meeting in the city of the southern North Island region of the Federation of Paraplegic and Physically Disabled, members said they were concerned about the number of deaths and injuries in the region.

In the past year there have been four deaths and four people admitted to the Burwood spinal unit, Christchurch, from the southern North Island. Most of these were younger than 25.

Congratulations were extended to Mr Michael O'Brien (Masterston), who was the recipient of the Harold O'Callaghan Memorial Silver, awarded annually at the Wellington association's dinner for achievement.

Mr O'Brien became a paraplegic in 1974 after an illness. At that stage he was a partner in a newly-formed building partnership and now with assistance has built the joinery for his own home on a hillside section.

During the early days of his treatment at Palmerston North and Christchurch he became convinced of the need for a paraplegic association in the Wairarapa. He gathered support, and on August 19, 1976, the Wairarapa branch of the Paraplegic and Physically Disabled Association was formed, largely due to his efforts.

A keen sportsman before becoming a paraplegic, Mr O'Brien set an example to others by competing in paraplegic sports gatherings and at his first attempt at competition took even medals.

DOMINION June 30, 1979

Age trend puts pressure on welfare

SYDNEY cardiorthoracic surgeon Mr Douglas Baird, with one of the latest in medical gadgetry — a remote-controlled heart pacemaker.

The device allows a patient with the pacemaker fitted to alter his own heart rate with an instrument held in front of the chest.

Mr Baird recently implanted one such pacemaker in one of his patients.

Similar devices are stocked by medical suppliers in New Zealand, but so far none has been implanted.

The patient has a choice of four speeds from 60 to 110 beats a minute. After doing tests

patients," Dr Baish dependence on public support is likely to be further.

show a marked the population, with fewer children. So age of the population could rise from 26.8 to 35.5 years between 2011.

likely to be a long-line in the number, with a 4.1 per cent decline in the number of children and a 1 per cent decline in group of 5-16 years.

man said there were effects on the system concerning manpower and its costs, and health care and the of resources within health system.

It gets the heart into top gear

DOMINION, November 16, 1979



HEALTH PROBLEMS-DRUGS:ALCOHOLISM

THE DOMINION

Concern at incidence of excessive drinking - DOMINION 10 10 79

FRIDAY

Incorporating the NZ Times

JUNE 1, 1979

The demon drink

PARLIAMENTARIANS could spend their time more fruitfully examining the liquor outlet trend rather than debating a call for a return to 6 pm closing. That call for a return to the pre-1967 days came from MP Mr Trevor Young in a notice of motion to the House. Mr Young, before entering Parliament in 1968, was general superintendent of the prohibitionist New Zealand Alliance, of which he is still a member of its education trust, and is a patron of the Society for the Promotion of Community Standards.

To support his call Mr Young referred to a Health Department report which, he said, showed that the proportion of patients admitted to psychiatric hospitals with alcoholism or alcoholic psychosis had risen from three per cent in 1966 to a current 7.6 per cent. This had happened since the change from 6 pm closing and through the extension of liquor facilities in recent years, he said.

Mr Young's concern over what is a major social problem is commendable; his logic however appears suspect. To heap the blame on the more liberal drinking hours introduced in 1967 is surely over simplification.

The rising alcoholism figures cannot be taken at face value. They reflect a greater awareness of the alcohol problem leading to sufferers being detected earlier than in the past; they are boosted by a growing acceptance by the medical profession that alcoholism is a disease and that the sufferer demands the same consideration and treatment as would apply with any other illness. Nor can it be denied that the stresses on the individual of today are far greater than in the past — there are increasing victims, some falling to alcohol, to drugs, others simply drop out. Organisations such as Alcoholics Anonymous have extended their helping hands; the Liquor Advisory Council has embarked on extensive education programmes.

The discovery rate of a political reporter ROBIN EVANS, *SHAVE* 10-11-79, has not been identified. THE HIGH number of incidents of domestic violence is forcing police to take a new line of approach to the problem.

That is not to say *DOMINION* 10-10-79 **Drug education**

Sir, — On October 10 you published a reply from J C Smith to my letter about drug education. There is one important point regarding

the reply which requires comment.

It seems from his letter that Mr Smith has assumed that drug education takes place only in schools. Certainly the schools have a role to play. Current thinking is to develop drug education programmes as an integral part of health education programmes. It is now widely recognised, however, that the aim of health programmes must be to assist individuals to make responsible decisions about their own lives, including decisions about the use of drugs. For this reason the

THERE is an alcoholic or heavy drinker in practically every Palmerston North street.

This fact has emerged from an ongoing research project of Dr Lewis Bieder, head of the Palmerston North Hospital's detoxification and clinical assessment unit.

The unit in Ward 5 is staffed with three doctors, a team of nurses, a psychologist, a social worker and other paramedical staff.

Since the ward was opened in April 1978 the staff have made a point of noting where each patient lived in the city.

A pin was placed on a map of the city corresponding to each patient's home

address. Clusters of pins appear round boarding-houses, workers' hostels and in the older sections of the city.

"It has been estimated there are between 50,000 and 55,000 alcoholics in New Zealand and possibly a further 100,000 heavy drinkers," Dr Bieder says.

The incidence of heavy drinking is of great concern to those who deal with the problem.

Last week the New Zealand Medical Association announced that it intended to stress to the Government 'urgency of the need to control excessive drinking.'

Dr Bieder is very much in favour of this move.

He agrees with the recent comments by a Christchurch researcher, Dr Morgan Fahey. Dr Fahey criticised "booze barns" in an address to the New Zealand Wine Institute and appealed for more sensible drinking habits like taking food with alcohol.

Dr Bieder would like to see the English corner pub introduced to New Zealand. He decries the loud music played in New Zealand's booze barns which prevent people from talking to one another.

"When they can't talk there is nothing else to do but drink," he says.

Research

As head of the detoxifica-

THE DOMINION

Incorporating the NZ Times

SATURDAY

JUNE 2, 1979

Costly pills, potions

THE WELFARE state, to which both major political parties subscribe, and which the electorate regards as sacrosanct, is in real danger of collapse. Nobody wants that to happen. New Zealanders accept a social responsibility and wish to go on doing so. But the truth is that government welfare services have reached a non-sustainable level. It mightn't necessarily mean that we

set our humanitarian sights too high. The measure is not whether our ambitions encompass socially desirable ends, but whether we can afford them. The answer is that, at the present rate of expenditure, we cannot. The exercise to which the Government must address itself is how to curb expenditure without ruining social performance.

Mr Gair, the Minister of Health, is obviously about to apply some surgery in his domain. He has been dropping hints. These have provoked angry responses from the Labour Opposition, charging the Government with wanting to kill "free" medicine. It isn't free at all, of course. Somebody has to pay. As a principle it is right and proper that health should not turn on an individual's ability to afford it. The trouble

naire honestly they can be told that the blood test shows they are drinking heavily.

"Getting someone to admit the problem and

Prevent overdose doctors advised

DOMINION MAY 5, 1979

DRUG overdoses could be halved if doctors refused to prescribe tranquillisers for problems of living, an Auckland psychiatrist says.

And he says the money spent on some drugs in New Zealand is adding to the hospital bill by increasing self-

This group includes tranquillisers with brand-names like valium, xanax and librium.

People who poisoned themselves with this kind of drug were also less likely to be suffering from a particular psychiatric illness.

The recruits programme involves a module of six class periods followed by two-hour marriage guidance council sessions. Recruits learn the likely forms of conflict they will face when attending a domestic incident, and the responses open to them. Emphasis is also placed on possible causes of domestic violence, the importance of mediation, and the use of various referral agencies.

Chief Superintendent J. Jamieson, director, training, at Police National Headquarters, believes recruits should be fully aware of the problems they face once they are "in the field", and how to cope with these.

In an endeavour to provide a more comprehensive background from which to work, the recruit training sessions are run jointly by both police instructors and education officers. During group courses, recruits are taught about the family structure, its social stratification, how society operates, and the background to some of the likely causes of disputes. Role playing, and acting out violent domestic scenes by recruits, also plays an important part in the sessions.

"Members of the class are involved in acting out the different parts of people in a domestic dispute, often with the role playing being video-taped so that a close analysis can be made and discussion can be drawn out of this," Mr Jamieson said, interviewed this week.

He said training also involves comprehensive instruction in all areas of police intervention.

broad term for all sedatives that affect the mind, including other types as well as benzodiazepines) were prescribed, overdoses could be cut by half.

Dr Large said the problem with tranquillisers other than benzodiazepines was less clear-cut. However it

"The family and includes lessons on how to deal with the initial contact on arriving, restoring calm, discovering what the problem is, and knowing the options open to deal with each individual situation.

Importance of mediation is stressed in the sessions, and referral options — such as the family doctor, a minister of religion, church or social services, Samaritans, Citizens Advice Bureau, the National Society of Alcoholism and Drug Dependence, the Social Welfare Department, the Marriage Guidance Council, the refuge centre for battered wives and associated support groups — are taught.

Mr Jamieson said while all these options are made use of police intervention usually defuses violent domestic scenes.

"There are still many people who hold basic respect for authority, and therefore this kind of mediation intervention — to determine how a problem should be handled — is very often the sort of catalyst needed to bring sanity to the situation."

While it is difficult to pinpoint patterns involving domestic violence, Mr Jamieson said alcohol is a key factor. Most calls police receive are timed between 10 p.m. and 1 a.m. — coinciding with hotel closures. He notes that it is also usual for police to be called back to the same families on repeated occasions.

There are no statistics kept relating to age or circumstances surrounding domestic violence, Mr Jamieson

Domestic Lessons for The Police

said it would be hard to find a definite pattern, "except that it grows less common with increasing age".

Domestic problems appear to be the same the world over, and police are also looking outside New Zealand to see how other countries and police departments are coping with the increase in this type of violence.

A specialist study unit within the police training directorate is researching the modern policing methods in crisis intervention used by other major law enforcement agencies.

Attention is being focussed on the United States because of the wealth of literature, information, innovations and experiments being carried out by some of the larger police departments in that country.

The better, more professional police forces in the United States are well advanced in this area and we are endeavouring now to take the best of the programmes we've got from overseas, and look at adapting them here," Mr Jamieson said.

He believes New Zealand police training methods rate highly with any of those in use overseas. But, he stresses:

"I think all of our training, whether it be unit studies or at the police college, are only as good as it is reinforced by the on the job training — which is still the most critical part."

"The only way a young policeman really learns is by being shown by his supervisors and peers, and from first-hand experience."

SOCIAL - HEALTH TRENDS IN N.Z.

Health, politics and a week

Sunday, December 16, '79

by The Boffin

CANCER, heart disease and many birth defects have environmental origins and are therefore preventable. We often know the risk factors and could eliminate them, or at least drastically reduce them, by simple changes in human behaviour.

Instead the opposite happens; cancer and heart attacks have reached epidemic proportions in all the developed countries.

Part of the reason is that we have almost eliminated some of the competing causes of death. If your life has been saved by penicillin or a timely removal of your inflamed appendix, you may succumb to cancer later, but that is not the whole story.

During the long course of human evolution we have learned to co-exist with most of the chemicals in natural environments, but the industrial age has changed all that. We now turn out thousands of new synthetic chemicals, some of which are capable of changing the fundamental nature of the pro-

teins controlling the growth of cells. Some of these mutations are cancerous.

Why do we go on producing these things? Why do we smoke cigarettes, which are responsible for about 20 percent of all cancers? Why do we manufacture and distribute 2,4,5-T which has been shown beyond all reasonable doubt to cause defects in unborn infants due to its dioxin content?

Political considerations come into it. Governments collect a lot of revenue from cigarettes and alcohol, which are potent health hazards. A recent cost-benefit study in Britain showed that in the long run the abolition of tobacco (if it was politically feasible) would cost money. The productivity of the people whose lives were saved and the saving in hospital costs would exceed the loss of tax revenue in the short term, but after about 20 years there would be a net loss due to the greater number of old people in the welfare system.

Public concern can be allayed when manufacturers of chemical pollutants ridicule the evidence

against their products on the grounds that it has been produced in laboratory experiments on rats, using larger doses than humans are exposed to. What are they suggesting? Should we carry out experiments on humans using lower dose-rates and wait 30 years for the results?

Action can be delayed by the long time interval between exposure and the onset of disease. For cigarettes this can be 20 to 30 years, and up to 50 years for asbestos. It is hardly surprising that epidemiological studies are not good early warning systems for new risk factors.

Industrial workers on production lines are more at risk than their bosses who work in office environments, as comparisons of death rates for different causes have shown in many countries. In general, workers are not told what chemicals they are exposed to, and in what concentrations. Diesel fumes, for example, are about as dangerous as cigarette smoke, and asbestos workers have abnormally high death rates from lung and bladder

Eyes on health planners

Dominion, June 1, 1979

By SALLY FAULKNER

TRADE UNIONS are keeping a close watch on the part-time activities of National Bank manager Mr Spencer Russell.

Mr Russell is also the chairman of the Wellington Health Services Advisory Committee (Whelsac), a nine-month old, 20-member committee — made up mostly of prominent health officials — which is working on a total revamp of local health organisation.

Broadly speaking, what Whelsac aims to do is get rid of the Wellington Hospital Board and the Health Department's district offices for Wellington and the Hutt, and replace them with a "health board".

It is a daunting task, and one which raises, in Mr Russell's own words, "some



MR RUSSELL... planning health service revamp

very difficult personnel problems".

But he is adamant the committee won't be handing out redundancy notices.

He speaks instead of a "slow rationalisation" of jobs over years — and perhaps a breaking-in period when the health board co-exists with hospital boards and district health offices.

A tentative date for the establishment of the health board is early 1983.

The board will aim at a community-based and preventative approach to health; co-ordinating the efforts of existing voluntary, service and government groups.

In line with this, it will have wider control of how money is spent.

Existing hospital boards are given tied funds for specific projects; but the health board will get a single government grant to spend as it sees fit.

The board will have some elected members, and some

appointed experts from fields like dentistry and paediatrics.

Wellington's health board will be the first in New Zealand, though a rural equivalent is operating in Northland.

The idea for the two experimental schemes was born out of a government advisory committee last year.

Till today Whelsac held its meetings behind closed doors, so the public has not heard much about what is in the pipeline.

But Mr Russell reports "lively interest" among doctors and other health groups with representatives on the committee.

The committee has invited more than 100 health groups to make submissions on the scheme, and it will hold a workshop in March.

Plunket's plans for the '80s

THE Plunket Society is to boost nurse in-service education and training in 1980 with projects totalling \$55,000 from grants and bequests.

The society has decided that during the next decade major efforts will be made to keep nurses more informed of advances in paediatric and community nursing and to see they are equipped to help families deal with the social pressures threatened in the Eighties.

"The early 1980s in particular promise to place many strains on young families and it is our intention to see that the Plunket Society is geared to help them cope with parenthood," says Mrs Joyce Andrews, Plunket's national president.

"The nurses are our front line and we owe it to them to see they receive the maximum encouragement and

from birth to five years.

The society will also embark on a major research project to improve the objective evaluation of family needs by Plunket nurses in order to up-grade the service.

Spread over three years, the \$30,000 project will be based in Dunedin. Contact will be made with mothers who will be monitored from pregnancy onward. After birth, infants and their individual characteristics will be observed and the home environment will also be studied.

Says Plunket's medical director, Dr David C. Geddis: "At the moment we know at the end of a month's contact how much support a

Community health

THE WELLINGTON Hospital Board is health nurse to give the go-ahead for a community health service in Newtown. It has been, and is, a controversial issue. Part of the opposition stems from prejudice against change from within the medical establishment.

There are, however, more defensible grounds for reservations. Still, the proposal amounts to no more than an experiment and much can be learned from it.

Premises are now to be found. The move to take health services into the community can advance the cause of preventive medicine, particularly in an urban area such as Newtown with its mix of races. It can also relieve strain on existing hospital facilities and ultimately ease demand for over-elaborate and high-cost medical establishments. The Danks committee looking into Wellington's regional medical administration might be invited to monitor the operation.

all-over health centre

Report plans novel

DOMINION MARCH, 5 '79

By BRIGITTE SPRENGER, Health Reporter

HEALTH centre proposed for Newtown residents aims to offer all medical and paramedical services for a low annual fee, regardless of the number or nature of visits.

DOMINION, June 1, 1979

Urban health service reshuffle near

REORGANISED urban health services came a step closer yesterday.

Wellington health services advisory committee members had their first meeting.

Committee chairman and National Bank general manager Mr S T Russell said later it would seek out all health groups in the community to hear their needs and aims.

A special advisory committee on health services has recommended a system of

regional boards taking the functions of hospital boards and district health offices.

A pilot scheme was smitten set up about 18 months ago. In the report, accepted as a long report by the Dean of the Wellington Clinical School, Professor Ralph Johnson.

At yesterday's opening, Professor Johnson said the committee had lined the basic concept of the novel payment scheme.

As times and circumstances changed it was necessary to rethink ways to tackle the health service which

In cases of hardship a donation would be accepted instead of the fee. And special family rates are proposed.

of enthusiasm so far shall take the proposal to Wellington Hospital Board for its approval," Mr Vasan said.

In his report, Professor Johnson said the steering committee had envisaged the centre as a service separate from the public hospital.

It was hoped the centre would be associated closely with the already established Newtown community centre to provide a broad social and medical service.

The committee had seen Newtown as unique, with special conditions and a great need for a health centre.

It had a large ethnic population, high birth and death rates, high residential density and many living in the area

SOCIAL - HEALTH PROBLEMS

Tb 'at risk' folk stay

Discrimination Govt achievements

fear hampers in field of health

MAORIS are eight times more likely than Europeans to get tuberculosis. Pacific Islanders are 20 times as vulnerable.

Yet some Polynesians may be missing early detection — or even prevention — of tuberculosis because they feel special treatment programmes for them smack of racial discrimination.

By NIKITIN SALLEE

a Maori thing to talk about health in the of other people.

"One thing they hate being told is they are perhaps inferior to other people with health preventive measures, building up par-

But why do Polynesians get tuberculosis? medical support, and ex-

THE Minister of Health, Mr Gair, writes to the editor of The Dominion:

Sir, — Your editorial of July 10 took the Government to task for not getting on with health preventive measures, building up par-

A letter to The Dominion

I can list some of the

further \$1,464,000 in 1978/79.

Most hospital boards throughout the country have used part of this grant to improve home help and home nursing services. Many other examples could be given.

The remainder of the \$27 million was allocated to such purposes as public health and occupational health nursing services, family health counselling centres, additional social

INTEGRATING THE YOUNG

DISABLED

EBONEE RASMUSSEN, aged 2½, suffers from a condition known as athrogyrosis — a lack of muscles in her arms.

She makes tri-weekly visits to the Waiwhetu sheltered kindergarten, set in the grounds of the Waiwhetu Primary School.

The centre caters mainly for children with cerebral palsy, but others with spina bifida, congenital malformations, frail dispositions, emotional problems, hydrocephalus (water on the brain), club feet or those who do not perform in larger groups, are also visitors.

Kathy and Rodney Rasmussen, of Days Bay, Ebon-

child and preparing her for primary school. They mention the special drawing apparatus which was made by the Crippled Children Society especially for Ebonee.

When Ebonee first attended the centre, her four-year-old sister, Meccedes, accompanied her during the settling-in period.

