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PROFESSIONALISATION OF NURSING IN ENGLAND AND SPAIN: A Comparative Study
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1 INTRODUCTION

1.1 Aim and Structure of the Research

From the perspective of the sociological theories on professions, nursing in Europe has been studied, analysed, or explained only superficially. Therefore, the identification of nursing as a profession has been made in a tangential way, even by nursing professionals themselves. In any case, it has been approached in isolation, analysed only from the perspective of some of these sociological theories.

All the authors who have written about nursing and its professionalisation tend to depart from the concept of profession and related characteristics. But in fact, in the recent sociological literature we find works which refer to nursing as a profession although characterising it as a ‘semi-profession’ (Etzioni, 1969; Forsyth and Danisievicz, 1985). The authors of such studies (which will be discussed later) refer to this aspect repetitively and overlook the fact that the situation may have changed since the time when the view of nursing as a semi-profession prevailed.

Several authors (Caplow, 1954; Wilensky, 1964; Vollmer and Mills, 1966; Villa-corta Baños, 1989) have clearly manifested that professionalisation is a dynamic and changing process, and as such, occupations which were not considered professions in the past, have now reached a more professional status as a result of group effort and social changes.

It is necessary to investigate the historical background of nursing and view it from the perspective of its evolution towards becoming a true profession. Furthermore, historically it has been an occupation mainly for females and it is very important to understand their concept of work and its influence on the development of this occupation-profession.

In this analysis, therefore, it must be borne in mind, firstly, that nursing personnel have mainly consisted of women, and secondly, that nursing has historically been developed in a religious framework. Both facts hindered an early evolution of nursing as a profession. Given the religious factor, the assumption of professional principles has been avoided and distorted on the grounds of the preservation of religious principles. Thus, we will initially explore its location in the religious arena and the influence of specific ideas at the social level and particularly
in nursing; the gender relationship expressed in society and, finally, the idea of female work as the reference for nursing work.

Religious upheavals during the 16th century in Europe led to the establishment of Protestantism in England while, in contrast, the Catholic religion maintained its influence in Spain. Initially, the Protestant Reformation did not affect the nursing and hospital system in Spain or in other Catholic European countries. Nevertheless in England, one important consequence of the Protestant Reform was the suppression of all Catholic charity-based foundations, which left a vacuum where there was once nursing care (Donahue, 1988). It was not until the 19th century that reformers, such as Florence Nightingale, began to establish nursing occupational/professional structures in the United Kingdom and in the British Empire. In addition, the completion of the professionalisation process and its recognition as a health profession required the acceptance of women as equal to men in every aspect of social life (rights, work, etc.). In England, the tendency towards equality started during the First World War, whereas in Spain complete equality was not achieved until the promulgation of the Constitution in 1978.

The permanence of nursing in the religious context and the absence of equality between men and women caused nursing to have to articulate around the paternal model which existed in society and, at the same time, permeated the health scene. Once nursing managed to leave the religious context and sex equality was achieved, nursing reached a position to start on its way towards professionalisation.

The theoretical framework for this study has been drawn from the sociology of occupations and professions. This is an extensive field with a substantial amount of literature in which one finds a number of competing theories on the nature of occupations and professions, and their place in society (Watson, 1991; Grint, 1991).

Occupational/professional roles are primary components of society. They constitute the fundamental connection of the individual to the economic and social systems. Changes in the nature of occupational groups over time reflect social conflicts, co-operation, negotiation and social mobility (Villacorta, 1989). This study focuses on such changes in nursing in two different cultures, one Latin (Spanish), the other Anglo-Saxon (English).

The professionalisation process in nursing has been analysed starting from 1850 and up until today, using the different sociological theories which group the authors in this field. Therefore, the aspects covered range from the characteristics
or trait school, to the evolutionary school or natural history of profession approach and finally to the school of autonomy or power.

This research was structured from three different approaches, following Freidson’s (1983: 34) recommendation. His analysis focused on the particular rather than on the general, and further explained that occupations should be studied not as a case of a general concept like profession but as an individual historical case; in this study, on one hand nursing in England, and, on the other nursing in Spain. In our attempt to bridge the present gap, the basis for general comparison was established as follows:

a) The trait approach, proposed by early authors was at first disregarded as a basis for this study, since it was considered to be inadequate because it implicitly accepts as stating point that there are or at least have been in the past ‘true’ professions which exhibit to some degree all of the essential elements. However, and in spite of this inadequacy, was decided to use it as a basis of the research because it provided a model based on the trait approach in order to establish the comparison of nursing in England and Spain.

In addition recent research has not approached the nursing profession in terms of testing the degree of accomplishment of nursing of all the traits of the models considered as true professions.

b) Professionalisation necessarily refers to a process – a unilateral view of the development of selected occupations –, and this refers to a particular institutionalised form of occupation. This served as reference to check the professionalisation process for the analysis of the differences between this model and the nursing profession in England and Spain during the period of time covered by this study.

c) The last aspect studied was from the perspective of power. The professionalisation of nursing was analysed in terms of attitude autonomy (personal decision making), from client and/or the institutions that nurses worked for. This attitude analysis was undertaken comparing two professional groups, medical and nursing, and their respective practitioners and students. One is inclined to share Ritzer’s belief that the power approach is the most theoretically promising (Ritzer, 1977: 63).

Research questions were generated, and attempts will be made to answer some of them throughout this research:
• Given different cultural ethos, was there homogeneity in the evolution of nursing occupation/profession between England and Spain since the same model was promoted internationally by Florence Nightingale?

In pursuing the answer to this question, others arose, such as the following:

• What were the predisposing factors in each country that contributed to the establishment of the different occupational/professional structures?

• What are the circumstances in which people in nursing occupation in England and Spain attempt to turn it into a profession and themselves into professional people? What are they claiming?

• What are the consequences of their claims and under what conditions are they likely to be successful?

From these sociological theories enunciated above, suitable indicators were drawn to be applied to the analysis of nursing as an occupation (for the case of power and autonomy, a survey was used as an indicator, derived from the works by Forsyth and Danisievicz, 1985). Once the indicators had been established, the historical data was organised in chronological order to provide information about each one of the indicators, and also, to better understand their evolution. Critical and comparative analysis was made in respect of each indicator.

Following the recommendations of Freidson (1983: 34-35), nursing was studied in England and Spain as a single case at the empirical level, not as specimen of a previous fixed general concept. In addition, each one of the cases, in England and Spain, were analysed as individual histories before making comparisons.

The starting point of this historical approach was 1850 in each case, and with each indicator. We selected 1850 because it pre-dates significant events in both countries. Thus the analysis considered the chronology with enough amplitude, where grounds for comparison were drawn.

Instruments were analysed from a synchronic as well as from a diachronic viewpoint. By a synchronic approach one is referring to broad types through which central factors of an object of research can be categorised. A diachronic approach refers to concepts for the periodisation and analysis of processes over time. The combination of both perspectives, synchronic and diachronic, provides an integrated and dynamic conceptual apparatus by which the phenomenon in question can be better explained.

Every historical datum, event or fact, related with each one of the indicators in both countries, from 1850 until today, was systematically taken in a detailed and
critical analysis of the development of the nursing profession. Each country was analysed as a individual case.

To analyse the different stages of this evolutionary process, historical research was undertaken following Polit's (1978: 225) descriptions of what constitutes historical research. The stages involved in conducting historical research do not differ too greatly from other types of social science research; for instance, a problem area is defined, hypothesis or specific questions are developed, then using a systematic framework, one collects data which is then analysed and the findings are then interpreted.

In establishing the plan for this study there was a gearing between data collection from primary and secondary sources, and theory development. The nature of the sources was important in evaluating qualitative aspects of the material, particularly by comparing it against the indicators and concepts described above. Historical sources for this project included: governmental documents, statistical compilations, archives of religious orders, hospitals, private organisations, contemporary journals and research papers.

In the planning of this project, it was decided to construct the process into a series of phases which can be described as follows:

**Phase 1**

This phase involved initially a literature review. It comprised a theoretical evaluation of the concept of professionalisation according to the main authors studied and the identification of indicators for the study.

**Phase 2**

Data collection in chronological order, reported and structured in accordance with the research indicators. The exposition of the historical data, referred to every one of the indicators.

**Phase 3**

Analysis of each of the cases in England and Spain, to see whether the indicators were achieved and if the indicators remain.

**Phase 4**

A comparative analysis was carried out, in which the evolution of the occupation in each country was compared.
Phase 5

An examination of nursing at the present time was undertaken in this phase concentrating primarily on the concept of autonomy.

This research involved multiple theoretical sociological perspectives and several data collection methods. Jick (1975) suggests the use of two or more data collection procedures in a single analysis, as this is more of an adequate approach in the study of complex concepts. In this case, the ‘nursing profession’ is a complex concept which encompasses diverse dimensions. The combination of different methods provides opportunities for compensation of the weakness of some with the strengths of others, all trying to achieve convergent validity and reliability in data collection, analysis and interpretation of results.

The data collected both before starting the analysis and throughout the research suggest that there is a certain level of convergence in the evolution of English nurses and Spanish nurses. Both countries comply with the criteria that sociological theories have proposed for all occupations over time.

In order to support this statement, we should try to answer the question of whether or not the idea of an occupation has existed in nursing. The answer is essential before taking matters any further, given the special features of nursing in history. The response should provide us with the causes which explain the difficulties in achieving the condition of profession, and with an explanation of whether there have been similar cases in the sphere of social transactions with occupations which enjoy professional status.

And finally, we compare the attitudinal autonomy of nurses and nursing students in England and Spain, as a measure of practice in an autonomous way, as is the case with ‘real’ professions, toward their clients (future clients in the case of students) and their employers (future employers in the case of students). As a complementary contribution, we shall also determine whether the autonomy of clients is respected by professionals.

1.2 Historical Indicators

The development of the first two indicators which were used in this analysis was the result of the review of the literature in terms of professionalisation and was basically made possible thanks to the publication of works such as *The Qualifying Association: A Study of Professionalisation*, by Millerson (1964), and *Professionalisation in Britain. A preliminary measurement*, by Hickson and Thomas (1969).
Millerson (1964) studies the definitions of profession from which we have drawn a list of features which show how different authors coincide in their use. This coincidence indicates their agreement as to the characteristics which a particular occupation had to acquire to be considered a profession.

From this idea, Hickson and Thomas (1969) established a list of 19 traits drawn from different definitions of profession. Some additional characteristics were analysed but they were eliminated because of ambiguity or redundancy. With the 19 traits, they elaborated operative definitions which permitted an objective in the analysis of the occupations. Once the operative definitions were prepared, their presence or absence was analysed in 43 qualifying associations, although nursing was not included.

As a result of the analysis, a series of coefficients were drawn, and those operative definitions which obtained a low coefficient were ruled out after analysing the reasons why they had had low values. In summary, 13 operative definitions were accepted for the two indicators: Public Service and Skill-Based Theoretical Knowledge. Earlier we showed these two indicators, organised in two large groups of definitions related with education and the condition of public service of the professions, and each was assigned a code.

Although Hickson and Thomas (1969) rejected another operative definition, which was called “Journals Published”, related to the publication of professional journals, it was decided to include it in this study as number 14 after reformulating it, and renaming it “Research Publications” as will be explained later (see section 1.4).

Once these 14 propositions had been selected, it was necessary to chronologically analyse the process of professional development in nursing, from the date established as its beginning, 1850. From this date onwards, a detailed diachronic analysis has been carried out on the nursing data in Britain and Spain which may have had something to do with each of the operative definitions. Then the facts and events were grouped in relation with each of the operative definitions and subsequently with each resulting indicator, the results were later compiled per country, and finally a comparative analysis of the results was carried out for both Spain and England.

The process of professionalisation, proposed by the Natural History School, provided the third indicator. It was drawn from Caplow’s work, The Sociology of Work (1954), and Wilensky’s (1964) The professionalisation of everyone. This indicator has a 5-step sequence in the progress of occupations toward professionalisation. These two authors coincide with 4 of the 5 steps each one pre-
sents. Wilensky differs from Caplow in terms of the emergence of a full-time occupation while Caplow changes the occupation’s denomination. In order to produce this third indicator we combined the steps established by both authors maintaining their order, and thus we obtained a 6-step sequence which includes all the features considered by both authors.

Once the indicator was obtained, its application was simplified by the chronological compilation of the data for the implementation of the trait theory. This permitted a quick organisation of the information in terms of sequencing; a table was also drawn, which favoured the comparative analysis.

The fourth indicator, on power and autonomy, was not drawn from historical facts, but from the data collected from a questionnaire distributed to medical and nursing students and professionals in order to assess current attitudes to power and autonomy.

1.3 Work Throughout History and its Effects on Nursing

All texts dealing with professionalisation and the nursing profession normally approach this subject from the concept of profession and the resulting characteristics. Thus, it is necessary to analyse the professional antecedents of nursing in the religious context and follow, from the perspective of work, its development up its present status. In addition, one must bear in mind that nursing has traditionally been practised by women, and one needs to understand the effects of this point on this occupation-profession.

To begin with, nursing will be established as part of the religious scene, as well as the influence of certain ideas on nursing, both at a social and a particular level, and the gender relations expressed in society. Finally, one needs to establish the concept of work in general and female work in particular, in order to relate work in the nursing framework.

One could state that, in the beginning, priests were the only professionals, followed by those who imitated them. The noun ‘profession’ is present in all Romance languages and also in English¹, and derives from the Latin term ‘professio’; in turn, this word comes from the noun ‘fassio’, a rare Latin form which has persisted in the compounds ‘professio’ and ‘confessio’. Likewise, the noun ‘fassus’ (infrequent in Latin) has remained in the compound nouns ‘confessus’ and ‘professus’, which are closely related. The verb ‘profiteor’ (‘professus sum’)

¹. See Onnions (1983) for the terms "profess" and "profession" which are traced back to the 14th and 13th centuries, respectively.
means to confess loudly or in public, to proclaim, to promise; while ‘professio’, apart from the meaning of profession, also means public confession, promise to consecration.

During the Middle Ages, the meaning of the term ‘professio’ shifted from social or public consecration to religious consecration (Onions, 1983). The professions par excellence of the time were the monastic ‘professio’ (joining the religious life, through a public and solemn commitment to observe the vows and rules after a trial period as a novice), and the canonical ‘professio’ (public recognition of the jurisdiction of a bishop by the clergy and followers). From this stage, the term was introduced in the vernacular languages and thus kept the primordial religious meaning of public confession of faith or religious consecration.

Nursing remained in the religious scene practically since the start of Christianity, and most of its members would join this way of life through a public commitment to observe the vows and canons. One can then draw the conclusion that nurses, while linked to the Church, remained religious professionals primarily, and did not undergo the separation process of other professions in the Middle Ages, a process which took place much later on.

The degree of religious specialisation increased with the complexity of society and the level of development in the division of work. Parallel to this process, a decrease in the religious sphere in social life occurred. As stated by Durkheim; in Social Division of Work (1960: 169), originally religion applied to everything, everything; which was social was religious: the terms were synonymous. Afterwards, the political, economic and scientific functions progressively became more and more independent from the religious function, achieving an independent structure and a more temporal character.

In the Western World the modern intellectual disciplines arose as a result of a differentiation from a primordial religious matrix. If we go back in time and focus on the Middle Ages, all wise men were – to a certain extent – religious specialists. As pointed out by Parsons (1976: 539), the Judeo-Christian world is undoubtedly the primary historic matrix from where modern liberal professions have evolved and differed from each other.

In the Lower Middle Ages, universities were set up with the aim of training young people who would become part of the clerical professions: Theology, Law and Medicine. Like the secondary educational systems which arose during this period, the universities had the very important mission of forging an educated class able to strengthen the inherited aristocracy which was to play an important part in the transit from medieval to modern society.
The university system which materialised earlier in several cases, towards the 16th century it was organised around four disciplines: Theology, Philosophy, Law and Medicine, which was the organisation followed by Spanish universities. In England, only two universities existed earlier for a long period of time, Oxford and Cambridge, both organised in colleges which in general were not specialised.

While this process was taking place, nursing was submerged into the social and economic thought of the Church, this being impregnated with Scholastic doctrine and whose essence is contained in the Holy Writ. This essence has been developed, elaborated and applied through the centuries, depending on the circumstances of each historical moment, through the teaching of the church and the intellectual work of Christian thinkers. Part of the sources of Scholasticism can be found in the Greek and Latin classical authors, such as Cicero, Seneca, etc., but specially Aristotle’s ideas, the author most cited by St Thomas Aquinas (1225-1274) whose doctrine constitutes the basis of the argumentation of Scholasticism.

1.3.1 Classical and Scholastic Perspectives

Greek philosophy on natural order prevailed for many centuries but was soon christianised by Theologians, giving way to what – at the end of the 19th century and beginning of the 20th – was called the ‘naturalist fallacy’, through which goodness was identified with the natural order and considered badness as the lack of order. According to Christian Theologians of the Middle Ages, God made nature and therefore the natural order is formally good. This order encompasses not only the things we call natural but also man and society.

In Plato’s account, in *The Republic* (VI, 10), society and the individual have an order and the correlation between them is perfect. In particular, moral order is the consequence of the privileged perception that the monarch has of the world of ideas, especially the idea of goodness. The function of the one who rules is to act as an intermediate between the world of ideas and the world of men. Oddly enough, the moral order does not stem from a free acceptance but from an imposition. It is a well-known fact that, in the Socratic tradition, the concepts are not contradictory, since the perceiver of goodness cannot decide it. Freedom is not opposed to what is necessary. By obliging his subjects to comply with the imposed moral order, the Platonic governor promotes the freedom of each individual. This is the moral justification of political absolutism. Therefore, good or-
der is identified with the common welfare, where justice seems to adjust to the natural order.

St. Augustine stated that ‘the part which does not adapt to the whole is corrupted’ (Conf. III, 8), and Thomas Aquinas added that man, as a part of the city, cannot be good unless he keeps the right proportion with the common welfare, and the whole cannot be perfect if its parts are not proportional to it. Thus, it is impossible for the common welfare to shine if the citizens – or at least those who rule – are not virtuous. As to the rest, the common welfare of the city only requires them to be virtuous in those aspects related to the obedience to superiors.

According to Scholastic thought, obedience is indeed that part of justice which regulates the relationships of inferiors with superiors. The appropriate relationship with the superior is called obedience, and likewise, the appropriate relationship with the father and relatives is called mercy. A good subject sees both things in the sovereign, as a representative of the common welfare to whom obedience is due and, as a father, an object of mercy. That is why a good subject must behave to the sovereign like a son to a father and vice versa.

These moral/philosophical concepts impinge on nursing because the doctor-patient relationship (both social and human) was perceived to follow this order. The order was not univocal, as the doctor was considered as the agent and the ill person, the patient. The duty of the doctor was to achieve the well-being of the patient and the patient’s duty was to accept his view.

In this case, the doctor embodied the common welfare and therefore moral perfection, whereas the patient sought a particular good, i.e. health. This is not a bad thing and cannot be considered unfair, but that particular good can only be found in the general economy represented by the doctor, and consequently, the only virtue which is required in the patient is obedience. The doctor is like a father who is owed mercy, he is like a superior and as such demands obedience; he is somebody from whom we benefit and he must be rewarded with our gratitude.

What the doctor aimed at accomplishing was an objective good, that is, the restitution of the natural order, this being the reason why he had to impose over the patient, even against the will of the latter. It is true that the patient could consider the actions of the doctor as ‘good’ or ‘bad’, but this would be a ‘subjective’ evaluation which, obviously, could not have the same rights as the objective truth. The one knowing the natural order, in the case of disease, was the doctor, and therefore he could act even against the patient’s will.
With the change from hospital to medical institution in the 18th century, the religious nurses of the time did not find any problems in articulating around the relationships doctor-'sovereign'/patient-'subject', as a means to achieve the welfare of the 'subject'-patient by becoming instruments and 'subjects' of the 'sovereign'-doctor.

1.3.2 The Hospital, a Spiritual Refuge or a Healing Institution?

Nursing developed in charity hospital institutions. Before the 18th century, the hospital was basically an institution that provided care for the poor but, at the same time, excluded and separated them. The poor, as such, needed care and – when ill – were carriers of diseases and potential disease distributors. In other words, they were dangerous. Therefore, the existence of hospitals was essential, both to shelter the poor and to protect the rest from their danger. Until the 18th century, the typical dwellers of a hospital was not an ill person who needed to be cured but the dying poor, a person needing material and spiritual care who needed final aid and the last sacraments. This was the essential function of early hospitals.

At that time, the hospital was correctly described as a place where one went to die (Foucault, 1985). The hospital staff were not meant to cure the ill but to gain their own salvation; the religious or lay personnel worked on a charity basis, and were at the hospital to carry out compassionate actions to gain eternal life. Consequently, the duty of the institution was to save the souls of the poor at the moment of death and those of the caretakers; they played a part in the transition from life to death, in spiritual salvation rather than in the material one, a function related to the separation of those subjects considered dangerous for the general health of the population.

The European hospitals of the Middle Ages were by no means a place for cure. In the Western history of care, there were two different institutions which did not overlap; sometimes they encountered each other but were basically different, i.e. medicine and hospitals.

Hospitals were important institutions even essential to urban life in the West since the Middle Ages, but they did not constitute true medical institutions at that time, and medicine was a non-hospital profession. It is important to remember this situation in order to understand the novelty represented by the introduction of hospital medicine or therapeutical medical hospitals in the 18th century.

Until the middle of the 18th century, with the corresponding transformation of the power system within the hospital, the religious staff (very rarely lay) held the
power; they were in charge of the daily life in hospital, the salvation and feeding of the patients. The doctor was called to treat the most seriously ill, this being more of a guarantee or justification than a real action. The medical visit was an irregular ritual, and in theory, it occurred once a day for hundreds of ill people. In addition, doctors were administratively dependent on the religious staff, the latter being able to dismiss the former.

From the moment the hospital is conceived as a healing element and the distribution of space becomes a therapeutical element, the physician is responsible for the hospital organisation. He is consulted on how to build and organise the hospital, and the cloister structure (around a central patio) is then rejected, as this had been the religious tradition for organising a hospital, giving way to a space based on medical organisation.

1.3.3 Women and Work: Nursing

One must refer to the condition of most nurses, as also being applicable to the social relationships of the rest of women in society. This situation can be verified by checking the hierarchic order of female religious orders in relation with the male ones, this being a situation still present nowadays in general terms; i.e. the impossibility of becoming priests in the Catholic religion and, until very recently, also in the Church of England.

The difference with the rest of women is found in the religious vows, in their dispensation from the creation of a family and ‘their only mission to become spouses and mothers’. But we shall not forget that the dispensation for the creation of their own family is only a result of having to take care of another large family, the people in need, through the practice of charity.

This intellectual universe did not change until the modern world settled. The achievement of the Protestant reform was the substitution of the idea of order by the idea of autonomy, or natural order by moral order, to the order of freedom; the second great moral paradigm of Western history had arisen, its history mingling with the history of the progressive discovery of human rights.

With the acceptance of this new mentality, the old human relationships established in accordance with a medieval idea of the hierarchic order started to be considered excessively vertical, monarchical and paternal. As an alternative, other relationships were proposed with a more horizontal, democratic and symmetric character. With this spirit, the greatest democratic revolutions of the modern world took place, first in England, then in North America and later in France.
The French revolution constitutes a decisive change in women’s history, as it represented a questioning of the relationship between the sexes without precedent. The conditions of women changed because the revolution introduced the issue of women, which led to a political questioning of society.

Actually, Duby and Perrot (1993: 42) quote Bonald who mentioned that the revolution had ruined the natural society in which women were the subjects and where men held the power. Both terms must be understood as opposites, one a person controlled by another person, unable to act with autonomy and with no rights. In Bonald’s view, everything remained in order while man, the power in the society, kept his place assigned to him by the nature of that society; if his weakness made him lose that position and obey the woman he ought to rule over, then he would be disobeying whom he should obey.

Edmund Burke a British statesman and political thinker, MP and opposed to the Revolution, also quoted by Duby and Perrot (1993: 43), wrote: “the Revolution had brought the most licentious, depraved, savage, nastiest and fiercest systems of habits ever conceived, a system which liberated women, relaxed the matrimonial bonds, and trespassed the immutable laws of the sexual distribution of roles to such an extent that even London prostitutes – who trade with infamy – found it disgraceful”.

In the same offended way, Burke continued saying that “among the Jacobins the mixture of sexes is left to random and claims against the dirty equity aimed for by the system which grants women the right to be as licentious as men”. He later added “it is not worth speaking about the fatal consequences which would be brought by a law which removes the protection to the inferior half of our species by the other half. The consequence could be fatal not only for the peace of couples but also for the whole of the social body” (Duby and Perrot, 1993: 44).

The Revolution recognised the civil personality of women, who became complete human beings capable of enjoying and practising their rights. The Declaration of Human and Citizen Rights (August 26, 1789) acknowledges in article 2 the essential right of every individual to freedom, property, safety and resistance to oppression. Consequently, all women – the same as men – have freedom of

2. Louis Gabrielle Ambroise Bonald (1754-1840) was a leading apologist for legitimacy, a position contrary to the values of the French Revolution; he favoured monarchical and ecclesiastical authority.
3. Edmund Burke (1729-1797), who was opposed to Jacobinism, expressed his ideas in Reflections on the Revolution in France.
opinion and election and their physical integrity and the integrity of their goods must be guaranteed.

These events marked a historical breach; they set the boundaries of a new civil society, different from the political space. The start of the modern era, however, was not favourable to women. From an *a priori* point of view, women were thought to have an identical destiny, the unique mission of becoming spouses and mothers, as reproductive species, not as full citizens. From its very beginning, it was affirmed that women had to be excluded from the public context and constrained to the domestic space. This could be explained in two ways: the feudal regime did not imply that the right – or even better – the privilege of some women could be applicable to all women: the democratic regime assumes that whatever is valid for one should be valid for all. Thus, it was a better option not to grant a right to any women than to make it applicable to all, as this would only lead to rivalry between men and women in general; nevertheless, democracy did not follow this exclusion systematically, since it assumed the principle when affirming the equality of rights of men and woman – actually a contradiction in terms.

Pluralism, democracy, civil and political rights are all an achievement of modernity. All democratic revolutions which have taken place in the Western world since the 18th century arose as a defence of such principles. However, it is striking that this democratic and pluralist movement which settled in the civil life of Western societies a couple of centuries ago did not have an effect on the equality between men and women until the beginning of the 20th century, and in some instances not even until the present day. For example, in medicine, the doctor/patient relationship has developed more in accordance with guidelines established by Plato than with modern democratic thought ones. A concept such as this would consider the patient not only physically but also morally incompetent, and as such, he/she must be guided by the doctor. This could explain why the doctor/patient relationship has traditionally been paternal and absolute.

Work is a subject which was briefly studied by Scholasticism. According to this doctrine, the obligation of manual work is already contained in *Genesis* (chapter 2): “God placed man in Paradise to work”; likewise, in chapter 3 when man commits sin, he is told: “you will earn your food with sweat from your work”, etc. Therefore, the precept of working concerns man, given the instituted nature and the fallen nature, and later on, the obligation of working is established for all those who do not have a way to subsist. Thomas Aquinas in *Summa Theologiae* (2-2, q. 187, a. 3), relates the obligation of manual work to natural law and which
applies to everybody, religious or secular. However, as this is a precept of natural law related to the common welfare, it does not oblige – ‘under sin’ – each individual in particular but only those who do not have other ways to make a living. The formulation of this natural duty – since there is no right without duty and vice versa – implies the idea of the modern right to work, that is, the social obligation of providing individuals, who are obliged to work to make a living, with a job.

Thomas Aquinas brings up another idea regarding work which can also be found in *Summa Theologiae* (1-2, q. 114, a. 1): when dealing with the merit of good actions he states that *merit* and *mercy* refer to the same thing; mercy relates to the reward one receives in return for his/her work. Paying the right price for something we receive is an act of justice, and thus to give a reward for work is also an act of justice.

Nursing developed within charity institutions where the staff aimed at obtaining merit to obtain in turn mercy (a salary) in the other world, which did not prevent them from obtaining their wages in this world too in the form of food and clothes and minimum pocket money (see footnotes 4 and 5).

Thomas Aquinas (see Sierra, 1975) summarises four fundamental principles in the religious doctrine about work and money. First, work as a duty and, therefore, a personal right of every human being. Second, work as something necessary, not only as an obligation when there are no other means to make a living, but also as a right to be paid without delay given the fact of being the only income of a worker. Both principles imply a clear formulation of the two features of human work described by Pius XII in a radio message on 1 June 1941, on the 50th anniversary of the Encyclical Letter *Rerum Novarum*: work is personal and necessary. Personal because it is carried out with the particular strength of each man; necessary because – without work – we cannot get what we need to live, this being a natural, serious and individual duty. The third principle refers to a fair reward for the work done. And the fourth says that, given the necessary trait previously indicated of the salary, and the strict meaning of the vital need formulated by Thomas Aquinas (*Summa Theologiae* 2-2, q. 32, a. 6., c.), the salary, which is at risk of being unfair, must permit a working family to live in harmony with their social situation; the practice of charity should then be permitted only when there is a part not necessary for living.

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4. Merit, quality of deserving praise or reward; excellence.
5. Mercy, kindness, forgiveness, restraint, etc., shown to somebody one has the right or power to punish.
Most societies in human history have organised work mainly based on sex division, in such a way that all men in an ethnic group learn and achieve different levels of expertise in all male trades, and all women learn the different female trades. Despite its evidently arbitrary character, the division of work according to sex is usually considered as stemming from ‘natural law’ whose transgression involves serious consequences.

From 13th until the 19th century, different authors have approached work only superficially, making comments on the right and obligation of working, work as human maintenance, salary and family salary. In regard to family salary, we can find many references to women’s work but always as something related and dependent on the work of men.

Mateo Liberatore⁶ (1810-1892), in *Instituciones de Ética y Ley Natural*, neatly formulated the principle of family salary, at the time being discussed within the social Catholic context. He established that the natural price of work is calculated by men with slight participation of women (who are most of the time busy with household chores) and must be enough for the maintenance of both and two or three children. The salary must then be in agreement with this rule. If there is an excess in his salary (this would be the case in higher jobs or trades), it would provide the worker with some extra comfort (quoted from Sierra, 1975: 855).

Women’s circumstances did not change until the 20th century, as can be observed in the Encyclical Letter *Quadragessimo Anno* (15th May 1931), where Pope Pius XI clearly defines the duties of a woman as mother, in the section called ‘The maintenance of the worker and his family’:

> the workers need to be given a salary for their own maintenance and for their families. It is only fair for the rest of the family to contribute in accordance to their possibilities to the common maintenance of the family... In the household and everywhere around it, mothers must develop their work, dedicated to domestic chores. But it would be a serious crime, which has to be extirpated from mothers, the fact that – due to the low salary of the father – women may have to leave their productive art of being at home, neglecting their particular duties and tasks, especially the bringing up of the younger children.

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⁶. Italian Jesuit reformer of ecclesiastical studies based on St. Thomas Aquinas’ Theology.
This quotation also described the social role of women referring to their providential mission, and their position as the nucleus and caretakers of the family is defined as a universally recognised fact. Therefore, they should never be allowed to work outside the home if that makes them fail in their duties as wives and mothers.

These references to work, salary and women provide us with an idea of how these aspects were considered in both the Catholic and Protestant traditions. Both have a Christian rooting and use the same sources, although at times the interpretations and applications differ. We know that women’s work was only considered with reference to that of men, as the latter were supposed to earn sufficient money to meet the needs of their families, this ideas remained, however, until social changes occurred in the consideration of women, which also coincided nursing leaving the religious domain.

How did this concept of life and social relationships affect nursing? In the 16th century, nursing continued being developed within female religious orders in Spain. In England, Henry VIII expropriated all the goods which belonged to religious orders and this caused all charity health care of the time to disappear. Not too long afterwards, the citizens demanded the presence of hospitals in the cities which would then be financed and run by the civil authorities, this implying the beginning of a civil control. Female staff were employed as nurses under the supervision of male personnel. Nursing was to go through a very difficult period until the 19th century (Donahue, 1988).

On the other hand, Spanish nursing remained in the hands of the church until the 1950s, with a progressive loss of positions in the religious sphere until the 1970s. This makes one assume that all the moral/philosophical concepts which have been identified here had been perfectly assumed by the religious orders. Annie Murray7 (quoted by MacDougall, 1986: 69) offers an exceptional testimony of this fact during the Spanish civil war. She wrote:

I arrived at a small Spanish hospital in Huete ... We had, I think, about twelve nurses altogether in the hospital of Huete, and there were also Spanish nurses and, you know, untrained people helping, Spanish people. We had many little Spanish nurses. Spain had no real trained nurses, they used the nuns, so these little girls had only had about three months training, but they were very keen and very good for the time they trained.

7. She was a British nurse who participated in the Spanish Civil War (1936-1939).
As noted earlier, this situation remained unchanged until the 1970s.

Similar characteristics can also be observed in England in 1859. Anna Jameson (1859: 13), a feminist and art critic, once gave a lecture entitled “Sisters of Charity” in which she spoke to a receptive middle-class public that knew about Nightingale’s feats in the Crimean war. In this lecture, she advocated the creation of Protestant religious orders to train women in nursing, teaching and social work, arguing that only through organised religious communities could the large number of superfluous single women find the training, discipline, and moral sustenance that would enable them to help the weak, friendless, and sick. Following the arguments of Jameson, these orders would help to regenerate society, which desperately needed women “on a larger scale [as] mother, sister, nurse, and help”. Jameson’s lecture brought to the attention of a larger audience what religious women had been doing for years. This proposed the substitution of those nurses who drank, accepted tips, catered to the whims of favourite patients and lacked training. This was the generalised stereotype of the time but there were some exceptions.

Confirmation of these ideas may be found in the actions of the matrons of the hospitals in these early times. They concentrated their efforts on improving the training, living conditions, and respectability of the nurses. As Martha Vicinus (1985) said, their writings were directed toward nurses and women interested in becoming nurses, and scientific learning was downplayed to avoid competing with the doctors and keep nursing an occupation for woman. This only emphasised the subordinate position of women in the medical hierarchy. Such duties were rationalised by the increased use of family metaphors, comparing the doctor to a father and the nurse to a mother.

Maggs (1978: 57) exposed clearly the model in England:

nurses seem to have fulfilled the role of the mythical ideal woman positioning herself between the male doctors and the patients, with the matron in the pinnacle of the model. It was her function to maintain the smooth running of an institution in which the sick temporarily resided, protecting male doctors from the actual day-to-day tasks of care and cure, by manipulation of a group of acquiescent women just as the mythical middle class housewife used servants to protect her husband from the cares of the home.