"Ebonee realises she can't use her arms as well as her older sister, who goes to Eastbourne Kindergarten," Mr Rasmussen says.

"Another advantage of the sheltered kindergarten, besides actively stimulating our daughter's mind, is that it gives me a little time in the mornings," Mrs Rasmussen says.

HOW sheltered kindergartens established by the New Zealand Crippled Children Society are helping disabled youngsters to integrate into the community is told in this Department of Social Welfare release.

DOMINION November 1979

"When you look at other handicapped people, Ebonee's handicap is not so bad," Mr Rasmussen says.

Improved self-confidence is the greatest change staff observe in the children, according to the Waiwhetu centre's head teacher, Mrs Jan Lamb.

"Changes like having the confidence of getting down

years old. Twenty months the youngest entry age at some children stay till the age of six.

The centre aims to phase them into a standard kindergarten before six years of age to help prepare the children for going to school.

Life at Waiwhetu is much the same as at other kindergartens, handicraft activities

THE DOMINION

Incorporating the NZ Times

FRIDAY

FEBRUARY 1, 1980

Preparing for life

JUSTICE Minister Mr McLay sees inappropriate education as one of the contributors to the frightening pool of unemployed youth. Education, he told youth workers in Auckland, should be oriented towards the type of employment a youth was likely to undertake. It should provide early work experience and continue into adult life. Wasted and unused learning might be avoided by such a system, he said. He pointed to what he said was a large number of unemployed and inappropriately employed university graduates as examples of a great many misused opportunities.

It is to be hoped that the views his colleague expressed are not shared by Minister of Education, Mr Wellington. That is not to hold up the present system as the best that the country's educators might devise. For all its shortcomings however it might prove infinitely better than any alternative that attempts to define at an earlier stage a pupil's likely vocation and to provide an education to cater more specifically toward that end.

In an era in which technological developments alter markedly employment roles, in which computers and machines are forcing increasing numbers into retraining programmes, the need is to broaden the basis of learning rather than to narrow it by a brand of earlier specialisation.

The need is for an education that provides a sound base on which a student's career — whatever the field chosen in teenage or later years — can be built. Only with such a basic preparation can youth be expected to meet the demands of later life and cope with the kinds of change that the workforce of the future will almost inevitably encounter.

The fact that there are university graduates who are among those out of work can hardly be accepted as evidence that there has been wasted learning; in the current era of record unemployment levels during which no sections of the community have escaped the chill winds of recession it is inevitable that there will be some.

Nor can too much notice be taken of the Minister's reference to inappropriately employed university graduates. In many cases a graduate is employed not to make use of specific learning that might have been acquired on the way to graduation, but because in the minimum of a degree

Allergy stalks industrial man

SCOTT JABLIN is allergic to the 20th century. He is — doctors say — one of the first victims of today's increasingly polluted atmosphere.

A mere whiff of ordinary air is enough to send Jablin, 25, into convulsions. As a result he has had to take refuge in a retreat 1800 metres up a mountain in California.

A joke? Not Scott Jablin. There is almost nothing that does not bring him out in a sweat, or make it difficult for him to breathe.

He is allergic to alcohol, all chemicals, cigarette smoke, fluoridated water, perfume, most plastics and the smell of petrol.

For a young man brought up in New York city such list of allergies can make life miserable. He cannot even breathe the normal air or drink water from a tap.

For most of his life Jablin has suffered from minor allergies, but recently things got so bad he could only breathe bottled air through a cotton face mask with a charcoal filter. The only meals he could eat had to be prepared from a specially grown organic food.

He had to wash with a sponge dipped in distilled water.

To stay alive he had to

From JEFFREY BLYTH, a British journalist based in New York.

have five injections a day of various serums, as well as periodic shots of adrenalin to control his symptoms.

One of his doctors recommended that he go to live in an area where the air is fairly clean and pure. Which is why he now lives with a family up Mount Shasta in California.

If Jablin was a unique case he would be someone who would interest only doctors. But he is not.

Medical experts at the United States National Institute of Health estimate that 17 per cent of the United States population — almost one in five people — suffer from at least one allergy disease. And the figure is growing.

Not all are such serious cases as Scott Jablin. But the number of people who are allergic to the chemicals and pollutants of modern society — everything from paints to pesticides — is growing.

There is, for example, Mrs Connie Rowley, of Dallas, who is allergic to plastics. Expose her to nylon stockings, a plastic telephone, even the synthetic seat covers in a car, and she breaks out in a rash. She cannot even eat an apple

that has been wrapped in plastic.

Then there are Bruce and Barbara Small, of Ontario, who are also allergic to modern chemicals — including such everyday things as Coca-Cola and coffee — that they have had to build themselves, at a cost of over \$200,000, a pollution-free home to protect them from the outside world. Their home has an air purifying system in every room.

Because they are even allergic to the fluoride and chlorine in the water piped into their home they had to have a special fresh water well dug on their property.

Because of his allergies Bruce, a management consultant, has to work at home. The smell of ordinary paint, or vinyl furniture, bothers him. So does even the smell of typewriter ribbons.

The only clothes either of them can wear have to be made of pure cotton or wool. No synthetics. There is not even a TV set in their home.

One of the most disturbing aspects of this new affliction is that it is affecting even very young people, including children. As Dr Phyllis Saiter, an expert on allergies, warns: "It is beginning to affect the way that many victims have to live."

"They really have to make major changes in their lives in order to survive. Usually they develop a certain

amount of tolerance to occasional exposure to chemicals and other things that make them sick. They can never hope to get back to eating, for example, pesticide-contaminated or wearing synthetic clothing. They have to limit themselves to leading restricted lives indefinitely."

It was Dr Alier recommended to Scott Jablin that he should go on in the relatively pollution-free atmosphere on top of Mount Shasta.

That was after he spent a month at the E Haven Medical Centre, Dallas, one of the two in the United States specialising in the study of modern day allergies.

One specialist, Dr T Randolph, a noted expert on allergies, is not optimistic about the future.

"If present trends continue — if more and more chemicals continue to be introduced — we are going to have more and more of these disabled people."

According to medical experts the dire warning of Scott Jablin is that he may be the first of many. If the pollution world continues there soon be many people like him — all victims of century living.

SOCIO-ECONOMIC ISSUES & PROPOSALS

Economics Education And The Economy New way for councils

Evening
Standard
Nov. 10, '79

Extending the Scope of Tertiary Education

ADMINION, August 30, 1979

TO discover what people want and then to give it to them... this was one of the main aims of New Zealand's first Community College when it was established on the outskirts of Napier four years ago.

Evening Standard August 8, 1979



THE Commission for the Future has launched the first of a series of three booklets outlining options and directions for the future. Entitled Resources and Technology, it assesses the country's resourcebase, and discusses the likely influence of new technology, particularly the impact of the microprocessor. In today's article, the first of six based on the booklet, the ideal of resource "sustainability" is examined.

The options are many

THE Commission for the Future has identified three main points of outstanding interest in New Zealand's future, as far as the nation's resources are concerned.

The country has substantial resources of energy, and can be considered "rich in fossil fuels".

The commission's two other central conclusions from an in-depth study of our resource base are that, because of these substantial supplies of energy, forests, and food, there is a wide range of options for the future.

But these resources should be managed carefully, with a view to attaining "sustainability", the commission says.

"It would be unwise to rapidly exploit natural gas and coal for our own use, and in so doing develop a level of energy demand which could not be sustained by renewable resources alone," the commission says.

Emphasising the sustainability concept, the commission notes that the larger the population, the larger the demand for fossil fuels. Competition for energy resources - and all resources - will inevitably mount as the population increases.

With these points in mind, the commission raises a series of issues and questions for New Zealanders to consider when looking at their long-term strategic values.

For example, to what degree does New Zealand wish to be inter-dependent with the rest of the world, as far as trade and investment are concerned?

And what type of life-style do we want? Central to this question, the commission comments, is the issue of industrialisation. Large-scale industrialisation, based on our own resources, would make New Zealand less dependent on world trade. But it warns that this would probably increase our dependency on overseas capital and expertise.

If New Zealand wants independence from trade and foreign investors, the best goal might be to rely on the nation's own resources and tailor small-scale industry to them.

"Complete independence from overseas trade and investment may only be achieved if we change our life-style to a simpler, more

labour-intensive, land-based one," the commission says.

Outlining the future allocation of land between competing uses (food, energy, tourism and so on), the commission again underlines the possibility of a sustainable economic return to the country and how that might be achieved.

It emphasises diversity as the best protection against fluctuating markets, and believes this could be achieved by developing new export commodities, such as deer, rabbit and goat products, and new horticultural products.

Interestingly, in discussing the future of tourism, the commission notes that New Zealand could make a feature of personalised accommodation at the guest-house and farm-house level, thus providing employment for people in a decentralised society.

Looking at options for non-renewable resources, the commission notes that if New Zealand chose to be less dependent on trade, land could be used to grow trees or crops for transport fuel. Coal could then be used as a source of materials rather than an energy supply. Plastics, for example, could be made from this fossil fuel.

On the subject of transport, the commission suggests that if New Zealand decides to constrain its dependence on overseas investment and expertise, "it may make sense to electrify much of our transport," using the renewable hydro power we have. Another option is to switch to alcohol fuels.

The third option of producing synthetic petrol from natural gas and/or coal is one which may well entail foreign investment, further industrialisation and/or the export of some of the energy.

Central to the whole issue of a sustainable future is this: "Are we willing to embrace the concept of sustainability now, or will we argue that a future generation must meet the challenge when it arises?"

Optimistically, the commission observes that "New Zealand's resource endowment is much better than New Zealanders have, in the past, realised".

What is crucial now is how we use those resources. And that, argues the commission, must be debated by all New Zealanders before such a vital issue as the future of the country can be decided.

Next: The quest for fuel.

By LESLIE BENNETTS of the New York Times

NEW YORK. - Jimmy is in the second grade and he likes school. He pays attention in class and does well. He has an above-average I.Q. and is reading slightly above grade level.

Bobby is a second grader too. Like Jimmy, he is attentive in class, which he enjoys. His I.Q. and reading skills are comparable with Jimmy's.

But Bobby is the son of a successful lawyer whose annual salary of more than \$35,000 puts him within the top percentages of income distribution in this country. Jimmy's father, on the other hand, works from time to time as a messenger or custodial assistant and earns \$4,800 a year.

In spite of the similarities in ability between the two boys, the difference in the circumstances to which they were born makes it 27 times more likely that Bobby will get a job which by the time he is in his late 40s will pay him an income in the top tenth of all incomes in this country. Jimmy has only about one chance in eight of earning even a median income. And Bobby will probably have at least four years more schooling than Jimmy.

These odds, according to a new report, are "the arithmetic of inequality in America." In "Small Futures: Children, Inequality, and The Limits Of Liberal Reform," a report to the Carnegie Council on Children, Richard de Lone challenges the traditional American view that a child's future in our society is determined by ability, early childhood training, education or drive. On the contrary, says de Lone, a former policy analyst for the Carnegie Council who is now executive vice-president of the Corporation for Public-Private Ventures in Philadelphia.

Although being born poor does not guarantee that one will remain poor, it makes it far more likely, de Lone says. In his view, "class, race and sex are the most important factors in determining a child's future."

Given the compounding penalties of being born poor, or a member of a racial minority, or to parents with little education and with intermittent or dead-end employment, or - a further disadvantage - female, a particular child will be unlikely to advance significantly above the socio-economic status of his parents.

The report, published by Harcourt Brace Jovanovich, was originated by the Carnegie Commission, a study group established in 1972 by the Carnegie Corporation of New York to investigate the position of children in American society and develop policy recommendations for the future.

"Small Futures" surveys the history of social reform movements in this country and brands them a failure, from the Jacksonian era to the Great Society of the 1960s. Although the standard of living for all Americans, including the poor, has risen during the last generation, de Lone charges that the distribution of income in American society - and hence the opportunities for those at the bottom of the scale - have changed little throughout American history.

"People born in the 1830s faced about the same mobility possibilities as people born in the 1970s," he says. And so, even with an expanding economy, de Lone says, "when the distribution is consistently unequal... no matter how fast the engine proceeds, the caboose never catches up."

In his view, one conceptual flaw which has helped perpetuate these inequities is the emphasis on programmes predicated on the mistaken assumption that helping children today will equalise their opportunities in the future.

Without equality in the present, de Lone says, that is simply not true.

"Confronted with unacceptable economic and social inequalities, we Americans

Better be born rich than the lucky?

have reflexively channelled our moral indignation into efforts to improve the morality, character, skills and intelligence of children - especially those who are poor, immigrant or non white."

Such attempts not only demand that children carry a grossly unfair burden, de Lone believes, but they have also proved ineffective.

"The dynamics of our social structure are not likely to produce more equality of opportunity unless there is more equality to begin with," he says.

The report, which traces the sources of inequality to a "basic tension between the democratic and capitalist strands of our heritage," argues that Americans have generally failed to perceive that the ultimate penalty of poverty is the pervasive influence on one's adult future of "a name in the past of controversy."

Eva Reich: "I am an image in son."

Scheme
gives
taste of a
better life

Evening Standard reporter

A NEW programme for people who want to become more effective human beings was launched at an inaugural lunch in the city yesterday.

The Tauhara New Age Action programme, a series of seminars, workshops, retreats and lectures on key human concerns, will extend throughout 1980.

It is the joint responsibility of two organisations, the Tauhara Trust and Tetra (Human Effectiveness Training and Resource Associates).

Tauhara is a charitable trust founded for the pursuit of spiritual and educational growth, and their successful integration into everyday life.

The trust is based at the Tauhara Centre in Taupo's Acacia Bay.

Although most of Tauhara's members live away from Taupo, they try to get together whenever possible at the centre.

The centre can accommodate

November
10, 1979

SOCIAL-HEALTH PROBLEMS & SOLUTIONS

Handicapped centre appeal

DOMINION June 1, 1979

Combined effort under way for Lower Hutt Physically and Intellectually Handicapped Centre

FUNDRAISING for a Lower Hutt centre to get physically and intellectually handicapped people into the community has got under way in Lower Hutt.

With \$26,000 already in the kitty the appeal is nearly quarter of the way to its \$120,000 minimum target.

The launching of the appeal was the result of six years' work to establish the Lower Hutt Community Resources Centre — a 40-place establishment to provide training, retraining and therapy for disabled people.

Lower Hutt mayor and chairman of the centre's trust board, Mr John Kennedy-Good, said it was hoped to start building the \$320,000 centre in early 1980.

Government subsidies will meet 80 per cent of the cost. The land in Glen Iris Grove was provided by the Education Department.



THE TRIBUNE, December 9, 1979

An open letter to old

Average Kiwi older

by Andrew Boyle of the Aged Peoples Service Council

IF YOU are nearing the age of retirement you are coming to an area of major change in your life. Your whole lifestyle will change. You will have more time and probably less money. For this reason retirement needs a lot of careful planning (which we may be able to help you with).

You have already faced and coped with many major changes: leaving school or university, getting a job, marriage etc. Why should this change be any different?

However if you have already retired you will know that this change is different. One day you are working and are productive, then you retire and suddenly society sees you as unproductive.

After we retire we are apparently worth nothing and may even be seen as a liability. Is this fair or even right?

We think that this is wrong. Just because we retire we should not suddenly be labelled "unproductive" and hence "useless".

Unfortunately modern society is very production-orientated. Status, income, marry early, etc. are all based on how the valuable society sees us. The truths uncovered in Trends, more we produce, the more a 300-page Health Department publication are given. Produce nothing. It says children are more and we are nothing. Likely to be born out of wedlock, and solo mums are cost-accountancy attitude of getting younger.

This is an unfortunate society that sees people merely as machines. When we

THE average New Zealander is getting older and more Maori.

They are less fertile than they were, and less likely to be married. These are some of the truths uncovered in Trends, more we produce, the more a 300-page Health Department publication are given. Produce nothing. It says children are more and we are nothing. Likely to be born out of wedlock, and solo mums are cost-accountancy attitude of getting younger.

Cancer

And people are moving to the North Island, in increasing numbers.

The disease most die of is

By SALLY FAULKNER

heart disease (it took 32 per cent of all who died in 1975).

And failing that, cancer, cerebrovascular disease, respiratory problems, influenza and pneumonia, accidents, artery disease or motor accidents in decreasing order of likelihood.

But after people do go there is less chance of doctors doing post mortems.

Trends says more people are going into psychiatric hospitals — but they do not

stay as long, and they are more likely to be voluntary patients.

Poliomyelitis, tuberculosis and hydatids cause fewer health worries than they used to.

But alcoholism, asthma, some forms of venereal disease, and chronic bronchitis are on the increase.

New Zealanders are attempting suicide more than they used to — males by strangulation, firearms and explosives; and females with sleep inducing drugs.

The average New Zealander is drinking more beer and wine, and eating less butter and meat, but more sugar and eggs.

Advice Centre For Disabled?

THE GUARDIAN, September 15, 1979

Communication, co-ordination and non-duplication are the predominant aims of a proposed disabled information and advice service to be set up in the city.

Initiator of this proposal, Mr Bill Wrightson, has the backing of the co-ordinating committee for the disabled, of which he is a member. "If we

incentive to get up and do things for themselves."

Mr Wrightson feels the service would be well utilised because of the large number of disabled people living in the city.

The service will initially operate for only three months in order to research the needs of the community. At the moment they are still looking for accommodation and will be approaching various organisations for help. An application for a

THE Occupational Therapy Department of Christchurch Hospital has prepared a very comprehensive collection of suggestions to help people afflicted with arthritis remain self-sufficient in the book Managing With Arthritis.

The subtitle of the book, Aids and Advice for Coping With the Activities of Daily Living reveals the motive behind the gathering of information. As stated in the

"We're going to have a reunion on December 1. It's a good chance to look around all the photographs we took."

preface, the book attempts to answer the question — "How can I manage with rheumatoid arthritis or other arthritic conditions?"

The first section of the book is devoted to general information such as how to sit, stand, lie most comfortably, care of hands, and avoiding strain. Then begins the key section, reducing effort and work. This was, perhaps, the most intriguing as the work simplification ideas and principles of motion economy can be used and adapted to almost any situation even for non-arthritis sufferers.

The second section deals with such problems as getting in and out of cars, climbing steps, eating, bathing and dressing. In this area the book is divided into

Paraplegics enjoy holiday of a lifetime

DOMINION, November 17, 1979

FOURTEEN paraplegics from the Wellington Paraplegic and Physically Disabled Association have returned from a Rarotongan "holiday of a lifetime".

The 10-day holiday was organised by association secretary Mr Ray Heath, of Lower Hutt. Mr Heath also acted as an escort for the paraplegics, along with 10

other volunteers from the association. He said the holiday would probably be a "once" in the lives of the paraplegics, some of whom were so disabled as to need "almost everything done for them".

"Few paraplegics ever travel overseas as everything about travel is so

difficult for them. It's hard to even get a plane, so to contemplate something like a trip to Rarotonga takes real courage," he said.

"But the trip was a great success. All the travellers had a marvellous time. The Rarotongan people were so friendly and kind to us all."