Before this, there may have been an opportunity to alter the evolution of nursing, an opportunity which was missed when Florence Nightingale did not allow the nurses to do anything with the patients in Crimea unless instructed by doctors
(Rhodes, 1984: 75). Nurses then became “handmaidens to the doctors” (Austin, 1977: 114).

From the latter, one could conclude that doctors had acted *per se* exclusively against the nurses but, according to Halliday (1983: 343), the English medical profession over the last century and a half has shown that, whereas “women practitioners were employed in hospitals as official members of the medical staff as early as the 17th century, by the end of the eighteenth century the upper ranks of the profession began to close to them and by the nineteenth century women were completely excluded from practice”. This showed that the main problem was not being a doctor or a nurse but being a woman.

The explanation given by Parry and Parry (1976: 68) is based on the beliefs of the time. That the introduction of women into the medical profession was viewed as a potential reduction in professional status, given their undervalued social position and the low consideration of their intellectual capacity. In addition, physicians of the period did not find it easy to combine femininity with the very difficult situations in which a woman doctor would have to get involved.

The same reflections could be applied to Spain until the 1970s. Up until that moment, Spain had had the smallest number of woman doctors (this also happened with the rest of the professions). In the decade of the 1970s, the situation started changing and, at present it is completely different: in the medical college of the University of Valencia, 68.21% of the students are now women (data obtained from the University’s Enrolment Office).

### 1.4 Sociological Schools and Professions

Over the years many different writers have examined the concept of profession and it is possible to allocate their opinions to schools of thought. The first of them was in terms of characteristics or traits, with authors such as Carr-Saunders (1933), Goode (1957), Moore (1970), who highlighted common identifying characteristics. This is a static, synchronic vision which basically proposes a list of traits with a view to verifying whether the occupations studied have such traits at a particular moment.

The second school of thought is the evolutionary school or natural history of professionalisation; authors like Parsons (1951), Caplow (1954), and Wilensky (1964) can be cited. They held that a profession is characterised by certain traits, and sought the achievement of the traits in a developmental sequence of events that could be predicted and tracked. This is described as a dynamic
process where the occupations try to obtain each one of the attributes of the profession.

Finally, in a third trend, authors like Freidson (1961, 1984), Ben-David (1963), Hall (1969), Forsyth and Danisievicz (1985), take into consideration professional autonomy and power in the analysis of the professions as a third trend. They examine the traits of scientific knowledge and ethics which are used to support the occupation’s claim to autonomy. The classic professional attributes are no longer conceived to be components of an ideal type, but as instruments which are used by different occupations in their attempt to increase their power and prestige.

1.4.1 Professionalisation

Through our analysis of the literature, it is important to underscore those characteristics of the professions that are relevant in the development of this research, and through it study nursing in the process of becoming a “full-fledged” profession, as understood by Etzioni (1969: xii), i.e. a profession deemed as having complete professional status.

Occupational/professional roles are primary components of society. They constitute the fundamental connection of the individual to the economic and social systems. Changes in the nature of occupational groups over time reflect social conflicts, co-operation, negotiation and social mobility (Villacorta Baños, 1989), and in the history of man’s work we can establish a scale of complexity that starts with the least complex, labour, and finishes with a profession as the most complex of the world of work.

Labour and work are defined by Grint (1991: 8) as a “bodily activity designed to ensure survival in which the results are consumed almost immediately”. In a second level of complexity, Grint also speaks of work as “the activity undertaken with our hands which gives objectivity to the world”. It is a form of socialisation that bear a social identity.

At the next level are the occupations, a concept that, like many other concepts, has a number of meanings. Sometimes we juxtapose occupations to crafts, constructing occupations as a simple form of identification with work. Sometimes we think of occupations as being grouped around common organisations where people can play different roles (Abbott, 1989: 27). Actually this concept has been scarcely treated in the bibliography and, as Freidson notes (1986a: 698), very poorly developed. Most often it is used in a common way as a specialised task or set of tasks that people perform in the economy.
On the final step in the scale of complexity are the professions. The professions appear in the 19th century, as a result of the disappearance of the guilds. Their precise nature, their characteristics, and their importance for society have been debated for many years. The term profession is an ambiguous one and there is little agreement on what it actually means. According to Freidson (1986b), a profession is an occupation that has performed successfully the transactions in the social market, achieving prestige and then achieving power and money.

As Goode (1969: 269) observes, all the occupations that seek recognition as professions are engaged in transactions in the social markets with varying levels of success. The prestige market requires special attention, because if the transactions are successful, they can be used to obtain more benefits in the other two, i.e. power and financial markets.

It is argued that the most important reason for the differentiation of occupations is the training and education that the members of the occupations undergo to become skilled to perform the tasks of an given occupation. Any professional project tries to gain control over education and secure the connection between education and occupation (Witz, 1992: 138).

It is said of the professions that they retain their members for life (Freidson, 1986b: 24). Members are less willing to leave the occupation, and more likely to state that they would choose the same work if they were to begin again. In addition, acceptance into a profession requires a period of socialisation, that is more necessary than in other occupations. The rewards obtained after the accomplishment of the period of socialisation are high, especially in the emotional sense, but no less in the financial sense. In this period of socialisation, professional commitment is inculcated.

A profession has the responsibility to educate its own practitioners; therefore the requirements for professional education and qualification should be laid down by a body composed exclusively of professionals. But not only professional commitment is inculcated; according to Freidson (1986b: 24), as a learned activity, it is necessary in this period of time to undergo a formal training that transmits a great variety of skills with a broad intellectual context. In this sense the professional is an accomplished expert, a full-time specialist cultivating a particular kind of skill and activity.

This training is carried out in higher education, as a period of extended training and education beyond the limits of a general school education. This may take place in colleges, universities or specialised schools. These institutions are,
without doubt, the major source of the transformation of formal knowledge that are the professions (Freidson, 1986b: 21).

These occupations require certain characteristics of the individuals for entry: a specific general certificate of education, “O” and/or “A” level subject(s), and a minimum age for preparation for the career (Hickson, 1969: 41), which usually coincides with university entrance requirements of each individual country.

With respect to the length of the period of education, some authors (e.g. Etzioni, 1969: xii) have said that an occupation becomes a full profession if the duration of the education is five years or more; however, if it is a three-year profession, then it is called a ‘semi-profession’. It can be argued, however, that this kind of division is arbitrary with no reasons given to make such a distinction. Goode (1969: 283), however, writes the following:

professions have persuaded a gullible public that all members must command an unnecessarily large body of abstract knowledge, but practitioners do not need that much knowledge in their daily practice, and occupations exist or could be developed which would carry out most of their tasks with a lesser amount of knowledge.

The expertise possessed by professionals is said to consist of a set of esoteric experiences and abstract principles that have been mastered and organised by the profession into a theory under its exclusive control; these are thought to be applicable to the concrete problems of living.

Professions have always been identified with special forms of knowledge and skills, with the formal knowledge developed and transmitted in universities, and which must be constantly added to through research. In universities the systematisation and theorising can develop rapidly in the hands of those members of the profession who specialise in research and writing rather than practice (Freidson, 1986a: 690); notwithstanding, the rest of the members of the profession are also able to contribute to the development of theoretical knowledge.

According to Borenham (1983: 695), knowledge provides a special characteristic to the work performed by the professional: “the work of ... professionals ... by its very nature is not amenable to mechanisation and rationalisation”. Freidson (1984: 11) further states that professional workers are “expected to exercise judgement and discretion on a routine, daily basis in the course of performing their work”. In other words, judgement in face of daily problems and discretion deciding what should be done is a recognised and a legitimate part of their work.
In a more systematic approach with respect to knowledge, Goode (1969: 277-8) identifies seven major characteristics which affect the acceptance of an occupation as a profession:

- The knowledge and skills should be abstract and organised into a codified body of principles.
- The amount of knowledge and skills and the difficulty of acquiring them should be great enough that the members of society view the profession as possessing a kind of mystery that it is not given to the ordinary man to acquire, by his own efforts or even with help.
- The profession itself should help to create, organise, and transmit knowledge.
- The occupational group possesses that knowledge and others do not.
- The profession is the final arbiter in any disputes over the validity of any technical solution.
- The knowledge should be applicable, or thought to be applicable, to the concrete problems of living.
- Society should believe that knowledge can actually solve these problems.

1.4.2 Professional as Power and as Public Service

 Granted that the agents of formal knowledge can be described as professionals, the problem still remains of delineating the position of professions that gives them access to power, the institutional complexity that creates and sustains that position, and the activities by which it can be said that professionals exercise power. If we accept, as Freidson (1986b:1) does, that “knowledge is power”, then we must ask ourselves in what way it can be accurately said that this is so.

Careers and their related disciplines establish the power of the norm, statistical or otherwise, which is often used as a “principle of coercion” in a variety of standardised institutions, in education, in health care, and in industrial work. Freidson (1986b: 6) stated that “Normalisation becomes one of the great instruments of power”; in other words, the disciplines are powerful enough to mould human beings to their will and to the will of the state. “Knowledge –writes Halliday (1983: 327)– becomes the new arbiter of fitness. And in the post-enlightenment triumph of reason the cardinal system of cognitive validation and legitimating becomes science”. In Western societies, science enjoys a remarkable prestige; all the occupations that become scientific, are in a good position to achieve professional authority. Power is thus central to the concept of profession, and if power in professional occupations appears to manifest itself in the autonomy in deci-
sion-making from clients and from employing organisations expressed by occup-
在全国, then the levels of attitudinal autonomy among occupational
成员 might well provide a means to index the professionalisation of occupa-
tions (Forsyth and Danisiewicz, 1985: 61).

The usefulness of the concept of autonomy to examine professional power
should begin with its definition. According to Hall (1969:82), autonomy

- involves the feeling that the practitioner ought to be allowed to make deci-
sions without external pressures from clients, from others who are not
members of his profession or from his employing organisation.

The autonomy of individual practitioners has frequently been examined and dis-
cussed as an attitude. Hall also suggests that attitudinal autonomy is crucial in
the self-understanding of the individual and hence in his behaviour at work. Hall
further adds:

- the individual reacts to his perception of the situation and his attitude re-
flects the manner in which he perceives his work. The perceptions or atti-
tudes of practitioners that they are free of decisional constraint is likely to be
indicative of their power.

Two different varieties of autonomy appear to be of particular interest. First, Hall
(1969: 82) had called the attention to the autonomy from the client. Second,
autonomy from the employing organisation which is very important to the profes-
sion phenomenon. However, this latter type of autonomy may be hampered “to
the degree that a worker is constrained in the performance of his work by the
control and demands of others, that individual is less professional” (Braude,
1975: 105).

What makes one occupation different from another? Forsyth and Danisiewicz
(1985) answer this question from a three-fold perspective: In the first place, the
idea of public service or its importance in the life of clients, produces an essen-
tial and unique social relationship between individuals performing such tasks
and society; thus it can be said that they perform an indispensable public service.

In the second place, the competence as being a source of monopoly. If a par-
ticular occupation is superior in obtaining desirable effects, its exclusive hold on
a service task is enhanced. Legal and coercive elimination of competitors may
also produce exclusive control. All such mechanisms serve to eliminate the al-
ternatives to seeking services performed by a particular occupation and provide
an exclusive character.
And in the third place, the idea of complexity, because there is a high level of indetermination and uncertainty. Jamous and Peloille (1970) refer to lack of determination as that part of the production process based on ‘means’ which escape rules and are attributable to ‘virtuosities of the producers’. Thus this knowledge cannot be applied mechanically.

1.4.3 Associations: Process and Credentials

Recognition by society offers protection to those individuals that have passed a period of socialisation in a particular kind of training and skill in an institution of higher education. The licensing or credentialing itself is a restraint of trade or commerce in that those who do not possess it are not free to offer goods or services on the market; as Freidson says (1986b: 114), “This not only contributes to the standing of the professions but it is also a safeguard for society against unqualified practitioners”.

Credentials authorise the performance of tasks in a discipline. This, however, has a double meaning: it is both a segment of formal knowledge and the consequence of its application to the affairs of others. The most elementary component of the credential system is the personal credential constituted by the individual degree, diploma, or certificate of training. This is the prime evidence required for both licensing and certification, although separate examinations may also be required. That personal credential is produced by the successful completion of a programme of study in an educational organisation.

In order to understand how the formal credential system works for individual professionals one must understand that it merely establishes the possibility of earning a living. Formal, impersonal credentials in the form of degrees or licenses constitute the minimal criteria, and establish the boundaries of the pool of those who are allowed to be candidates (Freidson, 1986b: 87).

The professions themselves vary according to the strength of their credential systems and in their relative scarcity in the labour market. Waters (1989: 963-964), quoting Parkin, writes about the credential system:

> Not merely does it serve the convenient purpose of monitoring and restricting the supply of labour but also effectively masks all but the most extreme variations in the level of ability of professional members, thereby shielding the least competent from ruinous economic punishment.

Modern professions differ from most occupations by having been given the power by either law or custom to control both training and qualification to work.
Baly (1984), commenting on the works of Sir Harold Himsworth, says that for a profession to exist there has to be a particular need in society; a recognition by society that the body of men and women undertaking to meet this need must be given special recognition. In other words, a tacit social contract is implied; in Baly’s (1984: 5) words:

an obligation on the part of the society to afford the professional man such status, authority and privilege as shall be required for him to discharge his obligations. Only in so far and for so long as this implied contract is obeyed will the profession in question survive.

At the foundations of the credential system, both generating it and being generated by it, are institutions of higher education, that must undergo a process of evaluation, called accreditation. This accreditation consists in the formal acknowledgement that an institution, to be included in the official list of accredited institutions, must conform with standards established by a state association (Freidson, 1986 b: 74).

Freidson (1986 b: 81) describes the main features of the accrediting standards for these institutions:

First, institutions such as colleges, universities and professional schools, should accomplish the institutional standards created by the state associations, in terms of assigning market value to the occupational credentials they provide to their graduates.

Second, the state association, using institutional credentials, qualify those institutions for recognition and chartering by the state. Students registered in these institutions are eligible to receive state benefits.

Third, the state association establishes a level of credential below which the institutions can not fall without loss of accreditations. Sometimes credentialing standards are abstract but in practice they always require that members of faculty possess a particular degree or credential as minimum standards to employ them at least for some of the positions of the teaching staff.

Fourth, standards will in practice establish some settlement of faculty positions as full-time jobs.

Fifth, accreditation standards attempt to protect the freedom of the faculty teachers, from economic and political pres-
sure, maintaining their degree of autonomy in programs and researches.

What is professionalisation? Authors agree that it is a term associated with the dynamic and complex process in which organised occupations attempt to make exclusive claim to perform a particular kind of work, control training and access to it, and retain the right of determining and evaluating the way the work is performed (Johnson, 1972; Rhodes, 1984; Gibbs, MaCaughan, and Griffiths, 1991). This necessarily refers to a process and there is sometimes the explicit argument put forward that this process occurs as a determinate sequence of events; that, in the process of professionalisation, an occupation passes through predictable stages of organisational change, the end state of which is professionalism.

Vollmer and Mills (1966: 7-8), in their work *Professionalisation*, suggest that

- the concept of a profession be applied to an abstract model of occupational organisation, and that the concept of ‘Professionalisation’ be used to refer to the dynamic process whereby many occupations can be observed to change certain crucial characteristics in the direction of a profession.

The designation for an occupation as profession is not a permanent monopoly of a few occupations. The term refers to a comparative status level attained after deliberate action by an occupation, where the early starters hold an advantage over latecomers in the number of professional characteristics they can boast.

The “natural history” of professionalism, as it has been called, finds its major expression in the work of American researchers, Caplow (1954) and Wilensky (1964). Caplow (1954: 240-241) speaks of the natural history of professionalisation in five stages:

1) the establishment of a professional association;
2) change in the name of the occupation;
3) development of a code of ethics;
4) prolonged political agitation to obtain the support of public power;
5) the concurrent development of training facilities.
While Wilensky (1964: 142-6) outlines the sequence as follows:

1) the emergence of a full-time occupation;
2) the establishment of a training school;
3) the founding of a professional association;
4) political agitation directed towards the protection of the association by law; and
5) the adoption of a formal code

Both authors make comments about the change of the occupations name, but it is only considered a step in the sequence, according to Caplow. They both explain that the occupations that change names have the aim of reducing identification with the previous status, and give a new title that will assure technological monopoly.

It is clear that the sequences outlined by Wilensky and Caplow are historically specific and culture-bound. Wilensky’s (1964) study of eighteen occupations show the process, and this approach was taken up by Hickson and Thomas (1969).

When the structural conditions for professionalisation are discussed, they are often confused with the defining characteristics of professionalism. It has been claimed, for example, that the emergence of a qualifying association or some form of controlling body, with the power to exert sanctions over its membership, or the development of educational institutions capable of providing lengthy periods of training, are among the necessary conditions for the emergence of a profession. And at the same time these very factors are claimed to be among the defining characteristics of the professions, and are therefore both cause and effect of their development.

It is submitted that, despite the marked difference in theoretical explanations of the phenomenon of professions, there is a consensus on the features of monopoly by statute and autonomy. The latter includes the freedom to form associations and to have statutory bodies composed mainly of a profession’s members.

The importance of this kind of autonomy is stressed by Parry and Parry (1976: 248) in their discussion of professionalism in which they propose:

That the defining characteristic is the control which professional associations themselves develop over professional colleagues who are formally equal. This is the basis for professional control over the education, markets for the service and organisation over which a profession may achieve dominance.
Professionalism has been, for nearly two hundred years, a powerful ideology of a growing section of the middle class. Translated into practical activity it involves a quest by occupational associations for self-governing autonomy in which control is exercised collectively by the occupation over its practitioners and over occupational recruitment. There is a search for legitimacy from the state in which it is hoped that through legislation the occupation may grant some degree of monopoly over the service it provides and a recognition in legal terms of self-governing autonomy.

A professional association is described as an organisation that is composed of practitioners who judge one another as professionally competent; it is responsible for the establishment and enforcement of rigorous standards for the profession; it provides colleagueship for individual practitioners, and it acts as an enabling body for professional practice, thereby mediating between the practitioner and the profession and among the profession, the practitioner and the public. To meet its responsibilities, a professional association must perform on essentially professional terms, wherein the outcome is based on professional judgement and not merely on majority vote (Merton, 1968; Beletz and Accord, 1987).

According to Waters (1989), the associations are collegial structures. This author arrived at a formal statement of the “collegial principle” which had not been previously made available by Weber (1968):

Collegial structures are those in which there is dominant orientation to a consensus achieved between the members of a body of experts who are theoretically equal in their levels of expertise but who are specialised by area of expertise. (Waters, 1989: 956)

The exercise of authority on the sole basis of expertise is the first and most important component of collegiality: the knowledge is specialised with respect to the college as a whole and is frequently differentiated with respect to each of its member colleagues. There is a series of ethical norms that governs practice within social relationships with clients.

If professions have an implied contract with society which gives them ‘status, authority and privilege’ then society wants certain assurances in return. The public want to know that the training and skill of these privileged people is the best. But skill is not enough, there must also be a code of ethics which indicates how clients and patients should be served and the attitudes that should be accepted (Baly, 1984: 5). This code of ethics must incorporate provision for disciplinary

8. Waters is actually bridging a gap left open by Weber (1968) in regard to "collegial structures".
action. Consequently any registered practitioner who, after due process, is found guilty of personal or professional misconduct may have his registration and right to practice withdrawn.

The first element of this code of ethics is discipline. Professionals should discipline professionals independently of the fact that there are other systems to punish their misconduct, like a trial before a judge.

A second element is that of equality which is implied by expert authority. If expertise is paramount, then each member’s area of competence may not be subordinate to other forms of authority. For this reason collegiate organisations are formally equal systems (Waters, 1989: 955).

The third element is consensus. All members of such organisation must participate in the decision-making process, and only decisions that have the full support of the entire collective “carry the weight of formal authority”. Collegiality emphasises processes of equality, consensus, and autonomy in which decisions emerge as a collective product and are morally binding on members (Waters, 1989: 955).

The professional association is the most obvious manifestation of formal organisation among professions. It is one key to understanding how the power of profession can be organised and directed into the lay world in general and the political economy in particular. Max Weber (1968) originally outlined the concept of closure, a concept which is closely linked to the study of occupations. Its essence is the definition of membership at a particular point in time, and the setting of criteria for those who may join subsequently (Macdonald, 1985: 541).

The establishment of a register of qualified persons has been a typical way in which insiders can be distinguished from unqualified outsiders. Also, the qualifying examination, conducted in educational institutions controlled by the professions, has been used as the mechanism by which closure of the occupations is achieved (Parry and Parry, 1977: 824).
2 METHOD AND DEVELOPMENT OF INDICATORS

The procedure followed in this research was to extract from the theoretical framework indicators generated by the three sociological schools. Once the indicators were drawn, they were applied to the historical data.

An indicator is defined as “something that gives an idea about the presence, absence, nature, quantity or degree of something” (Longman’s Dictionary, 1974)⁹. In this case indicators must serve to answer questions about the presence or absence of professionalisation elements. But is it necessary to establish more accurately what an indicator is? For this reason we want to analyse various definitions and approaches. According to the English National Health Service¹⁰ (1994a), an indicator is “valuable for making comparisons over time and [it is] used to monitor the effectiveness of particular actions”.

In the first place, as argued earlier, it is hardly necessary to emphasise professionalisation as a process over time; Wilensky’s (1964) study of eighteen occupations demonstrated the process. Therefore, as he expected, the older professions exhibit more professional characteristics than the younger professions.

The English National Health Service¹¹ (1991) further adds the need of a starting point for the examination of services in the light of local knowledge. This raises the question of whether there is any relationship between national and or cultural differences and the professional forms adopted. Is the professionalisation process the same everywhere? If a broadly based scale can be developed, comparisons can be attempted to see how far it can be sensibly applied in different societies.

An indicator should provide “useful, meaningful and timely data based on clear definitions”¹² and “form agreed basis for the continuous assessment of progress”¹³ (NHS Wales, 1992: 80). Thus each one of the indicators must be based on clear agreed definitions that in an opportune way, proceed to monitor the

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¹² NHS. Wales High level indicator working group. (1994) In Year Monitoring of Management Performance Against a Set of High Level Indicators. DHA/FHSA.
progress achieved. Furthermore the indicators “do not of themselves supply answers. On the contrary, they raise questions and highlight issues for further discussion and investigation”\(^{14}\) (NHSME, 94 b). By way of a illustration when we compare the outcomes, they often give evidence that further research is needed; e.g. in this investigation the professional traits should arise when the indicator is applied; if they do not appear, it is then necessary to ask why this happened, which evidences that more research is needed.

Usually indicators give only an idea about the presence, absence, nature, quantity or degree of something, and they do not supply answers. But in this case, indicators must also provide answers about the presence or absence of professionalisation elements. After their application many questions may be raised, with issues appearing for further discussion and investigation.

Hickson and Thomas (1969) have attempted to establish a hierarchy of professions in Britain, using a further extension of the trait theory approach and they suggest that these indicators of professionalisation can also be said to reflect a specific historical sequence of events through which all professionalising occupations pass in an identical series of stages. According to these authors;

> We must think of the occupations in a society as distributing themselves along a continuum. This continuum might well form a scale in terms of the characteristics of professions commonly cited. Indeed differentiation along a continuum – or continua – is implicit in the assumed process of Professionalisation over time. (Hickson and Thomas, 1969: 48)

They built a scale, based on a set of constitutive definitions of professional characteristics assembled from the literature; they excluded the obvious, ambiguous, and repetitious concepts, and obtained a list of nineteen assumed professional characteristic items, discriminating among the sample of qualifying associations so that there was a full range in the number of characteristics possessed. Associations may be scored on this scale by the number of items each possesses.

In their conclusion Hickson and Thomas (1969: 50) assert:

> This preliminary study affirms a measurable variable of Professionalisation. Given the limits of the data and sample, particularly the absence of attitude data on members of the occupations, the items linked by the Professionalisation scale may be held to denote the characteristics of a profession. Possession of more of those characteristics often referred to in the literature

\(^{14}\) NHSME (1994) Health Service Indicators. Background Information 92-93. London: NHSME.
signifies greater Professionalisation, and this can be economically ex-pressed by a single score. Associations other than those in the sample se-lected might be tentatively scored in this scale.

Nursing was not included in this study. This is the reason why these criteria have been applied to nursing, since the selected indicators seem very suitable (see section 1.4.1. below).

2.1 Professional Traits School Indicator: Public Service

This indicator is based mainly on the work of Hickson and Thomas (1969), as well as the next indicator studied (see I.4.2). These indicators are considered important and have a relationship with all the characteristics commented on previously (see Theoretical Framework); professions as public services (Table 1), need of training and education to teach specific skills based on theoretical knowledge.

Such indicators may be utilised in the study of the evolution of an occupation to a profession in any discipline. In this case they were applied to the study of the evolution of Nursing in England and Spain.

Table 1 shows the indicators and sub-indicators obtained from the works Hick-son and Thomas (1969) in the first place and also from Grenwood (1957) and Millerson (1964).
Table 1. Indispensable Public Service

<table>
<thead>
<tr>
<th><strong>Code</strong></th>
<th><strong>Indicator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.1. <em>Recognised Status Community Sanction/Monopoly</em></td>
<td></td>
</tr>
<tr>
<td>a.1.a. Only members are permitted to practice.</td>
<td></td>
</tr>
<tr>
<td>a.1.b. Scale of recommended charges or fees.</td>
<td></td>
</tr>
<tr>
<td>a.1.c. Royal Charter of incorporation.</td>
<td></td>
</tr>
<tr>
<td>a.2. <em>Fiduciary relationship/Code of conduct or ethics</em></td>
<td></td>
</tr>
<tr>
<td>a.2.a. Written code of conduct or ethics</td>
<td></td>
</tr>
<tr>
<td>a.2.b. Explicit ethic confidentiality</td>
<td></td>
</tr>
<tr>
<td>a.2.c. Advertising explicitly forbidden</td>
<td></td>
</tr>
<tr>
<td>a.2.d. Member explicitly not allowed:</td>
<td></td>
</tr>
<tr>
<td>a.2.d.a. to undercut one another;</td>
<td></td>
</tr>
<tr>
<td>a.2.d.b. to criticise a fellow professional</td>
<td></td>
</tr>
<tr>
<td>a.2.e. Either or both recognised disciplinary procedure or committee</td>
<td></td>
</tr>
<tr>
<td>a.3. <em>Organised</em></td>
<td></td>
</tr>
<tr>
<td>a.3.a. Eight or more specialist committees for different purposes over and above governing body</td>
<td></td>
</tr>
</tbody>
</table>

Profession as an indispensable public service, with the characteristics of being essential, complex and exclusive as mentioned earlier. In addition, it induces acknowledgement of the profession by society and leads to monopolistic practice. Furthermore, each profession produces a unique relationship between individual performing such tasks and society, a relationship which is regulated by a code of conduct/ethics.

Hickson and Thomas (1969), however, rejected six items with low coefficients. One of them was the so-called “written code of conduct or ethics”. For these authors it was very surprising to obtain a low coefficient on this item. However, it is considered important in so many definitions of a profession. They explain that the low co-efficient ensues from inadequate data, and does not call into question the relevance of codes as indicators of professionalisation. Maybe they did not use an adequate form to operationalise this indicator. They asked for written
codes and sometimes associations with potentially high scores on other characteristics lacked a written code because they could refer to tradition, and appeared not to need to fall back on codified standards. They proposed the operationalisation of the item as the existence (or not) of a recognised code, not specifically a written code. Newer associations, however, tend to adopt codes, perhaps in an effort to increase their status comparative with other associations, and to increase their general public standing.

Under professionalism, a continuous and terminal status is shared by all members. Equal status and the continuous occupational career are important mechanisms for maintaining a sense of identity, colleague-loyalty and shared values. Also the myth of a community of equal competence is effective in generating public trust in a system which members of the community judge the competence of one another. All the professions are organised to develop and maintain this doctrine.

In this study the same operative definition of organisation used by Hickson and Thomas (1969) has been used but applied with more flexibility. It appears arbitrary to specify eight committees in the structure, when sometimes there may be more or less, but the philosophy of a governing body remains.

2.2 Professional Trait School Indicator: Skill-Based Theoretical Knowledge

In Table 2 below, which shows the indicators obtained to test skill-based theoretical knowledge from the works of Grenwood (1957), Millerson (1964), Hickson and Thomas (1969), the professions exhibit a theory based repertoire of skills that requires extensive education. Its reliability must be examined through successive tests, and on some cases, the final exams may be carried out by the professional associations.

Once the studies are finished, the members of the profession are more or less prepared for contributing to the development of knowledge. Hickson and Thomas (1969) took in consideration the last indicator (b.3.a), but rejected it because of low coefficient. However, one would be led to disagree with their conclusion. Actually, for occupations who are beginning to become professions, this item on publications has acquire today an important significance.
### Table 2. Skill-Based Theoretical Knowledge

<table>
<thead>
<tr>
<th>Code</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.1.</td>
<td>Training and education</td>
</tr>
<tr>
<td>b.1.a.</td>
<td>Specified general certificate of education “O” and/or “A” level subject(s) required for entry (minimum age set for entry to first corporate grade of membership)</td>
</tr>
<tr>
<td>b.1.b.</td>
<td>Length of training required:</td>
</tr>
<tr>
<td>b.1.b.a.</td>
<td>Up to three years</td>
</tr>
<tr>
<td>b.1.b.b.</td>
<td>Up to five years</td>
</tr>
<tr>
<td>b.2.</td>
<td>Competence tested</td>
</tr>
<tr>
<td>b.2.a.</td>
<td>Three examination stages set, i.e. preliminary/intermediate/final (exceptions may be possible).</td>
</tr>
<tr>
<td>b.3.</td>
<td>Members prepared to contribute to development of theoretical knowledge</td>
</tr>
<tr>
<td>b.3.a.</td>
<td>Research publications.</td>
</tr>
</tbody>
</table>

Many occupations are involved in a search for the framework which fits their own skill-based theoretical knowledge, and they are trying to identify the paradigm (considering that this occupation which will become a profession, is in the pre-scientific stage of the Kuhn open-scheme of the progress of the sciences [Chalmers, 1987: 128]). This indicator called by Hickson and Thomas ‘Journals Published’; emphasises the fact that journals are an adequate support for research publishing and have indeed become an organic means for the distribution of techniques, theories, laws, etc., of the paradigm. In this study, however, we have referred to it as ‘Research publications’
### 2.3 Natural History of Profession School Indicator

Following Caplow (1954) and Wilensky (1964), the indicators selected for this analysis, to see the evolution from occupation to profession as a process, are shown in Table 3.

This list, although not necessarily in this order, proceeds from various analysts who have described a natural history of professionalisation. It describes the sequence of steps by which an occupation, through its transactions with society, is transformed into a recognised profession.

Table 3. Evolutionary or Natural History School

<table>
<thead>
<tr>
<th>Code</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>c.1.</td>
<td><em>The emergence of a full-time occupation.</em></td>
</tr>
<tr>
<td>c.2.</td>
<td><em>The establishment/founding of a training school and concurrent facilities.</em></td>
</tr>
<tr>
<td>c.3.</td>
<td><em>The establishment of a professional association.</em></td>
</tr>
<tr>
<td>c.4.</td>
<td><em>Prolonged political agitation directed to obtain the support of the public power and the protection of the association by law.</em></td>
</tr>
<tr>
<td>c.5.</td>
<td><em>Change in the name of the occupation.</em></td>
</tr>
<tr>
<td>c.6.</td>
<td><em>Development and adoption of a formal code of ethics.</em></td>
</tr>
</tbody>
</table>

Comparing the literature on the nature of professionalisation, it becomes apparent that the evolution of the professions is viewed differently by certain authors. Vollmer and Mills (1966) considers it as a “dynamic process” whereby an occupation changes some of its “crucial characteristics” in order to become a profession. Wilensky (1964), on the other hand, focuses on the process in terms of the different training steps towards becoming full-time occupations, while Caplow (1954) would concentrate on the establishment of a professional association.

The sequence outlined by Caplow and Wilensky can be considered historically specific and culture-bound to the United States, but their indicators of professionalisation can also be said to reflect a determinate historical sequence of
events through which all professionalising occupations evolve, if not tightly in the order of the sequence.

Hickson and Thomas (1969) noted that their work had a lack of attitude data on members of the occupations that they studied. This study attempted to fill this gap, with the next indicator.

# 2.4 Autonomy and Power School Indicator

As mentioned earlier (1.3.2), autonomy of individual practitioners has been examined and discussed as an attitude. In the United States, Forsyth and Danisiewicz (1985) developed a questionnaire, based on the concept of attitude towards autonomy: autonomy from clients and autonomy from the employing organisation. They utilised this to study students of eight occupations.

An adapted version of this questionnaire (see Appendixes 1 & 2) was used in this study, to check the autonomy or power in the nursing profession. It was felt necessary to extend the survey to medical as well as nursing personnel because there are, as far as can be ascertained, no similar reference studies available to make the comparison between England and Spain.

In this study we put face to face nursing and medical students and professional. In all the studies of professions and professionalisation the medical profession is presented as the paradigm, and fulfils all the prerequisites as a true profession.

The medical profession works with the same client group and in the same physical environment and management, which provide a certain level of homogeneity to the samples, but which ensures that differences found between them are real, and show the two occupations to be different from each other. Another valuable aspect is the behaviour of medicine as stakeholders in maintaining the nurse status. Finally the sample was more available than in any other occupational group.
3 HISTORICAL DATA BY INDICATORS AND COUNTRIES

3.1 Professional Traits School Indicator: Public Service

This indicator, Indispensable Public Service – described in Table 1–, is made up of three sections which we shall analyse next in England and Spain. Firstly, the social recognition of the profession through a Royal Charter or similar regulations, together with legal and restrictive elements which eliminate other competitors in the form of regulations of the activity to be developed by nursing professionals with the adequate fees for the services provided; and the prosecution of the intruders who – without complying with the professional requirements– may practise as such.

Secondly, the code of conduct as an internal legislation tool of the client/professional relationship, with the corresponding disciplinary system for those who may not comply with the regulations. And finally, the organised answer given by the professional association to the question of the social recognition implied in the passing of the Association Act or the granting of a Royal Charter.

3.1.1 Nursing Legislation in Spain

The establishment of functions sets the independence and autonomy of each individual, and their interdependence in society; this would not be possible without a minimum independence in each profession, establishing the boundaries of its specific contribution.