"The hotel we stayed at

was ideal for us. It was almost completely accessible to people in wheelchairs. There were even a couple of special paraplegic units. "A Catholic college lent us a sort of canopy-covered truck which we used for touring around in the daytime. It was just the right sort of vehicle to get wheelchairs on to."

SOCIAL ILLS & SOME RESPONSES

Loneliness is a killer

DOMINION
1979

Page 6 — The Tribune, Sunday, September 30, 1979

Emergency services are vital

CONTRARY to widely held opinion in this country, civil defence is not an alternative to the established emergency services — the fire brigade, ambulance and police.

The Director of Civil Defence, Major-General R. H. F. Holloway, says the emergency services are a vital component of effective civil defence, and in some parts of New Zealand their representatives are closely involved in local civil defence planning.

Major-General Holloway said civil defence, largely the responsibility of local and regional government in New Zealand, was or should be, a common sense way of directing all the resources of a community in a disaster situation. These resources include the emergency services and voluntary organisations concerned with community

welfare.

"Civil defence authorities only assume control in a saster when the situation becomes too big for the emergency services to co with, and when the safety of the public is endangered," he said.

The civil defence authorities would then be responsible for the co-ordination and control of the available resources, and have the responsibility for making use of these, he said.

Major-General Holloway believes the emergency services and community service-orientated organisations should be an integral part of civil defence planning by all local authorities. "In some parts of New Zealand this is the case and when tested, civil defence has proved effective."

Volunteers lauded..... Minister heaps on the praise.....

TRIBUNE 15.9.79 Lynette Cox

LOCAL Community Volunteers were showered with Health and Social Welfare, Mr George Gair, last

Speaking at the annual meeting of the Community Development Week, Mr Gair said Palmerston North volunteers were held in high esteem.

He said it was refreshing to find a group of people who recognised the importance of community development that the "Community Development Week".

"As Minister of Health and Social Welfare, I am continually heartened to see how people continue to assist and care for those in need, and do so without thought for financial reward."

"It is of course a mistake to advance the argument that all social services should be operated or paid for by the Government. Voluntary agencies have a wide pool of community resources, their flexibility can provide focus and leadership in the social area which may otherwise be neglected," he said.

"It is people such as these who will in the final analysis act as the catalyst which can shift the direction of dependent, indifferent community towards one providing mutual support, caring and a sense of personal independence. The word independence is one which needs to be stressed more and more often these days."

"The nature of our Health and Social Welfare system may have, for too long, encouraged some people to lean on the State, not so much as a means of short-term assistance in time of need, but rather as a long-term support which can become addictive, so perpetuating dependence, rather than rehabilitative, and thereby seeking to correct the problem."

Mr Gair defined community development as being about self-reliance, mutual support and involvement.

A BOTTLE of pills, however large or powerful, does not offer much warmth, but to most doctors it is the best prescription for loneliness.

Take, for instance, the woman who rang psychologist Yvonne Allen. She was near hysteria as she told how, feeling bewildered and alone, she went to her doctor because she had a serious sexual problem with her husband.

Her husband wanted her to do "things" she could not bring herself to do.

The doctor's answer to the woman's desperation had been a prescription for a large bottle of valium "so she could bear it."

When, asks Miss Allen, 31, will doctors learn to prescribe people not pills? When will they take their medicine beyond science and start seeing themselves as healing agents?

"Most people simply want a pair of ears but they feel if their illness does not have physical manifestations they cannot go to a doctor," she said.

Miss Allen, who graduated in psychology from the University of New South Wales in 1969 and later worked as a district officer with the New South Wales state service, has spent years dealing in the business of communication — loneliness.

People called her crazy when, four years ago, she started a practice which incorporated an introduction service — not a marriage bureau, just a communication programme which got people together.

Professor James Lynch, scientific director of the psychosomatic clinic at the school of medicine, University of Maryland, James has produced volumes of daunting evidence to support his theory that "the lack of human companionship, the sudden loss of love and chronic human loneliness are significant contributors to serious disease and premature death."

In other words you can die of a broken heart.

"Professor Lynch is acclaimed throughout the United States and Europe as an authority not only on cardiovascular disease but the medical consequences of loneliness," Miss Allen said.

"Would you believe, I went to the National Heart Foundation and asked them to support his visit. They weren't interested. I couldn't believe it — I explained he was being hailed in the United States as a genius and they said, okay when's he coming?"

"When I said in April, they said: Forget it, that's National Heart Week. I pointed out the timing was perfect, he could address their meetings. No, they said, the theme of their meetings was obesity, not loneliness."

"I said: 'And why do you think people are obese?' They said: 'We're not interested in the cause, we're only interested in the cure.'"

"I gave up."

Professor Lynch cites United States

SUICIDE is more common among single than married people. Often the problem is simply loneliness. And according to this report by LYNDALL CRISP there should be better cures for the lonely than a course of pills.



population statistics on causes of death which show single, separated, widowed and divorced people are more likely to die prematurely than those who are married.

Stuck with system

IT would not be my special intention to put the cat amongst the Hokowhitu canaries (seven of them) next year.

It wouldn't happen in a parliamentary electorate why then in this city?

The essence of the deceased cohesion socially that Dr Moody of the Police Association says is going to inevitably lead to armed police, is decreased identity.

The natural outcome of community councils in, say Westbrook, Milson, Riversdale etc., would be Community representation.

Someone answerable for instance, witness the fiasco this year relating to the Ministry of Sports funds, half returned and no provision for funding, no stimulus to local voluntary contribution because no such community rep exists.

Cohesion lack; identity lack are the key phrases.

Until suburban schools, the medical profession, pubs, sporting bodies, churches and the law come together, restructure will remain unlikely.

The establishment will continue to justify its existence by simply saying, like C. K. Keir: "We are stuck with

lonely."

"They tell me they've never broken it," (Dr) BRIAN BOOTH Palmerston North they've worked hard to reach the top, be successful and suddenly they find it's lonely on that pinnacle.

"And this business of women being over the hill at 40, good grief, they're just entering their sexual prime."

"Why are people lonely? Society is too superficial, mobile, materialistic and competitive. We must move back to our family bondings."

"It's easy to crowd your day with things that don't satisfy your basic needs — if you can admit that's what you're doing then half the battle's won. But people don't have an honest agenda."

"A lot of people go into marriage because it's better than not having anyone at all, others allow their relationships to degenerate to crisis point before they do anything about it. Too many people neglect the friendship side of a relationship, they don't communicate."

"Marriage should be soil for mutual growth. Because a woman wants to develop her own potential it does not mean she is a mad woman's libber who wants to reverse the family role."

Street groups end stifling suburban isolation



CAROL CROMIE
Thursdays

DOMINION, October 10, 1979

IT DOESN'T have to be Karori. You find them in every street in every suburb.

with live nearby or that your parents have retired down the road.

And acute loneliness often leads to bigger emotional problems. In Karori, at least, they

The street group is as simple as its name implies, a gathering of women living in the same street. The groups — there are now about a dozen in Karori — meet weekly in

with their neighbour. To set up a group, no resources other than a door knock.

The mushroom groups are evident. Sue hopes the other women will perhaps.

When the women come to realise the groups lead to a lot of pressure rearing children "With the street do things."

They provide a babysitting club — certainly not say neighbours," she says. But she stresses

WORLD-WIDE SOCIO-HEALTH ISSUES

How much risk is paradise worth?

FOOD SUPPLIES Hang By A Thread

THE WORLD'S food crops, in both the rich farmlands of America and the fields of Asia, are threatened with extinction at a

ROY LAISHLEY looks at a new book which argues that the world's food supply is precariously dependent on a narrow

industry with a vengeance. From no involvement a few years ago, Royal Dutch Shell is now the world's largest seed company.

Other major firms include the Swiss companies Ciba-Geigy and Sandoz and Union

IS IT possible the havoc we create is simply the result of an apple we ate?

Science and technology plus human greed and frailty equals a formula which projects uneasily into the future. Everything we do in a free society assumes the acceptance of some risk. But just how much risk is the future worth?

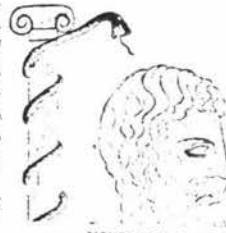
As the world awaited the re-entry of Skylab Art Buchwald reassured Americans. "Our people at Nasa are doing everything in their power to see it does not fall on the United States — because if it does their budget will be cut."

Robert Frosch, head of Nasa, told Americans the 85 tonnes of orbiting Skylab would break up into about 500

afONE of the more authentic experiences of the '70s — is representative of America today as social protest gatherings were in the '60s — is a visit to a holistic health meeting.

Countless numbers of Amer

THURSDAY



Nothing is more natural than for the body to heal itself.

—HIPPOCRATES

The day we built a terrifying future.

from a New Zealand correspondent in the States
Old age: dementing

(art 2)

Domination Correspondent
A SURVEY taken in Britain warns that degeneration of the brain in old age will become the most serious single health problem of the future.

And it says that failing brainpower — dementia — affects one in five people over the age of 80.

It is estimated that the number of over-eighties in Britain will increase by more than half a million to about 1.8 million by 1995.

The survey which was taken by the Office of Health Economics, found half of the sufferers will require considerable assistance and supervision but lack of money shows that support will be inadequate.

Dementia is the irreversible and usually progressive destruction of the brain in old age for reasons not yet understood.

It causes failing memory, intellectual deterioration and quite often distressing personality changes.

Most of Britain's demented people live at home and are dependent on family support but there is pos-

sionism over the future of these arrangements.

The survey shows over 25 per cent of the over 65s have no children to look after them and as many as 81 per cent of those aged 75 or over are single, widowed or divorced.

DOMINION February 2, 1980
CAPITAL day

The University of California's administration and patronage of the Lawrence Livermore Laboratory was cited, a lab that has been the "brains" of every major American advance in nuclear weaponry since Hiroshima; and the Lockheed production centre at Sunnyvale, where all the major components of the multi-warhead Trident nuclear missile system are being built.

In both cases there is evidence that as the level of protest mounts, public support is gradually being won, but there is a long way to go. Funding of the protest

terrifying future.

A small seed takes root...

Berrigan, "The future always belongs to the remnant that has come out of slavery."

THERE is, however, a new hopeful dimension to the efforts of the anti-nukes which may yet dwarf the potential of all other strategies. It is a legal offensive in United States Courts.

It is being suggested, not widely of course, that if the sixties was the decade when America was torn apart by Opposition to the war commitment in Indo-China, and the seventies when the scandal of Watergate shook the country to its foundations, the eighties may prove to be no less traumatic as international law is invoked in American Courts to bring the country's military leaders and armaments manufacturers to account for crimes against humanity.

On first hearing even the possibility is ludicrous. But in fact, no course is being more seriously examined at the present time, with some of the biggest legal names in America lending encouragement.

by MICHAEL COOLING of Reuters

LONDON, Wednesday — The human race need not fear for its survival in an increasingly crowded world faced with potential scarcities of many resources.

This is the cautiously optimistic prediction of a book (The Mitchell Beazley Atlas of Earth Resources), just published.

The book, four years in preparation, has attracted the approval of the World Bank whose president, Robert McNamara, writes in a foreword "As this volume makes evident, individuals are not poor because the planet's endowment of natural and human resources is meagre. Individuals are poor because they lack the opportunity to fully utilise those resources, and share more fully in their benefits."

In 1972 fears about the exhaustion of natural resources and the threat of ecological imbalance were strongly reinforced by the publication of computer-based forecasts for the Club of Rome in a book titled "The Limits To Growth".

A team at the Massachusetts Institute of Technology had built a computer model of the world which showed that without drastic and immediate steps to limit economic and population growth, industrial society in the next century would face a "doomsday" crisis.

Since then the perception of the global problems of population expansion, conservation and/or the wit of man to devise new strategies in an increasingly interdependent world has changed. It provides for a less doom-laden scenario.

Conservation in the world of tomorrow is

Division of world wealth shadows future

EVENING STANDARD

Palmerston North

October 3, 1979

peaked in the early 1970s. This fact has generally been greeted with mixed emotions, with any enthusiasm for the decline tinged by the knowledge it is an uneven one. Pronounced regional differences still exist in birthrates around the world.

For the West, a surfeit of elderly people over the next few decades will have far-reaching implications for social policy. By contrast the developing countries will be faced with a massive explosion in the number of young adults needing homes, jobs and transport. The book, underlines these problems.

they lack the opportunity (or knowledge) to fully utilize the resources. This book has received the approval of the World Bank, so presumably, if the 'gnomes of international banking' approve, the findings are based on reality as well as ideals.

The themes selected for the news sheets include:

The Family - Children at Risk

The Family - Children's Needs

The Family - Changes: Needs: Problems

Health Services - Trends and Facts

Health Problems - Chronic Conditions

Health Problems - Chronic Disabilities

Health Problems - Drugs: Alcoholism

Socio-Health Trends in New Zealand

Socio-Health Problems

Socio-Economic Issues and Proposals

Socio-Health Problems and Solutions

Social Ills and Some Responses

World-Wide Socio-Health Issues

Construction of News Sheets

The method of content analysis used for the construction of the news sheets required that the universe of content be analysed (Kerlinger, 1973). In seeking a profile of the social realities and resultant socio-health disorders experienced by New Zealand Society, a selection was made from the newspaper clippings collected during 1979.

Items were selected for the news sheets by the criterion stated on page 150. That is, the item had to relate to an explicit or implicit need for nursing assistance. Again, it is necessary to note that the

CLASS AND CATEGORY		CLASSIFICATION
I	FAMILY DISSONANCE AND DISCORD	100 - 110
	Assaults within the family	100 - 101
	Child and juvenile delinquency	101 - 102
	Children-at-risk: handicapped, deprived, neglected, abused	102 - 103
	Family stress: chronic illness	103 - 104
	Family stress: weakened kinship ties	104 - 105
	Family stress: psycho-social-economic	105 - 106
	Intergenerational communication gap	106 - 107
II	COMMUNITY - AT - LARGE	110 - 120
	Imbalance in age groups	110 - 111
	Increasing suicide attempts and deaths	111 - 112
	Individual and group alienation, violence, terrorism, illness related to own behaviour	112 - 113
	Reduced social exchange between generations	113 - 114
	Socio-economic stress, unemployment	114 - 115
	Socially reduced elders: loneliness institutionalism	115 - 116
	Inadequate/inappropriate and/or changing health/nursing services	117 - 118
III	SPECIFIC HEALTH PROBLEMS	120 - 130
	Drug addiction: criminally and therapeutically induced	120 - 121
	Alcoholism	121 - 122
	Bio-psychosocial disorders associated with chronic pathological disease and genetic disorders	123 - 124

CLASS AND CATEGORY		CLASSIFICATION
III (Cont'd)	Genetic Disorders	124 - 125
	Mental ill health associated with modern life stresses	125 - 126
	Increasing chronic diseases, especially cardiovascular and malignant disease	126 - 128
	Increased sexually transmitted disease	128 - 129
	Inadequate health care knowledge and self-care abilities	129 - 130
IV	ENVIRONMENTAL PROBLEMS	130 - 140
	Exploitation of natural resources	130 - 131
	Chemical disorders: radiation, air, food and water pollution	131 - 132
	Dehumanizing living and working conditions	132 - 133
	Industrial and technological hazards	133 - 134
	Natural disasters, flood, drought	134 - 135
	Traffic congestion and accidents	135 - 136

COMMENT

Collection of information about the social context in which New Zealand nurses practise provides essential data for the making of optimal curricular choices. An attempt has been made to collect from a wide range of official and voluntary agencies. In some instances, it has only been possible to refer to the sources from which the information can be obtained. The listing of centres from the Planning Research Index, 1979, and the Social Welfare Library Catalogues, 1975 to 1979 does not give full bibliographical details. But sufficient details

are given for easy location of the items listed.

There are, doubtless, many other sources from which data can be collected. But what has been provided is believed to be an adequate sample of the kinds of information needed to relate nursing curricula to the social context of New Zealand society at this point in time.

The characteristics of the information collected will be discussed in chapter 7.

DISSEMINATION OF INFORMATION

The dissemination of information has been discussed already in chapter 4 (p. 74 to 75). In brief, the main points stressed there for the successful application of an information system require:

1. the involvement of the users of the system in its (a) development, and (b) in the specification of its objectives and usage;
2. integration of collections of information into logical, comprehensive systems, such as the library system used above and/or data banks;
3. the organisation of data so that it is easily retrievable, and that regular access to it is possible;
4. that operation of the information system is the responsibility of the curriculum development and advisory committee (CDAC);
5. that regular meetings are scheduled by the CDAC with all relevant users so that incoming data or changes can be discussed;
6. that a member of the CDAC is made responsible for circulating, or informing about, new inputs and any changes made to the data base structure and content.

Dissemination of information about the social realities and resultant disorders of contemporary New Zealand society can be prepared for publication in appropriate journals in addition to being presented in

this thesis. When, as one believes should be the case, the collection of information about the social context in which nurses practise is an ongoing activity in curriculum development and evaluation, systematic exchange of information is important. This exchange of information should occur between all components of the nursing education system in New Zealand. Further, it should be a three-way exchange of information between central, regional, and local (or institutional) health/nursing authorities.

(V) ANALYSIS AND INTERPRETATION OF THE INFORMATION COLLECTED

This fifth step of the information system is dealt with in chapter 7. To some extent, a broad analysis of the data has been carried out in organisation of the material into a logical, comprehensive system for accession, retrieval, and ready availability for use.

(VI) APPLICATION OF THE FINDINGS TO CURRICULUM CHOICES IN NURSING EDUCATION

As stated earlier, this step of the information system merges into phase two and three of CRP which require a great deal more resources than can be allotted to this thesis. Nevertheless, application of the findings to curriculum choices is discussed in the final chapter.

CHAPTER 7

CHARACTERISTICS OF THE INFORMATION COLLECTED

OBSERVATIONS AND CONCLUSIONS

This chapter considers the characteristics of the collections of data detailed in chapter 6. The observations made here largely relate to information about the social context in which New Zealand nurses practise. But the collections of data contain some items from international and overseas sources also. Since they reflect the near universal concern for many of the socio-health disorders presented in the items of information about New Zealand society.

An initial broad analysis of the information collected has been necessary for construction of the news sheets (p. 161 to 173) and the coding of data according to library usage (p. 175 to 177). This is essential for its organisation into a logical, comprehensive system. Further, it produces a more manageable arrangement of material for observation and decision-making.

Content analysis has been the method used to identify the dominant socio-health disorders experienced by New Zealanders. The universe of content dealt with, that is, the social realities and resultant disorders, requires analysis to determine the health and nursing needs and problems of New Zealand society. This makes it possible to formulate broad educational goals, appropriate to requirements for health and nursing care, and to specify desirable nursing skills in oncoming nurses.

CHARACTERISTICS OF THE SAMPLE

The collections of data can be put into two main groups. The first group includes all information collected from official sources, and the second all data from voluntary sources. Prior to observing the

characteristics of the sample, however, some regrouping of material, from both official and voluntary agencies, is necessary.

First, *data from official sources includes reports, research findings, and statistical data from governmental and professional/expert agencies.* These items of information are detailed in

- Appendix B1 (professional sources), Appendix B2 (periodicals),
- Appendix C1 (official publications), Appendix C2 (hospital board statistics),
- Appendix C3 (hospital department statistics), and
- Appendix C4 (list of selected entries from an official index and catalogues). Only brief observations will be made about the material referred to in Appendix C4.

Secondly, *data from voluntary sources includes reports, documentaries, news releases, and letters from newspapers, NZBC, and various voluntary agencies publications.*

These items of information are detailed in

- Appendix A1, A2, A3, A4 (newspaper and radio items),
- Appendix B3 (social services directories and similar publications),
- Appendix C4 (some entries selected from official publications refer to studies or data from voluntary agencies), and
- Appendix D (socio-health and nursing agencies).

Observations about the characteristics of information collected from voluntary agencies will be concentrated on data extracted from the mass media. Only general observations will be made about the items of information listed in appendices B3, C4, and D. Moreover, items of information from the news sheets, newspapers, and radio broadcasts are integrated prior to observation. This involves, as shown below, matching the themes of the news sheets with the classes and categories chosen for coding of data previously (p. 175 to 177). In addition, the number of radio broadcasts

CLASS	CATEGORY	NEWS SHEETS - THEMES	RADIO PROGRAMMES
I FAMILY DISSONANCE	<ol style="list-style-type: none"> 1. Assaults 2. Delinquency 3. Children-at-risk- abused, handicapped, deprived. 4. Stress-chronic illness 5. Stress-weakened kin- ship ties. 6. Stress-psycho-social- economic. 7. Intergenerational- communication gap. 	<p>The Family- Children at-Risk P.161</p> <p>The Family- Childrens needs. P. 162</p> <p>The Family- Changes, Needs, Problems. P. 163.</p>	<p>39</p> <p>Broad- casts related to family issues.</p>
II COMMUNITY- AT - LARGE	<ol style="list-style-type: none"> 1. Age imbalance 2. Suicide attempts/ deaths 3. Alienation - individuals/groups 4. Intergenerational- reduced social exchange 5. Socio-economic stress: unemployment 6. Socially reduced elders/loneliness, institutionalism. 7. Inadequate/inapprop- riate and/or changing health needs and services 	<p>Health Service - Trends and Facts P. 164</p> <p>Socio-health Trends in New Zealand. P. 168</p> <p>Socio-economic Issues and Proposals. P. 170</p>	<p>27</p> <p>Broad- casts related to community issues.</p>
III SPECIFIC HEALTH PROBLEMS	<ol style="list-style-type: none"> 1. Drug addiction 2. Alcoholism 3. Bio-psycho-social disorders (chronic, pathological, trau- matic and genetic, in origin) 4. Genetic disorders 5. Mental illness/modern life stresses 6. Increasing chronic disease 7. Increasing sexually transmitted diseases 8. Inadequate health care knowledge and self-care abilities 	<p>Health Problems - Chronic Conditions P. 165.</p> <p>Health Problems - Chronic Disabilities. P. 166.</p> <p>Health Problems - Drugs. P. 167.</p> <p>Socio-Health Problems. P. 169</p>	<p>31</p> <p>Broad- casts related to specific health problems</p>

CLASS	CATEGORY	NEWS SHEETS - THEMES	RADIO PROGRAMMES
IV ENVIRON- MENTAL PROBLEMS	1. Exploitation- natural resources. 2. Chemical pollution 3. Dehumanizing condit- ions - living and working 4. Industrial/technol- ogical hazards 5. Natural disasters - flood, drought, famine 6. Traffic congestion/ accidents	Socio-health problems and Solutions. P. 171 Social Ills and Some Responses. P. 172 World-Wide Socio- Health Issues. P. 173	18 Broad- casts related to environ- mental problems

related to each class of data is indicated. Finally, in figure 7.1.

(p.184) the mean percent frequency of socio-health disorders, as reported through the mass media during 1979 is shown.

CLASS	CATEGORY	10	20	30	40	50	60	MEAN %
I FAMILY ISSUES	1. Assaults ... (8%)							
	2. Delinquency.. (30%)							
	3. Children-at-risk (18%)							
	4. Stress-chronic illness (3%)							
	5. Stress-weakened kinship ties (5%)							
	6. Stress-psycho-social-economic (30%)							
	7. Intergenerational communication gap (3%)							
	Total 26%							
II COMMUNITY ISSUES	1. Age imbalances -							
	2. Suicides (1%)							
	3. Alienation (14%)							
	4. Reduced social exchange... (2%)							
	5. Socio-economic stress ... (35%)							
	6. Socially reduced elders... (6%)							
	7. Inadequate/inappropriate services (52%)							
	Total 28 1/2%							
III SPECIFIC HEALTH PROBLEMS	1. Drug addiction. (13%)							
	2. Alcoholism (26%)							
	3. Pathological/genetic disorders (biopsychosocial) (12%)							
	4. Genetic disorders. (6%)							
	5. Mental ill-health... (17%)							
	6. Increasing chronic diseases... (18%)							
	7. Increasing sexually transmitted disease. (2%)							
	8. Inadequate health care knowledge... (4%)							
	Total 33%							
IV ENVIRON- MENTAL PROBLEMS	1. Exploitation of natural resources (23%)							
	2. Chemical disorders/pollution (26%)							
	3. Industrial/technological hazards. (20%)							
	4. Dehumanizing living/working conditions (8%)							
	5. Natural disasters.. -							
	6. Traffic congestion and accidents. (23%)							
	Total 12 1/2%							

(mean percent frequency for each category shown within brackets)

Figure 7.1. Mean Percent Frequency of Socio-Health Disorders (As reported in the mass media 1979)
(Idour, M. 1980)

The items of information selected are issues of social concern frequently reported in the mass media. They have been placed in the various classes and categories according to the main theme emphasised in the item. But, in a number of instances, they could fit into more than one of the classes and/or categories of data.

The categories or themes, found in the four classes of data, are indicative of the socio-health disorders, which are presently dominant in New Zealand society. Reliability of the selection made can be inferred from similarities in the content of the information obtained. It can be said that consensus concerning the dominance of certain socio-health issues is implicit in the frequency with which they have been reported by the mass media. Further endorsement is provided by the nature of the voluntary agencies servicing socio-health needs in New Zealand.

OBSERVATIONS OF THE DATA COLLECTED

I CHARACTERISTICS OF DATA FROM OFFICIAL (FORMAL) SOURCES.

1) Governmental Reports, Research Findings, and Statistical Data.

The material listed in Appendix C1, the statistics contained in Appendix C2 and C3, and some of the items listed in Appendix B2 and C4 come from governmental agencies. These include the New Zealand Department of Health (NZDH), health related departments such as the Social Welfare Department, and special sections of the health department, such as the National Health Statistics Centre (NHSC).

Overall they provide data about the socio-health needs and problems of New Zealand society. Some reports and/or studies provide a general survey of the socio-health status of New Zealanders. The NZHD annual report, 'The Public Health', for the year ended 31 March, 1979, and the NHSC report, '"Trends" in health and health services' 1979, are examples of reports which present a general survey of health and health related conditions. Examples

of studies which deal with specific issues are the NZDH study (NO. 251, 1979) on 'The Use and Misuse of Drugs', and the NZDH (Management Services and Research Unit) 1974 study on 'Aged Persons - Including Retirement-Accommodation Needs of the Elderly'.

NZDH 1979 Public Health Report

An overview of present socio-health problems can be taken from the NZDH 1979 report. In addition to the provision of statistics, the report discusses the implications of present health trends. Stress is given to the place that lifestyles can have on the causation of socio-health disorders. For example, one of the most serious problems is stated to be that of death and chronic disablement for the 15 to 24 age group due to road accidents. And alcoholism is stated to be an important accessory factor to accidents on the road.

The conflict between the use of resources for community medicine and for costly medical technology is also pointed out. The development of the New Zealand College of Community Medicine is seen to have considerable potential value for the evolution and organisation of future health services. This is contrasted with the high cost of technological developments such as computerized tomography, renal dialysis, open-heart surgery, and organ (kidney) transplants. These examples of costly medical technology are said to be linked to medical care specialities which can be provided only on a national or regional basis. The use of the health vote is under close scrutiny. But measures to apportion it more evenly between visible, and more dramatic, technological (surgical and medical intervention) treatments, and the less obvious, but compelling, preventive and promotional socio-health services needed in the community, are very complex. And the source of considerable emotional and political debate. The obtaining of sufficient resources to maintain and promote better health is seen as a major problem.

Administrative and policy issues covered in the report deal with:

- the use and cost (about 60% of the money allocated to health benefits) of pharmaceutical benefits;
- hospital board expenditure which continues to rise (over 70% going on wages and salaries);
- the development of health centres; and
- changes in educational policies for health professionals.

Among the diseases singled out in the report are cardiovascular illnesses, cancer (particularly of the lung), motor car accidents, alcohol and drug-related illnesses (and deaths), respiratory disease (bronchitis, tuberculosis), venereal disease, and viral hepatitis (now the most frequently notified disease in New Zealand).

When the causes of death are examined it is clear that the characteristics of present patterns of ill-health in New Zealand include an increase in those related to behavioural practices. Deaths from alcohol related diseases (1976-1977) rose 12%, one third of male deaths were due to accidents, poisoning, and violence. Mental disorders have increased greatly, and chronic, long-term illnesses continue to increase.

NHSC - 1979 Report on Health and Health Services

From the NHSC report on 'Trends' in health and Health services, 1979, the statistics on children, aged 0 to 4, admitted to hospital, showed the most common causes to be:

- 4080 (336 in 1939) - Certain causes of perinatal morbidity.
- 3309 (354 in 1939) - Congenital malformations (which can be questioned as a disfavoured effect of technological advances in medicine).
- 2361 - Other injury of external cause.
- 2206 - Pneumonia (still a marked problem).

2036	- Bronchitis
1653	- Diseases of tonsils and adenoids.
1652	- Effects of poisons.
1575	- Gastro-enteritis and colitis.
1231	- Hernia.
1117	- Diseases of the skin and cellular tissue.
1027	- Diseases of the ear and mastoid process.
916	- Asthma.
885	- Fractures and dislocations.
226	- Burns and scalds
212	- Meningitis, encephalitis and intracranial abscess.

This is not the full list of diseases for which children (0 to 4 years) were admitted. For instance, the greater number were admitted under 'other defined diseases' (5307). But if one adds certain of the above figures together the profile obtained is that:

7389	children were admitted due to perinatal morbidity and congenital malformations;
6811	were admitted with pneumonia, bronchitis, diseases of tonsils and adenoids, and asthma;
5124	were admitted due to injury, poisons, fractures and dislocations, burns and scalds;
3931	children were admitted with gastro-enteritis and colitis, diseases of the skin and cellular tissue, diseases of the ear and mastoid process, and meningitis, encephalitis, and intracranial abscess (of this group it would be reasonable to consider that most would be associated with an infection of some kind);
1231	children were admitted with a hernia. It is possible that the majority of these would be congenital in type.

Otago Hospital Board Statistics - Department of Geriatrics (1978)

(see Appendix C2)

These statistics show that the most common diseases for which the elderly were admitted included:

- 50 - with cerebrovascular disease (and if one adds 'old hemiplegia' - 32 - patients the number is 82).
- 40 - with trauma.
- 32 - with old hemiplegia
- 18 - with other nervous system/sense organ disorders.
- 16 - with arthritis and rheumatism.
- 15 - with Parkinson's disease.
- 13 - with heart disease.
- 11 - with other mental disorders (to which can be added senile dementia - 3).
- 11 - with other circulatory diseases.

The profile drawn from the statistics is that common to industrial societies where chronic illnesses increase and cerebro-vascular conditions predominate.

Dunedin Hospital - Clients seen at the Accident and Emergency Centre

(see Appendix C3)

This contains the statistics of one class of clients attended to at the centre. Particular note has been made of the numbers of children attended to who were under 5 years. It has been noted already on p.188 that for 1979, 1652 children under 4 years suffered an incident of poisoning. When incidents of poisoning are linked with cases of trauma one must accept that the number of children-at-risk in New Zealand society leaves a lot to be desired.

2) Professional Reports and Studies

Observations of official data includes that obtained from professional or expert sources. Some of this material may be the result of studies done in conjunction with governmental agencies. Or it may be the result of independent study and research. The weight or value of data from professional/expert sources will be dependent on peer evaluation and the extent of the research.

Studies which have been published, particularly in professional journals, will have passed criteria set by editorial review boards. Information obtained from such studies is, therefore, of value in the making of curricular choices.

Characteristics of Data in the NZNJ

For instance, the characteristics of the items of information extracted from the NZNJ (January 1974 to January 1980) disclose the socio-health and nursing needs and problems of concern to New Zealand nurses.

Throughout 1974 and 1975 the dominant concern of most articles was related to the giving of care in the community. The importance of the primary care role, of health centres, of public participation in the nursing and health choices made available to them, and of sustained long-term care for the elderly was stressed. Socio-health problems of particular concern related to the elderly, the needs of the family, alcoholism, and the effects of change.

During 1977 and 1978 the characteristics of the data extracted still indicate a marked concern with the needs of the family and the need for changes in nursing services. Another important characteristic is the emphasis on nurse-client relationships, and the need to prepare oncoming nurses to practise in contemporary society. This also includes a need to

provide practising nurses with learning experiences to assist them to adapt to contemporary New Zealand society and its needs. Socio-health problems of particular concern related to stress in New Zealand society, particularly in women and youth. Drug addiction, mental ill-health, the needs of the disabled, inequalities in health care, a concern for the relatives, and attention to values also received marked discussion during this period.

Another issue of particular concern in 1978 related to the needs of those attended to in accident departments. 'Loneliness' in general and, specifically, in relation to pain was also discussed.

In 1979 the need and demand for community health services continued to be a marked characteristic in articles concerned with socio-health needs. The changing role and status of health professionals in the delivery of health care was also an issue of concern. Socio-health problems to which particular attention was paid included the needs of the intellectually handicapped, the terminally ill, the sufferers of rheumatoid arthritis, and the risks children experience. The rights of patients also received attention and the need for nurses to act as patient advocates.

Characteristics of Data in Periodicals

Only a brief reference is made here to the characteristics of the data listed in Appendix B2. Many of the studies referred to are from international agencies. The marked characteristics of these items of information relate to the need for primary health care, a reorganisation of services, and a reordering of priorities in the use of resources.

Socio-health issues to which particular attention is paid include:

- the needs and problems of families;
- the occurrence and results of road accidents, with emphasis on accident mortality in childhood;

- environmental health, diarrhoeal infections, and the effects of poverty;
- the needs of the handicapped; and
- the needs of the elderly.

Characteristics of Data in Appendix C4

This contains material from official and voluntary sources but amongst the items listed are a number of professional reports and studies. Of these, as examination of the items shows, socio-health issues of dominant concern are those related to the needs of the disabled, the family, children, the elderly, alcoholics and their families. The occurrence and result of violence, delinquency, child abuse, drug dependency, mental ill-health, environmental pollution, the costs of sophisticated general and medical technology, and institutionalization of the elderly are issues of dominant concern in the reports and research studies. Loneliness, social inadequacy, and the needs and problems of special groups such as young families and migrants are topics dealt with in many of the studies.

II CHARACTERISTICS OF DATA FROM VOLUNTARY SOURCES

Observations of data from voluntary sources will be made, largely, from items of information extracted from the 'mass media'. As a basis for the observations, reference is made to the dominant characteristics of the data shown in figure 7.1. (p. 184). This demonstrates the mean per cent frequency of socio-health disorders as reported in the mass media. This includes data from all sections of the mass media.

Figure 7.1. shows the mean percent frequency of the four classes of socio-health disorders used for coding of the data. In addition, shown in brackets is the mean percent frequency of the various categories within each class.

Class I - Socio-Health Issues Related to the Family

This includes data gathered from the newspapers, radio broadcasts, and to a limited degree, from television. Socio-health issues affecting the family are widely reported throughout the mass media. Data related to the family was 26% of the total information gathered from the mass media. Of the categories of data within this class the issues of greatest concern, inferred by the frequency of reporting, can be seen to be:

- 30% of items dealt with some aspect of child and juvenile delinquency;
- 30% of items dealt with some aspect of family psycho-social-economic stress;
- 18% of items reported involved children-at-risk (accidents, poisoning, abused, handicapped or susceptible to genetic and environmental hazards);
- 10% of items reported dealt with family stress associated with weakened kinship ties (7%) and intergenerational communication problems (4%);
- 8% dealt with assault within the family;
- 3% dealt with stress due to chronic illness in the family.

In general, the characteristics point to the strain induced by rapidly changing social conditions in New Zealand society. This is associated with increasing urbanisation, economic stress, industrial/technological developments, mobile populations, and reduced family and friendship networks to support young families. - or to sustain the psychosocial needs of the elderly.

Class II - Characteristics of Socio-Health Issues Related to
Community Issues

The characteristics of socio-health issues affecting the community-at-large show that:

- 52% of items reported dealt with some aspect of inadequate, inappropriate, and/or changing socio-health and nursing services (with greatest stress

being given to inadequate services in the community);

- 25% of items dealt with some aspect of socio-economic stress and unemployment;
- 14% of items were concerned with individual and group alienation, violence, terrorism, or illness related to own behaviour;
- 6% reported the loneliness and social distancing experienced by the elderly; and
- 1% dealt with suicide.

As with the family, stress due to rapidly changing social systems is a marked feature of all the categories of disorder affecting the community at large. The interdependence of socio-health and economic factors is marked. 33% of the items reported throughout the mass media were in this class of data about community socio-health disorders.

Class III - Characteristics of Specific Health Problems

28½% of items of information extracted from the mass media dealt with some aspect of specific health problems.

- 26% reported concern about some aspect of alcoholism;
- 17% dealt with mental ill-health associated with modern life stresses;
- 14% were occupied with inadequate health care knowledge;
- 12% reported issues related to drug addiction;
- 11% dealt with biopsychosocial stress associated with pathological/genetic disorders;
- 9% were concerned with the increasing amount of chronic diseases;
- 5% dealt with genetic disorders; and
- 2% reported increasing sexually transmitted disease.

Once more, the dominant characteristic of all the categories of disorders in this class of specific health problems is the stress experienced by people in a time of rapid change. Another marked feature

is the inadequacy of self-care abilities, and the recognition of a need for more health knowledge and strategies to cope with change.

Alcoholism, drug addiction, and mental ill health (together totalling 55% of reported health problems) all point to some failure of individuals to cope and maintain self-care.

Disorders associated with pathological and genetic disease also point to deficiencies associated with industrial/technological developments.

Class IV - Characteristics of Environmental Problems

12½% of items of information extracted from the mass media related to environmental issues which affect socio-health and economic conditions in New Zealand.

- 26% of items dealt with chemical pollution;
- 23% reported concern about the exploitation of natural resources;
- 23% were concerned with some aspect of traffic congestion and accidents;
- 20% dealt with industrial and technological hazards; and
- 8% reported some dehumanizing aspect of living and working conditions.

The dominant characteristic of environmental problems points to a failure of social systems to keep pace with industrial and technological developments. Or to a failure to order priorities advantageous to a society's total needs.

Characteristics of Data in Directories and Similar Publications

The most marked characteristic of the social services directories (SSD), p. 249 to p. 251 is the number of voluntary agencies listed to service socio-health needs. Most of the voluntary agencies named are 'self-help' in ethos and organisation. They are also initiated and managed by affected individuals and/or their families, friends, and others in the community. In addition to encouraging 'self-help' in their members they

provide mutual support for each other. They also cover felt needs and gaps in the services provided by official socio-health and related organisations.