The nursing profession in Spain, as we know it today, stems from the unification of three health occupations, i.e. ‘practicantes’, midwifery, and nursing, which developed different areas of the same professional activity. This took place with the official creation of the first medical auxiliary studies which were to be structured through different regulations, and the different responses given by the groups to the regulations. They were differentiated occupations as far as performance areas, work duties and legal framework were concerned, but there was continual interference, which implied that their boundaries were not as clearly defined as desired.
As an antecedent to the start of these studies (1850), we find Fermin Caballero’s plan, dated 10th October 1843, which established the education of minor surgery to be a function of the Practitioners of the Art of Curing. This function was regulated by the Royal Order\textsuperscript{15} of 29th June 1846 and the title of ‘Ministrante’ was created; this new figure was authorised to make blood lettings, apply external medications, apply plaster, remove and clean teeth, practice the art of chiropody and administer vaccines. The creation of this category caused function conflicts with other categories (surgeons, blood-letters etc.) and the remaining 35 different “facultative”\textsuperscript{16} classes existing at that time, thought that the new category was unnecessary and untimely and that they themselves would have been able to satisfactorily meet such needs.

The solution was to come with the Organic Health Act dated 28th November 1855, which opened the door to the creation of ‘Practicantes’ and Midwifery as a logical consequence in face of the new health situation.

The Public Instruction Act of 9th September 1857 – known as the Moyano Act – annulled the studies of Minor Surgery or ‘Ministrante’ and created – in article 40, second paragraph – the qualification of ‘practicante’, and the midwife qualification in article 41 of the same Act.

The functions of both categories were developed in subsequent regulations; a Royal Order dated 26th June 1860 temporarily described the studies, which were finally developed by the Royal Decree\textsuperscript{17} of 21st November 1861 by the Ministry of Promotion; article 49, establishing that the qualification of ‘practicante’ only permitted one to practice the merely mechanical or subordinated areas of surgery, such as general and local bloodlettings, bandage and dressing application, etc., vaccination and the art of dentistry and chiropody. Article 50 established that the midwifery qualification authorised professionals to assist in natural births and post-natal situations but not in laborious nor preternatural births, having to call the ‘professor’\textsuperscript{18} who was the only one authorised for those cases. They were also authorised to help the doctors in the care of pregnant women, women giving birth, and in post-natal cases when required.

\textsuperscript{15} Royal Order, proposed by any Ministry with the participation of all the high members; it is the next in the ranking after the Law Decree. It is Royal because of the monarchic state and because it is sanctioned by the King.

\textsuperscript{16} This expression is still used for the medical professional.

\textsuperscript{17} Royal Decree, developed by the President of the Government, with the participation of the Council of Ministries. It has an urgent nature and is not supervised by the Parliament.

\textsuperscript{18} Denomination used to refer to physicians at that time.
The development of the ‘practicante’ and midwife figures created great controversy among doctors, and thus, a Royal Decree dated 7th November 1866 annulled the ‘practicante’ career, creating instead a new level, the 2nd category of ‘Facultativo’, or second class health professional.

The causes which led to the disappearance of the ‘practicante’ and midwife studies are found in the press of the time. For instance, in the article “¿A qué crearlas?” (Why create them?, published in El Genio Médico Quirúrgico\textsuperscript{19}, 1865), the following is a sufficiently illustrative paragraph:

we are saying this is because of the midwives, as they are so very few in number, they probably do not have professors nor premises where they can study; this normally happens with things which are not properly thought out or which are unnecessary; they ought to be annulled once and for all, and the same applies to the ‘practicante’ studies; let us put a stop to those who have already started and from now on actions with regards to the creation of degrees and studies should be better contemplated.

This article reflects the existing opposition to the ‘practicante’ and midwife studies, and the author’s wish to have them disposed of, thinking that their work could be carried out by the doctors.

Another article, entitled “‘Practicantes’ y Matronas” (“‘Practicantes’ and Midwives” in El Genio Médico Quirúrgico, 1866) illustrates the following opinion:

We will witness in short the start of the enrolment period for the studies of ‘Practicante’ and Midwife, and we do not understand how this matter has been taken further when everybody says these studies are unnecessary, and despite everything said by Sr. Herrera and Sr. Méndez Álvaro last year in Parliament; in any case, we do not think this will last long, we will see.

On 21st October 1868, a decree abolished the ‘practicante’ and midwifery studies, and the 2nd category of health professionals (the ‘facultativos’) was also abolished through an Order dated 27th October. However, the ‘practicante’ studies were re-established, since there was “a recognised need for a class of professionals for the mechanical and subordinate assistance in surgery”.

A Royal Order of 1st October 1860 had prohibited barbers and other individuals not holding a ‘practicante’ qualification to make bloodlettings and perform minor

\textsuperscript{19} Spanish journal which was popular among physicians toward the second half of the 19th century.
surgical operations; a function which together with odontological tasks, had been carried out by barbers and minor surgeons.

The ‘practicantes’ then took over the odontological work, but later on a dentist-surgeon profession was to be regulated by a Royal Decree, dated 4th June 1875, although it only permitted the treatment of oral diseases due to teeth alterations and the actions required for their cure.

This circumstance posed problems between the newly qualified dentist-surgeons and the ‘practicantes’, who ever since 1860 had dealt with the tasks traditionally performed by barbers. Later, a Royal Order of 6th October 1877 finally established that the ‘practicante’ qualification did not authorise the practise of dentistry.

Odontology studies were regulated by a Royal Order of 21st March 1901; during that year, the professorship of odontology and dental prosthesis was created in the Medical College of Madrid. As a condition for enrolment in these subjects, students were required to have passed a second year of studies; if this condition was met, students could then do a final test to become odontologists; they were then entitled to attend patients, treat their illnesses, and make dental prosthesis. Likewise, medical graduates could practise as odontologists without special qualifications and make dental prosthesis, if they had passed the corresponding examinations.

An order of 27th December 1910 reorganised the odontological studies, extending their duration and contents. The first year – which covered all the specific subjects – had to deal with all areas related to odontology, i.e. anatomy, dental physiology and histology, surgical technique, odontological clinics, and others relating to dental prosthesis, such as general principles and mobile rubber and metal prosthesis. The second year covered oral bacteriology, stomatological pathology, surgical prosthesis, and oral hygiene.

The theoretical lessons were combined with clinical activities of odontology and prosthesis, carried out in clinical placements. To acquire the qualification, students were required to have completed the second year of the medical degree, as well as having passed the subjects of therapeutics, medicine, and prescription. Despite this state of things and the publication of the Royal Order of 6th October 1877, prohibiting ‘practicantes’ to act as dentists, they continued performing as such; to that end, they requested the government whether they could act as dentists; the government’s answer appeared in the Royal Orders of 22nd January 1910 and 22nd July 1910, strongly forbidding the ‘practicantes’ carry out those tasks.
Parallel to the existence of ‘practicantes’ and midwives, religious orders, most of them female, experienced a great boom during the second half of the 19th century. This fact had to do with two major events: the cholera epidemic suffered in Spain from 1855 to 1885, and the Moroccan War from 1859 to 1860. However, the impossibility of the religious orders to meet all the needs derived from both events and through the Royal Order dated 6th July 1864, determined a “Committee for the instruction and organisation of Nursing and Voluntary sections of civilians to assist the wounded in the battle fields” was established. As a result, the Sections of the Ladies and Brothers of Charity or Voluntary nurses appeared, and their training was achieved using texts of a religious nature.

A close look at the tasks carried out by the ‘practicantes’ of the time can be found in Blanco Torres’s book, Instrucción del Practicante o Resumen de Conocimientos Útiles para la Buena Asistencia Inmediata de los Enfermos; y Compendio de las Operaciones de Cirugía Menor, Arte del Dentista y del Callista, published in 1870. In the appendix, the author describes the functions of the ‘practicantes’, which should not be limited to providing patients with immediate care, their mission is also to administer the prescriptions given by the ‘professors’, observing in detail the time, manner, and way in which the drug and diet was prescribed by the ‘professor’; the ‘practicante’ will keep written records of the order in which they have to be administered, in order to avoid confusion in the case of him being substituted. Similarly, the ‘practicante’ shall note and inform the ‘professor’ about any differences observed in the patient between his visits.

Recommendations were given for cases in which opposition and resistance was posed by the patient when having to take medicines or certain foods: the ‘practicante’ had to insist with patience, trying to persuade with good reasons – and if necessary – begging, convincing the patient of the advantages which the medication would bring for the complete cure.

According to Blanco Torres (1870), the ‘practicante’ could sometimes be authorised to perform some surgical cures and different minor surgery operations, and to act to a certain extent as an assistant in operations, cure of wounds, reduction of dislocations, fractures, etc.

The next ‘practicante’ and midwife regulation was published on 16th November 1888, and was partly modified on 24th May 1895; it enabled ‘practicantes’ for the practice of small operations covered under the name of minor surgery; these operations had to be authorised by a medical doctor. The ‘practicantes’ could
also assist the ‘professors’ in major operations, in cures, and in the use and application of remedies during the intervals of the visits by the doctors.

In January 1904, the Act on General Instruction of Health was issued: title I, recognised as health professions medicine and surgery, pharmacy, veterinary, midwifery, ‘practicante’, dentist, and in general other complementary professions which could be established through a special title; this Act, however, defined the ‘practicante’ and midwife professions as auxiliary. This legislation does not include modifications as to the functions previously described.

On 15th May 1915, the Count of Collantes, Minister of Public Instruction, signed the Royal Decree which created the nursing profession; this Order was published on May 21st and caused a conflict with the ‘practicantes’. They showed their disagreement and dissatisfaction through demonstrations throughout the different provinces, claiming the existence of a single type of auxiliary, alleging that the existence of nurses would contribute to the division of the Health Auxiliary Classes. Later, Sáenz de Cenzano (1922) in his handbook for ‘practicantes’ described the rights and obligations of the ‘practicantes’. among others things he writes:

The ‘practicante’ must follow the prescriptions of the medical ‘professor’ in the official and private clinic, being responsible for its technique but not its finality. The ‘practicante’ is the expert who accomplishes such indications.

This author also described the job of the ‘practicante’ during the doctor’s visit: he should follow the doctor’s orders, pay good attention to his prescriptions (writing them – not abbreviated – in a special book called a notebook, where all the indications to be observed, until the following visit, had to be written).

The performance of ‘practicantes’ in hospitals – in the context where they could develop all their professional activities – is also described: they had to be instructed, obedient, honest and virtuous to the greatest extent, they had to be respectful and pay absolute submission to the director of the clinic, first, and to the assisting medical professors of the institution.

In his book, Sáenz de Cenzano also described their character and conduct in relation to doctors and patients, stressing that this submission consisted in following the doctor’s orders, even when they had a different opinion; the ‘practicantes’ were only permitted to ask for clarification if things were not understood, but with the greatest respect, and for illustration when – once a thing is understood – doubts still arose as to its application; anything might then follow, except disobedience of an order, or incorrect application of an instruction. With absolute loyalty and aiming at perfection, the ‘practicante’
would carry out all the tasks assigned to him, without questioning them or changing them in time or procedure: firstly, because he cannot judge what is unknown to him, and secondly, because the slightest modification may bring some considerable damage and even the death of the patient, of which the clinic director or head doctor of the infirmary would be responsible.

Sáenz de Cenzano also mentioned precautions when having to inform the patients “the ‘practicante’ will be frugal in his judgements about the patient if – in the absence of the doctor – he is asked by the family” (1922: 14); and limited his activity in the cases in which the ‘practicante’ detected new problems: “if – given the knowledge of his profession – he sees something unforeseen which requires quick action, his obligation is to warn the family to call the doctor, but nothing else” (1922: 15). This quotations give us a clear picture of the role of the ‘practicante’, who in all his activities was subordinate to the doctor.

Meanwhile, despite the repeated denials obtained the ‘practicantes’ request again permission to act as dentists. The Royal Order of 3rd July 1924, however, denied once more their claim to practise as odontologists.

In *Compendio de Anatomia*, Cubells (1923) speaks in new terms about the need and tasks of ‘practicantes’ to be updated, thus avoiding obsolete knowledge; he also explains that the ‘practicantes’ had some autonomy: “if the patient has a surgical affection, which may be curable through topical treatment or minor surgery, he will act freely according to his knowledge and understanding, as a doctor would do in a similar case” (1923:14); however, if other cures required were not permitted to him, then the ‘practicante’ would have to call a doctor. It is then understood that the autonomy only applied to the area of minor surgery.

On the other hand, the conflict between nurses and ‘practicantes’ continued, as reflected by Calvo Pedrero, in *El Practicante Sevillano* (1928):

> there will not be in Spain any ‘practicante’ who does not welcome the incorporation of women as medical auxiliaries. The nurses in Spain are an imported product and, therefore, this new phenomenon must be integrated in the existing legal framework, that is, dependent on the ‘practicantes’ whose mission is prevention of avoidable disease, as stated by the Royal Order of 11th November 1928.

Later on, conflicts arose in the definition of functions between medical students and ‘practicantes’; an Order dated 25th November 1930 clarified the Royal Order of 27th May, and specified that only the ‘practicantes’, not the medical students, were authorised to apply treatments duly prescribed in the fight against sexually transmitted diseases.
On 13th October 1931, Manuel Azaña – War Minister during the Spanish Republic – uttered the well-known sentence ‘Spain is no longer Catholic’, and several religious orders threatened to leave their posts in hospitals. The answer by the Executive Committee, the Madrid College, and the ‘practicantes’ union, a branch of the ‘Unión General de Trabajadores’20 (–UGT– Workers Trade Union) was categorical, and these institutions offered their services “to meet any need in the assistance to the sick which would need to be covered if the religious orders chose to leave their posts in order to press the government as a result of the measures taken against them”. In numerous cases, members of religious orders had been acting without authorisation, which had resulted in a loss of job opportunities for lay health auxiliaries.

The Order of 14th September 1934 enabled all medical graduates to obtain the ‘practicante’ qualification after payment of the corresponding fees; the ‘practicante’ group soon reacted to this, which led to the publication of a new Order after only 20 days (5th October 1934), which stated that the individuals obtaining their title in this way were only entitled to develop one profession – both on a private or public basis –, which constituted a restriction and a not so desirable thing to the medical graduates.

In 1935, the Regulation for ‘practicantes’ of Public Home Care was published; article 3 established their obligations: medical/surgical assistance to the poor families assigned, auxiliary prophylactic, health, bacteriological and epidemiological practices prescribed by the doctor, assistance at births in towns which did not have a midwife, assisting the obstetrician in the necessary surgical operations and in other cases. The midwives continued having the same duties: assistance at normal births for the women assigned to them, assistance to the obstetricians in dystocic births, assistance in post-natal, and finally, if they attended a birth on their own, they had to issue the corresponding certificate and ensure the registration of the newborn in the Civil Registry.

Pijoan (1939; 16) in his book *La Enfermera Moderna* described, with a paternal attitude typical of the time, the subordinated nature of the nurse:

> the battle which an ill person goes through demands perfect discipline; the slightest doubt may be fatal; the doctor makes the decisions, not the family or the hospital management, as he understands best and orders. The Nurse will have to give up her own personal opinions if she may see things differently from the doctor, even so, she has no right to disobey.

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20 Spanish left wing trade union, was booming at this stage
This description clearly defines the situation of nursing in relation to the doctor.

In May 1941, the Ministry of Education published an Order establishing the rules for obtaining the nursing qualification; article 1 describes the nursing duties: assistance to the ill, cleanliness, feeding, collecting clinical information, administration of medicines, offering a service in institutions of a religious/patriotic nature. In this definition we find elements which would later become the essence of today’s nursing.

In 1943, Usandizaga published a *Manual de la Enfermería*. In his view, the nurse always has to obey the doctor’s orders and is not allowed nor enabled to manage any type of treatment; if she were to do such a thing, she would be intruding in the doctor’s field and would then be acting illegally. Her auxiliary functions are well defined, and surpassing them would imply lack of morality and, on many occasions, a crime.

This author also describes other nursing duties, such as assisting the ill and providing them with all the necessary care, whatever type (medical, personal, hygiene, etc.), and acting as the only connection between the doctor and the patient. This description illustrates the function of the nurse as a link in the doctor/patient relationship.

The nurse had to obey her superiors in all areas which constituted her professional mission, in any of its manifestations. In a complex structure such as a hospital, the observance of discipline was absolutely necessary; everybody had to know what they were expected to do and how to do it.

In another section, (Usandizaga, 1943: 2) seems to favour the unification of both groups ‘practicantes’ and nurses:

> there is confusion about this concept and the auxiliary functions are deemed to be divided into two categories: the so-called technical categories – injections, cures, anaesthesia, etc.; and the secondary categories – food, cleaning of the ill, etc.; and therefore, there is this idea of having two different categories of health auxiliaries.

He justifies his position about unification by referring to the results obtained in the countries where the level of care is high (possibly, he thinks of England and/or the USA), and says that the person not willing to deal with all types of care needed by an ill person was not to be called a nurse. It is not known what led Usandizaga to think in that way, as this position would be considered quite advanced for that particular time in Spain.
An Order dated 26th November 1945 specified, on a global basis and for the first time, the functions defined for each of the professionals. We consider such definitions and functions as quite illustrative of the limited role and dependence with which the health system assigned the professionals:

the ‘practicante’ is the most immediate auxiliary to the doctor in all his professional activities, [...] the Midwives are authorised by their qualification to assist in normal births and post-natal; [...] [the nurse] is an auxiliary subordinated to the doctor, and must always obey his orders, as she is not enabled to develop her mission independently.

The order was restrictive for the ‘practicantes’, although it permitted some autonomy; for the nurses, it was conclusive, as it clearly established dependence and subordination in relation to the doctor.

All this influenced the level of daily activity in the professionals, as the conflicts which had been experienced until then continued. Although the different auxiliary professionals were basically developing the same work, they constituted different groups, not only as to the functions established by law, but also as to the way practice itself was felt and experienced by the professionals, as the ‘practicantes’ were mostly male and the nurses were women, which probably had an effect in the behaviour of both groups.

The competition between ‘practicantes’ and nurses was seen as something problematic from the beginning of the 1950s. One of the most important issues particularly referred to the care which nurses could provide in hospitals and institutions, and the care to be provided in the patients’ homes. This conflict was patent at all times, as the ‘practicantes’ did not agree with the idea of home attendance by the nurses.

On the 1st April 1948, the Ministry of Labour published in the ‘Boletín Oficial del Estado’21 (–BOE– Spanish Official Bulletin) the Regulation of Health Services, which gave recognition to the health staff dependent on the Obligatory Health Insurance, i.e. ‘practicantes’, midwives and nurses; article 12 specified that the health staff had to fulfil their duties under the doctor’s orders. Shortly after in 1953, the creation of the profession of ‘Ayudante Técnico Sanitario’ (–ATS– Technical Health Assistant) took place, which meant the

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21 Official State Bulletin (Boletín Oficial del Estado [BOE]). The legal communication instruments of the state were so called after the Civil War. Previously, the denomination used was the Gaceta de Madrid.
unification of the studies of ‘practicantes’ and nurses (see section III.2.2), and both collectives then started to develop the same functions.

In her book *Orientación de Moral Profesional. Adaptado al Programa de Ayudante Técnico Sanitario*, Sister Miranda (1956) described the professional performance of the ATS:

> given the nature of their profession, ATS professionals work in close collaboration with the doctors; it is the doctor who establishes the limits of the field of action of the ATS, who must fulfil his/her tasks without ever surpassing the limits (1956: 45);

she also states that the ATS must assist the doctor in all those duties which may not be part of the doctor’s knowledge “and so the doctor will be relieved of the less interesting jobs, which gives him more time for concentration on his work” (1956: 45). As we have seen, this attitude to nursing appears repeatedly throughout history, and there has been a continual effort to transmit it, as the doctor’s time was considered to be more valuable.

On 17th November 1960, a decree was passed on the professional practice of the ATS, ‘practicantes’, midwives, and nurses, trying to gather their rules in a single regulation. This order manifests the shortage of these professionals in relation with the demand and establishes as a reason for this the duration and cost of the studies, as well as the obligation of completing the studies as a resident student. All this argumentation aims at supporting the creation of a new figure, the Clinic Auxiliary, “female personnel who – without needing qualifications – could develop non specifically technical elementary functions, under the supervision of more qualified staff”. This decree lists the places and fields where the ATS professionals would be able to work, and specifies that their performance must always be supervised by a doctor and that they have to be registered with the respective official colleges.

The ATS were then enabled to carry out the following functions: administration of drugs, injections or vaccines and curative treatments, provide immediate care until the arrival of the doctor who must have been called for the emergency, assist the medical staff in both general and specialised surgery, assist in normal births in the absence of midwives, and develop all the missions which require the qualification of ‘practicante’ or nurse. The decree validates the function of the ‘practicantes’ and nurses with that of the new ATS figure, although it specifies that the nurses will not be able to assist in normal births in towns or places with professionals especially qualified for that purpose.
The decree also included different tasks in the field of curative assistance or care and determined that their development had to take place under medical direction or indications, and thus, this concentrated the professional practice on disease. In addition, the mission of the clinic auxiliary was defined; this particular type of health personnel was in theory in charge of complementary functions, providing help to the other professionals, but given the shortage of qualified staff (particularly nurses in the 1960s), the clinical auxiliaries substituted the latter (not on a general basis, but to such an extent that claims arose against intruders). The problem was approached by the colleges in several provinces, but was difficult to solve, since – due to the shortage of qualified professionals –, the institutions had no choice and had to accept all types of personnel to cover their vacancies. We must take into account that all this was a consequence of a process of hospital expansion which provoked an increase in the demand of labour, as between 1951 and 1977, 131 hospitals were created in Spain (Herrero and Cuello, 1991: 64).

In July 1962, new subjects such as hospital co-ordination and organisation were brought into the arena thanks to the Hospital Act. The transformation and changes initiated in the health institutions partially contributed to the professionalisation process of the care providers, as one of the first actions taken in the hospitals was to try to get their staff (religious or secular) to be qualified or authorised. This represented an important step in the modification of the previous situation, when the shortage of professionals had caused the qualification level required to drop in some institutions.

The hospital transformation which took place in the 1970s. Apart from favouring the demand of employees, in general induced a different dynamics, especially in nursing, and inflicted diverse changes which could be globally considered as a tendency towards professionalisation and which in practical terms meant the development of the profession with more rigour, method, and order.

The change was gradual; some hospitals initiated the process and started to integrate the nursing department within the organisational structures of the hospital (with more or less independence and power). As to care and assistance activities, some aspects also started to gain importance, such as the continuity of the care during the 24 hours of the day, the follow up of the care provided by the nurses (male and female), which had to be included in a written nursing record of the history of the patient, in the treatment book (or similar documents, depending on the specific health centre), task organisation first and then care organisation on a global basis. Up to this moment, nursing was very little profes-
sionalised; had been developed by religious orders and, in addition, the nursing students were used as free hospital labour.

In 1963, the application of a new organisational model in nursing started in the Asturias General Hospital (Oviedo), which was “strongly inspired by the English model. Highly professional nurses with a high component of hospital planning in accordance with the needs derived from the nursing model” (Guilera, 1986: 33). In the following years, the model was used in other Spanish hospitals.

The year 1971 meant the consolidation of the model and the change in attitude of nursing personnel towards the Health Administration. As we have noted previously, ATS students were being used in hospitals on a free basis, but they initiated a conflict, rejecting the planning of their practical work in accordance with the needs of the hospitals, and so claimed a more rational planning and timetables in relation with their academic objectives in practical work. The fulfilment of their objectives gave way to organisational changes and an increase in hospital staffing.

A year later, in 1972, professional practice was to be regulated by means of a Regulation on regime, management and service in the Health Institutions of the Social Security (National Health Service). Later, in 1973 through the Statute of Qualified Health Auxiliary Personnel and Clinical Auxiliaries of the Social Security regulated the relationship existing between ‘Instituto Nacional de Previsión’22 (–INP– National Institute of Social Security) and the Qualified Health Auxiliary Personnel and Clinical Auxiliaries.

The Statutes classified the nursing personnel by taking into account their qualifications, the service provided in the Social Security, their links with the institution. They also dealt with the establishment of the staff, personnel selection, vacancy planning, working shifts, functions, duties and incompatibilities.

For instance, the first section of the functions of the nurses and ATS professionals states that they have to develop the functions of medical auxiliaries, following written or oral orders by the doctor. However, several duties are detailed; in general, the trend is less restrictive than in previous documents, as well as the ori-

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22 Autonomous organisation created in 1908, but dependent -in practical terms- on the Ministry of Work. Since 1944, it was responsible for the (national and obligatory) Health Insurance. It disappeared in 1978, when the Ministry of Health and Social Security took over (Insalud). This entity is regionally organised and is in charge of the General System of Social Security, thus being the most important institution in the Public Health Care in Spain.
orientation, which is more technical; basically, the contents are the same as those of 1960.

Throughout these years nurses (ATS at the time) developed their specific functions, applying techniques to a certain extent, depending on the type of service and the delegations made by the medical staff, this being a common practice in professional life. Indeed, there was a deep frustration as to their constrained role, as they could only develop what the doctor ordered, over-valuing the techniques, which as a matter of fact were mere manual jobs which did not entail professional discretionality and which the ATS stuck to, as they constituted the only security in a changing situation.

It may be argued that many experienced a feeling of frustration when observing how many things there were to do and how hostile the atmosphere was to changes. First reactions were to achieve the best technical performance; but the steps had to be taken in a different direction if the situation was to change. One of the elements of change came with the Decree of 23rd July 1977, which regulated the integration into university of the ATS schools as university schools of nursing, and the qualification which the students would obtain at the end of their nursing diploma would then enable them professionally, with the rights, attributes and prerogatives determined by the law.

Article 36 of the Spanish Constitution which was passed in 1978, reads as follows: “The Law shall regulate the particularities of the legal regime of the professional colleges and the practice of the qualified occupations. The internal structure and the functions of the colleges must be democratic”; as we can see, this has an effect on nursing as a qualified occupation.

While awaiting the corresponding Act for the regulation of the function of nursing as a qualified occupation, three guide-lines were published for the elaboration of the Nursing Curriculum in the Order of 31st October 1977. The curriculum of an educational programme must contain common syllabus subjects, and the contents – once the enabling qualification has been obtained – enable the holder of the qualification to develop the functions (which is an accepted criterion in jurisprudence); however, this is not strictly true, as the title does not enable unless its activities are specified by law.

As we have noted, the 1977 legislation for the integration of the schools refers to the attributes and prerogatives determined by the law; the norm which regulates

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23 In Spain three-year higher education studies are called diplomas, whatever the studies, this being similar to a degree in other countries.
the professional activities of nursing, is a 1960 decree which, including updating on 26th April 1973, remains the same, except for the new denomination of ‘ministry order’ (by the Ministry of Work) and not ‘decree’. This makes the development of an Act even more urgent, as was established in the Constitution; in addition, the statutory articles – which are still in force – are completely out of date, and the paragraphs referring to professional duties still relate to the assistance to the doctor or collaboration with other professionals; that is, the responsibility lies in the hands of the medical staff, which is in contradiction with the daily routines, the divorce between the statute and reality being obvious.

On 11th January 1980, the Spanish Official Bulletin included, as a consequence of the pressure, an order through which the ATS qualifications could be convalidated into a Nursing Diploma. This was done only at a professional, ‘corporate and nominative level’, not at an academic one. For the academic validation of the ATS studies as a Nursing Diploma, a course for the levelling of knowledge was established; after the validation order, the functions of the qualified nurses and the ATS roles were to be the same, and were specified in the Ministry Order of 26th April 1973, which hindered the updating of the nursing functions.

On 16th February 1984, the Official Bulletin of the General Parliament (later Order of 14 of June of 1984) published a proposal submitted by the Socialist Group; its objective was to develop the functions of the Second Grade Technicians of Laboratory and Radiology. This was done without having sorted out the situation of the specialities of the nursing graduates and – with quite a numerous group of ATS specialists in these areas – it constituted a provocation towards conflict, as both the ATS group and the new qualified nurses found their performance fields threatened by the newly created groups, and this is what actually happened.

One of the complaints was that the nursing diploma established in 1977 as a development of the General Act on Education had not been developed as a framework of functions which include the development of different Degrees and Specialities, as specified in article 36 of the Constitution: “The Law will regulate the practice of qualified occupations”. Due to this situation, it did not seem adequate to regulate the functions of other health categories which in some cases had to do with the mission developed until then by the ATS and the nursing diplomates.

Since then, there has been a continuous conflict with the Specialised Technicians (Laboratory and Radiology technicians, and others later), as they were then incorporated despite all the pressure against this; this situation lasted until recently, and
was aggravated by the existence of multiple ‘Function Framework and Professional Career’ projects which despite this deep discussion have not materialised. The only exception was in the regulation of the specialities by the Decree 992/1987, of 3 of July, which permitted the regulation of the midwifery education in accordance with European Union requirements only after the Spanish State had been denounced by the Commission of the European Community; after the regulation of the midwifery specialisation, no other specialities have been developed.

Always on an indirect basis, there have been attempts to legislate the work of the health professionals; for instance, on 11th January 1984, a Decree was passed on Basic Structures of Health, which in article 5 established the functions of the ‘Equipos de Atención Primaria’ (–EAP– Primary Care Teams) in which nursing is a major and essential element. This normative has later been echoed in the transferral processes in the health field; for example, the Order 20th November 1991 issued by the ‘Conselleria de Sanitat i Consum’24 established the Regulation for the Organisation and Functioning of the EAP in the Valencian Community, and also set the functions of the nursing personnel in article 30:

1) Apply the nursing care plan to those patients who may need it, in the different modalities of attention, and in co-ordination with the rest of the EAP members, and correctly register the activity.
2) Apply treatments derived from the medical care, and inform the patient or his/her family on their correct administration.
3) Perform the activities of Health Education, risk detection, opening of a history, as well as patient follow-up, request complementary tests, and carry out regular health check-ups according to the protocols and programmes established.
4) Supervise the supply, condition and conservation of the materials of the health centre.
5) Participate in the elaboration and implementation of health programmes, as well as in tasks common to the EAP.
6) Record and assess the activities carried out.
7) Other functions as EAP members.

This list of rules provides nursing with complete independence and autonomy, and sets some inter-dependence on other health professions in the scope of the health team to act within regulation boundaries.

24 Health Administration within the territory of the Comunidad Valenciana.
One must refer to what the 1986 Health Reform Act establishes; article 84 (section 1, chapter IV on personnel, title III, –of the structure of the public health system–) which reads: “the Social Security personnel –regulated by the Statute of Qualified Health Staff and Clinic Auxiliaries– will be ruled by the Statute/Framework which will be passed by the government in the development of this law...”; Item 2 of the same article further states:

This framework will contain the basic rules and regulations applicable for the classification and offer of occupational posts and situations, rights, duties ... In the development of these basic norms, the specification of the functions of each of the categories mentioned in the previous section will be established in the respective statutes, which will be kept as such.

This article again forced the government to describe the functions of the health professionals, including the nurses, but, as we have seen, the government – once more– was unable to comply with this commitment.

On 11th May 1990, the health administration, pressured by the unions, drew up a plan which include a commitment for the development of an Act on professional careers; the organisations involved (unions, colleges, associations, etc.) were asked to elaborate work proposals and, at the same time, 35,000 health professionals were addressed by mail; in addition, direct information was collected from doctors and nurses (Álvarez, 1993; 2). As a result of this study, the professional career projects were abandoned in the area of the National Health System, and the option chosen was to transfer functions to the directors of the health centres in the form of awards and sanctions, employing personnel in accordance with the work legislation and not with the statutes, negotiating with the professionals on an individual basis the complementary salary they were going to receive. Apparently, the government rejected development of a global regulation describing the positions as well as functions and promotion standards.

More recently, we find other legal rules which had a repercussion on the professional regulation of nursing. In this regard, we must mention two orders (28th February and 1st March 1985) referring to the management organs and the passing of the regulation for Social Security hospitals. The order of 28th February recognises the following management organs for the hospitals of the ‘Instituto Nacional de la Salud’ (–INSALUD– National Institute of Health): Managing Director, Medical Direction, Nursing Direction, and Direction of General Services, which form the Commission of the hospital management. The functions of the nursing manager are defined in article 7: this person is responsible to the Man-

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25 See footnote number 19.
aging Director for the correct functioning of the nursing services, coordinating and assessing the activities of its members, promoting and evaluating the quality of care, and of the research and academic activities carried out by the nursing staff, as well as all those functions which generally correspond to the Managing Director and which he/she delegates on the nursing manager; these three sections permit a wide performance framework and a greater autonomy, as the nursing manager is in charge of all nursing matters; indeed this makes a different reading from previous documents, which were characterised by a restrictive nature and certain ambiguity.

In these regulations, we can appreciate a highly progressive character, incorporating a more realistic perspective into the norm; however, there is a risk of regression, as happened with the Health Council of the Valencia Community, when the doctors wondered whether “direct attention” had to be given to the population under the “doctor's supervision”; fortunately, reason prevailed and the doctor's supervision was eliminated as exemplified by two appeals made by the Faculties of Medicine of Córdoba and Cádiz, aiming at restricting the autonomous functioning of the nursing clinics established in the Order of the Health Council of the Andalusian Board. Such an order dealt with the nursing function for the control and follow up of the chronically ill in the open institutions of the Health Care Network of the Andalusian Health Service. A sentence by the Higher Court established that the Order was in accordance with the legal framework.26

All these sentences and regulations directly defined the new functions of the nursing professionals; ideally, the function of nursing in Spain should be defined by an Act, in accordance with the Constitution, and including in its formulation the contents of the Community Directive 77/453/EEC, as well as the function contents in Directive 80/155/EEC which regulates the activities of the midwives and obstetric assistants.

3.1.2 Nursing Legislation in England

In England there are no laws in regard to nursing functions as we know them in Spain; the activities to be developed by the health professionals are negotiated by the groups, which make the scope of activities dynamic and changing. But we need to take into account, that since the creation of the UKCC for Nurses, Mid-

wives and Health Visitors (1983), Rule 18 established the foreseen outcome of contemporary educational programmes that every qualified nurse was expected to achieve. Updated in 1989 and adapted to Project 2000, Rule 18 is the result of power granted by the British Government to the UKCC for Nurses, Midwives and Health Visitors; it is not a law, but from a professional and civil perspective it is considered a reference.

**Comparative analysis**

Apparently, we are dealing with two different ways of performing: in Spain a regulation is set establishing everything a nurse should do and where the State acts as a referee in the negotiations between different professions which compete on common ground. This situation creates in Spain a level of monopoly over the content of nursing work and over some medical techniques which have been traditionally applied by nurses.

This regulation has imposed on nurses a way of performing, their role being constrained by a series of tasks and obligations. If there is a regulation, then there is no choice, and the compliance with the regulations is required as a part of the professional responsibility of nurses. This regulation, however, did not exclude doctors from making recommendations about the way nurses should carry out their functions. But this is more and more out of date, and at present a total parliamentary review is expected to establish by law the regulation of nursing work in Spain.

This legislation could be unsatisfactory if the regulation which defines a role is simply a list of tasks. It may be too static and block the evolution of the profession, especially when new technologies tend to change -on a daily basis- the way which specific activities are carried out.

But such a regulation must not merely be a list of tasks which will become obsolete sooner or later. It must be a broad description of the actions which can be taken by a nurse in terms of ends and means, and it has to describe how the nurse can influence society by taking care of its health.