For example, among the voluntary agencies listed are those that help individuals and their families to cope with the management of:

- epilepsy, asthma, diabetes, cystic fibrosis;
- physical or mental handicaps;
- alcoholism and drug addiction;
- chronic illnesses; and
- various social disabilities such as poverty (budgetary and welfare services).

CONCLUSIONS

Having observed the characteristics of the information gathered, from both official and voluntary sources, to identify the dominant socio-health disorders of contemporary New Zealand society one can draw certain conclusions about present needs and problems.

- 1) The disorders which predominate are largely those that occur in an 'age of degenerative and man-made disease' (Omram, 1974).
- 2) The problems of an ageing population are of increasing concern.
- 3) Inappropriate and/or inadequate socio-health services are not meeting the needs of people in the community. Over 70% of ill-health or self-care disabilities exists in those living at home, but over 70% of the health vote is spent on the 30% cared for in hospitals.
- 4) Many contemporary socio-health disorders have their origin in the conditions of life in an increasingly urban/industrial/technological society. Ischaemic heart disease, dental decay, hypertension and its effects, and increasing mental ill-health associated with stress, are examples of such conditions.

- 5) Increasing urbanisation, mobile populations, rapid and persistent change are important factors in contemporary socio-health needs and problems.
- 6) the basic social unit of society, the family, is under stress as is evidenced by the degree of child and juvenile delinquency, increasing assaults and violence within the family, and the increasing number of children-at-risk.
- 7) Urban and industrial pollution is increasing and is the cause, or suspected cause, of much ill-health.
- 8) Chronic illnesses requiring long-term sustained care predominate. In the community the number of individuals and families who require assistance increases steadily. Physically and intellectually handicapped individuals through genetic, pathological or traumatic incidents, require varying amounts of help with self-care.
- 9) There is a growing awareness that health services, the preparation of health professionals, and the settings for the provision of health care need reorganisation and a re-ordering of priorities.
- 10) The cost of health services outstrips resources, and emphasises the need to provide health education and promote self-care abilities. Health professionals need to assist individuals to take more responsibility for their own health.
- 11) The socio-economic factors that influence lifestyles also needs consideration. Communities must be given an effective part in the planning of socio-economic and health services. It is, for example, the responsibility of the whole community to consider and overcome the road accidents, alcoholism, and drug addiction that are the cause of so many deaths and morbidity.
- 12) The nursing requirements of New Zealand society must be based
 - (a) on the dominant socio-health needs and problems that exist, and

(b) be adapted to changing needs and problems as identified by the information seeking phase of CRP.

COMMONALITIES PRESENT IN SOCIO-HEALTH DISORDERS

There are a number of factors or commonalities associated with contemporary socio-health disorders in New Zealand society. This is true for most contemporary societies, although as Omram (1974) points out, it depends on the era of 'epidemiologic transition' that a society is experiencing. The commonalities relate to:

- 1) the status of individual and societal interrelationships;
- 2) individual and institutional abilities to cope with change;
- 3) the ability of individuals and groups to communicate with others;
- 4) the nature of individual, group, and societal values;
- 5) attitudes towards the environment and resources; and
- 6) technology and its management are closely interrelated with the problems confronting New Zealand society.

The application of an information system to the social realities and resultant disorders of New Zealand society led to the collection of items of information from a wide range of observed data. This was followed by a broad analysis for the purpose of classification of the data. It ends with the conclusion that desirable nursing skills in oncoming nurses must be relevant to the socio-health problems towards which nursing practice and education should be oriented.

Figure 7.2. depicts the types of nursing skills that can be considered most relevant to contemporary socio-health disorders in New Zealand society. Among desirable nursing skills the following require emphasis.

- 1) The capacity to solve problems.

- 2) The ability to manage change and to use strategies of adaptation, flexibility, and innovation.
- 3) Ability to communicate - to listen, respond, and to interact well with others.
- 4) The ability to make decisions relating to values and skills.
- 5) Technical proficiency.
- 6) The ability to function independently and in a team.
- 7) Careful, efficient use of resources.
- 8) Accountability for actions.

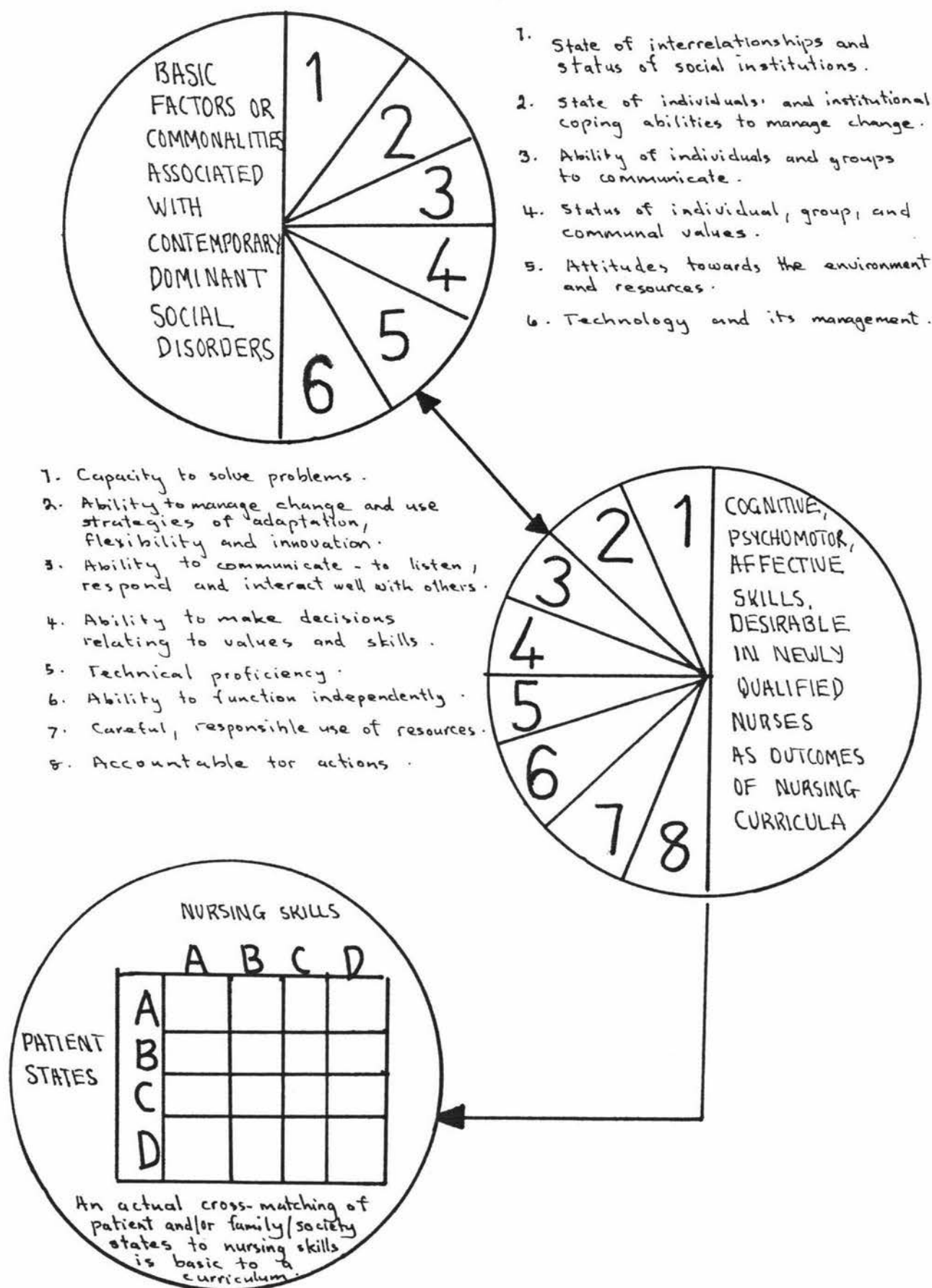


Figure 7.2. Nursing Skills Pertinent to the Commonalities of Socio-Health Disorders

(Flemer, M., 1980)

CHAPTER 8

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

SUMMARY

The basic argument presented in this thesis is that nursing, as a socially prescribed service, must continually identify and adapt to changing socio-health and nursing needs and problems. To fulfil its purpose nursing must appreciate the underlying causes of socio-health malaise and not just its outcomes. It must also determine the most appropriate settings or location of nursing practice. Further, it must make optimal curricular choices based on knowledge and understanding of the social context in which nurses practise. The organisation, content, and learning experiences chosen for nursing curricula must be relevant to the foremost social realities and resultant disorders.

Nursing education is seen to have two major functions. One is to prepare oncoming nurses capable of responding to societal and individual need for nursing care. Hence the learning needs and capacities of individual students must be determined if learning outcomes are to be successful. Secondly, curricular processes must be formulated to:

- (a) identify, on a continuing basis, the foremost social realities and resultant disorders of a society; and
- (b) update the broad and specific educational goals of curricula.

In other words, there must be an ongoing assessment of what is socially of the greatest value for society. And, more specifically, what the nursing requirements of a society are to help attain optimal socio-health goals for its members.

A particular approach has been taken in an attempt to answer the questions discussed in this thesis. A conceptual framework, the 'triadic nursing model', was developed in order to delineate the key issues

nursing has to deal with in contemporary society.

Acceptance of nursing as a socially prescribed institution is the main tenet of the model. It holds that nursing's purpose is essentially a response to societal and individual need for nursing assistance. Therefore, both the social and personal require study.

Since effective nursing care requires knowledge of the total environment of those who may require it emphasis has been given to the development of an educational tool with a system approach. Called the 'curriculum relevancy process' it provides for the ongoing identification of the dominant social realities and resultant disorders. It then acts, on the basis of the information obtained, as a problem-solving, evaluative process. And, finally, it leads to actions to adapt nursing curricula to the needs of society for nursing assistance, and maximize the outcomes for students.

Within the limits of this thesis it was only possible to pursue the information seeking phase of CRP. This led to elaboration of an information system to assist in the development of nursing curricula.

To gain information about contemporary social realities and their resultant outcomes two main activities were undertaken. First, an extensive review of the social realities of contemporary societies was made to define the social context in which nursing practises. This involved review of:

- dominant trends and problems;
- the realities of social institutions (focussed on the family);
- changing patterns of ill-health;
- the management of technology; and
- classification of values in an age of degenerative and man-made disease.

'Social realities' has been defined as the actual conditions, pressures, disabilities and abilities, limitations and resources that exist in the lifespan of people and from the environment within which nursing

functions.

The major issues which dominate in the social realities of today include:

- the problems of rapid persistent change and its effects on social institutions and individuals;
- diseases associated with increasing urbanisation, industrial and technological developments, mobile populations, and the hazards of pollution;
- the rapidly escalating costs of health services and the need to clarify values and make choices in the use of available resources; and
- the need to promote health education and promote the self-care abilities of individuals and their societies.

The second, and more specific activity, has been to use the information seeking phase of CRP to focus on the social context in which New Zealand nurses practise.

To gain a comprehensive portrayal of New Zealand society's socio-health problems and nursing requirements, information has been sought from both official and voluntary sources. As the Department of Health 1979 Report 'The Public Health' points out, ~~even~~ with all its expertise, it did not consider that it could give all the information needed to strike a balance between the health services provided and the needs that exist for health care. Moreover, it stressed that alongside the information collected about inpatients there is little corresponding information about those seen at outpatients, dispensaries, or in their homes.

The need for broader information about a society's socio-health problems is important for nursing education. When the characteristics of data extracted from the mass media is compared with that obtained by right, or on request, from traditional sources it is clear that there can be serious gaps in our understanding of socio-health and nursing needs.

For example, how does one establish the criteria for allocating time and learning experiences in relation to institutional and community nursing practice? Or how does one choose the locations where learning experiences are best provided? What content should form the basis of the various programmes and how can it be selected? What is the relation of the learning experiences to the location where nursing is to be practised? Data to answer such questions must come from official and voluntary sources.

The number of voluntary and self-help agencies to be found in New Zealand also indicate the number of inadequacies in the services provided. They do have, of course, a valuable role to play in their own right but, as several of the news sheets show, there is a considerable degree of need for help expressed through the mass media or literature published by the agencies. Pleas for help from the disabled or the chronically ill at home, for example, indicate a need for oncoming nurses to be given more exposure to the community than is generally provided. Focussing on community health problems helps to avoid confusion between the role of the nurse in sickness and in health.

CONCLUSIONS

Interpretation of the information collected, classified, and analysed leads to several conclusions. The over-riding impact made by the data is the need for individuals and societies to be cared for in ways that release their own self-care abilities and self-direction towards wholeness.

An examination of the overall profile of need formed by the issues affecting the family, the community-at-large, specific health problems, and the environment suggest that the following factors underly socio-health malaise.

- 1) A failure of interrelationships, inadequate coping strategies to manage change, and a widespread failure of social institutions, such as nursing and education, to include an orderly, adaptive process for change which assists people to function adequately in a time of continuous and rapid change.
- 2) A widespread inability of individuals and groups to communicate with each other.
- 3) Ill-defined values about work, sexual relations, intergenerational relations, shared responsibilities and rights related to the physical and social environment, individual integrity, group belonging, and healthy social exchange in primary and secondary groups.
- 4) A failure of responsible use and care of the physical environment and resources.
- 5) A failure of communities to grasp that new plans, new places, new strategies, and new machinery such as computers, cannot be better than those who initiate or use them; that, in reality, no solution is ideal for all time as the environment is constantly changing and individuals change in response to it; in other words there is a need to recognize the triviality of technology without responsive, sensitive human management.
- 6) Community services for educating, providing, and caring can lack relevance if they fail to take into account the causes of individual and group needs and their relationships with social-cultural and economic issues.

For consumers of the nursing education programmes - clients, students, and society --one must also include that, as Camus (1961) stresses, there is an urgent need to increase the amount of responsibility to be found in people everywhere. There is also a need to help them to acquire the coping strategies to deal with uncertainty and change, and,

where applicable, to bring about change. Educationalists, such as Toffler (1974) emphasise that to function in quickly changing environments learners must be provided with the opportunity to do more than receive and store knowledge and acquire skills. One must conclude that the development of the 'nurse person' (Simms & Lindberg, 1979) is the key to optimal outcomes for nursing education programmes since so many of the skills imply the use of the self in relating to and caring for others.

IMPLICATIONS FOR NURSING

There is a clear need for nursing to reorganise its services, practice settings, and educational policies if nurses are to be able to function in different situations. And if they are to function according to the needs of different clients. As oncoming nurses are generally of an age when interpersonal, moral, and reasoning skills are developing beyond a conventional level (Kohlberg, 1971: Piaget, 1965) attention to the development of the 'self' of the student must be seen as a vital and integral part of the learning experiences chosen.

The commonalities of socio-health disorders, and the nursing skills seen as desirable in relation to them, make it clear that the interactions of the nurse with the client are as important as the nursing care she administers.

Moreover, in a time when 'knowledge' and 'technological explosions' present many dilemmas, criteria of value must be identified for nurses, and learning experiences chosen to promote their acquisition. Awareness that material and human resources must be used more responsibly must also be promoted. In socio-health related services, as requirements become limitless and resources shrink, priorities must be established. In general, the preparation of nurses must include whatever gives them the broadest possible understanding of humanity and the world in which they

live (Henderson, 1978).

As defining the social context of contemporary societies in chapter 5, and, specifically, of New Zealand society in chapters 6 and 7 indicates, nursing priorities include provision of care related to:

- 1) the degenerative disorders of industrial societies and the epidemic and endemic conditions of developing ones;
- 2) behavioural and lifestyle disorders such as alcoholism, drug dependency, smoking, faulty dietary habits, and accidents;
- 3) the care of the frail elderly;
- 4) care of the lonely and alienated;
- 5) care of the physically and mentally disabled, and the growing number of chronically ill at home in the community; and
- 6) the changing social patterns of relationships and the increasing demand for provision of a sustaining relationship by those who need care. This is seen as a critical need in the 'global village' of today.

IMPLICATIONS FOR NURSING EDUCATION

- 1) Nursing education must be planned around the activities that newly qualified nurses must be skilled in. As an applied science, nursing must use a variety of social and natural sciences to assist nurses to develop the skills shown in figure 7.2. (p.200). And the location of need, over 70% in the community (Mahler, 1977 - ^{*}McLauchlan) should be the prime location of learning experiences.
- 2) One specific contribution that an alert nursing profession can make for ongoing identification and evaluation of current social realities is to (a) use educational processes; such as CRP, and
(b) to have flexible organisational structures which permit

ready adaptation as requisite. It follows that continuing education programmes are vital.

- 3) As the realities of social life form the environment in which nursing functions, nursing education at central, regional, and local or institutional level must operate information systems to gather relevant data.
- 4) The outcomes and commonalities of the social realities must form the socio-health indicators upon which nursing policy at central, regional, and local level is based.
- 5) The content of nursing curricula must be related to contemporary need. For example, the care of the frail and elderly, the lonely and the chronically ill needs psychosocial support expressed through good interpersonal skills and ability to communicate. Hence content from the behavioural sciences needs to be increased in nursing curricula, and teaching/learning strategies employed that facilitate learning in this area. The nature of socio-health problems is such that educational activity must be regarded as an integral part of a nurses activities.
- 6) The provision of counselling techniques to assist oncoming nurses to develop optimal coping abilities and to handle stressful situations - professional and personal.
- 7) The climate in learning situations must be warm, accepting, and stimulating, and learning experiences provided that help the student to develop a similar climate in the client situation.
- 8) Criteria of value need to be set and maintained through all stages of curriculum development, evaluation, and adaptation (criteria of value are shown in figure 3.2. p. 40, and figure 3.3. p. 41).
- 9) Implicit in the study are implications about a society's need to know, for example, about ecological interdependence and shared co-operative planning.

- 10) There is a great need for assessment tools to determine the readiness of oncoming nurses to practise in the social context in which they will be employed.

RECOMMENDATIONS

Examination of the social realities and resultant disorders of contemporary societies, including New Zealand, demonstrates that the resilience of nursing to keep on providing relevant care, requires oncoming nurses who can apply desirable skills to different clients and situations.

The complexity of contemporary societies compels nursing to be:

- flexible, dynamic, and responsive to changing needs;
- develop and use ongoing evaluative strategies in order to identify the socio-health needs of people who are coping with the realities of rapidly changing systems; and
- structure nursing education programmes so that they can be readily adapted to changing socio-health requirements.

This is emphasised in a number of recent studies, for example, by Katz & Füllöp, 1978: Hastings & Murray, 1976: Skeet & Elliott, 1978: Conley, 1973: Jacobs, 1976: Clark, 1978: Graham, 1979: Abdellah et al. 1973: CERI, 1975, 1977: NERF Manpower Planning Report, 1977: and WHO, 1977.

Katz & Füllöp, for instance, stress that:

- a) as health is increasingly considered a right not a privilege it requires a corresponding change in the attitudes of health professionals;
- b) there is still too often reliance on past educational experiences which have proved to be inefficient, and, as a result, there are still too many education programmes and processes which are irrelevant and

inappropriate; and

- c) innovations, alternatives, and strategies are developing which can lead to the use of properly trained manpower.