In England the role of nurses is rather ill defined and has traditionally been based on the acceptance of the orders of the doctors, which generates some conflicts or disagreement about the nurses’ functions and their pursued objec-

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26 Nurse, Midwives and Health Visitors (Amendment Rules, Approval Order) nº 1456, 1989.
tives. If there is no regulation, everything will be dependent on negotiations, which may mean that it is not efficient solutions that prevail but the wishes of those who are more powerful.

Traditionally, the state has not intervened, and has had confidence in the professionals. Maybe this is the correct attitude, because if matters are treated in a context of professional equality and collaboration, freedom in the solution of problems among colleagues and professionals is the best option.

But this option does not strictly apply to nursing, as sometimes the effort is greater and the reward the same. For instance, governmental directives were issued to reduce working hours of junior doctors and the initiative were extended to cover the scope of nursing practice as much as possible.

We wonder whether the Spanish ‘practicantes’ would have been considered nurses. In England apparently not, as the regulations of the former clearly established an important number of functions within the medical field, as well as a clear demarcation of the boundaries with the medical profession, and specific work in rural areas and house visits in cities. Parallel to the work of the ‘practicantes’, basic care was historically provided in hospitals, and the figure of the nurses in these centres was embodied by the nuns, who would then become qualified nurses in 1915.

The work of ‘practicantes’ and nurses overlaps but their performance is different despite a similar training. This facilitated the conceptual evolution of the hospitals, where the ideal was no longer simply to provide care but to fight disease, trying to recover the health of the patients by means of technology and specialisation.

There was a need to technically train the staff which traditionally had provided the care. For the ‘practicantes’, who –until then– had developed different techniques within the hospital, the situation became difficult because of the recognised need for the continuous surveillance of the patient, not only in the administration of basic care but also in the application of medical treatments, cures, new techniques, etc. These changes led to the creation of ATS in 1953.

All these considerations constituted a reflection of the new health situation derived from the Act on National Health Bases of 1944, where the need was identified to train a new professional capable of meeting the new and growing demand of the new health system, and where the care needs could not be satisfied by the ‘practicantes’ in one side and the nurses on the other.
We can draw the conclusion that today's nursing is not a direct descendant of the ‘practicante’ profession, even if they had similar activities and programmes, but their origin, training and functions were different. The role of the ‘practicantes’ differed considerably from the role of English nurses, the latter being more similar to Spanish nurses, as their model had been followed in Spain.

Nowadays, the differences in the roles in the two countries are mainly based on who carries out the medical techniques traditionally performed by the ‘practicantes’. In this regard, there is now also greater coincidence due to the changes resulting from the new regulations of the junior doctors, which has given way to a greater demand for an extension of the role played by the English nurses in this context.

In England there are no function laws as we know them in Spain; the activities to be developed by the health professionals are negotiated by the groups, which makes the scope of activities dynamic and changing. But we need to take into account that since the creation of the UKCC for Nurses, Midwives and Health Visitors (1983), Rule 18 established the foreseen outcome of contemporary educational programmes that every qualified nurse was expected to achieve. Updated in 1989 and adapted to Project 2000, Rule 18 is the result of power granted by the British Government to the UKCC for Nurses, Midwives and Health Visitors; it is not a law, but from a professional and civil perspective it is considered a reference.

### 3.1.3 Membership Restrictions for Practice: England and Spain

The Spanish State has always been concerned with the sanctions of the person claiming a professional qualification without actually being qualified, and has established regulations to guarantee, as Rodríguez Mourullo says (1988; 522), “that the qualifications of certain professions are granted with the indispensable guarantees of moral and cultural order, avoiding an appearance of truth, and often applying pecuniary sanctions which can be combined with a more dissuasive penalty, i.e. deprivation of freedom”.

During the 19th century in Spain, as in other European countries, it was seen as a necessity to introduce labour legislation because of the diversity of legal sources. This can be observed in the Constitution of 19 March 1812 (Tierno, 1975), where article 258 established the unity of the Civil, Criminal and Business Codes, which were to be “the same for the whole of the kingdom”.
It is important here to consider, from a chronological perspective, the concept of unfair competition in Spanish Law. As this is so because it set the boundaries of the professional practice of different professions, among them nursing.

The first Criminal Code to which we will refer is that of 9 July 1822 (López Barja, Rodríguez & Ruiz, 1988: 87-88); from the articles in this code, we will be able to deduce that professional intrusion or unfair competition refereed to doctors, surgeons, pharmacists, midwives and ‘ministrantes’, the precursors of the ‘practicantes’.

In the 1822 Code, First Part, Title IV, “Crimes against Public Health”, the 1st Chapter deals with “those who practice medicine, pharmacy, obstetrics or phlebotomy without being qualified”; article 363 of this Chapter reads:

Those who practice medicine, pharmacy, obstetrics or phlebotomy without being legally qualified will pay a fine of 25 to 200 'duros' and will be imprisoned for 1 to 6 months if they have been deemed not to have caused any damage to the person attended. If injury to the patient is verified, imprisonment will be from 1 to 6 years, apart from the payment of the fine; and they will also receive the appropriate penalty for having used false credentials.

According to this article, the aim is to fight the practising of the professions without legal approval, and to avoid other more serious types of crime, such as considerable injury to the patient. The possibility of a greater penalty if a false qualification is used, is also foreseen.

Article 364 establishes: “Those who have obtained approval as expressed by the previous article, must produce it in the Town Hall of their towns, if not they will be fined from 8 to 20 duros...”. In regard to this article, there had already existed previous references, aimed at controlling abnormal situations in the qualifications of health professionals.

Article 365 includes quacks and charlatans, who were possibly common figures at that time. They were informed that they would be breaking the law if they were to act attending the ill when they are not professionally qualified, and to give or sell simple or compound remedies; the penalties for these offences were established in article 363. This article reads as follows:

As determined in article 363, and subject to the penalties it establishes, under no circumstances or pretext or denomination, will quacks or charlatans be permitted, either in the assistance of the ill, nor in the selling or giving of

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29 A ‘duro’ is a 5-peseta coin in Spanish currency.
simple or compound remedies. Any person without the corresponding au-
thorisation to sell or give simple or compound remedies of any kind –in
whatever name they are given– will be punished in accordance with article
363.

In Chapter II, in the same Title, article 366 establishes:

No pharmacist or druggist will be allowed to sell or give any poison or drug
which may be harmful to human health, or any drink or medication whose
preparation may have involved any poisonous or harmful ingredients, until
they have received a prescription from an approved doctor or surgeon.

This article is aimed at preventing non-qualified people from prescribing harmful
substances, given the potential danger involved when prescribed by inexperi-
enced people.

In 1848, the Second Spanish Legal Code was issued (López Barja, Rodríguez &
Ruiz, 1988: 254-255); Chapter VII of the 2nd Book (Title IV), “on the usurpation
of functions, quality and assumed names” typifies professional intrusion in article
244, which states: “If a person pretends to be a public employee or a lecturer of
a university which requires a qualification, performing as such, he/she will be
punished with the penalty of correctional imprisonment”.

This extends the scope of forbidden conduct to all those professions which re-
quire qualifications, and professional intrusion is integrated under the title of
falsehood, a position that would be maintained in subsequent Codes. Intrusion is
made equivalent –from the penalty viewpoint– to usurpation of functions (as de-
defined later in the 1870 Criminal Code); the penalty for both cases is correctional
imprisonment from 7 to 36 months. With the appearance of the 1870 Criminal
Code, the crimes of professional intrusion and usurpation of functions would be
noted independently.

The next Criminal Code appeared in 1850 (López Barja, Rodríguez & Ruiz,
of functions, quality and supposed names”. Article 251 reads:

Those who pretend to be an authority, a public employee or a lecturer of a
university which requires a qualification, and perform as such, will be pun-
ished in the first case with the penalty of minor imprisonment, in the second
and third cases with correctional imprisonment.

This article is very similar to the 1848 Code, but it distinguishes different penal-
ties for each case.

Those who use the quality of professor, performing publicly as such without an officially issued qualification will receive the penalty of major arrest in its maximum degree or correctional imprisonment in its minimum degree.

Here, there is explicit reference to the public practice of a profession, which will be maintained in subsequent codes.

This legislation is completed with specific regulations which meant advances in the organisation of the health professions; this is the case of the Act on General Instruction of Public Health (1904); article 67 (title III) established that the qualifications have to be authorised and the professional practice regulated: nobody would be able to practice a health profession without being qualified. The following practices were recognised as health professions: midwifery, ‘practicante’, and those complementary professions of this type which could be created under special circumstances. Nursing was created later and amalgamated with ‘practicantes’.

In December 1925, following the initiative of several Provincial Colleges\(^\text{30}\) (self-denominated Professional Associations, although they had not been regulated by the State at this time), the so-called Health Professional Card is created for the ‘practicantes’ in order that they be able to produce it in any circumstance, which contributing to a more strict professional control. The card had to be signed by the College of ‘Practicantes’, the Health Inspector and the Civil Governor of the Province, as established by an order from the Civil Government.

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\(^{30}\) The professional colleges of the Spanish State – including the nursing colleges – are corporations of public law and thus participate in the tutorship and administrative control of basic rights; in the case of nursing, these are the right to health care and the right to health. This fact provides them with independence and operativeness.

Given their legal/public nature, colleges carry out some functions related to the professional discipline, deontological rules, criminal and/or administrative sanctions, and appeals, which could not be developed neither by legal/private associations and unions nor by political parties.

They act as consulting organs which manage different issues: technical planning of an overall sector in terms of functions, capabilities, resources, salaries and working shifts. Ultimately, the collective benefits from such actions, are not for the college or the administration, due to the public service and general interest of the professional mission of their members.
The 1870 Criminal Code was followed by the 1928 Code (López Barja, Rodríguez & Ruiz, 1988: 818), published through a Decree on 8 September, and came into force on 1 January 1929. During the drafting of the reform, the National Committee of ‘Practicantes’ sent different submissions asking for a new code to cover the issue of professional intrusion.

In Book II of this code (Title IV, “On falsehood”, Chapter VII, “On the usurpation of functions, quality and qualifications, and unlawful use of braiding, costumes, badges, and decorations”), article 408 establishes:

Those who are not legally authorised, and publicly practise any profession, developing activities which are not covered by an official qualification, even if the resources used seem to be safe, will be punished with, from 4 months to 2 years imprisonment and a fine of 1,000 to 15,000 pesetas. If in the cases mentioned, injuries are caused to the health or interests of a person, the maximum degree imprisonment penalty will be applied, with possibly a greater sanction if the crime is deemed to be more serious.

The Health Professional Card initiative for ‘practicantes’, developed by some Provincial Colleges in December 1925, seemed to be successful, and this was reflected in the College statutes on 22 December 1929 for ‘practicantes’, and 7 May 1930 for the midwives, which led to its formalisation through a Royal Order of 7 March 1931. This card was established as the only model of professional cards for all Spanish ‘Practicantes’, thus becoming the official document for the identification of the members of the profession.

In both statutes (‘Practicantes’ and Midwives), we find articles establishing that the Civil Governors

31, Provincial Health Inspectors and Medical Deputy Delegates would denounce anybody intruding in those professions, and that the Midwives and ‘Practicantes’ who practised professionally were registered with their respective colleges. The colleges had to pursue, before the competent tribunals, cases of intrusion; to this effect, the President and the Managing Board would act as representatives of the College.


31 The ‘Gobernador Civil’ is the State’s representative in each province.
The offence of intrusion, in defence of the rights of professionals, as well as the patients, produced denunciations by the colleges that did not always end in a conviction of those being denounced. For example, in 1933 the National Federation of ‘Practicantes had to give economic help to the college of Bilbao for it to appeal before the Supreme Court against an acquittal given to three religious nurses of the Civil Hospital of Basurto who had been denounced for intrusion (Gallardo, Vila & Jaldón, 1994; CXLIII).

In May 1935, the Executive Committee of the profession at national level, put a question to the Director of Health as to what exactly were the functions of nurses “to the point of not intruding on those of the ‘practicantes’; as this was a usual practice”. But it did not stop there, because a similar petition was lodged on behalf of doctors; there were already many of them interpreting the concept of the auxiliary in a derogatory form, while others were quietly in this situation, carrying out the functions of the ‘practicantes’. The midwives took advantage of this health agitation to ask for the suppression of the obstetric subjects in the ‘Practicante’ Diploma, with a view to obtaining professional advantages, as the ‘practicantes’ were only allowed to assist at births in those locations where a midwife was not available.

In addition to this, on 24 April 1937, an Order was passed in which the government authorised ‘Falange Española Tradicionalista y de las Juntas de Ofensiva Nacional Sindicalista’ (FET-JONS), to organise nursing courses. The Order established that the certificates proving the qualification obtained after the course were valid only temporarily, and only if an exam was passed to obtain a position in a province or town. All this created new types of nurses, which prompted numerous Provincial Colleges of the country to send reports exposing the problems of the sector and the fear of having a new case of professional intrusion with the new types of nurse.

The conflict between ‘practicantes’ and nurses was rooted in the definition of the nursing tasks: they could only provide care to patients admitted into hospitals, and always under the orders of a doctor; they were not permitted to attend in the

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32 Falange considered itself not a programme or a model of thought but a way of being or a way of generating doctrines by means of actions. They preferred to call themselves a movement and not a party, and their ideological basis consisted of 27 statements by José Antonio Primo de Rivera, which concisely covered the liberal concepts of Homeland, State, Individual, Freedom, Economy, Education, Religion, and National Revolution. The Movement (FET-JONS) presented the statutes as a political reform project in which three currents met: nation, Catholicism, and social justice, apparently strongly linked.
patients homes, as this function was covered by the ‘practicantes’. As a matter of fact, there were not many differences between the functions both professionals could perform, but the ‘practicantes’ wanted to stake their territory clearly, to avoid intrusion by those nurses who worked outside the hospital.

On the other hand, the Commissions for Professional Intrusion of the Provincial Colleges did remain, no matter what the situation. The actions taken in the Seville Provincial College were extreme: the Head of the Administration Office of the College, Sr. Maza, was denounced when they heard he used to give injections in his spare time. Sr. Maza was considered an excellent employee as to his administrative duties, and the denunciation was only withdrawn after he promised not to give injections again, otherwise he would have lost his job (Gallardo, Vila & Jaldón, 1994).

An Order published on 8 March 1941 regulated the functions of the General Council of Official Colleges of ‘Practicantes’, appointed on 22 December 1939. The Order determined that the Colleges of ‘Practicantes’ could continue functioning as they had been doing up to then, but the regulations were to be changed in a short time.

On 3 April 1942, the Order by the Governing Ministry dated 18 March was published, including new statutes. Several articles established the attitude to professional intrusion. The Order determined that the General Direction of Health, the Civil Governors, Provincial Heads of Health, and the Deputy Delegates of Medicine, and any other people with or without authority should denounce those individuals acting without the required qualifications and those ‘practicantes’ developing their professional practice who were not registered with their official college.

Therefore, the ‘practicantes’ were required to apply for their respective licence – ‘patente’\(^{33}\) – through their College; the college then was compelled to denounce all ‘practicantes’ who were acting as professionals without having a licence, this constituting a crime of intrusion. The Provincial Colleges were obliged to report to the Medical Colleges and Deputy Delegated for Health about any person favouring or protecting intrusion in the ‘practicante’ profession; the colleges then would have the duty of pursuing intrusion cases before the corresponding Tribunals.

\(^{33}\) This document was issued by the Public Tax Office and proved that the payment demanded by law for the practice of certain professions had been met.
A Decree of 23 December 1944 promulgated a new Criminal Code (López Barja, Rodriguez & Ruiz, 1988: 1271); article 321 in Chapter VII, “On the usurpation of functions and improper use of names, costumes, badges, and decorations”, established: “Those who claim to be professors and publicly act as such without having the official qualifications will receive the penalty of minor imprisonment”; this article is in line with the previous Codes.

The Act on Health Bases, dated 22 November 1944, established that the Colleges of ‘Practicantes’, Midwives and Nurses had to unify, which was done that same year through the creation of the General Council of Health Auxiliaries. This body would be regulated by a regulation drawn up by the General Direction of Health, subject to consideration by the Health Ministry.

On 5 December 1945, the Order of 26 November 1945 was published in the Official Bulletin of Spain, containing the Regulation of the General Council and the statutes of the health professions and the Official Colleges of Health Auxiliaries.

As to professional intrusion, the order established that the Council –on an exclusive basis– should control intrusion cases in the health professions, punishing strictly any transgression among them. To this end, the enthusiasm of the Provincial Colleges was enhanced, thus trying to control to a certain extent a problem which has constantly affected the relationship among these groups (‘practicantes’, midwives and nurses).

This regulation contained the statutes of the Health Auxiliary professions and of the Official Colleges; article 3, Chapter I, Book I, referred to the Health Auxiliaries, defined the conditions which could be considered as intrusion, stating that the public and private practice of the profession of ‘practicante’, midwife or nurse without having the corresponding qualifications or being registered with the Official College, or having paid the corresponding licence to the Tax Office established by the College, is considered intrusion and can be punished by Law. The practise of a specific and private activity of a Health Auxiliary profession by non-qualified individuals would also be considered intrusion.

Chapter I in Book II specified the objectives of the Colleges; article 20 stated that the General Direction of Health, the Civil Governors, the provincial Heads of Health and the Deputy Delegates of Medicine, as well as other authorities and private individuals, should denounce anybody committing an intrusion crime and the ‘practicantes’ who –although professionally acting– were not registered with their respective College; the articles said that the Colleges should pursue the intrusion cases before the corresponding tribunals. The Provincial Colleges should also report to the Medical Colleges and the Deputy Delegates of Health anybody
favouring or defending intrusion in the professions of ‘practicantes’, midwives and nurses. The Provincial Councils were assigned with the mission of ensuring that there was no intrusion between the different professional groups, and severely punishing the intrusion acts of professionals into activities reserved for other qualified bodies.

This last point is clearly reinforced by article 4 in Chapter II on the ‘practicantes’, the statutes of the Health Auxiliary professions –Book I–; this article stated that the ‘practicantes’, nurses and midwives would not be allowed –under any circumstances– to develop activities which were exclusive to other professions. The Official Colleges of Medicine, Odontology and Health Auxiliaries would severely punish their registered members who promoted or consented to intrusion. It is interesting to note that this last paragraph includes all professionals on an equal basis.

Later on, an Order dated 25 June 1951 from the Governing Ministry passed the Regulation of the General Council of Midwives and the Official Colleges of Midwives, which regulated the Midwifery College and General Council within the scope of the Council of Health Auxiliaries, establishing as a target the pursuance of intrusion cases before of the health authorities and even the courts of justice, the actions being taken via the President and Government Boards.

Article 4 covered in detail the intrusion issue stating that the General Director of Health, the Civil Governors, the Provincial Health Inspectors were obliged to pursue all those individuals who practised midwifery without being qualified, and also those who were but were not registered with their respective colleges.

For the prosecution of those acting without an official qualification, and those who acted as quacks with serious danger to the public health, the Presidents of the Midwifery Colleges would be endowed by (1) the Civil Governments of their respective provinces with the necessary power to require those individuals to stop their activities and by (2) the corresponding Provincial Health Inspector to initiate verification proceedings; after this, the case would be subjected to the knowledge and approval of the General Director of Health, who would determine the corresponding disciplinary sanctions. Likewise, the President of each College would report the case to the Civil Governor of the province, the Head of the Board, and in cases where the Provincial College covered more than one province, the Governor of such a province should also be informed with a view to issuing the corresponding fines established in the College Regulations.

If in intrusion cases the participation of a ‘professor’ was suspected of acting as a protector of the activity –tacitly or explicitly–, College of Midwives would be
able to report the case to the Medical College to which the ‘professor’ belonged and to require its intervention.

The College Boards would correct those professionals who evidently protected or helped professional intruders. Those midwives who – without being officially registered – carried out their activities for a longer period than that established in the statutes would be called before the College President who would set a 15 day deadline for them to register with the College. If this was not done, this fact would be reported to the health authorities, who would force the professionals to immediately apply for registration, not permitting them to practice in the meantime.

If registration was not fulfilled by that deadline, and the reasons for not doing so were not duly justified to the Governing Board of the College, a fine of 25 to 100 pesetas would be imposed by the Board, and this amount will pay for the College registration card. The person sanctioned was able to appeal to the General Council of Colleges, whose judicial decision would be final.

Nursing Colleges were also established, in accordance with an Order dated 12 May 1953, which established that the functions of the Colleges would be equivalent to those of the ‘practicantes’ and midwives, with the same treatment for intrusion cases.

The Order of 25 January 1954 dissolved the General Councils and the Colleges of ‘Practicantes’, Midwives and Nurses, creating a commission for the re-organisation of the Council and Colleges of Health Auxiliaries.

On 9 April 1954, an order (29 March) was published containing the Regulation of the National Council of Health Auxiliaries; one of the functions of this organisation was to avoid the development of intrusion among health professionals and energetically punished all intrusions of one profession into another. The regulation included an appendix with a Moral Code; Item 16 read as follows: “All registered members will report to the College all intrusion cases that they may know of”. The code established the moral duty – in relation to patients and in defence of the profession – of reporting all professionally related illegal activities.

On 30 July 1954, the statutes of the Provincial Colleges of Health Auxiliaries were passed; in the objectives section and in articles 3 and 4, the issues related to professional intrusion were set out: the Colleges had to pursue the intrusion cases before the corresponding tribunals; midwives and ‘practicantes’ were not allowed to develop activities which are exclusive to other health professions.
In the case of intrusion acts protected or consented to by Doctors, Odontologists or Health Auxiliaries, the respective college had to be informed to take the necessary actions. The cases which were not resolved in this friendly manner would be reported to the Provincial Health Head who would then resolve the situation with the due authority. In addition, the public or private practice of the profession on any of its three health auxiliary branches without the required qualifications or without being registered with the Provincial College would constitute an intrusive act which could be punished in accordance with the Law; the registered members had to report to the College those intrusion cases that they may knew of.

No additional modifications were made until the Act of Bases 79/1961, dated 23 December, concerning the revision and reform of the Criminal Code; Base V established:

Article 321 will be modified in accordance with current needs in order to achieve a greater efficiency in the control of intrusion, punishing those individuals who illegally develop activities of a profession, career, or speciality which requires academic and official qualifications recognised by the laws of the State or by international conventions.

Later on, the emphasis would be on the intensification of the penalties for those who, apart from committing the previously mentioned acts, publicly used a professional qualification without actually having it.

In article 572, the Act on Bases established as punishable those who, without being legally enabled, performed activities of a regulated profession which does not require an academic qualification but an official permit, and also those who do have the required qualifications but are not registered with the corresponding College, Corporation or Association.

According to norms set in the Act on Bases, the reform of the Criminal Code of 1963 modified the contents of articles 321 and 572. Article 321 read as follows:

Those who practise a profession without holding the corresponding official qualifications, or qualifications recognised by a legal norm or an international convention will be sentenced to minor imprisonment. If they publicly use such professional qualifications, an additional fine of 10,000 to 50,000 pesetas will be given.

Article 321 posed some interpretation problems in that some people understood ‘official qualifications’ as ‘academic qualifications’, as only the latter would have the characteristic of ‘official’ (Bustos, 1989; 419); in less restrictive interpretations, others asserted that, before the 1963 reform, the legal coverage was lim-
ated to professions which required academic qualifications. Nowadays, they are all covered, even if they do not require an academic certificate. The officialdom emanates from both the internal law and international conventions, but the academic feature is not essential; what was really required was an official qualification, that is, issued by the State or other body for that purpose enabled (Rodriguez, 1983; 956). The interpretations of this article can be especially important when applying it to the free movement of workers within the European Union.

After the 1963 reform, article 572 was modified as follows:

A fine of 250 to 2,000 pesetas will be imposed upon:
1. Those who are not covered by article 321 and develop a profession which is regulated by law without having the required official qualifications.
2. Those professionals who are not registered with the corresponding official College, Corporation or Association, when this requirement is demanded by the regulations.

In addition to the fine, re-offenders will receive the penalty of ‘minor’ imprisonment.

These acts will not be considered crimes but misdemeanours, which are the lowest infraction in Spanish Law.

The article – with subsequent increases in the amount of the fine – remained in force until the Organic Act 3/1989, 21 June, which cancelled the misdemeanours in no. 1 of article 572, and the aggravation for re-offending in the misdemeanours concerning the practice of a profession without being registered with a College.

Due to this reason, the legal services of the Colleges denounced in court intrusion by professionals who practised without being registered. The colleges paid their expenses through the payments made by the registered members; if the members failed to pay their quotas, the Colleges were entitled to initiate the necessary legal proceedings to claim the delayed payments. If a judicial decision was issued in favour of the college, part of the salary of the offender – the unpaid quantity plus the court expenses and interest – could be sequestrated; at present, there was a large number of verdicts which applied the law in this way.

Meanwhile, and after a long time without substantial modifications in the Regulation of the Council of Health Auxiliaries and the statutes of the Colleges of Health Auxiliaries, a Royal Decree of 29 June 1978 was published in the BOE, on 8 August in which the statutes for the organisation of an ATS College were passed; one of its functions was to adopt measures to avoid professional intru-
sion, and the members had the duty of reporting to the College any act of intrusion produced in the province that they knew of, as well as any cases of illegal practice due to not being registered or being disqualified, and thus professional intrusion and its abetting were considered very serious misdemeanours.

In England, it might seem that Florence Nightingale and Mrs. Bedford-Fenwick had no point in common, but this was not correct: both consider that no one could be considered as a nurse if they had not received adequate training. Florence Nightingale drew a line between the trained nurse who was qualified to nurse and the attendants of the hospital before her and her school. Mrs. Bedford-Fenwick wrote in an editorial of the *Nursing Mirror* (quoted by Greene, 1975: 54) that “Everyone will agree that no person can be considered trained [as a nurse] who has only worked in hospitals and asylums for the insane” drawing the same line of separation between trained and untrained nurses.

During 1903 and 1904, two unsuccessful Bills for the registration of trained nurses were presented to Parliament, which were spurred on by the passing of the Midwives Act of 1902. Their effect was such that in June 1904, Parliament ordered to set up a Select Committee of the House of Commons, to report on the whole question of the Registration of Nurses, which decided in favour of registration saying:

> it is desirable that a register of nurses should be kept by a central body appointed by the state, and that, while it is not desirable to prohibit unregistered persons from nursing for gain, no person should be entitled to assume the designation of ‘registered nurse’ whose name is not upon the register.34

(Select Committee on Registration, 1905: 4)

The Nurses Act of 1919 established that after three months from the date on which the Minister of Health gave public notice that a register of nurses has been compiled under this Act, any person who not being a person duly registered took or used the name or title of registered nurse, either alone or in combination with any others words or letters, or any name, title, addition, description, uniform or badge, implying that he was a registered nurse, would be liable on summary conviction to a fine.

The same applied in the case of any person who being a person duly registered and whose name was included in any part of the register, at any time after the expiration of the period aforesaid took or used any name, title, addition, descrip-

34 HMSO (1905) Report from the Select Committee on Registration of Nurses. House of Commons. London: HMSO.
tion, uniform, or badge implying that his name was included in some other parts of the register; or at any time with intent to deceive made use of any certificate of registration as a nurse issued under this Act to him or any other person. In both cases the person shall be liable on summary conviction to a fine not exceeding, in the case of a first offence, ten pounds, and in the case of a second or any subsequent offence, fifty pounds.

In the same way, if any person wilfully makes, or causes to be made, any falsification in any matter relating to the register, he shall be guilty of a misdemeanour and shall, on conviction thereof, be liable to a fine not exceeding one hundred pounds.

The Nurses Act of 1943 established the roll of nurses and in the same way, established restrictions to uses of the name of the Register and the enrolled nurse. Two years later, the Nurses Regulations of 1945, established the different situations when a person who was not a registered nurse or an enrolled assistant nurse could use the word nurse.

In section 17 of the Nurses Act of 1949, we find penalised the acts that falsely implying inclusion in the list, saying that any person who being a person whose name was not included in the list, took or used a name, title, acronym or description implying that his name was so included, would be liable on summary conviction to a fine not exceeding, in the case of a first offence, ten pounds and, in the case of a second or subsequent, fifty pounds.

The Nurses Act, 1957 had a section of offences and penalties, such section established to pursue professional intrusion in the same terms, as the Nurses Act of 1919, the Nurses Act of 1943 and the Nurses Act of 1949, with the same fines and extended this regulation to enrolled nurses and nurses whose name were on the list.

The Nurses Act of 1957 referring to intrusion included new situations such as a person who, knowing that some other person was not registered or enrolled, made any statement or did any act calculated to suggest that that other person was registered or enrolled, shall be liable on summary conviction to a fine not exceeding, in the case of a first offence, ten pounds, and, in the case of a second or any subsequent offence, fifty pounds. That section of the Act, treated specifically the case of children’s nurses.

It also gave the power to the Minister to authorise by regulations the use, either generally or by specified classes of persons or in specific circumstances, of specified names or titles containing the word nurse or of the word nurse otherwise qualified in accordance with the regulations.
The Nurses Act of 1969 made reference to the Nurses Act of 1949, and substituted a paragraph that gave a new dimension to the intrusion among different parts of the register, saying that being a person whose name was included in any part of the register but not in another part, took or used any name, title, addition, description, uniform or badge, or otherwise does any act of any kind implying that his name was included in that other part shall liable on summary conviction to a fine, established the same for the enrolled nurse.

In the Nurse, Midwives and Health Visitors Act, 1979 we read that a person committed an offence if, with intent to deceive (whether by words or in writing or by the assumption of any name or description, or by the wearing of any uniform or badge or by any other kind of conduct) if he falsely represented himself to possess qualifications or to be registered in the register, or in a particular part of it.

He also committed an offence, who permitted another person to make a representation about himself or made by himself with intent to deceive, or made with regard to another person any representation which was false to his own knowledge. A person guilty of an offence of a false claim of professional qualification was liable on summary conviction to a fine of not more than £500.

**Comparative analysis**

Both countries – Spain and England – approach the intrusion problem differently due to professional roots, social structure and a different view of the problem. For instance, in England, nursing leaders identified the need of training in nursing care.

Protection against intrusion and therefore, against those who – without being qualified – act as nurses, is not regulated by the 1919 Act. It only protects in terms of usurpation or intrusion of the name of registered nurse. This is basically due to several reasons: firstly, it was difficult to establish that nursing care had to be provided only by qualified and trained nurses; health centres would have then suffered a shortage of nurses, as most of them had not been trained, let alone had qualifications.

Secondly, there was a problem with its definition: traditionally, nursing care had been provided by mothers, relatives of the ill, etc., which posed a difficulty in trying to stake the professional boundaries of something which was usual and natural in the human species. In addition, the definition of nursing work in health centres was difficult due to the vagueness and arbitrariness in the assignation of tasks (this was normally done in relation with subordination to the doctor).
On one hand, we also need to add that the nurses themselves did not claim a definition of nursing work. On the other, if the nursing field had been specified, describing it and drawing lists of tasks, this may have led to nothing, since the technological evolution makes today’s activities—considered essential—obsolete tomorrow. All these elements may be found in the roots of the non-existence in England of a set of rules on the nursing functions, which we could call a monopoly Act on professional activities. This fact poses more difficulties when trying to protect the profession against intrusion, as there is not a description of what needs to be protected. Only recently, Rule 18—produced by the UKCC for Nurses, Midwives and Health Visitors—has defined the expected outcome for qualified nurses that could be considered as a definition of the nursing function.

And finally, the chronic shortage of nurses in England may have been one of the causes of that lack of definition and non prosecution of intruders. In contrast, Spain had a different starting point: the first group which could be considered the antecedent of today’s nurses were the ‘practicantes’, who were subordinated to and technically dependent on the doctor, which favoured their protection against intrusion from the very first moment.

This situation made them belligerent when acting against intruders, not only laymen, but also against other professional groups related to their working field. Examples abound in the history of the ‘practicantes’ where they are described as jealous custodians of their rights, which they would defend against the physicians and other emerging professional groups such as female nurses, protected against intrusion from the moment they were created, in fact the rivalry between ‘practicantes’ and nurses was perceived in the reciprocal accusation of intrusion, by which they tried to establish the limits of each. This situation was partially a result of a different conception of both careers by public powers, when—in essence—the training was the same. These attitudes can be seen in the legislation which developed around them, and, in any case, the ‘practicantes’ also tried to invade the grounds of other groups, such as midwives, claiming as theirs the activities of the latter professionals. Such attitudes as protectors of their rights have been fully maintained by the ATS and at present have been inherited by both male and female nurses.

The comparison of the data in indicator a.a.1 “Only members are permitted to practise” shows a higher level of protection by law of the Spanish nursing professionals in reference to intrusion. The laws are used in Spain as a deterrent for non-qualified individuals who may develop the professional practice, whereas in England there is only specific protection for the registered and enrolled ‘nurse’ denomination.
3.1.4 Scale of Recommended Charges or Fees

As we have already seen, the midwifery and ‘practicante’ professions were institutionalised as “Medical Auxiliaries” in 1857 in Spain; this situation remained until the 1970s, and therefore it is not strange to find that some aspects of medical practice are reproduced in these professions, for instance the fees.

The concept of fee is unique to the professional field. It could be defined as the payment given for certain services; it is not a fixed nor periodical quantity such as a salary or wages, and it is especially found in medicine and law. In accordance with the principles of medical paternalism (see section I of this dissertation), the doctor should be obeyed as a father, on the grounds of his/her performance, this figure being a superior entity, someone from whom benefit is obtained, who has to be rewarded with gratitude. All this is in terms of strict distributive justice, as between patient and doctor, parishioner and priest, subjects and sovereign, there is not quid pro quo justice: their services are much more unique than these provided by the other members of a community; thus equality will never be possible in the exchange.

This is the reason why the sovereign, the priest, the doctor and consequently the ‘practicante’, midwife and later on the nurse are paid in accordance not with the principle of quid pro quo justice but with the concept of honour. The money received is then honorary, as – when the differences are so great – quid pro quo justice is not possible (Gracia, 1989: 213).

Since the very first moments of associate regulation of ‘practicantes’, it is usual to find clear reference to honorary fees, pursuing two objectives:

- Guarantee a minimum income aimed at not depressing professional decorum.
- Avoid professional competition.

The colleges would then act as referees in any disagreement which could arise with regard to prices, if they were both excessive or too low, which might affect professional dignity.