Jacobs, 1976: Hastings & Murray, 1976: Clark, 1978: Simms & Lindberg, 1979: and Steele & Harmon, 1979, in particular, provide some very good material on recent trends and innovations.

Two points of note can be taken from the fourteen educational programmes that Katz & Fü. löp refer to in their study. First, emphasis is given to the need for effective coordination between professionals, and between professionals and society, to ensure that the programme is relevant to its role in improving the health status of the community of which they are part. Secondly, the selection of students for optimum utilization of learning opportunities is considered vital for successful outcomes.

Among current innovations and responses being made by nursing certain ones referred to below, are seen to be especially important.

Person-Centred/Community-Focussed Nursing Education Programmes

As the broad or central goal of a nursing education programme relates to the needs of a society for health and nursing care its members can be considered as central people in the 'learning system'. This is increasingly recognized and forms the basis of person-centred and community-focussed curricula. Clark (1978), in defining 'learning system' as a combination of interdependent factors - people, media, and materials - that interact to achieve a goal, has not specified who is included in 'people'. But one can interpret it widely to include the potential and actual clients of a society.

The place of clients in the learning system is seen to exist, not only with the experiences provided in learning situation, but in their participation with the task of identifying health and nursing needs. There is a growing appreciation that the identification of socio-health and

nursing needs should form the basis of curricular construction rather than an overriding concern with the maintenance of institutional health services.

Mussallem (1975) reports that health and social sciences are finding that the care provided by health professionals may not be very significant. Further, she refers to Illich's suggestion that health professionals are only interested in illnesses which are treatment based. Nor does he exclude nurses from this criticism as he points out that they deny people the right to have an interest in their own care. This is now a less legitimate criticism than previously, but, as Mussallem (1975) notes, over 80% of nurses are still located in health service institutions where they have not the opportunity to alter the course of events that bring patients to the hospital. And only about 9% of registered nurses work in settings where the primary concern is not illness.

In her description of the problems of the very old - the 80 to 90 year olds - Auld (1979) provides a ready example of the value of including members of a society in the task of identifying their health and nursing needs. Auld names the problems requiring examination and solution as those of forgetfulness, of incontinency, or reduced immobility, and the lack or absence of caring family members. Specifically, in this instance, the people in the 'learning system' must include the client population, those closest to them, and the wider society. Since the required solutions are primarily those of care and companionship, independence should be maintained in their own homes for as long as possible, and, when institutional care is necessary, it should be provided in homelike, not hospital, institutions, and be run on a new nursing model and not the traditional medical model.

It is not, in other words, an institutional problem, but a problem of people and relevant others in their lifespace. Peters (1973) notes that one of the main problems in planning the care of the elderly

is to 'respect their personalities whilst grouping their infirmities. To the old, as to the young, choice is a precious prerogative'.

Oncoming nurses require considerably more exposure to the community than is generally provided if the outcomes seen as desirable by Auld (1979) are to be achieved. This is not to imply that institutional health services can be ignored, nor a profitable use of technological innovations, but that in the use of 'learning systems' the total learning situation must be the basis for assessment of socio-health requirements.

The clustering of health professionals in disease treatment settings for learning experiences focuses attention on the treatment of illness rather its prevention, and on the illness rather than the person. Moreover, the student nurse's learning needs tend to be secondary to service needs. On the other hand, focussing on community nursing problems helps to avoid confusion between the role of the nurse in sickness and in health (O'Connell, 1978: Baly, 1973: Peplau, 1977: Mussallem, 1975: Milio: Smith, 1979).

A curriculum, based on the priority of needs of contemporary societies, will be related to:

- (a) the degenerative disorders of an ageing population in industrial societies, or the epidemic, endemic, and nutritional disorders of a predominantly young population in developing societies;
- (b) behavioural disorders such as alcoholism, drug dependency, smoking, obesity or wrong dietary habits, accidents or trauma associated with behaviour and other 'life-style disease';
- (c) the care of the frail elderly;
- (d) the physically and mentally disabled, the many for whom medicine has little to offer by way or cure (Clark, 1979 notes that after the curable and preventable has been contended with there is still a good deal left, and often ignored, and that what this requires is 'care');

and

- (e) the changing social patterns of relationships in, especially, industrial societies. These place new demands on nurses, for example, the provision of a sustaining relationship is, as Nakagawa (1974) believes, a critical human need. Begg, 1976: McLauchlan, 1976: Kennedy, 1979: Etzioni, 1979: and Illich, 1975 regard this as a particularly critical need in the 'instant suburbs' of industrial societies.

Henderson (1978) stresses that the most successful preparation of nurses will always include whatever gives them the broadest possible understanding of humanity and the world in which they live. Simms & Lindberg, 1979: Steele & Harmon, 1979: and Clark, 1978 are particularly concerned that the 'self' of the student is given adequate opportunity for growth, clarification of values, and the acquisition of 'affective' as well as cognitive and psychomotor skills. As Stenhouse (1976) points out, it is the business of education to liberate and to stimulate creativity and not just to inform. In relation to the acquisition of 'affective skills' for oncoming nurses, it is the business of nursing education to promote the growth of creative interactions and the making of judgements of value and not just to supply a list of principles by which to act.

Certainly if the all round excellence required for a nurse to be 'compassionate' and 'competent' - the two key qualities one believes to be central to nursing - is to be achieved, the acquisition of 'affective' skills must be actively and deliberately pursued in the educational programme.

Continuing Education Programmes

Due, in part, to the 'knowledge explosion', and partly to new insights about the nature of the learning process, it has become generally

accepted that no basic course will ever provide a nurse with what she will need to know for skilled performance throughout a lifetime career (Leone, 1966: Michahelles, 1977: CERI, 1975: Popiel, 1973: NERF, 1977: ANA, 1975: Bergman, 1978: Australian Report on Nursing Education & Training, 1978: Simms & Lindberg, 1979: Toffler, 1974)

Steele & Harmon (1979) write that the nurse must assume the stance of the continuing learner in order to be an effective practitioner. Steele (1978) also emphasises the need for education to be regarded as a process, and, consequently, for content and learning strategies to be selected to show processes and to enable students to experience learning as an ongoing continuous experience. The aim is to set students off on a journey of discovery (Bruner, 1966), and not to confine them to the products of established learning.

Acceptance of the need for continuing education is reflected by the planning of continuing education programmes at national, regional, and institutional levels in the majority of contemporary societies. The amount of content in general and specialized nursing is so great that it is virtually impossible for it to be dealt with in a specified period of time.

Student-Centred Learning Strategies

Learning strategies which are increasingly favoured are those which emphasise the importance of the learning climate for student development and growth, the integration of theory and practice, the acquisition of problem-solving and affective skills, place patient participation high in learning experiences, and view the teacher as a facilitator and role-model rather than as an instructor (Toffler, 1974: Standeven, 1977: Hughes, 1979: Koonz, 1978: Wong, 1979: ICN, 1973: Rogers, C, 1976: Bergman, 1977: Clark, 1978: Orem, 1971: Jacobs, 1976: and Steele & Harmon, 1979).

Jacobs (1976) considers that the health professions have, generally, neglected the uniqueness of individual students as learners and made little attempt to match learning needs with modes of instruction. On the contrary, he notes, initial student differences become exacerbated with two results: student attrition is considerable, and there is a wide range of 'quality' among graduating health professionals.

Individualized Learning, Self-Instruction Programmes, Media Use

Self-direction and individualized learning is stressed by many educationalists today. This, in part, is due to the 'knowledge explosion', but, as Clark (1978) notes, individualized learning through tutors and apprenticeship programmes is not new. What is new is the development, for example, of simulation experiences, games, and programmed instructions or learning packages. Additionally, as Jacob's remarks above make clear, the adaptation of learning measures and instruction to the individual student is of more recent origin.

Generally, a problem-solving approach is used in conjunction with learning of this nature in order to find solutions for immediate application. Richardson (1978) considers it reasonable to believe that instilling, for example, basic and generalizable skills of self-observation and self-assessment of progress or change, has considerable potential for improving the quality and generalizability of learning in a number of academic and skill training programmes.

Clark (1978) finds that one of the main advantages of individualized and self-instructional approaches is that it allows students to use a variety of perceptual structures and learning styles in order to achieve desirable goals. A main disadvantage is unfamiliarity or lack of commitment to this type of learning strategy by the teacher or faculty.

As Steele (1978) comments, changing the role of the teacher

from an information-giver to a learning facilitator, alters interrelationships and responsibilities. Consequently, adequate preparation and clarification of the new strategies is essential for staff and students. For faculty there are increased responsibilities for planning and collecting material prior to the course commencing. But as the course proceeds the onus for learning rests with the student. Successful management of these learning strategies also requires effective combining of the use of educational technology with a humanistic, person-centred approach.

Changing Curricular Approaches

Over the last decade or so there has been considerable growth in the quality and variety of curriculum approaches used by nursing education. Brief mention is made of only two of these, that is, of a 'core curriculum' and an 'integrated curriculum'.

A 'core curriculum' is basically organised around the major problems of significance to students, and subject matter is brought in only as needed to manage these problems. Vars (1976) points out that, although the term is sometimes applied to any type of interdisciplinary programme, it is more accurately used in reference to block-time programmes with a distinctive curricular emphasis.

Vars (1976) also notes that core curriculum is regarded by many curriculum experts as one of the few genuinely different approaches to education this century. Additionally, he believes that present attempts to 'humanize' and 'personalize' educational programmes can be seen as a part of core philosophy, newly adopted under such labels as, for example, 'humanistic curriculum'.

A core curriculum is often found in association with a modular system which allows for additional modules to follow the core curriculum. These modules are added according to student motivation and competencies;

and as may be required due to changing social realities (Michahelles, 1977: Steele, 1978: Briggs, 1972: Vars, 1976).

An 'integrated curriculum' is one which Graham (1979) describes as being essentially of a spiral nature in which basic ideas are repeatedly visited and built upon. This is considered to deepen understanding and learning as the basic ideas are used in progressively more complex forms.

Carney (1977) describes such curricula as integrating content and skills and eliminating divisions of study according to specialities, for instance, medicine or surgery. Instead, central themes are utilized such as healthy growth and development, deviations from health, stress, and adaptation.

Combining or replacing two or more subjects in a course helps to avoid gaps and duplications. For example, the efficiency of dealing with all aspects of a topic such as drug abuse instead of parcelling it out between health, science, and social studies is stressed by Vars (1976). Cornillot (1977) makes a similar point when he refers to programmes centred around the theme of health.

This study has raised many questions about the ways in which nursing education relates its programmes and curricular choices to the realities of social life. The need for educational processes, such as CRP, to determine the relevancy of nursing education programmes is great. Only the information-seeking phase of CRP has been fully pursued, but utilization of the whole process is recommended if the findings of the first phase are to be validated.

- 1) Since socio-health problems, actual and potential, must be determined before nursing action and educational choices, can be made, a systematic approach to information system development is essential.

- 2) Since knowledge of the student's progress and of the measure to which use of the 'self' is effective in professional and inter-personal relationships must be assessed, the incoming behaviour of the student must be known.
- 3) Since there is a constant need for adaptation to changing needs there must be a willingness to take risks by trying new things (Steele, 1978).
- 4) Since the use of conceptual frameworks help to delineate and provide meaning for nursing actions they are seen as an integral part of curriculum development.
- 5) Since many socio-health problems are complex, with multiple causative factors, a team approach must be taught to oncoming nurses.
- 6) Since action-learning programmes have good potentials which have yet to be used to their fullest advantage their use is worth exploring more fully. Further, one urges that the location of the learning experiences for such programmes be primarily, and initially, based in the community.
- 7) Problem-solving learning is recommended as the key technique to use for action-learning programmes, and the nature of the problem can set the nature of the learning required. Nursing knowledge evolved from the humanities and the natural sciences provides the cognitive base for such action.
- 8) Since the knowledge and technological 'explosions' are so great, and change is constant, the most favoured method for organising nursing education programmes is perceived to be a modular one. This allows for the adaptation, amendment, extraction, or addition of modules as may be necessary. It also facilitates reentry into

nursing for those who have periods of interruption for any reason.

CONCLUSION

The organisation of socio-health services in the 1980's is basic to the development of nursing curricula and the needs and problems of nursing education. One can conclude that a greater amount of care is needed for the chronically long-term ill at home in the community. One can reduce the mentally ill in institutions and devise support systems for them in the community. But while the majority of nursing roles are in health institutions one must prepare them for such practice.

At the same time as socio-behavioural sciences are given more emphasis in curricula, basic nursing skills, technical and general, must be reaffirmed as vital for nursing practice. The major dilemma is how to prepare oncoming nurses for practise according to dominant socio-health needs whilst they function within health systems which cannot or do not adapt readily to changing needs.

APPENDICES

APPENDIX A

COLLECTION OF MATERIAL FROM THE 'MASS MEDIA'

APPENDIX A1

A list of items from appropriate files in the
DOMINION Newspaper reference library.

APPENDIX A2

A list of items obtained from the files of the
NZBC reference library. Items from NZ major
daily newspapers for the period of 1979.

Legend:

NZBC	-	New Zealand Broadcasting Corporation
NZH	-	New Zealand Herald
ODT	-	Otago Daily Times
AS	-	Auckland Star
EP	-	Evening Post
DOM	-	Dominion
PR	-	Press Release

APPENDIX A3

A list of socio-health and nursing related programmes
broadcast over 2ZA, 1979

APPENDIX A4

A list of socio-health and nursing related programmes
broadcast over National 'YA's, 1979.

APPENDIX A1

A list of items obtained from files in the
Dominion Newspaper Reference Library.

FILE	DATE	ITEM
Social Welfare	16.1.79	'Rowling calls for welfare spending rethink .. need to apply strict priorities .. cost effectiveness to these areas
"	"	7.3.79 Social welfare review .. cutbacks
"	"	2.5.79 Social work survey draws big response .. survey to discover the number of people in social service work
"	"	30.5.79 Course will help those who help. Porirua Hospitals training unit to train .. social workers, psychiatrists and personnel managers.
"	"	14.6.79 "Health workers find first job wage collection - initial grant from the Mental Health Foundation pays first 6 months
"	"	25.6.79 Department of Social Welfare family home .. parents .. costs.....
"	"	27.6.79 Beneficiaries treated like dirt .. gaps in community services .. fewer training facilities.
"	"	30.6.79 'Put pressure on welfare.. number of old people will increase during next 25 years .. growing pressure on health and community welfare
"	"	11.7.79 Car costs cut care schemes.
"	"	25.7.79 Welfare extends marriage support.
"	"	20.8.79 Bleak job view for social workers
"	"	7.9.79 Pregnancies top benefits followed closely by .. mental disorders and circulatory, respiratory or digestive complaints
"	"	3.10.79 'Cuts put girls on street .. only accommodation costs calculated. Moving to poorer environments.

APPENDIX A1 Cont'd

FILE	DATE	ITEM
Social Welfare	10.10.79	'Home saves hospital beds' .. may keep elderly people out of hospital .. provide intermediate care for frail and aged people.
"	26.10.79	'Family poverty shocks agencies'... budget advisory officer reports his office accepted 22 new families
"	30.10.79	'Capital avoids poverty' .. difficult to assess poverty .. the poor aren't who you think they are....
"	24.11.79	'Workers seek fresh image...' Community workers plan a new image.
"	29.11.79	'Welfare widens role' .. adolescent support unit
"	14.12.79	'They're young but they're not children' .. delinquents
"	22.12.79	'Grants help liquor battle. Salvation Army - \$222,000 for Alcoholics Liquor Advisory Council
Health	13.1.79	'Booze and Buns may be New Zealand's ruin'.
"	25.1.79	'Lice Boom Hits Capital's Children'.
"	31.1.79	'Schoolgirls receive inoculation'
"	6.2.79	'Medical expert reveals NZ Pill deaths'
"	6.2.79	'Dangerous Prawns on Sale'
"	13.2.79	'Eye loss brings negligence claim'
"	7.2.79	'Pill death reports alarm women'
"	16.2.79	'Health scholar - WHO Scholarship ...'
"	23.2.79	'More to light than meets the eye .. effect on health and danger of artificial light..'
"	27.2.79	'Boat hygiene flurry'
"	28.2.79	'Fishing boat health formula devised'

APPENDIX A1 Cont'd

FILE	DATE	ITEM
Health	12.3.79	'Equality promotes female baldness'
"	13.3.79	'Schoolgirls face baby health threat'
"	14.3.79	'Government approves grant for College of Medicine .. of Community Medicine Wellington.
"	26.3.79	'Health Centre nears .. Newtown Health Centre starts with a co-ordinating team of two people..'
"	7.4.79	'Health booklet offers traveller advice'
"	18.4.79	'Public Health costs must be reduced'
"	26.4.79	'Less drug use in N.Z. poll (than in UK or USA)
"	2.5.79	'Unfit raise death risks ...'
"	3.5.79	'Promiscuous bacteria cause humans trouble (antibiotic resistance).'
"	5.5.79	'Essential to control Health Service Costs'
"	5.5.79	'Reverend Befriends Addicts'
"	16.5.79	'Polynesians hit by Bronchitis'
"	22.5.79	'Health expenditure outstrips services'
"	22.5.79	'Wages take more extra health funds'
"	31.5.79	'Preventive Health - Money spent on community health seems to encourage people to go to hospital .. increases awareness of health facilities'
"	13.6.79	'Farmer Denies Methyl Hazard'
"	14.7.79	'Non-hospital Care Not Always Cheap'
"	18.7.79	'Life shortens as more money spent on health' ... areas such as unemployment, housing, occupa- tional hazards .. treatment of children and abuse of alcohol .. also crucial ..
"	18.7.79	Letter. Minister of Health - stating health preventitive measures undertaken by government.
"	23.7.79	'Alcohol and Cigarette Abuse Campaign Use Wrong Angle..'