At present, this is a conflicting issue in a new proposed Act of Professional Colleges; the Tribunal for the Defence of Competition issued a report, on 24 July 1992, supporting the radical liberalisation of official professional activities, such as the disappearance of minimum fees, which would become a factor for economic reactivation. Since the publishing of this report, the colleges have established fees for orientation purposes or as a suggestion for professionals.
Let us see now the evolution of the fee issue since the formalisation of the professional colleges of nursing: the college regulations for ‘practicantes’, dated 22 December 1929, and for midwives, dated 7 May 1930, established in article 14 that the colleges (‘practicantes’ and midwives) were to set their fees for common services, subject to the study and approval of the respective medical colleges; if problems were to arise in such a procedure, the Civil Governor of the province – advised by the Health Inspector, and having heard both parties – would then resolve the situation.

The mission of the colleges, specified in article 5, is to act as a referee in case of disagreement on the price between ‘practicantes’/midwives and their clients (whether they are individuals or corporations); if agreement is not reached, an appeal could be made to the corresponding medical college, both parties being able to appeal later against the college decision to the corresponding authorities.

Later, on 18 March 1942, the Government Ministry (Ministerio de la Gobernación) published the Statutes for the Official Colleges of ‘Practicantes’; section H, in article 5, established that the mission of the colleges was to resolve the differences between the registered ‘practicantes’ and their clients as to prices and the services provided, and if agreement was not reached, the General Council of the ‘Practicante’ College would deal with the case.

Article 13 established that the ‘Practicante’ College had to set the minimum fees for the more common services, which would then be subject to assessment by the General Council. As a novelty in the statutes, we find that the fees do not have to be endorsed by the Medical College, the General Council ultimately acting as a referee for appeals.

An Order dated 26 November 1945 established the following (section H, article 22): the mission of the colleges is to solve, as a first resource, the differences between the registered members and their clients in regard to the fees or services provided; if an agreement is not reached, an appeal will be made to the General Council of the Health Auxiliary Colleges. This regulation does not mention explicitly the setting of fees, taking for granted this procedure; as in the previous case, the appeals are made to the General Council when an agreement on fees is not reached.

The Order of 25 June 1951 exclusively refers to the Statutes and Regulation of the Midwifery Colleges; section 11 in article 6 (Chapter I: Constitution and Objectives of the Colleges) reads as follows: colleges should solve, as a first resource, the differences between registered midwives and their clients (whether they are individuals or corporations) in relation to the fees or the services pro-
vided; if an agreement is not reached, an appeal should be made to the corresponding Medical College, whose decision can be appealed against by any of the parties involved before the corresponding authority.

Article 13 of Chapter II, on rights and duties, establishes that the prices of the midwives were not subject to a regulation, but if they were found to be excessive, the Governing Boards would then be able to regulate the prices, after having heard the professional’s view on the subject. Likewise, the Boards could summon and even punish those registered members who publicly charged prices for their services which could affect professional decorum (taking into account type and place of work, as well as other circumstances).

An Order of 29 March 1954 passed the Regulation of the National Council of Health Auxiliaries; this was a new college regulation which incorporated, in an annexe, a Moral Code including articles on fees and unfair competition:

12. All registered members must report in a written document to the College all illegal acts carried out by a member in his/her professional life, providing as much evidence as possible.

13. A registered member who takes charge of the assistance of a sick person without agreement with colleagues.

14. If the parties do not reach an agreement, the case will then be subject to the decision of the College.

17. The registered members will set their fees for particular cases in accordance with the College rates, approved by the National Council.

18. Those registered members who, in the development of their professions, may come across difficulties in getting their fees paid, may require the College to act as their representative if they want to initiate a legal procedure.

We note that articles 17 and 18 refer to fees as being set in accordance with the rates approved by the General Council, and to the fact that Colleges would provide protection for their members if their fees are not paid by the clients.

Articles 12, 13, and 14 refer to issues related to disagreement and unfair competition, determining how important it is to be cautious when attending patients who were clients of a previous professional. The college should be informed about any illegal actions committed by the members; for instance, unfair competition (drop the prices, rob clients, etc.). The college is ultimately in charge of the solution of these conflicts.
On 30 July 1954, the Statutes of the provincial Colleges of Health Auxiliaries were published, including the objectives of the Health Auxiliary Colleges; article 9 (Chapter II) establishes that the colleges must set the rates for minimum and obligatory fees in their respective provinces which would then be passed by the National Council. Another task of the colleges is to solve, as a first resource, the differences between registered members and their clients (whether they are individuals or corporations) in relation to the fees or the services provided; if an agreement is not reached, an appeal should be made to the National Council of Health Auxiliaries.

The situation remained as such until 1978 when article 3 (Chapter I) and articles 18 and 19 (Chapter IV) of the Order of 29 November established the objectives and functions of the Colleges as well as the system of payment of fees by clients: the General Boards will regulate the minimum payment for the professionals when payment is not made with tariffs, fees or rates; the Governing Boards may be able to reach agreements in order to set guide-lines on minimum professional fees; another function would be to deal with the collection of the professional fees on a general basis or after a requirement from a particular registered professional, provided the college has the adequate conditions established in the Statutes; in any case, the expenses derived from these proceedings would be paid by the individual member, unless otherwise stated in the particular Statutes of the College.

The Colleges are entitled to resolve acting as a referee, the disagreements which may arise with the compliance of the obligations of the members in their professional practice, if they are required to do so by the parties involved, and to provide information in legal or administrative proceedings referring to professional fees, aiming at keeping a harmonious and cooperative relationship among the college members, “avoiding unfair competition between them”; this is illustrated in the fees sent to the members, which stated that setting fees under the established minimum rates constituted a serious fault (article 59, section C, in the Statutes).

The last regulation foresaw the development of a Deontological Code, published on 14 July 1989; article 67 reads: “Nurses (male/female) must never compete unfairly with their peer group”; thus, this has become a rule which must be kept in mind by the professionals.

**Comparative analysis**

This issue is found in Spain only, as the techniques used by the ‘practicantes’ could be offered as private services to the population in return for a fee. This fact
prompted the ‘practicantes’ to set fees similarly to what doctors did and in accordance with the practices carried out.

Likewise, the work setting of the ‘practicantes’ facilitated the fee system, as very few ‘practicantes’ worked in hospitals (the majority would visit patients at home, mainly in rural areas).

There are no nursing fees in England at present nor have there been in the past. Fees are recommended by other professional associations as in Spain, but not nursing as noted. This is probably due to the fact that nursing activities were mainly developed in hospitals, where the nurses kept a working relationship and earned pre-established salaries; if they were to assist patients outside the hospitals, doctors would still act as an intermediate link charging for the services themselves and then paying the nurses out of the sum received.

We must add that none of the nursing regulations include rules establishing the possibility of setting minimum charges for the services. In England the free market character has deep roots in the population; maybe this explains why in the case of service provided by professionals, free competition prevails.

In any case, indicator a.a.2 Scale of recommended charges or fees constitutes, in Spain, an element for the protection of the professionals which guarantees an income permitting a high standard of living, thus preventing situations where the professionals could undercut one another.

Apparently, this situation was at the beginning a consequence of fear and not of a real problem of professional working at low rates; the measures taken were mostly preventive. Another possible explanation could be the prevention of bargaining over prices because of the existence of a list of fixed fees for the services of the ‘practicantes’ even though on occasions they might waive entirely the fee.

The dissemination and shortage of professionals in Spain made this measure useless, as there was work for everybody and competition made no sense as far as clients were concerned. This situation disappeared by means of the actions taken by the European Union, which tried to favour the spirit of competitiveness. This is positive in the sense that the only ones who will survive are those who are competitive at providing services at a fair price. In the Spanish Professional Colleges, there are still lists of recommended prices (not to be followed as rules) possibly due to one of the reasons mentioned previously, that is, avoiding arguments with clients about the price of the services.
3.1.5 Royal Charter of Incorporation: England and Spain

By means of a professional register in England, those individuals professionally qualified can be distinguished from the unqualified. Anybody interested in contracting a professional can then check that a person has the required feature for suitably developing his/her professional activity by simply consulting the register. The unity in a particular occupation is achieved thanks to the registers and the characteristics which define the inclusion or exclusion from the register.

Why a Register in Nursing? Because it was the only way to draw a line between those who were fit to practice as nurses and those who were not; the way to achieve this was to have a national examination to ascertain whether each individual trainee had benefited sufficiently from her course. Only those who had passed this examination were to be admitted to the register. The establishment of a register made it possible to remove the name of any nurse who had discredited her profession.

The first to recognise the need for a registration of nurses was a physician, Dr Henry Wentworth Acland, in 1864. He expressed regret that the Medical Act of 1858 had failed to include nurses as candidates for registration. He wrote, in a preface to a *A Handbook for Hospital Sisters* by Miss Florence Lees: "the Medical Act of 1858 allows women to be registered as medical practitioners. It makes no provision for the registration of trained nurses. That this ought to be remedied can hardly be of doubt" (Hector, 1973: 34).

During 1867, Dr. Acland, member of Britain's Medical General Council, tried to include legislation for the training, examination and certification of nurses. In the preparation of this proposal, he asked Florence Nightingale for recommendations and support, but Nightingale’s replies indicate clearly her aversion to the plan. After this, no actions were undertaken and the issue remained unresolved.

In 1886, Henry Burdett, a Hospital Manager organised the Hospitals' Association which included the registration of nurses as one of its purposes. This association created a nursing subcommittee, and a group of nurses, members of this subcommittee (which included Ethel Gordon Manson, (Mrs. Bedford-Fenwick) submitted a registration plan requiring a three-year training period, but Burdett did not support the idea and made a counterproposal requiring only one year of training. Mrs. Bedford-Fenwick and her colleagues resigned from the Association. This group of nurses, with Mrs. Bedford Fenwick as leader, immediately started to organise a new association and in 1887 they created the British Nurses’ Association (BNA), with Mrs. Bedford Fenwick as permanent president.
It was “a union of nurses for professional objects” which, according to its supporters, contained the elite of the profession (Abel-Smith, 1960: 69).

Then, in 1887, nurses registration became again an open issue; the General Medical Council passed a resolution in favour of the “authoritative certification of competent trained nurses who, when certified, should be subject to common rules of discipline”. At the same time, the newly-formed BNA was agitating for a standard three-year training period in a hospital. After this, a certificate of proficiency would be awarded by an independent body of examiners, and a nurse would be entitled to have her name placed on a register of nurses. The British Nurses Association argued that from such a system a standard of excellence in nursing would be established and the public would be protected against employing nurses who were incompetent or disreputable (Howse, 1989: 33). In 1891, the Association applied to the Board of Trade for a Royal Charter, this application was refused. The Association then requested and received Queen Victoria’s permission to use the word Royal in its title.

a) The British Nurses Association, a First Step Towards the Register

The objectives of the British Nurses Association was to make nursing “a legally constituted profession” that is, to obtain a charter to enable the BNA to create a register of certified nurses, set standards and control entry (Smith 1984: 169). The Association applied again for a Royal Charter in 1892, and this was conceded on June 6th, 1893 with the following purposes:

1) The founding and maintenance of a scheme for the benefit of nurses in the practice of their profession and in times of adversity, sickness and old age.
2) The maintenance of an office or offices for supplying information to persons seeking nurses and to persons seeking employment as nurses.
3) The maintenance and publication of a list of persons who may have applied to the Corporation to have their names entered therein as nurses, and whom the Corporation may think fit to enter therein from time to time, coupled with such information about each person so entered as to the Corporation may from time to time seem desirable.
4) The promotion of conferences, public meetings and lectures in connection with the general work of the Corporation.
5) The doing of anything incidental or conducive to carrying into effect the foregoing purposes.

In the original, the word ‘list’ in point three was ‘register’, Miss Nightingale and her allies being responsible for this substitution. In July 3, 1893, The Times published a letter signed by Florence Nightingale and eight matrons where they...
wrote: “the list will have nothing in common with legal registers of the medical profession but will simply be a list of nurses published by the Association” (Abel-Smith, 1960: 72).

In fact, the Royal British Nurses Association opened a register –list– by 1905; 2,600 nurses had registered by 1905 out of the 80,000 nurses that were included in the country’s census. It seems that the admission requirements to the register were very clearly established and maintained, if we read the controversy raised by the Lancet as a consequence of the acceptance of mental nurses.

In The Hospital, a journal of the Hospitals’ Association, Henry Burdett reversed his position on registration and started to campaign against the British Nurses’ Association. With him in the antiregistration position there were officials from a number of prominent London hospitals, some provincial hospitals, and the rural doctors who formed the bulk of the Incorporated Medical Practitioners Association (Abel-Smith, 1960: 69). Each of these groups had their own fears; and the officials from the London hospitals believed that higher standards would severely limit the number of nurse trainees and produce a nursing shortage: a perceived threat with a very serious financial problem in the future labour supply (Birnbach, 1985). The provincial hospitals feared they might not be approved as nursing training centres and so might lose the probationers they needed, and rural doctors feared the competition of qualified nurses, while the London doctors who dominated the BMA believed that registration would lead to more good nurses and so benefit their patients (Storey, 1978: 24).

When the Nightingale Fund Council argued against the concept of Registration before the Privy Council of 1891, the point was made that it was merely a test of a nurse’s knowledge on a particular day and it would offer no safeguard for the public, or the new profession of nursing unless there could be continual assessment (Baly, 1984).

As Smith wrote “Florence Nightingale seized on the suggestion that general certification entailed formal examinations. These, she asserted, could never prove fitness to nurse. Moreover, lectures could never develop ‘character’ which came from ‘practical training’. Examinations could never replace the ‘continuous assessment’ weekly records, notices of character progress, practical work in ward and matron’s monthly reports, which made up Nightingale’s reasoning. After all,

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35 Select Committee on Registration of Nurses. The Lancet May 20, 1905: 1392-1394.
musicians and painters were accepted for their ‘work’, not their examinable theoretical knowledge”.

In the words of Florence Nightingale (1915: 142), in a letter to the probationers:

She may have gone through a first-rate course, plenty of examinations, and we may find nothing inside. It may be the difference between a Nurse nursing, and a Nurse reading a book on Nursing. Unless it bear fruit, it is gilding and veneering: the reality is not there, growing, growing every year. Every Nurse must grow. No Nurse can stand still. She must go forward or she will go backward every year. And how can a Certificate or Public Register show this? Rather, she ought to have a moral ‘Clinical’ thermometer in herself. Our stature does not grow every year after we are ‘grown up’. Neither does it grow down. It is otherwise with our moral stature and our Nursing stature. We grow down, if we don’t grow up every year.

Moreover, Nightingale in her letters feared that the growth of the individual would be subordinated to the collective, and that practical skills would become mere theoretical skills.

At the same time, in 1895, the British Medical Association passed a resolution “that an Act of Parliament should, as soon as possible, be passed providing for the registration of ... nurses”. In 1896 the Parliamentary Bills Committee of the British Medical Association met with representatives of the nursing profession to discuss this matter, but no action was taken (White, 1976).

Meanwhile, the midwives seemed to be obtaining all the privileges, through the Midwives Act, under the Central Midwives Board in 1902, seventeen years ahead of the nurses. The midwives obtained the support of James Aveling, an obstetrician, who recognised that this group of women needed help and thought they had to be educated, examined, licensed and registered, which had to be achieved by the Medical Council (Hector, 1973). On July 31st, 1902, the Midwives Act was approved and a Central Midwives Board was created.

A Select Committee had been set up in 1904 to assess the need for nurse registration. The 1904 report\textsuperscript{36} is a formal presentation of the minutes of evidence. In the appendices the committee included a paper handed in by Dr. Bedford-Fenwick on behalf of the British Nursing Association supporting, and another handed in by C. Burt on behalf of the Central Hospital Council for London, op-

\textsuperscript{36} A Breviate of Parliamentary Papers 1900-1916. To consider the expediency of providing for the Registration of Nurses, p. 280.
posing registration. The former argues that “since Dr. Acland’s proposal of registration fifteen years earlier, nursing had become a skilled calling, but that it was still possible for an untrained person to call herself trained; registration would furnish a guarantee of the technical efficiency of every trained nurse and midwife”. While in the second paper Mr. Burt’s argues that “registration would have to be based on examinations and would leave out of account the personal qualities which cannot be so tested”. Another witness who objected to the register was Sidney Holland, honorary secretary of The London Hospital, Whitechapel. His reason was clear: “We want to stop nurses thinking themselves anything more than they are, namely the faithful carriers out of the doctor’s orders” (Howse, 1989: 33-34).

In 1905, the Report of the Select Committee on Registration of Nurses recommended that a register of nurses be kept by a central body, and that no person should use the title ‘Registered Nurse’ unless registered. On the hearing of the evidence of this committee on May 16th of 1905, Sir Victor Horsley gave some arguments against the arguments of Florence Nightingale. Sir Victor was asked what he thought about the suggestion that State Registration would not ensure that a nurse remained competent, he replied:

That contention is absurd, because the same applied to the registration of every man. If an individual has gone through a long course of professional training to acquire expert knowledge, that individual is justified in requiring from the State the registration of the fact, and unless the individual misbehaves in any way, that registration remains good37.

The Report of 1905 states that

‘amidst many divergent views met with in this evidence, there is a general opinion in favour of some change in the conditions under which nursing is carried on’. But upon the question of what changes in the condition of nursing would be desirable, unanimity could not be found.38

In 1906 the British Medical Association passed further resolutions in favour of nurses’ registration, the association had first discussed registration twenty years earlier, and voted in favour of it in 1905.

37 HMSO (1905) Report from the Select Committee on Registration of Nurses. House of Commons. London: HMSO.
38 A Breviate of Parliamentary Papers 1900-1916. To consider the expediency of providing for the Registration of Nurses, p. 280.
In 1903 an unsuccessful Bill for the registration of nurses was put forward in the House of Commons, another one in 1904 and each successive year into either one of the Houses of Parliament, until 1914, when World War I broke out. Sometimes there was more than one, as different organisations made attempts.

Rhodes (1984: 43) quotes Williams when he writes:

> We see that, when 19th Century doctors talked of nursing as a skilled profession it was in terms which accepted changes in the character of nurses, but which rejected those changes in their work status which did not stem from a medical definition of nursing.

From this words it can be clearly noted the idea of doctors about nursing in the 19th century, and the limits to which they will give support to the development of the nursing profession.

In war time, many nurses with good training returned to the hospital wards, each one with their own training. We could find there nurses with one year training, with three years training, others with years of experience and some with no training, etc. The Red Cross was then faced with these many different levels and the need to develop some order in the nursing profession became evident. The initiative came from Sir Cooper Perry, member of the Army Medical Board, Sarah Swift, Chief-matron of the Red Cross Society and Arthur Stanley, the Chairman of the Joint War Committee of the British Red Cross Society and the Order of St. John.

In a letter addressed to the nurse training schools at the beginning of 1916, the Honourable Arthur Stanley proposed the creation of a College of Nursing, to co-ordinate the various interests involved in organising the teaching and examination of candidates for entrance to the profession, just as the Royal College of Physicians and Surgeons, the College of Accountants, the College of Barristers, Engineers and other similar bodies. The letter received a favourable response and a conference was called at St. Thomas’s; Mrs. Bedford-Fenwick and organisations connected with her were not invited.

By the end of March 1916, a new College was established and formally came into existence; it started as a company known as the College of Nursing Ltd., who had rather broad aims for nurses; apart from registration they also intended to press for legislation.

The main objectives were:

1) To promote the better education and training of nurses and the advancement of nursing as a profession in all or any of its branches.
2) To promote uniformity of curriculum
3) To recognise approved Nursing Schools.
4) To make and maintain a register of persons to whom certificates of proficiency or of training and proficiency had been granted.
5) To promote bills in Parliament for any object connected with the interest of the Nursing profession, and, in particular with their recognition by the state.

The articles of association specifically prevented the College from imposing on its members or supporting with its funds ‘any regulation which, would make of the College a Trade Union’ (Abel-Smith, 1960: 89).

From this moment the college wanted an amalgamation with the Royal British Nurses’ Association because it would unite the profession and delete the word limited (Ltd.) from its title, bringing the College a Royal Charter. Princess Christina took part and indicated: “should a satisfactory scheme of union between the College and the Royal British Nurses’ Association be formulated, she would be disposed to accept a position of honour in the conjoint society”39. The Royal British Nurses’ Association decided to amalgamate with the College. After this brief moment of unity, problems arouse and attacks between the organisations started.

Meanwhile, the war was over and Parliament was well disposed toward women in general and nurses in particular because they had replaced men in a variety of essential jobs and had nursed the wounded during the war. Women had earned the vote and their demands could not be ignored, among them the demands of the nursing profession.

Together with this the Conservative Administration feared that nurses would form trade unions influenced by the opposition, if they opposed the registration of nurses.

b) The Register and Unionism

In this favourable situation, a bill sponsored by the College of Nursing Ltd. was presented in the House of Lords in May of 1919. Meanwhile, the Royal British Nurses’ Association introduced a bill in the House of Commons in June 1919. Neither of them were successful, as each side thought their proposal was the best; the Minister of Health eventually gave up his attempt to bring the two camps together as agreement was not attainable. Viewing this situation the government decided to bring its own bill, that was approved in December 1919.

39 Form an editorial in Hospital, June 24, 1916: 309
In particular the Nurses Act of 1919, subsequently amended in 1943 and 1949 with the Consolidating Act dating from 1957 with later additions and amendments (1964, 1967, 1969, etc.), is of vital importance to the standing of nursing as a profession. These amendments contain rules, in addition to the official definitions of various terms, and information about the General Nursing Council’s responsibility for the formation and maintenance of the Roll and the Register, the approval of training institutions and the procedure for the training and examination for the Roll and the Register.

These rules concern the age of entry, the educational requirements, the number of times it is possible to enter an introductory training course, the period of training, details of fees for admission to the index of pupil or student nurses, examination fees, enrolment and registration fees and information about breaks and transfers during training.

The rules set out in detail the responsibility of the statutory body for the possible removal from and the restoration to the Register or the Roll of Nurses together with the Rules about the Council’s Investigating Committee and Disciplinary Committee.

The Nurses Registration Act of 1919 established a General Nursing Council for England and Wales, which was to become a body corporate by that name with perpetual succession. The Council, which consisted of 16 nursing members and nine lay members, specified three different categories of nurses who should be admitted to the register: existing nurses, who had been practising in a recognised capacity before the Registration Act; nurses who were already in training when the Act was introduced; and those who came into the profession through the new entrance system and who were to achieve qualification through professional examinations (Howse, 1989: 34). The most urgent task was to frame rules which would enable existing nurses to register during the two year period of grace before the state examination was introduced, so that an election could be held within three years, when the term of the first caretaker Council was to end.

The duty of the council was to form and keep a register of nurses for the sick, subject to and in accordance with the provisions of the of 1919 register of nurses that was created in five parts: general, male nurses, mental nurses, sick children’s nurse and any other prescribed part. Where any person satisfies the conditions of admission to any supplementary or prescribed part of the register, his name may be included in that part of the register notwithstanding that is also included in the general part.
The General Nursing Council’s functions were to make rules regulating the formation, maintenance, publication and admission to the register, examinations which may be prescribed as a condition of admission to the register and training, approval of training schools, uniform, and discipline, subject to the approval of Parliament.

In 1943 a new Act was issued by Parliament for regulating the formation, maintenance and publication of the roll of assistant nurses, a new level of nursing subordinate to the registered nurse. And, later, the Nurses Act of 1949, meant the end of the General Nursing Council for England and Wales which had been constituted in accordance with the schedule of the Act of 1919, and reconstituted it in accordance with the first schedule of the new Act.

The new Council consisted of thirty four persons; seventeen persons elected as follows, fourteen, who shall be nurses registered in the general part of the Register, two mental nurses and a sick children’s nurse, all of them elected by persons who on the date of election are registered in every corresponding part of the register. Twelve persons appointed by the Minister as follows, two registered nurses employed in the National Health Service, two holding certificates given by virtue of section 14 of the Act of 1943, one male nurse, a registered nurse in charge of a ward in a hospital approved by the Council for the purposes of training, and three persons appearing to have had experience in the management of Hospitals. Three persons appointed by the Minister of Education; and two persons appointed by the Privy Council, of whom one shall be appointed to represent universities in England and Wales. The duties of the council remain unchanged.

In addition, in regard to the training of nurses this Act developed the Area Nurse-Training Committees (ANTCs) and constituted a committee for each hospital area, whose duty was to advice and assist the Hospital Management Committees, Boards of Governors and any other authority. Likewise the duty was to have constant regard, respects persons engaged in the area of training nurses, to the methods employed by those persons in training nurses and to promote, with a view to securing the improvement of methods employed in the area of training nurses, research and investigation into matters relating to the training of nurses, and to render to the Council reports of the results of research and investigation promoted by the Committee. For this purpose experimental training of nurses was established.

One of the most significant developments achieved was to give the power to the Council for the development and growth of experimental forms of training. All
expenses incurred by the Council with the approval of the Minister which were attributable to defraying expenditure incurred by area ANTCs (other than expenditure incurred by such committee in conducting examinations on behalf of the Council) had to be defrayed by the Minister out of moneys provided by Parliament, and all other expenses incurred by the Council under this Act and all expenses incurred by them under the Acts of 1919 and 1943 had to be defrayed by the council. Then all expenses incurred by an ANTCs in research or establishing new training syllabus, etc., with the approval of the Council had to be defrayed by the Council. But in fact as White (1982b) said, the Minister severely cut down the money each year. Another novelty of this Act was to close the supplementary part of the register containing the names of the male nurses and amalgamated this part with the general part of the register.

In the Nurses Act of 1957, the constitution of the Council consisted of thirty four members as in 1949, with the same internal composition, seventeen elected by the persons who on the date of the election were registered in the different parts of the register, twelve appointed by the Minister, three appointed by the Minister of Education and two by the Privy council. The duty of the Council was to maintain, in accordance with the rules set out by them, the register of nurses established in pursuance of the Nurses Registration Act, 1919, which consisted of a general part, a part containing the names of nurses trained in the care of persons with mental diseases, a part with the names of nurses of sick children same other part that may be prescribed and maintain the Roll of assistant nurses established in the Nurses Act of 1943.

The Council made rules to regulate the conditions of admission to the register and roll respectively and the conduct of any examinations which may be prescribed as a condition of admission, and such rules contained provisions requiring as a condition of the admission, that that person had undergone the prescribed training carried out in an institution approved by the Council and possessed the prescribed experience in nursing.

Copies of the Register, Roll and the List should be kept at the office of the Council available for inspection by any person, and published at intervals of not more than twelve months. Being the council who had to make rules in respect of the uniforms or badges that were worn the persons registered and the issue of certificates.

The Nurses (Amendment) Act of 1961, increased the number of elected members of the General Nursing Council from seventeen to eighteen, and the members appointed by the Minister are increased from twelve to thirteen.
Later on, in the Nurses Act of 1969, the constitution of the General Nursing Council is increased once again, the number of members elected passed from eighteen to twenty-two, the members appointed by the Minister, then the Secretary of State passed from thirteen to fourteen, the number of members appointed by the Minister of Education, then the Secretary of State for Education and Science, decreased from three to two, and included were members from other professional groups, as one member certified as a midwife and engaged in the teaching of obstetrics and finally a registered nurse and health visitor engaged in the teaching of health visitors.

Of the elected members of the Council fifteen were general nurses or nurses registered in any part of the register, three mental nurses, one nurse for the mentally subnormal, one a sick children’s nurse, an enrolled nurse and an enrolled mental nurse or an enrolled nurse for the mentally subnormal, of the rest of the members appointed by the different Secretary of State; two were registered medical practitioners, engaged in teaching persons in training for the general part of the register, a registered medical practitioner engaged in teaching persons in training prescribed for admission to a part of nursing and care of persons suffering from mental disorders, two registered nurses engaged in training for the admission to the general part of the roll, two registered nurses engaged in training for admission to the general part of the roll of nurses trained in the nursing and care of people suffering from mental disorder, a nurse employed in the National Health Service engage in teaching persons undergoing training for admission to the register or to the roll, and two persons engaged in the control and management of hospitals.

There were some changes too in the duty of the Council at that time which were as follows: to maintain the register of nurses established in pursuance of the Nurses Registration Act of 1919 that consisted of a general part, in containing the names of all nurses who satisfied the conditions of admission, requiring conditions established in the Nurses Act of 1957, a part containing the names of nurses trained in the nursing and care of persons suffering from mental disorders other than severe subnormality or abnormality, a part containing the names of nurses trained in the nursing and the care of persons suffering from severe subnormality or abnormality, a part containing the names of nurses of sick children and such other parts as may be prescribed.

When this Act came in full operation the Enrolled Nurses Committee established by section 3 of the Nurses Act 1943 ceased to exist.
Professor Asa Briggs was invited in March of 1970 to chair a Committee whose terms of reference were, as explained in the general note in the Act: “to review the role of the nurse and the midwife, in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service” (HMSO, 1972: 1), looking at the subject in the light of an integrated health service. The Nurse, Midwife and Health Visitors Act of 1979 represented the first legislative product of the work of the Briggs committee.

The main purpose of the Act was to establish a United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visitors and four National Boards, which replaced the General Nursing Council. The maximum number of members of the general council was not more than 45, prescribed by the Secretary of State. The members would be nominated by the national boards and appointed by the Secretary of State. Each National Board nominated no less than five members and included at least two practising nurses, one practising midwife, one practising health visitor, and one engaged in the teaching of nursing, midwifery or health visiting. The Secretary of State’s appointment had to be made from among persons who were either nurses, midwives, health visitors or registered medical practitioners, or had such qualifications and experience in education or other fields as, in the Secretary of State’s opinion, would be of value to the council in the performance of its functions.

The Central Council for Nursing, Midwifery and Health Visiting was to prepare and maintain a central register of qualified nurses, midwives and health visitors and to determine, by means of rules, education and training requirements, other conditions for the admission to the register, this being the principal function of the Council. Also to establish and improve standards of training and professional conduct, ensure that these standards meet the community obligation of the United Kingdom, determine by means of rules the conditions of persons admitted to training and standards of training to be undertaken, provision of standards to be met by persons who are already registered, and give advice to nurses, midwives and health visitors on standards of professional conduct.

The Council would also rule and make provisions as to the documents and other evidence to be produced, and the fees to be paid, by those applying for registration or for additional qualifications to be recorded, or for any entry in the register to be altered or restored. These provisions were vital to the protection of the public and would ensure that those who cared for us are in all aspects qualified to do so. The Act is concerned with the government of the professions by requiring that nurses, midwives and health visitors should be registered for practice in
their profession and by the enforcement of standards of professional conduct through a disciplinary process.

By the Nurse, Midwives and Health Visitors Act 1983, the Council reviewed regularly the register which considered the relevance of the parts that needed changing, and when any changes were required, open or close those parts of the register, and/or indicate different qualifications and different kinds of standards of training, it recommended to the Secretary of State.

The admission to a part or parts of the register following the successful completion of an approved course of training in the United Kingdom has to be made by an application in writing. The admission is after the applicant:

- passed the appropriate examinations as laid down by these rules;
- presented a document indicating that the applicant has undergone the training required by these rules;
- paid the registration fee;
- has produced evidence of good character from an approved training institution.

The appropriate examination was held or arranged by a Board which was designed to assess the student's theoretical knowledge, practical skills and attitudes and demonstrate her ability and competence specified by that particular part of the register.

By the Nurse, Midwives and Health Visitors Act of 1983, the register which had been prepared and maintained by the Council in accordance with section 10 (1) of the Nurse, Midwives and Health Visitors Act of 1979, opened 11 parts of the register and established the new distribution of the persons already qualified.

The parts of the register were as follows:

<table>
<thead>
<tr>
<th>Part</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>First level trained in general nursing.</td>
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<tr>
<td>2.</td>
<td>Second level nurses in general nursing (England and Wales).</td>
</tr>
<tr>
<td>3.</td>
<td>First level trained nurses in the nursing of persons suffering from mental illness.</td>
</tr>
<tr>
<td>4.</td>
<td>Second level nurses trained in the nursing of persons suffering from mental illness (England and Wales).</td>
</tr>
<tr>
<td>5.</td>
<td>First level trained in the nursing of persons suffering from mental handicap.</td>
</tr>
<tr>
<td>6.</td>
<td>Second level trained in the nursing of persons suffering from mental handicap (England and Wales).</td>
</tr>
</tbody>
</table>
Part 7. Second level nurses (Scotland and Northern Ireland)
Part 8. Nurses trained in the nursing of sick children
Part 9. Nurses trained in the nursing of persons suffering from fever
Part 10. Midwives
Part 11. Health Visitors

The record contained a full statement of the personal details of the person held in the register, together with a full statement of each register entry, and each additional qualification which has been recorded. Requirements of admission to part or parts of the register following the successful completion of an approved course of training in the United Kingdom is established by the rules of this Act, being the same as in the Act of 1979.

The Council stated in this Nurse, Midwives and Health Visitors Act of 1983, the age of entry to training at an approved training institution and the minimum educational conditions for entry to training leading to qualification for admission to parts of the register. In regard to age, candidates had to be no less than seventeen and one half years old on the first day of the commencement of the course except that, in exceptional circumstances the Council on the recommendations of a Board could agree on earlier entry but in no circumstances, would it be less than seventeen years of age.

In respect of educational requirements a minimum of five subjects at ordinary level A, B or C grade in the General Certificate of Education of England and Wales or Grade 1 in the Certificate of Secondary education; or such other qualifications as the Council may consider the equivalent to those, or a specified pass standard in an educational test approved by the council.

The successful completion of training, leading to a qualification which shall meet the requirements of the Nursing Directive, (European Council Directive No. 77/453/EEC) concerning the co-ordination of provisions laid down by law, regulation or administrative action regarding the activities of nurses responsible for general care.

To qualify for registration student shall have had her/his name on the index of students maintained by a Board, having completed the relevant training required under rules 14 and 17; and have passed an examination, held or arranged by a Board in accordance with section 6(1)(c) of the Act which may be in parts, and which shall be designed so as to assess the student’s theoretical knowledge, practical skills and attitudes and demonstrate her ability to undertake the relevant competencies specified in rule 18 of these rules.
In the Nurse, Midwives and Health Visitors Act of 1992, the number of members of the Council is to increase to a number not greater than 60, and a multiple of three, the two-thirds of the members of the Council shall be appointed by the Secretary of State elected at that time. The remaining one-third of the members of the UKCC will be appointed by the Secretary of State without reference to elections. This is the only point in which lay members may be included and there is no requirement that any of the appointed members come from outside the profession of nursing, midwifery and health visiting. The statutory guidance to the Secretary of State on the exercise of these powers is the need to secure representation for the four parts of the UK and experience in education.

The composition of the National Boards was altered too. They were to become smaller, and appointed by the Secretary of State rather than elected. A National Board was to consist of a Chairman, a chief executive of the Board, an officer under the Board and such number of other members as required, all of them appointed by the Secretary of State. The appointments have to be made from among persons who are registered nurses, midwives and health visitors, or have such qualifications and experience in education or other fields as, in the opinion of the Secretary of State, will be of value to the Board in the performance of its functions.