APPENDIX A1 Cont'd

FILE	DATE	ITEM
Health	26.7.79	'Health Service Scrutiny Begins'.
"	30.7.79	'Overeaters unite to put stopper on Binges'.
"	2.8.79	'Figures on Health Services suspect - Hospital Boards Association.
"	2.8.79	'Scope in Health Research' - a developing field of community health may offer new scope for skilled medical research.
"	7.8.79	'Auckland folk seem sickest'
"	7.8.79	'Gair launches savings study - 3 working parties - one will study information systems to ensure decisions are soundly based(pharmaceuticals)
"	11.8.79	'Emphasis on good health envisaged'. N.Z. Planning Council.
"	13.8.79	'Disco Fans Risk Duck Walk'
"	16.8.79	'Sectional Interests Could Harm Health Planning'
"	16.8.79	'Sensible Lifestyles for Better Health'
"	27.8.79	'Pills beat Counsel for Problems .. anticipated consequences of materialist technology had imposed additional anxieties'.
"	28.8.79	'Out Obesity'.
"	28.8.79	'N.Z. Diet Criticized'
"	3.9.79	'Maori Health Level Low says Doctor'. Maori Infant Mortality rate $\frac{21}{1000}$ c/f $\frac{16}{1000}$ for total population .. accident rate twice that of non-maori'.
"	8.9.79	'Problems - Fishing Boats increasing risk of typhoid and other gastric diseases ...'
"	29.9.79	'Holistic Health'
"	8.10.79	Heart week Stresses Family'
"	11.10.79	'Heart Doctor Makes Excess Diet Target'

APPENDIX A1 Cont'd

FILE	DATE	ITEM
Health	15.10.79	'Computer Eye Effect Survey'
"	31.10.79	'Beds, doctors exceed demand'
Nursing :	12.1.79	"World Nurse Need Shown' Dr H. Mahler WHO
"	7.2.79	'Plunket Extends Service'
"	23.2.79	'Nurses Fear Policy Causes Poor Service - sinking lid policy of hospital boards'
"	7.4.79	'Unhappy nurses confront Gair' ... over contraceptive counselling decisions...
"	17.5.79	'Nurses Pay Keeps Pace' .. Occupational health nursing ..
"	15.6.79	'Jail Nurse Row goes to McLay'
"	20.6.79	'Uniforms Cost Fortune'
"	6.7.79	'Mp's Join Nurses Against Health Cuts'
"	13.7.79	'Hutt Hospital Nursing Conditions Sharply Criticized'
"	22.7.79	'Nurses leave their homes' ... re Nurses Homes
"	23.7.79	'Staff loss effects worry Nurses'
"	4.8.79	'Hospital Cuts Plan Worries Nurses'
"	15.8.79	'Step In, Nurses Told .. and get patients with alcoholic problems treated .. about 80 reasons related to alcohol which get patients admitted to hospitals ...'
"	4.9.79	'Full right advocated ... Public Health Nurses.. May be allowed to give contraceptive advice to under 16 year olds.
"	10.9.79	'Nurses Group Worries About Breakups'
"	13.9.79	'Measures Tackle Nursing Needs' ... nursing education .. and spread the supply of nurses more evenly .. Government plans ..

APPENDIX A1 Cont'd

FILE	DATE	ITEM
Nursing	24.9.79	'Nurses may be allowed to give contraceptive counselling..'
"	26.9.79	'University Nursing Degree Considered' (Otago)
"	10.10.79	'Plan Backed By Nurses' .. nurses appear to favour .. proposed to be trained at a Technical Institute ...
"	11.10.79	'Shortages Denied'
"	29.10.79	'Survey' Public Health Nurses .. Lice Infestation
"	3.11.79	'Nursing Base Gains Priority'
"	18.12.79	'Nurse Training Move Continues .. transfer of nursing education from Hospital Board control to Technical Institutes is about 43% complete..

APPENDIX A 2

A list of Items from Major Daily Newspapers
obtained from files of NZBC reference library

FILE & PAPER	DATE	ITEM
Medical Services	12.1.79	Service in the Sticks .. Rural area - Ngatea - one of first rural community medical centres in New Zealand.
NZH	26.1.79	Hospital has its Perils $\frac{1}{20}$ admitted ... get a hospital related infection.
ODT	17.2.79	'Community Health Services Expand .. cover all ages of people ...
Press	22.2.79	'Lyttleton Council Support Centre/
"	22.2.79	'High Suicide rate among Doctors'
ODT	1.3.79	'Health Centre Site Found on Foreshaw - Dunedin City Council
"	2.3.79	'Rehabilitation Units Required .. need to be established in major general hospitals throughout New Zealand.
Press	3.3.79	'Patients Rights Code Overdue'
AS	4.3.79	'Your Time is Up Doc. A New Breed on the Way ... an internationally known nutritionist
ODT	15.3.79	'Community Care Uncoordinated .. hospital intervention has been largely unplanned .. a spate of projects develop- ed and intitiated under pressure.
Press	17.3.79	'Plea for Co-ordination in Rehabilitat- ion ... increased training at under- graduate and postgraduate ... also .. needed'.
AS	21.3.79	Professor blasts hospital standard .. of A & E care ... totally unacceptable ... need special training for Doctors and Nurses working in A. & E. Departments.

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
EP	28.3.79	'Pharmacists role in the Healing Process.. Self medication survey by Chemists Guild.
AS	5.4.79	'\$1 million cold shoulder' ... health centre being built at Wiri may not be fully used because some groups in community may not feel .. at home ..
ODT	7.5.79	'Integration an Essential' Health Manpower Planning must be integrated and not left to individual occupational groups ... 1978 Dept. of Health Report.
ODT	26.5.79	The Health of N.Z. (editorial)
EP	30.5.79	'Health Survey at Strathmore' ... residents want to know more about their medicines and more health education
ODT	31.5.79	'Health Service Planners Meet'
Press	7.6.79	'New Mini-Computer takes the Embarrassment out of doctor-patient relationship.
EP	11.6.79	'Doctors are given Prescription'
EP	11.6.79	'Crisis in P. Health System Marshall warns .. health seen as a primary responsibility for the whole of society ..
DOM	16.7.79	'Remarkable Drop in Spinal Injuries ... up to date 13 only.
ODT	27.6.79	'More money maust be put into NZ medical services... emphasising community medicine rather than treatment in hospitals will not save money ...
Press	2.7.79	\$50,000 Medical Centre Planned for Akaroa
EP	4.7.79	'Attitudes Change to Surgical Use of Human Spare Parts'

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
EP	8.8.79	'Self-Help is Best Policy'
EP	9.9.79	'A Chance to Practice it Patiently - Health by Family Dr'.
ODT	16.8.79	'Sensible Lifestyles for Better Health'
NZH	21.8.79	'Cuts to Dr. Surplus planned'
ODT	1.9.79	'New Health Centre for Industrial Area - Dunedin'
ODT	10.9.79	'Fresh Approach Needed in Patient Treatment'
EP	22.9.79	'Medicine Gone Outside Realm of Sick ... health is now being defined so widely that medicine is being drawn into areas where it has little to offer'
AS	2.10.79	'Locum Service Vital to Keep Pressure off the Doctors'
ODT	16.10.79	"Health Care Linked with Social Policy. Mr Gair ... in long run social policy will be seen to be of far greater significance than health .. in determining the ultimate wellbeing and good health of the community'
PR	22.11.79	'Midwife Shortage Cast for S.I. over next 2 years'.
PR	22.11.79	'Only 10% of Surgery, Psychiatric Treatments needed (Prof. Cooper)'
<u>NURSING</u>		
ODT	7.1.79	'Grievances by Nurses'
ODT	12.1.79	'Nursing Issues' (editorial)
ODT	6.2.79	'Karitane Nurse sent to South Dunedin Area'

APPENDIX A2 Cont'd

FILE & PAPER	DATE	TIME
PA	21.2.79	'Nurses Unhappy With Hospital Boards... 68% inefficient nursing management most difficult part of their job'
DOM	23.2.79	'Nurses Fear Policy Causes Poor Service'
NZH	27.2.79	'Nurses Support Course' .. a clinically oriented Advanced Diploma of Nursing course...
NZH	7.3.79	'North Says Hands off our Nurses ... Northland Hospital Board of Community College ... sound geographical, social and educational reasons for keeping training centre in the north ...
AS	7.3.79	'Health in your Hands. Message for Nurses' .. nurses urged to be health teachers rather than just curers.
NZH	2.4.79	'Carrington turns away alcoholics because of more shortage'
EP	6.4.79	'Education goal set for nurses ... to implement complete transfer of nursing education from apprentice style system to student-based system.
EP	7.4.79	'Tech-trained nurses best?
EP	9.4.79	'Suggestion given racist tag' ... re. Maoris and Polynesian being given preferential treatment and allowed entry into nursing schools...'
AS	29.5.79	'Nursing Problems Under Scrutiny'
Press	9.6.79	'Training Plan for Nurses' Technical Institutes may undertake training.... Karitane nurses ...
NZH	19.7.79	'Too few hospital nurses' (Middlemore Hospital)

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
ODT	19.7.79	'Nurses Speak for Patients' ... should have an active voice as a patients advocate in respect of patients needs.
EP	11.8.79	'Hospital Crisis Warning as staff fly out...'
EP	13.8.79	'Nurses Fighting Move to Close Hospital Ward'
PR	28.8.79	'A Revolution Gone Wrong' hospitals warned make no hasty nurse-training changes'
ODT	3.9.79	'Plan to Retrain Former Registered Nurses... a course to start for Dunedin Nurses'
PR	4.9.79	'Nurses want wider powers' ... re counselling on contraceptive advice.
Press	17.9.79	'More courses, more students for nursing ' (Health Minister)
ODT	19.9.79	'Nurses Need Critical Look at Profession'
EP	2.10.79	'Threat to Nurses Seen' .. in times of financial cutback it is nursing budget that takes.... most cuts...
AS	10.10.79	'Hospital training "stressful" '
EP	19.11.79	'Senior Nurses Seek Promotion for Continuing Education' 5th Canterbury H. Board Nursing Supt.... very few social changes that will not affect us in some way... nurses must be involved in community decisions and be represented on local and national bodies...
EP	19.11.79	'Waikato University lecturer .. students committment drop sharply when went into a ward.

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
EP	19.11.79	'Men Entering Nursing seem headed for Top'
SOCIAL LIFE AND CUSTOMS		
NZH	19.4.79	'Services in Decline' ... social need is never static.
EP	15.9.79	'No use pushing people around' ... malaise of world ... learn to use every negativity creatively ... listen ... see world as a global village...
AS	11.6.79	'Two-faced drink rules irk expert ... 200 health experts view alcohol and alcohol related accidents as a major medical problem <u>VS</u> liquor advertisement on buses.
NZH	28.6.79	'Drinkers heavier by the Year'
EP	12.9.79	'Social Gaps Wider' ... inadequate nutrition and health care and increases in child abuse and stress diseases..
NZH	26.10.79	'Suffocating under Protection' N.Z. is over-protected, over-legislated and over-licensed.... $\frac{2}{3}$ of all government spending on health, education, social welfare.
EP	4.12.79	'Quality of Life' ... N.Z. $\frac{7}{50}$ in quality of life survey. 2nd in world in area of health and education.
HEALTH		
Press	16.1.79	'Alcohol - Overeating 2 Big Problems in N.Z.'
NZH	14.2.79	'Call to Curb Spread of Disease in Hospitals'

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
Press	17.2.79	'Health Risks ... a greater public awareness of health hazards is an objective of Health Department in Christchurch'
EP	3.3.79	'The Ailing Condition of Health Education'
PR	27.3.79	'Make Changes Slowly says expert' - wise to experiment with different types of health administration before setting up a new system.
Press	27.4.79	'Prevention Will be Health Officers Job S.I.'s First Health Education Officer. Teaching of Heart-lung resucitation and preventive medicine.
Press	27.4.79	'Knowledge of Health Care Inadequate' Secrecy had no place in health care. (Beaven, B.W.)
ODT	18.5.79	'Conqueroring Colds' Family Doctor
PRESS	29.5.79	'Try the Garden not the Drug Cabinet for Your Daily Vitamin C'
EP	16.6.79	'Health Money ... often Poorly Spent' WHO. $\frac{1}{5}$ of some health spending actually impairs or frustrates health. Gair.
EP	6.7.79	'Survey links Health and Income' (Porirua C.H. Project)
EP	16.7.79	'Health Funds Need Care Too'
EP	17.7.79	'Workplace Health Teams' (Team - a nurse/ health inspector, and a clerical assistant)
NZH	25.7.79	'Immunizing Can Avoid Tragedies'
EP	13.7.79	'Poised for Priority Punch' Family Doctor

APPENDIX A2 Cont'd

FILE & PAPER	DATE	ITEM
Auckland Star	15.9.79	'Pain Poorly Controlled' ... cancer patients are suffering unnecessarily ... because their symptoms are being inadequately controlled.
AS	17.9.79	'Eat for Health and Slice Pill Bill, say Visitor' (Dr Bourbour - an Iranian nutritionist).
NZH	19.9.79	'Health not only Doctors Responsibility' (Minister) Co-operative planning of a cross-section of health agencies is vital if major health problems are to be successfully tackled.
EP	24.9.79	'Allergy said to be Masquerader'
ODT	28.9.79	'Suicidal N.Z. Lifestyle kills at Alarming Rate' .. obese N.Z'rs ... lazy also...
ODT	1.10.79	'Physical Fitness Clinic in Dunedin Popular'
ODT	6.10.79	'More Say for Volunteers' .. Voluntary agencies to be given more say in planning health system. (Gair- Health Minister)
EP	15.10.79	'Bills Activities for Elderly Impractical' (Health Amendment Bill)
DOM	10.11.79	'That Headache'
EP	22.11.79	'Many Teenagers Prefer to Take a Chance'
EP	1.12.79	'Emotions Ought to be Part of Health' says G.P.

List of programmes broadcast over 2ZA, 1979

DATE	PROGRAMME
29.1.79	"After School Child Care"
1.2.79	"Choosing to be Childless"
19.2.79	"Training for Childcare"
21.2.79	"Family & Marriage Guidance Council"
22.2.79	"Report on Conference on Alcohol & Drug Abuse"
27.2.79	"Growing Up - Foster Homes"
1.3.79	"Bunnythorpe React to Local Typhoid Case"
6.3.79	"Adoption"
28.5.79	"Contraception for under 16 year olds"
30.5.79	"Abortion Programme Talkback"
6.6.79	Talkback "Crossfire on Welfare State"
7.6.79	"Report on Year of Child Exhibits" - social work projects
11.6.79	"NSAD pulling out of Manawatu"
13.6.79	"Human First Aid Being Taught at Vet School"
19.6.79	"Schizophrenia"
20.6.79	"Battered Wives"
22.6.79	"I.Y.C." International Year of the Child.
26.6.79	"Dental Health"
27.6.79	"Prisons and Prisoners"
28.6.79	"Pressures of School Poverty"
29.6.79	"Homosexuality"
2.7.79	"Accident Compensation"
4.7.79	"Creche at High Schools"
5.7.79	"School Pupils and Drugs"
25.7.79	"Education Cuts"
26.7.79	"Education Cuts"
23.8.79	"Report on Psychologist Conference"
5.9.79	"Psychosexual Medicine"
5.9.79	"Talkback on Marriage Guidance"
10.0.79	"Report on Mental Health Seminar"
11.9.79	"Nursing"
12.9.79	"Effect of T.V. on kids"
17.9.79	"A week of Cancer Programmes with Talkback and Public Participation"

APPENDIX A3 Cont'd

DATE	PROGRAMME
26.9.79	"Talkback on Exam Pressure"
2.10.79	"Pregnancy Help"
3.10.79	"Getting Fit"
9.10.79	"Child Psychology"
6.11.79	"Suicide Rate in Palmerston North" - Talkback
9.11.79	"Disposal of Nuclear Waste at Massey"
13.11.79	"Legal Help for Children" In Divorce Cases for instance.
7.12.79	"Youthline"
19.12.79	"Educational Gains"

List of programmes broadcast over 2ZA, 1979

APPENDIX A4

List of Programmes Broadcast over National 'YA's
Network News and Current Affairs Programmes.

THEME	DATE	PROGRAMME
Abortion	27.4.79	'Abortions, anaesthetics and Parental consent'
	1.5.79	Comment on abortion situation
Accidents	18.1.79	MOT Campaign to cut down accidents
	30.1.79	ACC advertising campaign to promote mouthgards
	21.6.79	ACC report on children who ride bikes
	18.7.79	Results from use of seatbelts
	26.9.79	Survey on cost of traffic accidents
	15.10.79	Guidelines on compensatable injury published
Alcohol	18.5.79	Study on hotel drinking habits of ethnic groups.
	30.4.79	Problems associated with early diagnosis of alcoholism
	26.7.79	Gains in dealing with alcohol abuse
	20.2.79	Alcohol cost to N.Z. Industry and workforce adversely affected by it.
	15.11.79	Alcoholism
Conference	11.9.79	Cancer Conference Starts Today
	29.6.79	Teenage morals paper presented to demographers conference
	7.5.79	Save our Homes Convention ends in Hamilton
	18.5.79	International conference on effects of agriculture, industry and water quality.
Dairy and Milk Products	3.4.79	N.Z. milk radioactive
	2.2.79	Danger of lead pollution in sheepmeat
	28.5.79	Commission for Environment's warning about selling milk in cardboard containers.
Drugs	11.1.79	Narconon starts drug survey in Auckland
	15.1.79	Drug trafficking increasing
	31.1.79	Police and Customs involved in seminar on international drug problem

APPENDIX A4 Cont'd

THEME	DATE	PROGRAMME
Drugs Cont'd	8.2.79	NSAAD disagrees with suggestion that heroin be introduced as a painkiller.
	3.4.79	New self-help group for a particular kind of addict.
Ecology- Conservation	1.6.79	Commission for Environment not happy with planning of ammonia urea plant at Kapuni
	26.2.79	Ven Young opens symposium on public involvement in environmental planning
	26.3.79	Oil pollution of the sea
Economy	5.6.79	N.Z. Planning Council Study on 'social policies'
	29.6.79	Children and family costs
Education	24.7.79	SPUC attacks human development course for schools
	9.4.79	Social Studies kitset at secondary schools
	6.6.79	Rural education and urban drift
	19.4.79	Family breakdown, threat to education
	29.3.79	Suggestion that social science should be included in health related university courses
	9.5.79	NZEI Conference 'teacher stress'
	9.2.79	C.P.S. Report criticizing standard of physical education taught in schools
Handicapped	21.6.79	Plight of deaf children
	6.7.79	Early detection of mental retardation
Health and Medicine	14.9.79	Alternative approach to mastectomy
	12.9.79	Valium being investigated for addictiveness
	16.10.79	Aluminium in water makes patients demented
	9.7.79	New restrictions on why minor tranquillizers are prescribed
	13.8.79	Cot deaths and diet
	28.8.79	What priority should be given to surgery
	17.9.79	Talking about cancer starts today

APPENDIX A4 Cont'd

THEME	DATE	PROGRAMME
Health and Medicine Continued	1.11.79	People will soon buy medicine over counter instead of consulting doctor
	17.7.79	Tranquillisers - good or bad
	13.8.79	Survey on contraceptive use among N.Z. women
	11.6.79	Use of medication in the home
	26.6.79	Deficiencies in our intensive care service
	28.6.79	Doctors call for more emphasis on general practice in med. student courses.
	4.7.79	N.Z. needs improved emergency services
	17.4.79	Plunket report - N.Z. has highest record of children involved in car accidents
	11.4.79	Review committee set up by Minister Health concerned about child poisoning and burns
	26.1.79	Karitane nurses prove popular in their new role
	16.5.79	Child rearing
	30.3.79	Standards of mental health care in N.Z. under attack
	6.3.79	Genetic manipulation
	12.3.79	Multiple Sclerosis Society symposium in Auckland
	15.3.79	New regulations for cigarette advertisement
	20.2.79	Christchurch specialist warns about risks from occupational poisoning
	7.12.79	Increase in rubella
Racism	13.6.79	Humans Right Commission to undertake inquiry into race relations
Statistics	27.7.79	Survey on elderly people in New Zealand
Women	23.1.79	Battered wives booklet
	24.1.79	Battered wives increase
	24.6.79	Soc. Research on Women survey of immigrant women
Welfare	9.1.79	Tired schoolchildren
	27.3.79	Phone help service called 'Parents in Stress' set up in Hamilton

APPENDIX A4 Cont'd

THEME	DATE	PROGRAMME
Welfare Continued	18.5.79	Scheme to provide intensive foster care of emotionally disturbed children
	15.10.79	Search for foster parents for difficult and disabled children
United Nations	20.4.79	WHO survey on N.Z.'rs teeth
	25.5.79	WHO calls for ban on tobacco advertising

APPENDIX B

COLLECTION OF MATERIAL FROM RELEVANT
JOURNALS, PERIODICALS AND DIRECTORIESAPPENDIX B1

A list of items from NZNJ for the period of
January 1974 to January 1980.

APPENDIX B2

A list of periodicals, news releases, conference
and research reports that deal with some aspect
of contemporary socio-health issues.

APPENDIX B3

A list of (a) NZ social services directories,
and of (b) several similar overseas publications.

APPENDIX B1

Items from New Zealand Nurses Journal January 1974
to January 1980

DATE	ARTICLE
January 1974	'Growth and Development' (Part 2)
" "	'Practice Nurse Scheme Extended'
April 1974	'Community health nursing and change - are we prepared?'
May 1974	'Health Centres'
July 1974	'Nursing - the Departments View'
August 1974	'Education in Health Sciences'
January 1975	'The Primary Care Role'
March 1975	'Occupational Health Nursing'
April 1975	'Elderly Citizens and Long Term Care'
" "	'Alcohol, Alcoholism and the Nurse'
" "	'Change and the Plunket Nurse'
June 1975	'Alcoholism'
July 1975	'Change and the Plunket Nurse' A reply to the April article
August 1975	'Alcoholics and their Families'
October 1975	'Mosgiel Health Centre'
" "	'Public Participation in Nursing'
November 1975	'Clinical Assessment' .. of Behavioural Skills
December 1975	'On Nursing Standards' (Part 1)
January 1976	'The Nurse Specialist'
" "	'Theory and Practice Correlation'
" "	'Nurse - Family Relationships'
" "	'Inequality of Health Care'

APPENDIX B1 CONT'D

DATE	ARTICLE
February 1976	'Nursing Standards' (Part 2 - see Dec '75)
March 1976	'Good Health - the by product of an untrammelled ethos'
" "	'After 3 years' (Polytechnic Nursing Programmes)
" "	'Planning Nursing Care'
" "	'Implementing change in the Organisation of Nursing Care'
May 1976	'The Nurse in Contemporary Society'
September 1976	'Curriculum Evaluation in Nursing'
November 1976	'What about the relatives?'
March 1977	'Reporting on Midwifery'
May 1977	'The Mental Health Foundation'
July 1977	'Drugs, Youth and Society'
" "	'Beliefs and Values'
" "	'Learning the Characteristics of Helping Relationships: Nurse-Teacher Genuineness and Student-Nurse Self-Disclosure'
October 1977	'Women in Distress'
January 1978	'Nurse Teachers are Role Models Whether They Like It Or Not'
February 1978	'Towards 2000: a community perspective'
" "	'The Nurse's: role in the promotion of mental health in obstetrics'
March 1978	'The development of Nursing as a Profession in New Zealand'
" "	'Institutional Neurosis'
April 1978	'The Disabled and the Community'
July 1978	'The Nurse in Crisis'

APPENDIX B1 CONT'D

DATE	ARTICLE
August 1978	'Pain and the Hospitalised Patient' (Part 1)
September 1978	'Pain and the Hospitalised Patient' (Part 2)
August 1978	'Loneliness'
September 1978	'The nurse and the provision of primary care in accident departments'
November 1978	'The pain of loneliness - an aspect of "pain" and its relief'
June 1979	'Need and Demand in Community Health Services'
July 1979	'Care of the Terminally Ill'
" "	'Mental Handicap and the Nurses Role'
September 1979	'The Child at Risk in Play'
" "	'But a Patient must Fight Back'
November 1979	'Negotiating Ambiguity: An Aspect of the Nurse- Doctor Relationship'
January 1980	'A Role for the Nurse in Caring for the Individual Suffering from Rheumatoid Arthritis'
" "	'Changes in Health Care Delivery which have Affected the "Role" and "Status" of Health Professionals'

APPENDIX B2

A list of periodicals, news releases, conference and
research reports containing socio-health
and nursing related items.

PUBLICATION	DATE	TOPIC
No.251 'Health' NZDH	1971	'The Use and Misuse of Drugs'
Regional Office - Western Pacific WHO	October 1973	'Report of the Seminar on Family Life Education' South Pacific
WHO Magazine World Health	July 1976	'WHO Priorities' Top Priorities 1. Strengthening of Health Services 2. Environmental Health 3. Health Manpower Development 4. Expanded Programme on Immunization 5. Research Leprosy : Cholera
WHO News Release	March 1977	'Accident Mortality in Childhood'
WHO News Release	August 1977	'Developing Countries Urged to Create National Councils for Environment
WHO News Release	August 1977	'Primary Health Care' WHO Director-General (Mahler)
WHO News Release	September 1977	'Human Factor Held Responsible for Most Road Traffic Accidents'
WHO News Release	November 1977	'Harnessing the Resources of Traditional Medicine'
WHO News Release	September 1978	International Conference on Primary Health Care Alma Ata, USSR. 'Seeks Firm Commitments to Remedy Failures of Existing System'
WHO News Release	July 1979	'Inter-regional Scientific Working Group On Environmental Health and Diarrhoeal Diseases Prevention' Kuala Lumpur
Temple Smith London	1974	'Poverty Reports; a review of policies and problems in the last year'

APPENDIX B2 Cont'd

PUBLICATION	DATE	TOPIC
Conference Report, New York	October 1971	'Multi Handicapped' Conference. Introductory topic - 'International Patterns of Residential Care'
Management Services and Research Unit - NZDH	1974	'Aged Persons - Including Retirement - Accommodation Needs of the Elderly'
Survey Report MUNSU.	1977	'Health Awareness and Health Actions of People'
The Porirua Health Care Survey	1976	'Health in Porirua'
"Ripple" Community Volunteers Magazine No 14	January- February 1979	'A Community takes on A New Responsibility' The Newtown Health Project
Special Advisory Committee on Health Service Organisations	November 1979	'Proposed Northland Pilot Scheme - Framework for Discussion'

APPENDIX B3

(a) New Zealand 'Social Services Directories'

PUBLICATION	DATE	REGION
Contact: Directory of Auckland Social Services	1978	Auckland City Council
Directory of Auckland Social Services	1974	South Auckland
'Help' The Guide to Social Services and Community Activities	1973	Christchurch
Social Services Directory	1975	Levin Index (Manawatu)
Register of Social Services	1976	Otago
Directory of Social Services, Agencies and Organisations	1975	Napier
Social Services Directory	1975	Palmerston North
Directory of Services of the Intellectually Handicapped in Auckland	1975	Auckland
Directory of Community and Social Services	1977	Porirua Basin
Directory of Organisations in Auckland and Wellington with relevance to Pacific Islanders	1977	Pacific Islanders Educational Resource Centre
Directory of Social Services	1977	Wellington and Hutt Valley
'The Next Step' Facilities and Services for the Intellectually Handicapped	1978	North Canterbury
Directory of Treatment Facilities for Alcoholism in New Zealand. Alcoholic Liquor Advisory Council	1978	New Zealand

APPENDIX B3 Cont'd

DUNEDIN COUNCIL OF SOCIAL SERVICES INC. (1980)

SOCIAL SERVICES SECTION

<u>TABLE OF CONTENTS</u>	<u>PAGE</u>
ACCOMODATION/HOUSING	1
<u>Example</u> - Nine sources of emergency accomodation are listed.	
COMMUNITY HEALTH GROUPS	3
<u>Examples</u> - 5 alcohol related organisations. Arthritis & Rheumatism Foundation of N.Z. Cancer Society of N.Z. Clinical Special Educational Unit Clinic for Special Physical Education Coeliac Society Cystic Fibrosis Society Good Samaritans Otago Asthma Society Otago Diabetic Society Otago Multiple Sclerosis Society Parkinson's Disease Support Plunket Society Psoriasis Society Schizophrenia Fellowship	
COMMUNITY SERVICES	7
<u>Examples</u> - Budget Advisory Service City Health Department Housebound Service	
COMMUNITY WELFARE GROUPS	10
<u>Examples</u> - Adoption Support Group Youthline Social Skills Unit Community Counselling Service Unemployed Drop-In Centre Emergency & Citizens Advice Service Family Care Centre Gamblers Anonymous Red Cross Society of N.Z.	

A sample of One SSD (Otago) and the Services Listed

APPENDIX B3 Cont-d

DISABLED	15
<u>Examples</u> - Access - Dunedin Association of Deaf Children Crippled Childrens Society Inc. Royal NZ Foundation for the Blind Dunedin Paraplegic & Physically Disabled Association Rehabilitation League NZ Contact	
EDUCATION AND RELATED SERVICES	18
<u>Examples</u> - Adult Literacy Centre Concerned Parents Association Learning Information Speech Clinics Schools for the Deaf	
COMMUNITY AND SOCIAL ACTION GROUPS	20
<u>Examples</u> - Amnesty International Human Rights Commission S.P.U.C. Refugee Action Camp	
LEGAL ADVICE AND ASSISTANCE	20
<u>Examples</u> - Consumer Institute Emergency & Citizens Advice Service Legal Advice Centres - Free Service Women's Refuge	
FAMILY ASSISTANCE AND CHILD CARE	21
<u>Examples</u> - Birthright Day Care Centres Pied Piper Nanny Services Contact Parents Centre Child Protection Co-ordinating Committee Plunket-Karitane Child Care and Family Support Service	
PREGNANCY ASSISTANCE	24
<u>Examples</u> - Family Planning Association Parents Centre Social Welfare Department S.P.U.C. Contraception Advice	

APPENDIX B3 Cont'd

HOSPITALS/HOMES 25

Examples - Otago Hospital Board Community Services
 Otago Hospital Board Home Help
 Otago Hospital Board Meals-on-Wheels
 Otago Hospital Board Assessment and Rehabilitation Service

SENIOR CITIZENS AND BENEFICIARIES 28

Examples - Assessment & Rehabilitation for Elderly
 Otago Beneficiaries Association
 Community Nursing
 Old Peoples Welfare Council
 Sunshine Club (for lonely)

GENERAL WELFARE SERVICES 30

Examples - Accident Compensation Commission, Dunedin Branch
 Health Department
 Education Department
 Environmental Health Services
 Probation Service
 City Health Department
 Ombudsman
 Dunedin Council of Social Services, Incorporated.

A sample of One SSD (Otago) and the Services Listed (cont'd)

APPENDIX B3 Cont'd

(b) Overseas 'Social Services Directories and Handbooks'

PUBLICATION	DATE	TOPIC
National Mental Health Foundation, London	1974- 1975	'A Selection of Pioneer- ing Community Mental Health Services'
Report of a Special Committee of the Royal College of Psychiatrists, London	1979	'Alcohol and Alcoholism'
The Directory of Social Change, Volume 2, London	1977	'Community Economic Development' 'Action Research' 'Social Audit'
Kings Fund Centre, London	1975	'Organisations Relating to Health and Social Services'
Voluntary Social Services, London	1978	'A Directory of National Organisations. p.35 Compassionate Friends'
Self-Help and the Patient, Oxford, Patients Association	1976	'A Directory of Organis- ations concerned with particular diseases and handicaps'
United Nations Handbook	1979	-Economic and Social Council (55-133) -Special Bodies of the U.N. (134-138) -Intergovernmental Agencies (149-200)
U.S. Department of Health, Education and Welfare. DHEW Publ No. (OHO) 76 - 30082	1975	'Child Advocacy Programmes'

APPENDIX B3 Cont'd

PUBLICATION	DATE	TOPIC
Directory of Agencies U.S. National Association of Social Workers, Washington.	1975	Voluntary, International, Intergovernmental Agencies.
Source on Aging. 1st Edition Part 2 - Chicago	1977	P. 34 Role and Status, Cult, Norms and Values P.61-130 Part two - 'Health'

APPENDIX C

COLLECTION OF MATERIAL FROM FORMAL OR OFFICIAL SOURCES

APPENDIX C1

A list of socio-health and nursing related publications.
Time period ranging from 1973 to 1979.

APPENDIX C2

The statistics of one department (geriatric) of the
Otago Hospital Board for 1978.

APPENDIX C3

The statistics of one class of clients seen at the
Dunedin Hospital Emergency Centre, 1979.

APPENDIX C4

A sample of items from the

- (a) 'Planning Research Index, 1979, and
- (b) 'Department of Social Welfare Library Publications -
1975 to 1979.

Note: Items from these two sources give only the title
and the name of the author or organisation responsible
for the publications. Full bibliographical data can be
obtained from the publications under which the entries
are listed.

APPENDIX C1

DATE	SOURCE	TOPIC/SUBJECT MATTER
June 1973	Department of Health	"Department of Health - Function and Responsibilities"
January 1974	Department of Health	"Occupational Health Services In New Zealand"
1976	N.Z. Plunket Society	"Changing Patterns of Child Care"
1975	Department of Health Special Report No. 45	"Maternal and Infant Care in Wellington. A Health Care Consumer Study"
1978	National Health Statistics Centre. Department of Health	"N.Z. Health Statistics Report Cancer Data, 1978 Edition"
1978	National Health Statistics Centre. Department of Health	N.Z. Health Statistics Report 'Hospital Management Data'
March 1979	Department of Health	'The Public Health' Report of Department of Health For the Year Ended, 31 March, 1979.
1979	N.H.S.C. Department of Health	'Trends' in health and health services, 1979 Edition.
1979	Town and Country 1 Planning Division of the Ministry of Works and Development	"Planning Research Index"
November 1979	The Department of 2 Social Welfare Library	<u>Catalogue</u> of Publications held by Social Welfare Library - a reorganised and reclassified listing of books inherited from the former Social Security Department and the Child Welfare Division of the Department of Education.
1976	The Department of Social Welfare Library	Catalogue of Library Recent Publications, Volume 1. - No. 1, 2, 3, 4.

1, 2. A list of socio-health and nursing related publications
- 1973 to 1979 is provided in Appendix C4

APPENDIX C1 Cont'd

DATE	SOURCE	TOPIC/SUBJECT MATTER
1977	The Department of Social Welfare Library	Volume 2. - No. 1, 2, 3.
1978	The Department of Social Welfare Library	Volume 3. - No. 1, 2, 3.
1979	The Department of Social Welfare Library	Volume 4. - No. 1, 2, 3.
1978 Calendar Year	Statistics Department Otago Hospital Board	Statistics cover general patients for the whole of O.H.B. area classified by Department and Diagnosis. WHO International Classification of Diseases is used for Diagnosis classification. One sample (p of statistics is given.
1979 Calendar Year	Accident & Emergency Centre Files, Dunedin Hospital	Monthly Statistics of Poisoning Cases seen at Dunedin Hospital, Accident & Emergency Centre. Number of cases of children under 5 noted. (Details p

A list of socio-health and nursing related publications
- 1973 to 1979 is provided in Appendix

APPENDIX C2

OTAGO HOSPITAL BOARD - STATISTICS ANALYSIS OF PATIENTS DISCHARGED DURING 1978

<u>DIAGNOSES</u>	DEPARTMENT - GERIATRIC					
	No. of Patients	No. of Discharges	Total Days Stay	Average Days Stay	No. of Operations	No. of Deaths
Malignant Neoplasm	8	8	361	45.13	1	5
Endocrine Nutritional & Metabolic	7	7	2508	358.29		2
Senile Dementia	3	3	426	142.00		1
Other Mental Disorders	11	12	633	52.75		
Parkinson's Disease	15	16	2418	151.13		2
Old Hemiplegia	32	32	4032	126.00		5
Other Nervous System/Sense Organs	18	20	10719	535.95		3
Heart Disease	13	13	449	34.54		3
Cerebrovascular Disease	50	50	4034	80.68		5
Other Circulatory Diseases	11	12	508	42.33		
Pneumonia	7	7	209	29.86		1
Chronic Bronchitis	9	9	1524	169.33		3
Other Respiratory Diseases	1	1	18	18.00		
Diseases Of Digestive System	3	3	55	18.33		
Diseases of Genito-Urinary System	5	7	686	98.00		2
Arthritis & Rheumatism	16	16	5055	315.94		1
Other Musculoskeletal Diseases	5	5	169	33.80		1
Senility	1	1	36	36.00		
Symptoms & Ill-Defined Conditions	6	6	195	32.50		
Trauma	40	45	2718	60.40		5
All Other Conditions	33	40	926	23.15		1
TOTAL	294	313	37679	120.38	1	40

APPENDIX C3

DUNEDIN HOSPITAL - ACCIDENT & EMERGENCY CENTRE

Statistics for one category of clients treated at the
centre during 1979.

DISEASE ENTITY	MONTH	NUMBERS TREATED	NUMBER OF CHILDREN UNDER 5 YEARS
Poisoning	January	23	4
	February	23	13
	March *	26	5
	April	19	7
	May	22	6
	June	25	5
	July	26	6
	August	17	3
	September	28	11
	October	19	4
	November	18	3
	December +	9	5

* From 19th only

+ Till 19th only

The Files did not always indicate the type of
poisoning that occurred. But some poisons
that were named included:

Sedatives : Alcohol : Detergents :

Petrol : Foxglove : Body Spray :

Antibiotics : Janola :

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APPENDIX D

COMMUNITY SOCIO-HEALTH AND NURSING AGENCIES

Appendix D contains a list of socio-health and nursing agencies examined by MUNS 1979.

APPENDIX D

Health/Social Care Agency	Purpose
A Private Nursing Bureau	Met a need for nurse clients and consumers who needed a more flexible structure than health care institutions supply.
A Psychiatric Clinic	For acute admissions - treatment of psychiatric disorders for up to 30 days.
Telephone Counselling Service	A support service of a general type. 'Coastline'.
Hawkes Bay Addiction Centre	Initially for alcoholics - now scope includes care and rehabilitation of both short and long-term patients with problems of alcoholism, drug abuse, obesity, gambling.
Mothers Helpers	Provide emergency help in the home, generally on a short-term basis.
Mt. Albert Centre for Mental Health	In operation for about 1 year - acting as a crisis centre.
Waikato Extramural Hospital Auckland Extramural Hospital	Paramedical skills brought to assist the family doctor in the care of clients in their own homes.
Alcoholic Anonymous	A self-help organisation coping with alcohol related problems
Titoki Healing Centre	Offers medical care, counselling, community service.
Newtown Health Project	Initiated to deal with health-social problems - high birth and mortality rates - above average infant deaths ...
Winstone Health Centre	Winstone Limited - Occupational Health Centre
"Hillview" Mental Health Centre	An intermediate agency between statutory and voluntary organisations - gives crisis care: group therapy: identifies individuals and families at risk.
Biochemistry Laboratory	A '24 hour callback system and night shifts'

APPENDIX D Cont'd

Health/Social Care Agency	Purpose
Tiwan Smelter Health Centre	24 hours service - staffed by 1 fulltime, 2 parttime R.N. Industrial Nurses - Preventative and Worker Incentive Programme
Nurse Maud Association	Provides a district nursing service for the community.
Family Health Counselling Centre - Takaroa	For people with health-related social problems. A resource service for General Practitioners, Nurses, and others.

A list of socio-health and nursing agencies examined
by *MUNS, 1979

* MUNS - Massey University Nursing Students

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