But what was happened to the Royal College during this time? In 1928 the Royal College was granted a Royal Charter, and in 1939 in the words of the annual report, His Majesty King George VI uttered the following words: “graciously pleased to command that the college shall be known as the Royal College of Nursing”. In 1946 the College received a Grant of Arms (Simpson, 1976: 39), in further pursuit of its objectives.

In 1974 the RCN was forced to make a choice: remain a professional association and forego its long standing involvement in pay negotiation or register as a union, because the McCarthy Committee\(^{40}\) (1977) recommendation that a sole bargaining agent be appointed for nurses, trained and untrained together, and the Trade Union and Labour Relation Act of 1974 required unions to register.

To become the sole bargaining agent for nurses, the Royal College of Nursing had to register as a trade union and prove that its membership among nurses was more complete than that of the other unions. In this context, the alliance

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with untrained nurses was the surest indication of its intention to move towards unionism: its registration as a trade union in June 1977 seemed to reconcile its aspirations to professional status with functioning as a union in matters of pay, much as the British Medical Association has done (Bellaby and Oribabor, 1980: 305).

c) The Spanish ‘Practicantes’ Association

A Parliament Decree dated 8 June 1823, followed by another one dated 20 July 1837, established the free practice of scientific professions without having to be registered with a specific corporation or college, and the only obligation was to submit their qualifications or titles to the respective local authorities. Therefore, the free practice of a profession was ‘sanctioned’ as the standard formula of qualified employment.

This simple 1837 legal framework became the basis for a process where the professions initiated and completed their professional statute, compelled by the codifying and guardianship processes established by the State over all social functions.

The development of Official Professional Colleges also became a paradigmatic process; the lawyers were the first in establishing this professional control system, and their first College statutes were published by a Royal Order dated 28 May 1838.

In the case of the health professions, the first connotations of a college system appeared in the Health Act of 28 November 1855. Article 80 established the constitution in each city of a Medico/Pharmaceutical Jury with the aim of preventing and correcting –from a disciplinary perspective– the faults committed by the professionals, as well as dictating the legal actions against the professional fees, and defending the moral principles of the profession. This article was not transformed in the corresponding regulation on colleges proposed by the article itself.

However, all through the 19th century, according to Albarracín Teulón’s research (1971), medical doctors attempted on numerous occasions to create associations, this being frustrated repeatedly. All this shaped an organisational system which at the end of the 19th century identified the constitution of colleges as a very clear objective, which led to a deep corporate debate where the problems of professional practice, the internal relations, and the social links were discussed. The debate was carried further specifically around the college issue in the health professions, but at the same time, it was a reflection of the atmosphere in other scientific professions which also had associative objectives.
The *Gaceta de Madrid* of 15 April published a Royal Decree of 12 April 1898 which established the obligation of registering with a college for doctors and pharmacists, including their Statutes. But things went even further; from that moment, an intense debate took place between the defenders of the obligatory college registration and those against it, to the extent that a Royal Order dated 6 October 1902 set up a mixed Commission of detractors and supporters of college registration for the revision of this issue; the measures established by the Commission were not taken any further.

Later, a General Health Instruction was published, on a provisional basis, in the Royal Decree of 18 July 1903, which would finally be published on 12 January 1904. The Instruction accepted college registration as “optional” for Doctors, Pharmacists and Veterinarians, for the mutual improvement, support and instruction of the respective classes, with the possibility of achieving an official status, as established by the Instruction, in those provinces where two thirds of the professionals were registered; this suspended obligatory college registration in the case of Doctors and Pharmacists.

Obligatory college registration for Pharmacists was established by the Royal Decree of 23 October 1916, the statutes for Doctors were published by a Royal Order of 6 December 1917 (*Gaceta*, 10 December). Both regulations were definite and have continued to be in force up until the present day.

In the case of the Nurses, once the Act of Public Instruction (Moyano Act) was published in 1857, the professional categories of ‘Practicante’ and Midwifery are clearly defined at an educational level; without such legislation no type of college registration would have been feasible. As a consequence of the academic structure promoted by the educational system, there rose a corporate nucleus, organised as a professional control instrument; from this moment onwards, a “bonding” process was implemented together with an adoption of roles based around this professional nucleus, which would move towards the consideration of the colleges at an official level.

From the beginning the ‘practicantes’ tried to re-group all its members by means of different associations. According to Blasco (1993: 9), the first attempts date back to 1883, and although the minutes of this constitution have not been found, the existence of the ‘Practicantes’ Union of Madrid, Zaragoza and Barcelona has been reported. In 1884, an idea arose in Zaragoza for the creation of an association of Spanish ‘practicantes’. A letter, which included the Association’s regulations was sent to all the ‘practicantes’, and as a consequence different associations were set up in different provinces, as was the case in Córdoba, estab-
lished on the 13th February 1886 and presided over by Sr. Rafael Rozas y García.

In Madrid, on 1st June 1885, a project for the statutes of the League of Spanish ‘Practicantes’ was elaborated, including 8 bases with the corresponding articles. Conflicts arose between the defenders of the General Association of Spanish ‘Practicantes’, established in Zaragoza, and those defending the League of Spanish ‘Practicantes’, set up in Madrid.

In Barcelona, in November 1895, the Minutes were published of the opening session of a ‘Practicante’ Association, containing the papers submitted and read by the ‘practicantes’: “Artificial reproduction as a means to fight sterility”, “Draft of the history of medicine”, “Conception of modern pharmacy” (the latter was presented by a pharmacy ‘practicante’). The event concluded with a few words by the President, who “congratulated the medical doctors for having such intelligent and honourable assistants” (Alcón, 1986: 99).

Undoubtedly, all through this process two facts can be observed which are worth studying: on the one hand, the interest in the individualisation as a ‘Practicante’ group, aiming at acquiring a particular social statute; on the other, the potential influence of the doctors –by means of their college registration attempts– on the ‘practicantes’, as this caused the ‘practicantes’ to develop similar actions in the achievement of their targets.

On 11, 12, 13, 14 May 1903, the first National General Assembly of Spanish ‘Practicantes’ was held, a previous consolidated organisation must have existed at a provincial level, which probably stemmed from the different associations mentioned before.

On 22, and 23 January 1904, the Act on General Instruction of Health was published, which defined the health professions of ‘Practicante’ and Midwife. A few months later, on 3, 4, 5 May 1904, the second National General Assembly of Spanish ‘Practicantes’ was held.

In May 1905, the third National General Assembly of Spanish ‘Practicantes’ took place, gathering 40 representatives from all over Spain, and the Central Board of Spanish Colleges was created as the representation, before the authorities and the Executive Board of the General Association of ‘Practicantes’. The first decision made by the Board was to publish a newsletter called Boletín de Practicantes. The assemblies took place on a yearly basis, except for some periods in which they were cancelled due to internal problems or other reasons; for instance in 1906, and therefore the fourth National General Assembly of Spanish ‘Practicantes’ was held on 13 - 15 May 1907.
The fifth National General Assembly of Spanish ‘Practicantes’ would not be held until 1912. This time the objective was to prevent the nurses from the Rubio Institute from being identified and sanctioned as ‘practicantes’ if they had not completed the ‘practicantes’ studies. As we already saw in another section, these nurses did not have official recognition until 1915, and therefore ‘practicantes’ used to accuse them of professional intrusion. The recognition of nurses was the culmination of the crisis in the evolution of the college organisation; three factors contributed to this: the passive attitude of the Madrid College which acted as Central Board, their rivalry with other Colleges, and the lack of real improvements. The crisis provoked several colleges to close down.

In 1916, the Cádiz College initiated a campaign for the re-establishment of the disappeared colleges, by means of their journal, El Practicante Gaditano; the association in Regional Federations was promoted as well as the association with other health groups. As a result of the effectiveness of the proposals, an Assembly was held on 21 May 1917 for the creation of the Basque-Navarran Federation of ‘Practicantes’, which required as a previous step the functioning of the Colleges of Navarra and Guipúzcoa, which had closed down during the crisis. Once the colleges started working, their presidents and directives agreed, at the end of 1917, on the provisional creation of the Basque-Navarran Federation, this having to be approved by the corresponding College Assemblies.

On 24 September 1918, a new meeting of six colleges from northern Spain (Guipúzcoa, Álava, Vizcaya, Navarra, Santander and Logroño) was held in Logroño: the following agreements were reached (Gallardo, Gil-Martín and Jaldón, 1992b: 16): work on the dignification of the profession, create the Union of ‘Practicantes’ of Northern Spain, demand obligatory college registration, demand the fulfilment of the work posts established by law, ask for the suppression of the restriction in midwifery, and propose to all the Spanish Colleges the creation of a Body of Spanish ‘Practicantes’; the National Federation of ‘Practicantes’ would derive from this last item.

In 1919, the National General Assembly of Spanish ‘Practicantes’ published a survey in the Boletín Oficial de Practicantes, which included the final census which shaped the Class: 45 provincial colleges, 3 groups, 10 published journals, and 2,168 members. The survey showed what was the organisational level reached, with coverage in nearly every province.

41 In that moment the generic denomination of all health professions, i.e. doctors, ‘practicantes’ midwives, apothecaries, etc., was: ‘Clases sanitarias’. ‘Practicantes’ used to enjoy this denomination.
In May 1921, the 1st Assembly of the Union of Health Classes was held; up to that date, this group had included doctors, veterinarians and pharmacists; the participation of ‘practicantes’ was large, with 178 delegated from 45 ‘Practicante’ Colleges which at that moment consisted of 4,370 members (Gallardo, Gil-Martín and Jaldón, 1992b: 16), which means that only in two years the number of members had doubled (since the 1919 survey).

On 20 - 23 October 1926, the Assembly passed a new Regulation in the Federation, which was approved by the General Director of State Security on 20 January 1927; in other words, the Federation could operate legally. During the assembly, it was agreed to demand obligatory college registration, promoting the National Federation but at the same time giving the option to the colleges of whether to register or not register with the UGT, apart from the Federation.

A constant internal debate arose in the ‘practicantes’ organisations, as to the promotion of the professional colleges or registration with trade unions (to my knowledge, there were no corporative unions in Spain at that time). The defenders of the college trend argued in support of college registration – as shown in the media of the time – alleging quality differences in opposition to traditional workers.

In October 1928, the National General Great Assembly of Managing Boards of Provincial Colleges of Spanish ‘Practicantes’ was held. The following year, the imminence of obligatory college registration was clearly observed in the Royal Order of 23 October 1929 on industrial contribution tax; this Order stated that “the colleges were to be in charge of the effectiveness of the tax application”.

**d) The Spanish College: ‘Practicantes’, Midwives and Nurses**

As announced in the Royal Order of 22 December 1929, General Martínez Anido signed the approval decree of the new official corporations, contemplating obligatory college registration. In 1930, a Royal Order dated 7 May established official and obligatory college registration for midwives.

Both regulations established (article 21) that ‘practicantes’ and midwives would have to pay their respective tax contribution via the college; the college was obliged to report to the authorities about those working professionals who did not meet their tax payments. Therefore, the colleges became tax offices representing the State, although this remained at a secondary level, given the priority of regulating the issue of obligatory college registration.

The Colleges had the obligation of providing their members with a professional card. Due to the numerous different card models, a Royal Order (7 March 1931)
had to be issued in order to establish a single model of professional card for all Spanish ‘practicantes’.

The Royal Order of 20 March 1931 (Gaceta de Madrid, 24 March) proposed the modification of item 7 in the Statutes of the Midwife and ‘Practicante’ College, with a view to establishing another rule: a qualification certificate had to be produced to carry out college registration and to practise and not the studies certificate which was the procedure up to then where fraud cases had been reported.

A few months later, on 13 October 1931, the Minister of War, Manuel Azaña, uttered the famous statement “Spain is no longer a Catholic country”, which caused several religious congregations to threaten to leave their posts in the hospitals. The answer from the Executive Committees of the Madrid College and the UGT Union of ‘Practicantes’ was categorical: they were “available for the assistance of the ill, where a need was caused by the vacancies left by the religious organisations in their reaction to the government measures” (Gallardo, Gil-Martín and Jaldón, 1993: cxxv). It was obvious that, in many cases, religious representatives were practising without authorisation, which meant loss of employment for the health professionals.

The unions continued growing, and the Federation of ‘Practicante’ Groups of UGT was created on 14 April 1933. Shortly after, the abandonment of posts by the religious took place; for example, on 24 February 1936, the mayor of Elche and his office met in Elche (Alicante), a letter had been received from the nuns of the Beneficencia Hospital of the town, communicating their decision of leaving the centre; the corporation then decided to set up a lay nursing service consisting of a nurse inspector and 9 nurses42.

Another example is found in the Diputación Hospital of Valencia, where the institution itself started to substitute the religious personnel for lay staff, as shown in the Book of Minutes of the Managing Board –5 March 1936–, where the first agreement was “to declare publicly the purpose of the Managing Board in the institutions dependent on the Diputación, that is, the substitution of the religious personnel working there”; the fourth agreement, reached on the same date, showed the necessity of an Order to carry out the substitution, in collaboration with the directors of the centres and taking into account the budget available.

The Civil War first, and then the Dictatorship, hindered all the secularisation possibilities at the time and blocked the subsequent change of roles.

42 Historic Municipal Archives of Elche, year 1936, file 147.
If we go back in time, in 1933 the ‘practicantes’ got in contact with the International Nursing Council (INC) in Geneva with a view to joining this organisation; their entry application read:

in Spain, the only legally recognised auxiliaries are the ‘practicantes’; like in Cuba and other countries where this profession is mainly developed by men, we believe this should not represent an obstacle for admission, and – as there are thousands of male auxiliaries– we require the International Nursing Council to change its name to International Council of Health Auxiliaries. (Gallardo, Villa and Jaldón, 1994: cxliv)

They did not achieve such a goal, as the INC has kept its name. They finally joined ICN that same year (1933).

During the first half of 1934, the country lived in an atmosphere of political confusion with repercussions on the profession, such as conflicts between UGT and Falange and other right-wing groups. The battle between unions and professional colleges manifested once again in Seville: the delicate economic situation of the college was taken advantage of by a college member (a UGT unionist) who proposed the derogation of obligatory college registration in the General Assembly of 3 March; however, the proposal was rejected by nearly everybody (Gallardo, Villa and Jaldón, 1994).

The economic weakness was affecting all the colleges, since the obligatory registration order given by General Martínez Anido was not respected by the ‘practicantes’ (some would not register, others would just not pay their corresponding fees to the College). Nevertheless, the Act on ‘Asistencia Pública Domiciliaria’ was passed in 1935, including favouring aspects for the solution of the economic problems. Through the regulations developed by this law, a ‘Practicante’ Body for Public Home Care was created, with which all official ‘practicantes’ had to register if at the moment of enforcement of the regulation they were the holders of their professional posts. To be able to register with this new body, an application had to be made to the Sub-secretariat of Health, via the college; the college then dealt with the National Federation of ‘Practicante’ Colleges, and this organisation then addressed the application to the Sub-secretariat.

As an immediate consequence, the colleges improved their economic status, as –if the ‘practicantes’ wanted to join the new body– they had to have their payments updated. Despite this, in numerous provinces the colleges still had to contract lawyers to pursue the debtors in court. Ultimately, the regulation established that the salaries had to be paid through people enabled by the college to
that end, and therefore, the college had the option of collecting the fees from the salaries.

On 7 - 10 June, the National Assembly of ‘Practicantes’ Colleges was held; some of the issues discussed were relevant, such as a paper titled “Practicante Professors”, which supported the thesis that the teachers or professors of the ‘practicante’ syllabus had to be ‘practicantes’, and as will be seen later, the academic staff of these studies consisted of medical doctors (Gallardo, Villa and Jaldón, 1994; cxlviii).

On 22 December 1939, the General Council of the Official Colleges of Spanish ‘Practicantes’ was appointed; its functions were regulated on 8 March 1941. Later on, an Order of 18 March 1942 was to regulate the functions of the Provincial Colleges.

The Act on Bases of National Health (22 November 1944) established in Base 34 that the organisation of the health professionals was represented by the Colleges which officially carried out the obligatory registration of all those developing a health practice. Then professionals were then integrated within the colleges until they were to be incorporated in the unions.

Every province had to have a College of Health Auxiliaries including qualified ‘practicantes’, midwives and nurses. This gave way to the Order of 22 December 1944, which established that the General Council and the Provincial Colleges of ‘Practicantes’ were to be called of Health Auxiliaries, also including the midwives and nurses. The Order also stated that –through the old General Council of the Official Colleges of ‘Practicantes’ – the corresponding orders had to be issued to the Provincial Colleges for them to prepare for the new college registration with the denominations of Health Auxiliaries for ‘Practicantes’, Midwives and Nurses.

On 26 November 1945, the Ministry of Government passed the Regulation and Statutes of the General Council of Auxiliaries and of the Provincial Colleges, including the statute of the health professions (this aspect will be commented on in another section). This Order established the composition of the Management Board of the General Council of Health Auxiliaries and of the Provincial Colleges: a president, one secretary, one bursar, one clerk, and eight representatives, two of them had to be midwives and another two nurses; this meant they were a minority.

The appointment of the positions and representatives was freely made by the Health Direction. As to the General Council, article 7 state that the Council would function in Plenum and the Executive Committee would be permanent. The Executive Committee would consist of the president, the general secretary, the
bursar, and the clerk, all of them having to have ‘practicante’ qualifications. As the ‘practicantes’ were mainly men, the institutional positions were always in the hands of the men.

The Secretariat consisted of three sections: 1st ‘practicantes’, 2nd midwives, and 3rd nurses. Each department dealt with the matters of their professions, through the General Secretary of the Council.

According to Córdoba (1994), on 9 January 1951 the General Direction of Health passed the statutes of the Professional Association of Spanish Nurses, which were published in the journal *Enfermeras*. The foundation statutes include their objectives, covering all aspects which could contribute to the recognition and social prestige of the nurses, at the same time seeking their own identity as health professionals; they wanted to put an end to the conflict between the nurses and the ‘practicantes’. One of the objectives was to endorse what was already regulated and legislated on the functions of nurses. In the first edition, reference is made to an order which the nurses wanted the General Direction of Health to issue in order to get authorised to apply the treatments prescribed and to be supported in the fulfilment of their functions, and so “avoid the damage and unjustified actions which are normally suffered by the nurses”\(^{43}\).

During the 1950s, another movement arose apart from the Professional Association of Nurses: the Union Nursing Group, which derived from the Health Union (all health workers were first included in a Union of Diverse Activity, which then was divided, one of the divisions being the Health Union). Its objective was the improvement, from a moral, professional and economic point of view, as well as the defence of the professional interests of the nurses and the fight against intrusion.

These tasks were more appropriate to a professional college; in Barcelona, in 1935, we find an antecedent in a Nursing College whose statutes (covered by the Act on Professional Associations of April 1932) were not passed due to the Civil War. In some provinces, both movements –Union Group and Professional Association– became the basic nucleus of the colleges which started to spring up especially since 1954 (Alcón, 1986: 171).

As an expected result of these actions, an Order dated 12 May 1953 was published, stating that Colleges of official nurses had to be set up in each province as soon as possible; registration was to be obligatory for those professionals who were duly qualified for practice. These colleges were to function as similarly

\(^{43}\)Letter of the Spanish Nurses Association no. 1, 1951.
to the ‘Practicante’ and Midwife Colleges, in accordance with the rules established by the Ministry. By means of this Order, the nurses created their own college, thus meeting those expectations held for a very long time.

Previously to that, the midwives had managed to get an Order published (25 June) in which the statutes of the Midwifery College and the Regulation for a General Council of Midwives were passed. With this normative, each of the groups obtained autonomous functions in the field of professional colleges.

Shortly after, an Order dated 25 January 1954 dissolved the Professional Colleges of ‘Practicantes’, Midwives and Nurses, the General Councils, and the Association of Spanish Nurses (apparently, there was not enough time for the setting up of the Nursing Colleges), and a few months after, the Regulation of the National Council of Colleges of Health Auxiliaries was passed by an Order of 29 March 1954; likewise, the statutes of the Provincial Colleges of Health Auxiliaries were passed by an Order of 30 July 1954. Article 27 of the latter indicated that, considering the different performances of each of the three professions encompassed in the Health Auxiliary profession, the Management of the Provincial College was to be divided into three sections (‘Practicantes’, Midwives, and Nurses), acting independently in their corresponding fields.

The performance of each of the sections seemed to have some autonomy, as for each section there was a Managing Board consisting of a President, a secretary, a bursar, and three representatives, and in addition to these three managing boards there was a Presidential Board formed by the Presidents of each of the sections. Oddly enough, the Nursing section thought about having a fourth representative from the nursing group of the Union of Diverse Activities, appointed after a proposal by the General Secretary of the Movement. This Union was a vertical type entity promoted by the State through the political organisations of the so called ‘Movement’.

A new Order (20 December 1954) reminded nurses that they were obliged to register with the Official Schools of Health Auxiliaries as well as with the corresponding union, that is, the nursing group of the Union of Diverse Activities. The Colleges continued acting as tax collectors, as one of the functions determined in item I of article 9 was to distribute on an equalitarian basis the tax charge among the working members.

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44 The ‘Movimiento’ was a fascist umbrella organization that had the power after the Spanish Civil War.
Later on, the ATS category was created, and the Order of 13 January 1958 established the obligatory registration with a college for male ATS professionals in the ‘practicante’ section, and for female ATS in the nurse section, which implied a differentiated college registration per sex, this ratifying the statements in the Order of 30 July 1954.

This remained in force until April 1977, when an Order dated 1 April 1977 established the adaptation of the college organisation of ATS to the rules in the Act on Professional Colleges. The Order admitted that college discrimination due to sex had no equivalent in any other professional organisation, and in addition contradicted the spirit and form of the Act of 22 July 1961, which recognised women as having the same rights as men in the development of all types of political, professional and working activities.

A subsequent resolution by the General Direction of Health (27 April 1977) stressed these aspects and developed an Order of the Ministry of Government; article 1 states that the national and provincial managing organs of the three sections (‘practicante’, midwife and nurse) would bond in order to constitute the joint ATS Provincial Boards. The reaction was immediate, and after a meeting of the three sections of the General Council of Health Professionals, an informative letter was circulated in which the Provincial Board of the Council considered that the Order of 1 April as having consummated the intruding of the Ministry in the functions of the college organisation, this being ‘illegal’ to a certain extent, in the view of the organisation. The Order was impugned by the Council, although polls were organised for the election of new managing boards in each Provincial College, adapted to the rules of the Act of 1974 on Professional Colleges.

The transition from a College with three sections to a professional College without internal differences was not free from problems, in fact, conflicts arose in numerous provinces; however, unification took place finally.

In Valencia (Las Provincias, August 4 of 1977), once the polls established by the Ministry Order of 1 April 1977 were held and the Unitarian Provincial Board chosen, the intervention of the Civil Governor was necessary, as the directors of the different college sections were not willing to give way to the newly elected members. The priority of the Unitarian College Board was the elaboration of new statutes, which were passed in the Royal Decree of the Ministry of Health and Social Security of 29 June 1978, which are still in force.

The statutes included a temporary rule for the incorporation of the newly qualified Nursing professionals into the ATS colleges so that they could develop their profession with the same corporate rights.
After long years of differences, academic, working and corporate unification was finally achieved. However, the Administration of Justice – in a verdict dated 13 May 1980\textsuperscript{45} – and given the appeals made by the different college sections, annulled the Order of the Ministry of Government of 1 April 1977, alleging it was not in accordance with the law.

Numerous considerations were made in this regard; both the boards and the statutes were in a situation of illegality, as they had been elected and elaborated by an order which had been declared null. Finally, the General Council indicated that nothing was affecting the legality of the college organisation\textsuperscript{46}.

The current statutes allow for a wider framework of action, although the line specified by the professional college law must be respected. Each province has its own college, so there are 50 (52 with Ceuta and Melilla), each is managed by a provincial General Board and a Managing Board, the latter consisting of a Plenum and a Permanent Commission.

The Spanish Constitution was later voted and passed, which again brought changes to the existing situation; two of its articles concentrated on the problems of the professional colleges: article 36 reads:

\begin{quote}
the Law will regulate the peculiarities of the legal system of the professional colleges and the practice of official professions. The internal structure and functions of the colleges must be based on democracy;
\end{quote}

In addition, article 22 establishes (1st item) “the right of association is recognised”.

Since the Constitution was published, professional colleges are awaiting a legislation which may be a kind of a framework for reference. Several draft projects have been drawn, but they are not what the colleges expected. In their view, this framework law has to protect the institutions, and at the same time, guarantee an adequate service to society, without restricting their service capacity in any way. In those projects, the government has proposed that the colleges evolve from a close guild corporation system to the social service, as those colleges

\textsuperscript{45} Decision by the Administration of Justice, 13th May 1980 (0J6023358), Appeal no. 10352, 10402, 10517. Decision by the Higher Court (25th August 1982) which confirmed that of 13th May 1980; however, the ATS and Nursing Diplomats General Council indicated that it did not affect the legality of the college organisation.

\textsuperscript{46} Editorial from Nueva Enfermería, 22: 1.
which cannot understand that their mission is well beyond a close guild system and will probably not survive within the constitutional context, having to give way to freely associated organisations with freedom of admission and expulsion of their members.

This argumentation is then part of the projects mentioned and constitutes one of the major sources of disagreement between the Government and the Corporation, focusing on obligatory college registration as a requirement to practice the profession, this being the model indirectly established in the Constitution. Of course there are pros and cons, but it is the model at present and only a constitutional reform would be able to modify it.

Another one of the theses defended by most of the political groups, which is reflected in the projects, is that politics can only appear in political parties and unions, which immediately causes contradictions.

Through these manifestations, we can understand that the difficulties and disagreements of the 1930s with the appearance of the nursing colleges are still applicable; this could also be said of all the Official Colleges of the different professions. This situation led to actions such as that of the President of the Professional Union (this organisation groups all official professions), Antonio Pedrol Rius, in Club Siglo XXI:

> The Professional Colleges sociologically constitute fundamental pieces in democratic countries, as political action is not and must not be limited to the political parties and unions; on the contrary, it is extended and enriched in the Colleges, associations and other free citizen groupings. (Quoted by Jurado, 1984: 23)

This has motivated numerous appeals against obligatory college registration, starting with a passive resistance of not paying the college fees. Therefore, the individuals who do not pay can be charged with intrusion by the courts and are normally sentenced to paying the outstanding sums, the interest, and the court expenses.

In addition, the Act on Professional Colleges is not contrary to the Constitution, according to a sentence by the Constitutional Court; Sentence published on 11 May 1989 states that in face of a doubt introduced by the ‘Audiencia Nacional’\(^\text{47}\), the constitutionality of the Act on Professional Colleges establishes that “for the practice of official professions, the registration with the corresponding college

\(^{47}\) Supreme Court of Justice.
will be required in the area where the profession is to be practised” (quoted by Rollán, 1989: 15). The sentence then includes the obligation of registering in a College and of following its disciplinary rules. This not being incompatible to the right in article 22, 1st section, of the Spanish Constitution in which “the right of association is recognised”. The sentence thus throws some light on the obligation of college registration when working for public administrations; if registration is not carried out, in these cases, the colleges can investigate and denounce professional practice in those cases where registration in a college has not taken place.

The Constitutional Court does not define the obligation of registering, but states that the obligation is possible because it is not in disagreement with the Constitution; it is the legal organs and the public powers who have the capacity of defining college registration as obligatory and voluntary; that is to say, the problem is again transferred to the strictly political sphere, to the necessary regulation via the Act on Professional Colleges. The state, then, is declaring that it will only recognise those who do register.

However, we must note that any new regulation or modification made will affect the whole of the registered professions, this implying an improvement, maintenance or regression for other professional colleges. Obviously, the modification would not only affect nursing, it would also involve a similar evolution for the other professions.

As we have already seen, in the 1920s and 1930s important conflict arose between the professional colleges and the unions. The Civil War suspended such conflicts but they re-appeared in the democratic context when the Constitution was passed and the subsequent approval of the right to belong to a union. The unions consider that the Colleges and particularly the obligation of registering with a college prevent the citizens from joining a union. This may have been one of the reasons which prompted unions to instigate the unconstitutionality of the 1974 Act, as well as the Royal Decree of 29 June 1978 on nursing. The situation with the unions differs, as workers can freely join any union as far as they commit themselves to comply with its statutes, they can also leave a union and cannot be obliged to register.

Therefore, any employee in any activity sector can join a union, in this case that which we call a ‘class’ union. On the contrary, the professional college establishes exclusiveness, as only those with the required qualifications can register. The health professionals are obliged to pay college fees, whereas employees who are not registered with a union are not obliged to pay; in addition, paradoxi-
cal phenomena have been taking place, such as the increase approximation of historically contradictory social structures, i.e. colleges and unions. The colleges are acquiring union structures whereas the unions are more and more corporate.

However, the differences can be clearly shown, as Rosa Serra Bodoy, President of the Barcelona College, said in an interview after the 1977 polls:

> as to labour defence, our college is trying to set the boundaries of the fields subject to the action of the unions and of the strictly professional areas covered by a college. Part of the profession wants the college to assume the professional and labour defence, but the Board think that the labour defence has to be carried out by the unions, whatever their ideology. The college has to deal with specific issues in the defence and improvement of the profession. (Castro, 1978: 22)

The issues mentioned concerned education, curriculum, professional regulations, health law, deontology, etc.

Recently, a corporate union called ‘Sindicato de Ayudantes Técnicos Sanitarios de España’ (SATSE – Trade Union of Spanish Health Workers) appeared, which covers only ATS professionals and Nursing graduates, the possession of one of the two titles being essential. The functions of the Nursing College and the SATSE Union cover a common area in which it is more and more difficult to detach their respective tasks.

Comparative analysis

At first sight, it is easy to note there is a lot more legislation in Spain than in England; this is probably due to the fact that Spain has undergone numerous political and social changes which have had an effect on all nursing levels.

In both countries, the conflict among the members of the nursing profession stemmed from the choice between purely professional organisations and unions; in the end, the former have been most successful. This could not have been otherwise, as the class trade unions have had their hands tied when having to solve particular problems of the relationship between users and health professionals.

The conflict results from their work itself, i.e. health, which has implications for the entire population. If this had not been dealt with from the perspective of the Professional Colleges in Spain or the GNC in England –later on called UKCC for

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48 SATSE, Trade Union for ATS and nurses only.
nurses, Midwives and Health Visitors—, the power given by the State to these organisations could not have been developed adequately by the class unions at the relevant time.

The situation differs at present, and doubts could arise as to the appearance of corporate unions which do not aim at defending workers in general but nursing professionals in particular, requiring the members to be qualified in order to join. However, the level of operation of the nursing organisations (Colleges, UKCC) to which the State has delegated the self-control function and surveillance of the professionals and the health of the population through the compulsory registration of all the nursing professionals which makes these organisations most suitable for the accomplishment of the objectives.

What are these professional organisations, the Colleges in Spain and the UKCC for Nurses, Midwives and Health Visitors in England? They are peer communities, in this case nursing professionals who practise under certain laws and regulations. They are edifices, not purely minds coming together, built to give a service in the protection of the health of the population; these organisations maintain control over their members (all professionals, compulsory by law) to give the maximum efficiency and the best quality of service to the population. The governments delegate in them the guardianship of the behaviour of the professional members.

Through this authority, Colleges are responsible for their members in terms of their self-control and the protection of individuals in society. This explains why registration is compulsory, otherwise the self-control could not be achieved, as there would always be professionals who would not comply with the set rules, and being outside the system, they would not have to accept them. The disciplinary committees deal with self-control and the application of the defence of individuals and society. Within this process, the development of the Ethical Code (or Code of Conduct) represents the last stage in the assumption of the State’s delegated authority.

Since the establishment of the Professional Colleges in Spain in 1929, regulations were developed in the statutes referring to the system of election of the General Board and the Managing Boards of the Colleges, specifying the democratic nature of this process even in the first legislations, prior to the Civil War. After the Spanish Civil War, the General Director of Health, after a proposal of the General Board (composed by the Chairmen of the Provincial Colleges), appointed the Chairman of the General Council of Colleges of Spain. This was the procedure until 1968, when – through the Order of 7 May – the democratic
model was recovered for the election of the Managing Boards and the Chairman in the ATS College. It is interesting to note that the General Board was and is made up by the Chairmen of the College, who had been elected democratically, and the Chairman of such a board is –in turn– chosen among them and by themselves. The composition of the General Board and the Managing Boards of the provincial ‘colegios’ was always in the hands of the professionals.

Before the Civil War, female nurses started to take actions for the creation of a professional college; unfortunately, the war shattered all their expectations, and nurses remained at a second level like all Spanish women of the time. The government which arose with the end of the war discriminated against women in all areas, and particularly, their representation and basic rights – such as the right to work for married women – were cancelled.

In the 1950s, they had a chance to organise professional associations, but this never came true either, as they were quickly integrated into a new organisation called Health Assistant Colleges. Although they gained representation in the Boards, they remained at a second level, since the President had to be a ‘Practicante’ (a male nurse).

In England, the selection of part of the members of nursing organisations has always been the responsibility of the Ministry of Health, the Ministry of Education and/or the Privy Council, these being able to appoint nurses, midwives, health visitors, registered medical practitioners, or any person of value to the council in the performance of its functions (lay members). The rest of the members were democratically elected among the different registered members, to the number established in the different Acts.

This is a qualitative difference compared to Spain, since in England the professional behaviour is influenced by the presence of such lay members in decision-making, which may indeed pose problems for professional progress and change. It is not possible to know what the situation would have been like in Spain if the ‘practicantes’ had not been the first members of nursing practice. Maybe the fact they were men caused the Nursing Colleges to be considered equal in regard to other professions. In addition, the regulations demanded that the Presidents of the Colleges be ‘practicantes’. This situation remained despite the democratic nature of the elections and the integration of the existing colleges into one, but the college positions have been occupied – to a great extent – by men.

The evolution in England has been different: men had a separate register in the GNC, with no representation in the decision-making organs. However, we need
to note that the situation has changed and men are equally considered in the UKCC for Nurses, Midwives and Health Visitors.

Another important difference can be found in England, where the GNC and later the UKCC for Nurses, Midwives and Health Visitors were organisations which directly qualified the members through their own systems of training and examination. This is not possible in the Spanish Colleges, as they are only consultative organs, with representation in the ministerial commissions for the development of new nursing programmes in Spain, but the full responsibility both for the design and the implementation of the programmes is in the hands of the educational sector, more specifically of the lecturers of nursing in Spanish universities.

Therefore, one could state that both the professional charters, General Council of the Colleges in Spain and the GNC, and later the UKCC for Nurses, Midwives and Health Visitors in England, take part in the educational design, but additionally, in England they had control over the quality by directly qualifying the members through their own systems of training and examination. Now the UKCC, through National boards, validates the curricula of individual institutions including assessments.

At this point, we should ask ourselves: how do we know that the general statutes included nursing as a recognised profession? The answer is given by the meaning and application of the legislation, which implies the differentiation of this professional group in both countries, which makes it equal to those who are considered professionals and different from those who are not.

Furthermore, in Spain, the regulation of any profession – in compliance with which the colleges are constituted – must be in line with a profile established for all professional colleges, i.e. the Act of Professional Colleges of 1974. Nursing professional associations must comply with it, thus being essentially equal to the other recognised professions.

To sum up, if we take into consideration the similarities and dissimilarities between nursing colleges led by the General Board of Nursing Charters, and the UKCC for Nurses, Midwives and Health Visitors, we find that both are professional organisations recognised by the State under the law; they also play a social role of professional control and are at the service of the public. Furthermore in order to be able to practise one must be registered and pay the established fee. These organisations have developed a code of conduct with a view to protecting the professionals and the clients, which is used as a guideline in disciplinary processes. Both institutions participate in curriculum design; in Spain the responsibility is not direct, whereas in England the curriculum design and its
modifications was for a time directly controlled by the GNC. The contemporary system of validation is now similar.

The GNC and later the UKCC for Nurses, Midwives and Health Visitors are English statutory organisations of obligatory registration which constitute a professional register. On the other hand, there are unions which the English nurses can join, for instance the Royal College of Nursing. At present, nurses can actually be registered with both types of organisations, UKCC on a compulsory basis, and a union.

In Spain, the General Council of Nursing Colleges – made up of all nursing associations, one for each province – constitutes a group of statutory organisations with obligatory registration. As it is the case in England, Spanish nurses can also join a union, for example SATSE, for qualified nurses only. Some nurses can participate in both organisations at the same time, that is, a nursing college and a union. Nevertheless, colleges can combine statutory and non-statutory functions.

3.1.6 Organisational Committees

As noted by Waters (1989: 958-959), collegiate organisation implies the constitution of collective forums, called committees, in which collegiate decisions are made. Collegiate organisations have a complex committee system that assures the equal participation by all the members. These committees are oriented to the search for and achievement of consensus, but consensus is usually replaced by democratic voting procedures. Sometimes these committees adopted procedures for the protection of minorities.

There are various types of committees, such as:

- General committees; all of the members of the organisation.
- Specialist committees; which comprise members of a special area of interest.
- Delegate committees, which are engaged in routine administration and assigned to making policy drafts.

In regard to nursing, the 1919 Act indicated that the council should make rules for the following purposes: for “enabling the Council to constitute committees and for authorising the delegation to committees of any of the powers of the Council, and for regulating the proceedings (including quorum) of committees”. The council had the power to assign committees for the develop of different tasks, from the policy making drafts to the decision-making of the meeting of all members of the General Nursing Council.
Furthermore, in the different Acts issued since the Act of 1919, we can find many committees created by statutory order to work in a particular sector of the organisation like the Assistant Nurses Committee in the Nurses Act of 1943, the Area Nurse-Training Committees in the Nurses Act of 1949.

In the Nurses Act of 1957, within the supplementary provisions, it is said:

that the council may make rules for enabling them to constitute committees and for authorising the delegation to committees constituted by virtue of rules under this paragraph of any of the powers of the Council, and for regulating the proceedings (including quorum of such committees).

In this Act of 1957, the second and fourth Schedule maintained the Area Nurse-Training Committees and the Assistant Nurse Committee respectively and created a new committee in the third Schedule, the Mental Nurses Committee.

The Nurses, Midwives and Health Visitors Act of 1979 was constituted by order as standing committees of the Council a Midwifery Committee and a Finance Committee. The council had also power to establish other specialist committees including those for district and mental nursing and for clinical nursing studies, that is, the whole range of post-basic specialities, such as intensive care, renal nurse, operating theatre nursing and the care of the elderly.

The amendments of the 1979 Act effected by section 3—constitution of standing committees of the Nurse, Midwives and Health visitors Act of 1992—ensure that the Secretary of State has no power to constitute standing committees of the UKCC unless the Council requests him to do so. This increases the independence of the professions from government in line with the principle that the professions should themselves determine what they need rather than have it laid down by law.

From 1929, the professional colleges in Spain developed different items in their regulations about the Executive Board, specifying the elections system, which became democratic until the Civil War. After the war it was designated by the General Direction of Health which has been previously proposed by the General Council composed of the Presidents of Provincial Colleges. In 1968 the Order of May 7, re-established the democratic election of the Executive Board. The Council and the Executive Board was always composed by nursing professionals (‘practicantes’ first, later ATS and, finally, nurses).

a) Disciplinary Procedures or Committees

In the Nurses Act of 1919 it was established that the Council should make rules to prescribe the causes for which, the conditions under which, and the manner in
which nurses could be removed from the register, the procedure for the restoration to the register of nurses who had been removed therefrom, and the fee to be paid on such restoration, establishing with this a system of disciplinary control by the General Nursing Council.

Later, in the Nurses Act of 1957, it was established that the Council had to make rules prescribing the causes for which, the conditions under which and the manner, the procedure for, in which persons could be removed from the register and the roll respectively, and the fee to be paid on restoration to the register and the roll respectively of persons who had been removed therefrom. The same was established for the List being the same respectively as in the case of the restoration of a person to the register.

The person aggrieved by the removal of his name from the register, the roll or the list could, within three months after the date on which notice was given to him by the appropriate authority that his name had been so removed, appeal the High Court which gave directions in the matter as thought proper, including directions as to the costs of the appeal, and the order of the High Court to be final.

The references in the Nurses (Amendment) Act of 1961 to the removal of a person from the register, the roll or (in England and Wales) the list for disciplinary reasons are references to this removal therefrom on grounds which involve the commission by him of a criminal offence. Also any misconduct on his part not constituting such an offence, or on the ground that the entry of his name thereon was procured by fraud, and established that in all the proceedings before the General Nursing Council for England and Wales relating to the removal or restoration of a person from the register or the roll for disciplinary reasons, there should be for the purpose of advising the body a barrister, advocate or solicitor.

In the Nurse, Midwives and Health Visitors Act of 1979 it is established that the disciplinary function should be a function of the Central Council as it would be the Guardian of the Register. It was therefore a decision for the Central Council whether someone should be placed on the register or removed from it because of the qualifications he had or for reasons of professional misconduct, as the case might be. An entry on the register might be removed, altered or restored, from the register or a part of it, for misconduct or otherwise, whether or not for a specified period.

The Central Council determined rules, circumstances and the means by which, a removal from, and restoration to the register would occur. The rules made provision of the procedure to be followed, and the rules of evidence to be observed, whether before the Council itself or before any committee constituted. The
committees were constituted from members of the Council, the persons of this committee were selected with the due regard of the field in which that person worked and constituted by the rules to hear and determine proceedings for a person’s removal from, or restoration to, the register or for the removal, alteration or restoration of any entry.

The rules should make provision as to the procedure to be followed, and the rules of evidence to be observed, in such proceedings, whether before the council itself or before any committee so constituted, and for the proceedings to be in public except in such cases (if any) as the rules might specify.

If on the appointed day by the Secretary of State any disciplinary proceedings were pending before any of the replaced statutory bodies or before any committee of theirs; or had begun but the body or committee seized of them had not communicated its decision to the person who was the subject of the proceedings, that body or committee should refer the proceedings to the Central Council and the Council should dispose of the matter in whatever way it thought just.

An appeal by a person aggrieved by a decision of any of the replaced statutory bodies or any committee of theirs to remove or suspend him from one of the registers, rolls or list maintained under any of the enactment’s repealed by this Act could be continued and disposed of as if the provision of the repealed enactments under which the appeal was brought had remained in force.

Later, in the Nurse, Midwives and Health Visitors Act of 1979, the functions of the National Boards were established and among these functions we would find the next, to carry out investigations of cases of alleged misconduct, with a view to proceedings before the Central Council or a committee of the Council for a person to be removed from the register.

There is a special disciplinary procedure in the Nurse, Midwives and Health Visitors Act of 1983 that gave the regulations to remove and restore the name of a person in a Part or Parts of the register in the case of failure to pay to the Council the registration fee. The payment of the annual registration fee must be done before the last day of the immediately preceding registration year; such retention fee established by Council with the approval of the Secretary of State.

A person whose name had been removed from any part or parts of the register because of failure to pay the annual registration fee, was entitled to make application to the Council for her name to be restored thereto. Her application had to be accompanied by a written explanation of the reasons for her failure to pay the appropriate retention fee or fees promptly. If the Council would so direct, she/he should also submit such written references as to her conduct knowledge, ex-
perience or character as the Council could reasonably require in support of such explanation, and the Council would be entitled to make further inquiries of such person or her referees.

If the Council was satisfied in the light of such explanation and of such references and inquiries (if any) that it was reasonable that the name of such person should be restored to the register, they should grant her application and restore her name to the appropriate Part or Parts as from the date on which she should pay all sums due and restoration fee of an amount to be determined by the Council with the approval of the Secretary of State.

In the Nurse, Midwives and Health Visitors Act of 1992, the UKCC was empowered to deal with all the stages of inquiries into allegations of professional misconduct. In this Act, the Council is responsible for regulating nursing, midwifery and health visiting throughout the United Kingdom and is the only body which may remove a practitioner’s name from the register for misconduct, thereby removing the practitioner’s right to practise. This Act additionally empowers the Council to suspend a practitioner’s registration, to give cautions as to future conduct and to include non-Council members as members of Conduct and Health Committees, and the Council is to keep a record of any caution as to future conduct given in the course of disciplinary proceedings.

The power to caution will prevent the unnecessary pursuit of less serious cases before the professional conduct committee and will thus help to reduce the backlog of cases before the UKCC. Appeals against a decision of the Professional Conduct Committee to remove the name of a practitioner or to alter any entry in the register may be made, within three months, to the High Court in England and Wales.

This Act spells out the purpose of a Professional Conduct Committee hearing:

1) to hear evidence under oath and to decide whether matters alleged are proved;
2) to consider proven facts in context and decide whether, in professional terms, they constitute misconduct;
3) to hear information about the respondent’s previous history, and any submission in mitigation of proven misconduct and
4) to decide whether the name of the practitioner should be removed from the register in the interests of patients and clients.

However, the purpose of these Committee proceedings is not:

5) to punish the practitioner appearing before the Committee
6) to provide an employer with grounds to dismiss the practitioner and;
7) to provide an employer with an additional avenue of complaint to use when an appeal against dismissal has been upheld.

In Spain the General Council of Colleges and the Executive Board have the power to create and develop commissions and/or committees that were necessary for the management. This is common in most of the regulations issued by the government. In each of the regulations from 1929 one of the items that is always present is the regulation relative to disciplinary measures, for the case of non-fulfilment of members of the regulations, or legal, moral or social misdemeanour. In every situation the Executive Board assessed the information and sent it if necessary to the legal body.

For these situations punishments were established after the information was collected and the hearing of those concerned was carried out. The range of sanctions went – and still remain – from a private admonishing (with no record being kept) to a temporary or total suspension of the inscription in the college. In addition, if a member was suspended he could appeal to court.

**Comparative analysis**

In Spain, the General Council and the Managing Boards of the ‘Practicante’ Charters as well as the organisations which have continued them, were able to set up all the commissions and committees considered necessary. In England, all the Committees for the government of the GNC and later on the UKCC for Nurses, Midwives and Health Visitors were established in the regulations, but this did not impede both organisations to set up complementary committees every time they had been needed. In both cases, the self-governing of nursing was guaranteed, whether or not the quantity of committees specified (see section a.3.a was covered: Eight or more specialist committees for different purposes, in table 1 ‘Indispensable public service’); in any case, the possibility of creating the committees were guaranteed in accordance with the management and self-governing needs derived from daily activities.

Both in Spain and in England, from the first regulations on ‘Practicantes’ Colleges in 1929 (in Spain) and the Nurses Act in 1919 (England), each of the regulations which have followed to date always include a section regarding disciplinary measures which need to be taken in case of non-compliance with the statutes or organisational rules or when the conduct of the members did not respect
the regulations or professional, social, moral or legal duties established by the professional organisation.

The existence of self-discipline mechanisms reinforces the confidence of the public in the profession in those situations of non-ethical conduct which may not necessarily lead to legal proceedings. This section supports the idea of public service and this is why the governments have developed regulations establishing certain privileges for these professional groups.

Some sanctions were defined for such situations after carrying out a data collection process and after hearing those concerned. In Spain, the sanctions range from a private admonition which does not remain as a disciplinary record to temporary or permanent suspension as a member of the college, whereas in England the actions taken could be a word of caution or the suspension from the register on a temporary or final basis. However, information may be provided to the courts by the College Boards at any time if there is evidence of a crime.

Suspension from the College or withdrawal from the register is a measure which prevents one from practising on a professional basis, and therefore there is a right to appeal in court. This aspect is treated similarly in the English and Spanish nursing regulations and section a.2.e. of Table 1. “Indispensable Public Service” specifies that professional organisations should have recognised disciplinary procedures or committees. In both countries both elements are covered.

3.1.7 Code of Conduct. Nursing Code of Ethics

Most occupations publish a code of professional conduct as a stage in their development as professions. Nursing is no exception to this rule. The first codes for nurses on ethical behaviour become codified in the 1950s by international and national nursing organisations. In the health professions, the aim of any ethical code is to improve the condition of the health of society, which then gives the right to professionals to follow their profession.

Society must have a particular need, and be prepared to give special recognition and privileges to the body of people (profession) who meet that need. Each profession produces a unique relationship between individuals performing such tasks and society. This is a fiduciary relationship which is regulated by a code of conduct/ethics.

The public wants to be certain that the professional training and skill is the best to meet the needs that brought the profession into being, and training and skills must be continually improved by research. In this way, professions become
more specialised and esoteric, so the lay public becomes more vulnerable to dictatorial professionals.

How can the public know that professionals are doing their work well? The public can only trust, and the public will trust, because professionals will establish standards of morality more exacting than that required in general, because. As Baroness MacFarlane said (1982: 3), “The main thrust of the professional ethic is that the client’s welfare is more important than personal gain. I believe that professional status is hollow if it is sought as an end in itself, but if it is achieved as the highest good for the patient, then it is a bonus”.

A code of professional conduct is required in order to make explicit those moral standards which should guide professional decisions in these matters, and in order to encourage responsible moral decision making throughout the profession, indicating how clients and patients should be served and the attitudes that should be accepted. Professional ethics is a type of applied normative ethics which applies ethical principles and rules that determine which actions are right and which are wrong in particular problem areas.

Codes are never a substitute for personal moral integrity, and they can often be hardened into legal formulae. Professional ethics develops in dialogue with society and are open to public scrutiny, the conduct of the professional becomes subject to review and sanctions.

A code of professional practice is essential to any professional occupation since it acts both as guide to the members, and as a pronouncement to other professions and to the general public about the standards its members intend to maintain. Without such a statement, and even more important without maintaining the standards claimed by the code of practice, public confidence in the profession would diminish. Professionals must act so as to increase people’s trust, and this is why professions have their own disciplinary bodies, which have the power to act against these practitioners who destroy trust, through malpractice, negligence, incompetence or other behaviour that makes them unworthy of that trust.

Codes do not remain static, but evolve with society and with the profession’s role in society, requiring a constant re-evaluation of the codes to bring them into line with what is currently considered ethical in society. The field of nursing ethics continues to evaluate codes and recommends their updating, to foster the development of ethical reasoning by nurses, and to identify the interrelationship of bio-ethics with nursing ethics and the role of the nurse in decision-making about bio-ethical issues in general, as well as those found in particular client situations.
In this way the International Code of Nursing Ethics (1953) of the International Council of Nurses (ICN), one of the first codes for nurses issued, states “The nurse maintains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority”, A later version of the International Code of Nursing Ethics (1973) further states: “The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person”, This illustrates a shift both within nursing and society from the point of view that the nurse’s first responsibility is to the proper authority –normally until recently a physician– within the perspective that the nurse’s first responsibility is to the client.

In England as well as in Spain the professional nursing bodies issued a written nursing code of professional conduct, or ethical code, to express how clients and patients should be served and the attitudes that should be accepted. The code of nursing ethics consists of the ethical principles and action-guides particular to nurses and nursing.

In 19th-century England, Florence Nightingale sought not only to establish nursing on a firm foundation of scientific knowledge, but also to identify and insist upon ethical behaviour. In one of her letters to the probationers she wrote:

I must have moral influence over my Patients. And I can only have this by being what I appear, especially now that everybody is educated, so that Patients become my keen critics and judges. My Patients are watching me. They know what my profession, my calling is: to devote myself to the good of the sick. They are asking themselves: does that Nurse act up to her profession? This is not supposition. It is a fact. It is a call to us, to each individual Nurse, to act up to her profession. (Nightingale, 1915: 143)

This insistence upon ethical behaviour came from a deep realisation of the duties inherent in social roles and from an attempt to correct abuses by largely untrained persons engaging in nursing activities at that time.

The first Code of Professional Conduct of the Royal College of Nursing of the United Kingdom was presented as a discussion document (1976), before English nurses accepted the International Nurses Code of the International Council of Nurses. This document expressed clearly a particular professional and committed responsibility in answer to the special recognition and privilege provided by society to a professional body in part V, ‘Professional responsibility and personal responsibility’ saying:
As citizens of the state and as private individuals, nurses should defend and actively pursue those moral values to which their profession is committed, namely, individual autonomy, parity of treatment and the pursuit of health. In some circumstances this may require protest against, and opposition to, social and political conditions which are detrimental to human wellbeing; and in others, the altering of personal habits which set a poor example in health care. In all other respects nurses have the right to regulate their private lives according to their own standards of morality, provided that their style of life does not cast doubts on the integrity and trustworthiness of their profession.

Like other professionals, nurses have the right to conduct their private lives without undue interference from colleagues or employers.

In 1979, the Parliament created the United Kingdom Central Council for Nurses, Midwives and Health Visitors and the four national Boards by Act; these new bodies overlapped with the former bodies from 1980 and replaced them in 1983. The principal functions of the Central Council was “to establish and improve standards of training and professional conduct for nurses, midwives and health visitors”. The establishment of standards was a principal function, but at the same time the Act encouraged registered nurses to consider carefully both their practice and the settings within their practice, and helped them to explore their personal accountability and to see an improvement in standards of conduct.

In 1983 the Council prepared its first edition of the Code of Professional Conduct for Nurses, Midwives and Health Visitors: the code addressed major issues of professional attitude and conduct, seeking to achieve an improvement in standards. After a period of discussion, the review of the code resulted in the publication of a second edition in November 1984. The UKCC’s code begins with an unequivocal statement:

Each registered nurse, midwife and health visitor shall act, at all the times, in such a manner as to justify public trust and confidence, uphold and enhance the good standing and reputation of the profession, to serve the interests of society, and above all to safeguard the interest of individual patients and clients.

And the code further adds:

Each registered nurse, midwife and health visitor is accountable for his/her practice.

In 1954, in Spain the Governing Ministry developed the Statutes of the National Council of Health Assistants which included an annex with a 19-article Code of
Conduct, possibly inspired on the International Code of Conduct of Nursing adopted by the International Nursing Council in 1953. This moral code mainly developed the idea of subordination to other professionals, limiting the professional autonomy and independence. Each health assistant willing to join the relevant section of the College was obliged to sign the oath contained in article 19 of the Code of Conduct. In 1973, the Spanish College Organisation adopted the new Deontological Code drawn up by the International Nursing Council as a guideline to resolve ethical problems in the practice of the profession. Ever since, there was an obvious need to have a Deontological Code especially designed for Spanish nurses.

Section 16 in article 75 of the Statutes of the College Organisation –approved by the Royal Decree of 29 June 1978– established the General Council to pass the deontological rules derived from professional practice, which were to be compulsory.

In April 1988, the General Council of the Nursing Professional Colleges appointed a committee made up of nursing professionals (male and female) who practised in different contexts with a view to preparing a project which would be discussed later, applicable at a national level. After the suitable legal surveys were completed, the Deontological Code was passed in July 1989; its compliance was obligatory and any breach would entail disciplinary sanctions, as established in the Statutes of the College Organisation.

**Comparative analysis**

A code of conduct is the written expression of the function which is delegated by the government to professional associations, and is produced by the professional association in defence of individuals and society itself. In the development of the code of conduct of both Spain and England, we find a common pattern which is defined in this case as the expression of a new conception of what the job entails.

There seems to be a pattern which could be applied in both countries: firstly a stage when a written code is not considered necessary in nursing, and a secondly, where ethical codes are used as references developed by international nursing institutions based on their experience; and thirdly, a stage which sees the need to develop a specific code of conduct in each country able to analyse the personality of the citizens and professionals at a national level. Spain and England, two European countries which were to join a common effort called the European Union, were to be urged on by the passing of legislation which invited each country to update their own.
On the one hand, the idea of providing care is a positive one, as it aims at preserving, guarding and assisting. Caring implies being diligent and polite and this is inherent in the idea of an ethical code as far as the care actions themselves entail offering the best, trying to do good in the established relationship; therefore, it is something obvious which does not need to be written, as it is determined tacitly. On the other hand, we may have been using as references the codes of conduct of other professions, such as medicine, where the nurses are described as subordinate, their first loyalty being to the physician (this seems to be the case for Spain).

In England, the subject of ethics was taught to nurses in the late 19th and early 20th century. It fell out of favour for a while but has returned to the curriculum in the last twenty years. However, in the early days, the emphasis on ethics, both in England as well as in Spain, was upon the production of a virtuous and obedient woman, loyal especially to the doctor and to the institution which employed her. The emphasis is now upon the production of an independent and responsible professional whose loyalty is first to her/his patients.

With the passing of time, organisations such as the ICN acquired a high level of expertise as well as concern about ethical problems. This international association fosters the establishment of connections and links among nurses from all over the world. In the 1950s, the search for peer contacts made a 19th century organisation with a long history to be able to develop a wide and generic ethical code to be used as a reference in the existing national organisations. This code was immediately used as a reference both by English and Spanish nursing.

In line with this, in the 1970s, the RCN in England – an organisation with a long history – thought its members needed a reference document for the solution of ethical problems. In the 1970s, the ICN Ethical Code was re-formulated and accepted again as a reference for the national organisations in the case of England and Spain. A feeling of a differentiated and unique professional group started to be felt, and in both countries there was seen a need to analyse the history of nursing and its professional and ethical aspects. In other words, nursing started building itself as a profession, this being a process which coincided with the growing interest in certain disciplines such as the history of the profession and its ethics. It was time to develop a code of conduct both in Spain and in England.

But it is necessary to consider some more elements, especially the frequent changes in moral and social conduct rules, which have been possibly influenced by the rapid increase in the use of high technology in the health field. And there-
fore, the means which were considered extraordinary became ordinary, this causing the change of the ethical scenario.

All this evidences a trend which is very clear at the moment: each year, the number of complaints made by patients due to malpractice or negligence increases. In face of this, the absence or vagueness of national written references or their obsolete nature, or too wide a coverage, could have lead to conflicts with the law. This is where the specific and written codes of conduct in each country aim at facilitating the analysis of the situations, making the relationship of the profession with the law easier.

In addition, in January 1976, the Parliament Assembly of the European Council passed a document drawn up by the Commission of Health and Social Affairs which summoned the governments to take measures regarding patients in terms of the right to freedom, personal dignity and integrity, to information, an adequate treatment and a right not to suffer. With this document, the autonomy paradigm started taking shape also in the health field (Gracia, 1989: 177).

One also needs to take into account the establishment – in 1977 – of the 77/452 EEC guidelines for the recognition of titles and the 77/453EEC for the standardisation of titles; the latter included an annex about the theoretical and technical (practical) disciplines where section (a) on “Nursing Care”, defined professional ethics as a necessary subject to be taught.

The document resulted from the debate on the contents which nursing training had to include. It set the guidelines which –after the subsequent sharing and harmonisation of the contents– led to the integration in the curricula of those aspects which had been missing in the past, for instance, professional ethics.

The establishment of curriculum guidelines which needed to be developed in all European countries, opened a new dimension in all the nursing schools. It was then necessary to produce documents, incorporating these ethical data, facts and knowledge. This amount of information accumulated over the last few years, demanded the development of specific written codes of conduct for the nursing profession. Indeed, these were to be related to other professional codes, but they would be specific due to the fact that nursing was a different profession.

One could then draw the conclusion that nursing both in England and Spain complies with the point a.2.a having a written code of conduct or ethics of Table 1, one of the sub-indicators of Indispensable Public Service.
3.1.8 Explicit Ethic Confidentiality

‘Secret’ constitutes a situation in which a tacit or explicit commitment has been made by two or more people, knowing that they must keep the knowledge that they share about a particular fact.

Professional secret is a promise – tacitly formulated before receiving a piece of information – by a person who, acting as a professional, can be the receiver of confidential information. Based on the professional relationship, the client confides to the professional aspects of his/her private life, and therefore, the need to keep secrecy is a logical consequence of defending the client’s privacy.

Professional secrecy is based on the ethical duty that a person has when he/she becomes a necessary confidant to other individuals in the practice of his/her profession. In the case of nursing, these individuals are the patients. The violation of professional secrecy constitutes an abuse of confidence, a serious transgression of the good faith and trust of the patient.

The issues related to professional secrecy in nursing are: the nature of the disease, and the participating circumstances which – if revealed – may cause disgrace of the patient, his/her family, or some type of damage.

The first reference to professional secrecy in the Spanish Law is found in the Criminal Code of 8 July 1822, which – in the group of crimes against the public good – also regulates “the violation of secrets confided to a public professional, and the illegal opening or taking of closed letters...”. The penalty is aggravated if, by revealing the secret, the person who confided to another suffers some damage.

Article 424 in the same code established that ecclesiastical representatives, lawyers, doctors, surgeons, pharmacists, midwives, and any other person who, having received confidential information in their professional status, illegally reveals the secret, will be arrested for a period of two months to a year and will have to pay a fine of 30 to 100 ‘duros’.

In 1848, a new Criminal Code was passed; article 276.2 established the penalties of professional suspension, major arrest and fine of 10 to 100 ‘duros’ for “those who practice an official profession and reveal secrets confided to them as a result of their professional activity”. Only two years after – in 1850 –, a new Criminal Code was published, including the same text and penalties, but stating that these regulations on professional secrecy were only applicable to professions which required a title.
The next Criminal Code which deals with the professional secret issue is that of 1928: its article 684.2 established penalties of 3 months to 2 years imprisonment and fines of 1,000 to 5,000 pesetas for “those who may divulge secrets which have been confided to them due to their professional status or employment position”. We shall note that the secret does not only affect the professional field now but also the world of employment.

This penalisation was to disappear in subsequent Criminal Codes including their corresponding amendments, and only some aspects related to lawyers and ‘procurators’ were kept. However, the subject remained in the Civil Code (1983), which dated from the last century and which has undergone numerous changes. Article 1,902 of the Civil Code deals with the breaking of professional secrecy both doctors and nurses in terms of civil responsibility, establishing the obligation of compensating both material and moral damage derived from negligence or other damage.

In Spain, since the normalisation of the Health Auxiliary professions in 1857, the doctors in charge of education and academic matters have written numerous books for ‘Practicantes’, Midwives and later on Nurses, including chapters which describe the so-called moral qualities, and/or duties of these professionals in relation to professional secrecy.

All this stems from the fact that ‘Practicantes’, Midwives and Nurses have information on the diagnosis, results of diagnostic tests, and treatments administered, as well as information on the antecedents and disease of the patients; they may also be the receivers of valuable information which may be useful not only to themselves but to other professionals.

Due to the abundant production of academic books for ‘Practicantes’, Midwives and Nurses, we have at present the opportunity to study how these professionals had to behave when coming across facts which they could not reveal due to their professional status.

Several texts from the past, will now be analysed, focusing on the treatment given by several medical authors to the subject of professional secrecy, until reaching the present day, when the issue has been regulated through the Professional Code of Spanish Nursing, published in 1989, where professional secrecy has been regulated by and for the nursing profession.

In 1922, Sáenz de Cenzano, in his book Manual del Practicante put some emphasis on prudence, “the ‘practicante’ must be very prudent and must keep those secrets confided to him” (1922: 14). This author then warns about the problems that revealing the secret may cause to the patients, such as restless-
ness, “when patients confide in us or inform us about their ailment, we are in possession of secrets which –if revealed– may lead to restlessness in the patient or the disgrace of a family” (1922: 17). The author describes the effect that breaking confidentiality could have for patients.

In the same book, Sáenz de Cenzano devotes some pages to the nurses in a section called “Moral Conditions in Nurses”: this chapter illustrates the image of the gossip which the women of the time had and includes the moral qualities which were necessary in a nurse:

A nurse must be discreet and try to get rid of the bad image which women have from this particular point of view; however, being discreet will not prevent a nurse from obtaining information on the disease of a patient, especially in a hospital, so that the doctor can have the data for the case history, thus saving time. (Sáez de Cenzano, 1922; 19)

This shows the function of nurses as collectors of information used in medical work.

In another book, also called Manual del Practicante, Cubells (1926) refers to the prudence required and the resistance needed by the professionals in face of the curiosity of other people:

Prudence ... we do not refer to prudence here in relation to healing, but to the capacity of keeping silent in some moments in life when an imprudent or indiscreet word can really affect the patient, his/her family, and sometimes even the practicante’s reputation. In this regard, the ‘practicante’ must keep the secret of his profession and must not tell anybody the ailment – especially some diseases– of his clients, even if somebody insisted, driven by curiosity and intrusion in other people’s lives, which is unfortunately quite a frequent practice. (1926; 18)

Another author, García Tornel, establishes equality between professional secrecy for doctors and nurses/'practicantes' in his work Manual del Practicante y de la Enfermera:

Like the doctor, the nurse must be utterly discreet in the practice of her duties, and therefore, her eyes will not see and her ears will not hear anything which does not concern her outside the medical realm; this is a considerably important precept for nurses, and their discretion and reserve must call on the trust and affection of patients and their families. (García Tornel, 1938; 172–173)
In *La Enfermera Moderna* (1939), Pijoan describes similar situations stressing the importance of being discreet, as well as the different situations in which other people may like to intrude in confidential aspects of the health of the patient as known to the nurse:

It is supremely important for a nurse to remember the absolute obligation of being discreet. We frequently find patients are delirious and so unveil their secrets, or patients who—in the belief of having a serious illness—tend to confide in the people around them; in moments of distress—especially when a life is in danger—families confide a lot of things in doctors and nurses, even serious secrets which do not belong to them; the nurse does not only have the obligation to keep them but to forget them or try to forget them; she must be cautious because she may come across people interested in knowing the secrets which she may not consider important; some people may use their wits to get the secrets out of her, but as an established rule, the nurse will never say anything she has seen or heard, not even in her conversations with colleagues or families, as things which she may have found out by chance could be very valuable for others. (Pijoan, 1939: 15-16)

Usandizaga wrote in 1943 a *Manual de la Enfermería* which includes a section entitled “Professional Secrecy”:

In the development of her functions, the nurse may get to know diseases, private family matters of the patients, etc. Obviously, if these things are spread, serious damage could be caused. Even if the information seems unimportant or banal, the nurse is always compelled to keep the secrecy of what she has come to learn in her profession ... A nurse may be faced with the problem of having to answer some questions of the family and relations of the patient; her only reaction must be to refer them to the doctor, who will then decide. To allege ignorance of a fact may be used as a practical resource to avoid having to answer indiscreet questions. (Usandizaga, 1943: 7)

Maybe, the relinquishing of the nursing responsibility of providing the patients with information stems from the latter aspect, which to a certain extent was quite an easy thing to do; on the other hand, as a result of such a conduct, present day nurses are considered a professional to whom patients would not refer when trying to obtain information, possibly because they notice the nurse is lying in alleging ignorance, and then refers them (or their relatives) to the physician.

Later in his book, Usandizaga tries to describe the “model nurse” by quoting a paragraph from the book *Morale Professionelle de l'Infermière*, by Mlle. Chaptal:
Above all, the nurse should inspire trust, because she will always tell the truth and will be discreet. Veracity and discretion complement each other, without them there is no trust. Nothing should ever make a nurse reveal a professional secret; a useful tool to keep secrets will be to allege ignorance. A secret whose possession is confessed is half betrayed. (Usandizaga, 1943: 12)

The idea of alleging ignorance to avoid answering questions is once again mentioned and totally incompatible with “she will always tell the truth”.

As we have already seen, professional secrecy is not discussed after the 1928 Code, it is regulated by the deontological norms of the Professional Colleges, and their existence does imply certain protection of the secret.

In 1954, the Spanish Official Bulletin published an Order of the Ministry of Government dated 30 July 1954 which encompassed the Moral Code of Health Auxiliaries, including references to professional secrecy: “professionals are obliged to keep all the secrets known in their profession, except in the situations established by the Natural Law and the laws of the country” (art. 7); article 19 reproduced Florence Nightingale’s Oath which had to be sworn by all professionals registered with a College, concerning professional secrecy:

I solemnly promise in front of God to lead an honest life and develop my profession with devotion and loyalty. I will refrain from anything harmful or malign, and from administering –knowingly– any drug which may be harmful for health. I will do my best to raise the good name of the profession and keep the inviolable secret of all personal and family matters in me confided during the accomplishment of my functions. With loyalty, I will try to assist the doctor in his/her work, procuring welfare to all under my care.

Later on –in 1956–, Sister María Rosa Miranda wrote a book, Orientación de Moral Profesional, which includes a section called ‘Discretion and Reserve’, establishing the conduct to be observed by ATS professionals:

All this should be kept with strict discretion and reserve. Comments should never be made nor secrets spread, secrets which are confided in the professional practice. Although they may seem insignificant, many family details –if made public– may bring serious consequences. The Health Auxiliary will never manifest that he knows certain things, nor force confidentiality or penetrate in the secrets of the heart. Likewise, the ATS professionals must not comment on their own impressions, which the may regret later; their opinions should be reserved for specific matters; the best thing is to remain silent or simply talk about indifferent subjects. See to it that you keep
your honour high, together with your discretion and reserve, fulfilling your duties without fail. (Miranda, 1956: 32)

Again, this author put the emphasis on silence as the best defence for not breaking professional confidence. This could be best understood in the context of the time, where nursing was considered as subordinate and auxiliary to the doctor.

The breach of professional secrecy constitutes an abuse of the trust of the patient by the professional, and can affect both the patient and the institution where the professional works. Due to this fact, the Labour Law determines the obligation of keeping professional secrecy, establishing sanctions for its violation or damage caused. The Spanish Statute of the Workers (art. 54) dealt with dismissals as a result of a serious breach by the worker, and section 2d specified that one of the causes for dismissal can be the transgression of the good faith established in a contract, as well as the abuse of trust in the practice of a job.

The working regulations for health establishments in article 75.3g defined indiscretion and negligence as very serious faults against professional ethics, especially if they led to claims by third parties or to irreparable damage.

The Statute of the Official Health Auxiliary Personnel and Clinic Auxiliaries of the “Social Security”\(^{49}\), passed by an Order of 26 April 1973, considered breach of professional secrecy a serious fault (art. 124.6), and if this resulted in serious damage to the Social Security or third parties, the fault was then considered very serious (art. 125.4).

In the same year – 1973 –, the Spanish organisation of colleges adopted the Code of Ethics of the International Council of Nursing; the section titled ‘Nurses and the Individual’ established that the nurse must be reserved as to the personal information received, as well as discreet, if that information has to be shared.

In the Statutes of the Organisation of Colleges, dated 29 June 1978, article 57 in Section VIII (on distinctions and disciplinary awards and measures) defined what actions were considered very serious faults and contemplates the different situations related to professional secrecy; item –a–: actions or omissions which may seriously affect the dignity of the profession or its ethical rules; item –c–: offence to the dignity, honesty or honour of people in professional practice; and item –i–: serious infractions in the duties of the profession; all of these situations could

\(^{49}\)‘Seguridad Social’ is the usual denomination of the Spanish National Health Service.
bring a disciplinary sanction, and any evident sign of criminal conduct had to be reported to the legal authorities.

These statutes prompted the development and subsequent approval of the deontological rules to regulate professional practice, and in 1989 the Deontological Code was passed, which explicitly regulates professional secrecy, and so articles 19, 10, and 21 establish that a commitment has to be made by professionals to keep secret all the information about the patient which they may have come to have in the course of their duties; similarly, the limits of the professional secrets are also set, as there may be exceptional situations where the nurses may have to break confidentiality due to legal reasons.

In 1978, the Spanish Constitution was passed; article 18 in Section I ‘Fundamental Duties and Public Liberties’ – in Chapter II, Title I ‘Fundamental Rights and Duties’ –, guarantees the right to honour, personal and family intimacy, and their own image; whilst this article was being developed, the Organic Act 1/1982 of 5 May, on Civil Protection of the Right to honour, personal and family intimacy, and the own image, was passed, this being the normative applicable at present for the protection of the civil context of professional secrecy.

The Act states: “one cannot ignore that some of these rights have or will have criminal protection... Therefore, for those cases with criminal protection, this will have preference since it is the most effective ...”. Article 1.1 establishes that the right to intimacy is protected on a civil basis in all types of illegitimate intrusions, and therefore, civil actions can be taken in cases of revelations of information about a person by not only professionals but also by intruders, independently of the criminal responsibility entailed.

In addition, we find other articles in the Spanish Constitution which have not given rise to laws, but do deal directly with professional secrecy; for instance article 20.1 “all the rights are recognised and protected: d) the Law shall regulate the right to the clause of conscience (which has specifically been regulated) and the professional secrecy in the development of the liberties”; and article 24.2 “... the Law shall regulate the cases in which – due to kinship or professional secrecy – a person will not be obliged to testify about assumed criminal actions”.

As we have already seen, professional secrecy, apart from being part of the right to intimacy, also has its own identity as a safeguard of a specific institutional guarantee, that is, the specific public interest “that in certain professions, such as doctor [nurse], lawyer, priest, is more outstanding given the high mission commended” (Bajo, 1980: 598). In professional secrecy in nursing, the aim is always to guarantee the right to intimacy of the patient. The institutional guaran-
tee justifies the obligatory registration with a college for nurses – as well as for doctors, lawyers, etc. –, although, as we have written in another section of the paper, this may seem contrary to the constitutional right of association (art. 22 of the Spanish Constitution), this right is sacrificed for the fulfilment of a specific public interest, i.e. health.

Regarding this subject, in England, for instance in 1922, Mildred Heather-Bigg included references in her book *Home Nursing* – which was written according to the revised syllabus of the St. John’s Ambulance Association – saying that:

> Invalids often talk somewhat freely to a nurse about their private affairs, and it need hardly be said that any confidences of the patient must be most scrupulously observed. (Heather-Bigg: 11-12)

Quite a lot of time went until an English nursing association such as the Royal College of Nursing wrote – in the Code of Professional Conduct – a Discussion Document (1976) about the relevance of keeping the professional secret in the relationship with the patients; article 5 of this document says in this regard:

> Information about patients or clients should be treated with the utmost confidence and respect and should not be divulged to persons outside the primary care or treatment team without the person’s consent, except in exceptional circumstances. (RCN, 1976)

The same document described the circumstances in which the secret should not be kept, recommending on the procedure to provide the information:

> In unusual circumstances, it may be necessary to disclose confidential information for the well being of the patient or others in the nurse’s care, but this should never be done without full consultation with relatives and with medical and nursing colleagues; and whenever possible the patient should be told why such a disclosure was felt to be necessary. (RCN, 1976)

After some years, in 1983, the UKCC for Nurses, Midwives and Health Visitors drew up the following in article 4 of the Code of Professional Conduct:

> Hold in confidence any information obtained through professional attendance on a patient/client. Such information must not be divulged unless judged necessary to discharge her professional responsibilities to the patient/client; normally the consent of the patient/client should be obtained. Exceptionally the professional practitioner may be required to divulge information held; he should seek advice before responding. (UKCC, 1983)
This text was modified together with a large number of articles after a year, and a second edition of the UKCC Code of Conduct was published. At present, this is displayed in article 9 as follows:

Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the patient/client, or a person entitled to act on his/her behalf, except where disclosure is required by law or by the order of a court or is necessary in the public interest. (UKCC, 1984)

**Comparative analysis**

In this section can be observed two different ways (the English and the Spanish) of approaching the same problem which converge in the same point. On the one hand, we have the right of the patients that nurses should maintain the secrecy of the information obtained in the course of the treatment; on the other, the nurses’ moral principle or duty to respect the secrecy.

In England, this situation has been dealt with through the character training in nurses, who are trained to develop a high sense of their moral duties with regard to the patients, thus respecting the right to maintain the secrecy of the information obtained as a result of the nursing activity.

The UKCC for Nurses, Midwives and Health Visitors provided for the surveillance and guarantee of the rights of the patients, their principles being compiled in the different ethical documents produced.

In Spain, different health professionals –among them, the ‘practicantes’ first, then the nurses and later on the ATS– were conditioned by different legal regulations which dealt with the breach of the professional secrecy derived from the practice of the profession, punishing –maybe excessively– the breaches of this right of the patient by health professionals. These rules were gradually softened up until today, but if damage is done the responsible person still needs to pay for it (civil suit), even though the nursing professional organisations themselves already establish punishment for the breach of confidence through their disciplinary committees.

This is also the case in England: the patients may go to court to get compensation for the damage done as a result of a breach of secrecy, but the professional organisations are also able to punish by means of their disciplinary committees.

In both countries the point a.2.b. “Explicit Ethics Confidentiality” of the Table 1, of the indicator “Indispensable Public Service” is covered.
3.1.9 Advertising

The historical references to the prohibition of advertising by nursing professionals are chronologically described as follows:

In Spain the first reference is made in the Act on Bases of Health of 22 November 1944, although the reference was not explicit when the act was originally published. The Act was modified in July 1946 and new contents were included in Base 34, which dealt with the professional organisation, establishing that:

no advertisements of clinics, health centres or similar institutions will be allowed in newspapers and on radio stations unless they are backed by a censorship form issued by the Provincial Health Department and by a Commission of the respective Faculty of Medicine.

Later on, article 18 of the Order 25 June 1951, in which the statutes and regulations of the Midwifery Colleges were established, stated that the college members were not allowed to publish professional advertisements of any type, as – according to the norms set by the superiors – all publicity based on advertisements or slogans would constitute a reason for a correction action imposed by the College Board. Registered midwives would be allowed to hang a professional sign in their homes with only their name and surname, indicating their professional category, that is, midwife, and the times of their practice.

Continuing with the chronological evolution of this matter article 24 of the Order of 30 July 1954, which contains the Statutes of the Provincial Colleges of Health Auxiliaries, established that “the members of a college would not be permitted to use professional publicity media of any type, except for a professional sign indicating their names and professions which would be placed on their front doors”.

Section e in article 16 of the Royal Decree of 29 June 1978, which includes the Statutes of the Nurses and ATS College, establishes the following duty for members:

members must apply to the college for the corresponding authorisation for advertising their professional activities; this will not be done without the required approval.

On 14 July 1989, the Deontological Code of Spanish Nursing was published; a paragraph in article 67 read: “Nurses should never compete unfairly with their professional peers, nor carry out misleading professional advertising with a view to attracting clients”; the publicity is restricted to the requirements of article 16 in the Royal Decree of 29 June 1978.
The references to the prohibition of advertising by the nursing professionals in England are chronologically described as follows: The first reference is made in the 12th point of the UKCC code of professional conduct for Nurses, Midwives and Health Visitors of 1983, and is expressed in the following words:

Avoid advertising or signing a advertisement using her professional qualification(s) to encourage the sale of commercial products, or services. Any nurse, midwife or health visitor who wishes to use her professional qualifications to advertise her professional services or to take part in any form of commercial advertising should seek advice at the UKCC offices.

As a result of this point nurses would receive advice from the UKCC offices in the case of any advertisement. The prohibition was not complete there being some cases where it would be permitted.

The second reference is in the 2nd edition of the UKCC code of conduct published in 1984, where in point 14 this issue is treated in very similar terms “Avoid the use of professional qualifications in the promotion of commercial products in order not to compromise the independence of professional judgement on which patients/clients rely”, It also makes a clear reference to the need not to betray the trust of the patients.

Comparative analysis

It is surprising to find indicator a.2.c. “Advertising Explicitly Forbidden” in the literature, as usually professions do not need to advertise in order to supply their services and the professionals are sure of their level of competence, the advertising of their services is not required.

This section must be understood as trying to prevent a potential abuse by professionals; it is a self-limitation which prevents internal problems among the members, thus avoiding the damage which could be caused to the clients in case of fraudulent advertising. It would be better understood as a recommendation than as a prohibition, and in fact, both in England and Spain, the professional colleges offer advice on this matter. While in England the emphasis has been on not advertising products, in Spain it has been on avoiding conflicts between individuals who charge fees for services.

The Spanish regulations which limit advertising in nursing date back to 1944, as opposed to England, where the first references appeared in 1983 (UKCC code of conduct).

The last written legislation does not imply that there was not a professional self-limitation; as we have reiterated throughout the study, in many aspects related to
their professional life, nurses had received a ‘character’ training which totally de-
terred them from certain practices.

In Spain, this area is regulated at the same time for all health professionals
through a legislation stemming directly from the government, i.e. the Act of
Bases. This could coincide with one of the things previously mentioned in the
fact that the government decided to resolve the situation by prohibiting advertis-
ing, thus preventing internal conflict among professionals.

In global terms, the freedom to advertise is limited in both countries, where this
indicator being covered completely. Only the advertising services offered by pro-
fessional nursing organisations may be used at present.

3.1.10 Criticism Among Members

Nursing strives to provide a rewarding relationship among nurses and other
health professionals, and this relationship should be determined by the goal of
obtaining the maximum benefit for those in their care.

Apparently, criticism among professionals seemed to be a very common prac-
tice, which led authors like Cubells to make some recommendations on how
‘practicantes’ should behave with doctors, in his manual for ‘practicantes’:

It is certainly incorrect for ‘practicantes’ to discredit doctors in the street,
peoples’ houses, in the pub, and any other places, or to talk about their pri-
vate conduct or professional life in unfavourable terms... Therefore, this
should be taken into account, and one should be inspired by the well-known
proverb ‘Do as you would be done by’; in their practice, ‘practicantes’ should
not make an opinion on the disease of the patient, nor tell the patient –
through gestures or other signs – whether the doctor is or not in the right as
to the knowledge of the illness, whether he is prescribing the right treatment
for the ‘practicante’ to administer; such opinions – apart from being impru-
dent and showing bad faith – are easily believed by common people and
always affect the doctor’s reputation. (Cubells, 1926: 13)

This is one of the first references to insidious criticism among professionals; it
prevents the ‘practicantes’ from forming such opinions, given their subordinate
condition.

The Orders of 1929 and 1930 which established the ‘Colegio’ of ‘Practicantes’
and Midwives respectively state in sections –a, b, c,— of article 5, that the col-
leges must see to it that the ‘Practicantes’ and Midwives receive in their public
and private performance all the respect, consideration and reputation they de-
serve as holders of an academic title. The colleges should also take care of the
decorum and good name of the social class represented by these professionals,
as well as keeping the necessary harmony and fraternity among all the members
and among the different colleges, establishing and promoting cordial relations-
ships, always maintaining the required subordination and discipline with the pro-
vincial Faculty of Medicine which deserve observance and respect.

Later on, Pijoan (1939: 17) offered indications and lessons for nurses in his trea-
tise on the modern nurse: “a nurse will speak with moderation and should never
fall into the bad habit of recriminating her colleagues, the doctors, or the pa-
tients; hospitals are places where gossiping may seem an easy thing to do”.
These words acknowledge the damage that criticism and recrimination may
cause among colleagues.

On 18 March 1942, after the Civil War, a new regulation for the updating of the
colleges is put into force, containing the same text of sections a, b, and c of arti-
cle 5, with the same college objectives which are found in the legislation for the
setting up of the ‘Practicante’ and Midwifery Colleges (1929 and 1930, respec-
tively).

Usandizaga (1943: 9) followed the same line as his predecessors when he
wrote:

Nurses must fully comply with the order given to them; they must not judge
the doctors, as ultimately, they are not to be held responsible. Furthermore,
they must not only show complete obedience to the orders but also must ref-
frain from making comments or manifestations. In the professional field, the
nurse must respect and obey the doctor.

The author warned the nurses about complying with the orders of the doctor,
and at the same time told them they were not in a position to criticise the physi-
cian (Usandizaga only refered to doctors and did not apply this to the rest the
professionals).

Article 3.1 in Order 26 November 1945 established that one of the objectives
and aims of the General Council of Health Auxiliaries was to take all the actions
necessary to promote the Class spirit, awaken professional awareness, and re-
quire the authorities to do their best for the improvement of the social, moral and
economic spheres of the profession. The same Order –sections a, b, and c, of
article 22– reproduced again the same text of article 5 of the previous orders on
College Regulation, which referred to the actions and performance required in
the promotion of the Class spirit, thus aiming at reducing criticism among pro-
fessionals.
The Order of 25 June 1951, on Statutes and Regulations for the Councils and Colleges of Midwives, established that the mission of the college was to defend the rights and prestige of the Midwives, guaranteeing their independence and decorum in all the aspects of their professional practice and keeping harmony among the members, who must observe the most elemental professional precepts gathered in the Regulation, and to adopt the necessary measures to maintain the decorum and the good name of the class. In addition, colleges must establish and promote cordial relationships, always maintaining the required subordination and discipline to the provincial Faculty of Medicines which deserve observance and respect, whenever their participation is required in professional matters; they should see to it that their members comply with the enforced rules of the health field and as many others as may be dictated.

The Order of 29 March 1954, containing the Regulation of the National Council of Health Auxiliaries, established the following objectives: see to it that all the Health Auxiliaries received in their professional development the social, economic and professional consideration they deserved, trying to keep harmony both among the registered professionals of the three sections and among the rest of the health professions, and maintaining as much as possible the professional and social prestige by demanding that all the members act –both in their private and professional lives– with a high moral concept, promoting everything which may help them increase their cultural and professional level.

The application and observance of the Moral Code attached to the Statutes should be noted. This includes some articles which aim at promoting the Class spirit, thus limiting criticism among professionals:

Art. 8. The registered professionals must be utterly loyal to the doctor; their mission is to collaborate with loyalty, observing the doctor’s orientation and criterion, refraining from all types of criticism and comments.

Art. 9. When the registered members provide public or private institutions with their services, they must take care of the prestige and the social and economic interest of the institution.

Art. 10. The fundamental ethical principles oblige all registered professionals to guarantee the moral and professional prestige of their colleagues, avoiding criticism and defamation.
Art. 11. Should a professional hear of serious faults or imprudence in his/her colleagues, he/she will warn the ‘offender’ charitably, or discreetly report to the College, following the dictates of his/her conscience.

Art. 12. All registered professionals must report any illicit act they may be aware of, concerning a professional; this must be done by means of a written document, providing as much evidence as possible about the case.

Art. 15. As a primordial duty, registered professionals are obliged not to show personal attitudes which may cause damage to their patients.

Article 9 of the Order of 30 July 1954 – published together with the Statutes of the Provincial Colleges of Health Auxiliaries – describes the mission of the colleges; we find a text which sounds familiar, as it synthesises previous regulations: colleges must take care of the prestige and good name of the professional class they represent, keeping the necessary harmony among the members and between the members and the colleges, imposing the observance of the deontological principles in the Moral Code. These statutes also establish the duty of the college members of complying with the rules set in the Moral Code of the College, in both their private and professional conduct.

In 1956, Sister Rosa Miranda published the book *Orientación de Moral Profesional Adaptado al Programa de ATS*, which describes how the behaviour of the ATS professionals should be in relation with the doctors, their colleagues and the institutions where they work, with special reference to the situations where criticism can be used for introducing slander, thus causing damage to colleagues, other professionals, or the institution. As far as doctors are concerned, the author says:

> Doctors must be obeyed and respected, they deserve constant loyalty and exceptional discretion. No comments shall be made if they are likely to damage the doctor’s professional prestige, his possible mistakes should not be mentioned, and faults which may not be observed should not be noted; if some involuntary omissions are made or some things are involuntarily forgotten by a doctor, he/she should be tactfully told, without giving much importance to the fact. (Miranda, 1956: 46)

All this aims at stressing the subordinate position and the indisputable support of the ATS professionals, at the same time warning about criticism of doctors and other colleagues.
The book also describes the attitude which ATS professionals should show, that is, avoid excessive familiarity, promote cordiality, cover up resentful feelings and refrain from insidious criticism, and be tolerant with other people’s faults to obtain in turn the same attitude. According to this author, slander is the result of false imputations of some moral/professional mistake, fault, or defect, which cause damage to the interest or reputation of the slandered person. Slander causes the health profession and even medical science to lose their prestige, and therefore must be punished. The book finishes as follows:

Those ATS professionals who speak badly about their colleagues do not deserve to be among them. When criticism becomes a usual practice, it contributes to discredit the health class which as a result loses respect, lowers the profession and freely feeds the malice of the public. (Miranda, 1956: 50)

With these manifestations, Miranda contributed to the development of corporativism among the ATS professionals themselves as well as between the ATS body and the doctors, favouring a common front of health classes.

The Royal Decree of 29 June 1978 through which the Statutes of the College Organisation of ATS were passed, still holds today. Article 3 sets the function of the colleges: “to regulate – within its own scope – the professional activity of the members, taking good care of the professional ethics, dignity and respect for the rights of individuals, and to maintain the discipline in the college itself and the profession”. In turn, article 17 establishes as the aim and function of the college to act as a referee in the professional divergences which may arise among colleagues, these being subject to the resolution of the Governing Boards or, the General Board.

Chapter VIII describes the system of distinctions and disciplinary awards of the colleges: articles 57 and 58 establish the following faults: “attacks against the professional dignity, honesty and honour of the people” (this could include nursing professionals, and is considered a very serious fault), “Inconsiderate acts towards other college members” (whatever kind of act; this is defined as a serious fault).

In addition, item 16 of article 75 entrusts the General Council of ATS Colleges with the following mission: “to pass the deontological rules which regulate the practice of the profession; the rules are obligatory and must be applied and interpreted to achieve best compliance”.

Spanish nursing had assumed and recommended the deontological code of the 1973 International Council of Nursing as a guide for the solution of ethical problems; the code explicitly refers to situations where the nurse must accept or delegate responsibilities, and describes situations of malpractice or negligence cases. The section entitled ‘The nurse and nursing practice’ reads: “the nurse will evaluate – with a professional critical spirit – the ability of the individuals
whenever she has to accept or delegate responsibilities”; likewise, the section ‘The Nurse and her colleagues’ also reads: “when the care given to a patient is endangered by a colleague or any other person, the nurse must make the most suitable decision and act in line with it”.

The Spanish deontological norms – passed by the General Council of Nursing Colleges on 14 June 1989 – regulate the practice of the profession and are obligatory, and therefore must be applied and interpreted to achieve best compliance. These are some of the articles in the deontological code:

Art. 61. Nurses (male or female) are obliged to report all negative attitudes towards the patient that they may observe in any of the members of the health team. They will not become accomplices of individuals who deliberately neglect their professional duties.

Art. 62. The relationship of the nurses with their colleagues and the rest of the co-operating professionals must be based on the mutual respect of the people and the specific functions of every person.

Both articles, together with the Nursing Code of the International Council show a positive attitude, and consider that there is not a place for insidious criticism in the professional relationship with colleagues.

In England as well as in Spain examples can be found of medical writers who discouraged nurses from discussing with patients anything which might undermine confidence in the physician or medical attendant. An example was quoted by Rafferty (1995: 46), from Thompson’s book (1841) *The Domestic Management of the Sick Room: Necessary, in Aid of Medical Treatment for the Cure of Disease*, that said:

All whisperings, consultations, exchanges of looks, denoting anxiety for his fate, as well as all expressions of commiseration respecting his condition, should be carefully refrained from by every attendant in the sick room.

One will find as well nurses like Heather-Bigg, Matron of the Charing Cross Hospital who wrote a book called *Home Nursing* in 1922. She included a headline about ‘Loyalty’ and describes loyalty to the doctor as follows:

Loyalty to the doctor consists in saying and doing nothing to lessen his patient’s confidence in him, and never comparing his methods with those of others doctors. (Heather-Bigg, 1922: 11-12)
Like many ethical codes the UKCC code of professional conduct for Nurses Midwives and Health Visitors take precautions to prevent cases of attacks or acts against the professional dignity of a colleague trying to give a friendly atmosphere of discussion and questioning among colleagues. Obviously this will improve the quality of care and training.

Examples of this are in the UKCC code, the 2nd edition of the 1984 code in point 5 says “Work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care system”. Again, point 7 of this 2nd edition code said “make known to an appropriate person or authority any conscientious objection which may be relevant to professional practice”, assuring in this way that malpractice and misconduct situations will be noticed.

Comparative analysis

The historical development of the prototype of the English nurse which entails her subordination to the medical professionals, includes the idea of not openly criticising others, either nursing or medical professionals.

With reference to what was said in the first chapter, nursing articulates as a means for the achievement of the goal set by those who have the knowledge, in this case the doctor, and this cannot be argued with let alone criticised. This may have been one of the causes of the existence of a smaller number of written references in England reminding nurses not to criticise doctors or other nursing professionals. The attitude in this particular matter was also included in the forging of the character.

This was not the case in Spain, as all manuals for ‘practicante’ would include more or less abundant explicit references aiming at eliminating criticisms of doctors, this being also applicable later on to the nurses and ATS professionals. One of the reasons for this could be that the ‘practicantes’ were men and their training was done by medical lecturers in medical technical aspects. The ‘practicantes’ were well considered and held a high level of credibility amongst the population, and although they were subordinate, they could perform independently, which was noticed by the population. On the other hand, doctors may have felt afraid of the ‘practicantes’ who could potentially have a wider knowledge in some particular subjects.

All these issues created an atmosphere among the doctors, who thought they ought to remind the ‘practicantes’ about their situation of dependence and subordination. This did not apply to the English nurses, as they were completely aware of their dependence on the doctor from the first moment.
We fail to find a professional figure in England comparable to the Spanish ‘practicante’, as the latter encompassed part of the roles of the different English professionals: general practitioner, health visitor, and nurse. The ‘practicante’ represented a figure suitable for its time in accordance with the Spanish social structure.

Therefore, we could state that criticism among members has seen different stages which may be identified in both countries, England and Spain: a first stage in which both the English nurse and the Spanish ‘practicante’ must remain silent and whose main loyalty is to the doctor, including his mistakes and malpractice. In a second phase, the nursing associations call for a polite and correct relationship between the nursing professionals and other professional groups, where speaking about conflictive situations related to negligence or malpractice is avoided, loyalty to the doctors prevailing over other things, but it is possible to perceive a initiation of a constructive criticism. And finally, a third stage is defined by the change in the orientation of loyalty, the clients being the receivers this time; the objective is now to establish a good relationship among the professionals (medical or nursing), encouraging the denouncing of those situations with potential injury to the client which may result in the lack of confidence in the profession.

But how do we know that nursing was and is an essential public service? At present in the UK there are almost 600,000 professionals registered with the UKCC for Nurses, Midwives and Health Visitors; in Spain, the number of professionals registered with the General Council of Nursing is nearly 150,000. In both cases the percentage of professionals who are employed by the health system is fairly high. With this information, is it feasible to consider the question raised how do we know that nursing is/was an essential public service? and how does society manifest that nursing is an essential public service? In order to answer the questions, I shall attempt to analyse such manifestations.

In a first stage, society demands a particular group —in this case nurses— to deal with those situations or contexts where a disruption or a risk to health may occur, and to which nursing provides care. Taking care is a universal phenomenon which is expressed through actions which differ in each culture and has different connotations in the care providers and the receivers, depending on experience and meanings. There are also particular circumstances such as ideologies and power relations which set the conditions in which the care is administered and which indeed have consequences for the care providers. As Marie Françoise Collière (1982) stated, to care is to keep life going, and all living beings deprived
of care die, thus referring to earlier times and to the present day, which makes us aware of the need and permanence of the nursing care.

We need to point out that the activities involved in care have different levels of complexity: for instance, unqualified people may assume certain levels of care with their relatives or other individuals who may require it, even using technological means. Even in a situation where nursing care is in practice provided by a lay person, the necessary skill has to be imparted by a professional nurse. This was the practice until the institutionalisation of care.

The activities and interventions of nurses throughout the history of the profession are a reflection of the nurses' thinking about nursing. They constitute a deposit of their personality and performance which gives them an identity. This deposit is the constitutive element of nursing history which allows us to understand why there is no profession without tradition and therefore without history. This nursing deposit is the overall answer given by nurses to social needs. Therefore, it is not difficult to appreciate that the relationship between nursing and society has indeed been a special one.

This special relationship receives from society three characteristics which identify nursing as an essential public service:

1) The specific training in nursing: this implies a particular way of learning and understanding based on a constant reflection about the nature of care and health. Through training, professionals acquire authority in nursing.

2) The legislation which can be traced down in time and which establishes, defines, shapes and identifies the professionals by implicitly setting the scope of the actions and, of course, the constraints as well.

3) And finally responsibility; in the development of training and the identification of professionals there is a tacit commitment to perform in an optimum manner, avoiding injury and unsought consequences. In any case, there are social mechanisms for the control of the actions of nurses who could be held responsible for their acts. At that level, nursing has established self-regulations for the analysis of the responsibilities for the actions, that is, a code of conduct.

Society provides certain levels of protection and monopoly in nursing practices which – before their development in England and Spain – were influenced by prejudices against women, this being the majority group in the development of
nursing care. In Spain, this type of bias had an effect upon nursing schools before the 1950s, when the 'practicantes' tried to avoid their establishment.

The shortage of nurses is the focus of numerous debates in the English Parliament; it is striking how often the issue of its public nature has been used to demand the adaptation of the professional group, lowering the admission and training standards with a view to increasing the number of nurses who could then meet the care demand of the population.

3.2 Professional Traits School Indicator: Skill-Based Theoretical Knowledge

3.2.1 Training and Education in England

In England and Spain, nursing training and education represents today a period of socialisation – at least three years of formal training – that transmits to nurses a great variety of skills, with a broad intellectual content, identifying special forms of knowledge that should be applicable to the concrete problems of living in society.

The amount of knowledge in nursing cannot be acquired by the students’ own efforts, but only under special schemes of training that combine theory and practice under the supervision of other nurses who have the responsibility to educate future practitioners. The training of nurses gives the students the tacit knowledge of nursing, what Wilensky (1964: 149) described as “acts of understanding complex entities which we can not fully report”.

The education of nursing is initiated after obtaining a specific General Certificate of Education, with ‘O’ or/and ‘A’ levels. Currently nursing education is undertaken in higher education centres, colleges and universities, that leads to the student achieving understanding of abstract, expert, nursing knowledge which is organised under specific rules and principles.

The final and more important objective is to foster the judgement and discretion of nursing students giving them resources to decide what should be done in the face of the daily problems that students as professionals of nursing in the future will face in their relation to people in society.

In both countries, England and Spain, the professional commitment is inculcated, and every one of the nursing professionals has the duty of maintaining his knowledge up-dated (code of conduct), increasing his knowledge by research or
by taking some additional courses in nursing science. In sum the professional life of nurses is expected to be a commitment to their profession.

a) St. Thomas’s School of Nurses in London

As Rhodes (1984) notes, undoubtedly every commencement is difficult: the initiation of the first school of nursing must have had a lot of problems. Maybe the doctors felt threatened, or they thought that with training they would have more difficulty in finding able nurses.

One of the opponents of developing the nursing school was South, a surgeon at St. Thomas’s, who produced a pamphlet entitled *Observations on Training Establishments for Hospitals’* (1857) in which he comments:

> That this proposed hospital nurse-training scheme has not met with the approbation and support of the medical profession is beyond doubt. The very small number of medical men whose names appear in the enormous list of subscribers to the fund cannot have passed unnoticed. Only three physicians and one surgeon from one (London) hospital, and one physician from a second are found among its supporters.

In 1859 negotiations were entered into by the Nightingale Fund Committee with the treasurer and governors of St. Thomas’s Hospital to set up a training school. The hospital was to receive from the Nightingale Fund approximately £22 per head for board and lodging for each probationer (Prince, 1984: 155). The period of training was originally one year, but at the end of this time nurses were expected to take up a post selected for them by the fund Committee and to remain answerable to it for a further three years (Rhodes, 1984: 42). Each student nurse was supplied with a ‘List of Duties’ and progress, which was controlled by the matron, by the Fund Committee and ultimately by Miss Nightingale.
Apart from social etiquette, discipline and character formation, they were given a list of duties which is extracted from Nightingale's writings (quoted from Meyrick, 1991: 66-67).

Future nurses are expected to become skilful:

1) In the dressing of blisters, burns, sores, wounds, and in fomentations, poultices and minor dressings.
2) In the application of leeches, externally and internally.
3) Applying administration of enemas for men and women.
4) In the management of trusses, and appliances in uterine complaints.
5) In the method of friction to the body and extremities.
6) In the management of helpless patients, i.e. moving, changing, personal cleanliness of, feeding, keeping warm (or cool), preventing and dressing bed sores, managing position.
7) In bandaging, making bandages, and rollers, lining of splints, etc.
8) In making beds of the patients, and removal of sheets while the patients is in bed.
9) You are required to attend at operations.
10) To be competent to cook gruel, arrowroot, egg-flip puddings and make drinks for the sick.
11) To understand ventilation, keeping the ward fresh by night as well as by day; you are to be careful that great cleanliness is observed in all utensils; those used for the secretions as well as those required for cooking.
12) To make strict observations of the sick in the following particulars:
   - the state of secretions, expectorations, pulse, skin, appetite, intelligence, as delirium or stupor;
   - breathing, sleep, state of wounds, eruptions, formation of matter, effect of diet or of stimulus, and of medicines.
13) And to learn the management of convalescents.

The following injunction was also included in the memorandum; In it the nurse in training was required to be:

- Sober, in spirit as well as in drink, and temperate in all things.
- Honest, not accepting the most trifling fee or bribe from patients or friends.
- Truthful, and to be able to tell the truth, includes attention and observation, to observe truly – memory, to remember truly – power of expression, to tell truly what one has observed truly as well as intention to speak the truth, the
whole truth, and nothing but the truth.

- Trustworthy, to carry out directions intelligently and perfectly, unseen as well as seen, “to the Lord” as well as unto men — no mere aye—service.
- Punctual, to a second and orderly to a hair; having everything ready and in order before she begins her dressing or her work about the patient; nothing forgotten.
- Quiet, yet quick; quick without hurry; gentle without slowness; discreet without self-importance; no gossip.
- Cleanly and neat, to the point of exquisiteness, both for the patient’s sake and her own; neat and ready.

With such exemplary rules and aims, strictly enforced in an environment closely similar to that of a religious order, it is clear that the formation that they received was basically aimed at their character. However, it seems that this list of duties was the only syllabus of this school.

The trainees had to be between twenty-one and thirty-five to be admitted to the Florence Nightingale school. No hospital receives a probationer under twenty-one years of age, and twenty-three or twenty-four was more general.

It was clear at that time, as noted by Rhodes (1984: 41), that the ward sister carried out programmes of nursing formulated by doctors:

> The Nightingale Fund initially paid a fee to Mrs Wardroper, the matron of St. Thomas's to oversee the moral conduct of probationers and to be head of the school. The medical resident, Mr. Whitfield, received a fee for 'instructions' of probationers; and sisters who helped with the training also received a fee from the Fund. But despite these arrangements, it is difficult to ascertain exactly what was taught in the early days.

Nurses concentrated on character formation and the practical aspects of the trainees and it seems that medical personnel offered the scientific content.

Seymer (1960) presents the opinion of one of the early probationers who says in regard to the formal training at St. Thomas:

> Progress was slow in regard to organised teaching. When I entered the school in 1867 there were a few stray lectures given, some antiquated medical books and a dummy upon which to practice bandaging: the taking of temperatures, pulse and ordinary test for urine being strictly the work of the medical students. (Seymer, 1960: 43)

Rhodes’s (1984: 45) comment that certain techniques were reserved for students of medicine due to the fact, as he says, that “they were of a diagnostic nature”. He also notes:
It seems that the first ten years of the Nightingale school were not the great success implied by most histories. Probationers were learning practical skills on the wards from sisters who were themselves untrained and who represented the nursing system so often criticised by the reformers. In addition to this they were receiving only a few lectures or ‘instructions’ from a medical practitioner. Not an auspicious start for a new ‘profession’. (Rhodes, 1984: 45)

By 1870 F. Nightingale had become more personally involved and, according to Baly (1982: 9), she was not only disappointed but also horrified at what she found at St. Thomas’s. The probationers themselves thought their training was totally inadequate.

This provoked a letter by Miss Nightingale to Henry Bonham-Carter in which, among other things, she said:

Our school is not a training school, it is taking half the hospital work ... the capable probationers are actually doing Sister's work

In another letter to the same person she said: “Our Sisters at St. Thomas’s do not give instruction as promised”. Apparently, the treasury had been only concerned with saving money, staffing the hospital at least cost. This, undoubtedly, had to bring about cheap staffing of the hospital at the expense of adequate nursing education. Miss Nightingale wanted the hospital sisters to become more personally involved in the instruction of future nurses, involvement which up to that point, had been practically non existent.

Medvei and Thornton (1974: 248) quoted what one of the first entrants to the St. Bartholomew’s school had to say in 1877 about the training of nurses:

How were we taught? Well, by sisters – very little... Few of the sisters both could and would teach us. Sir Dyce Duckworth or Mr. Willet lectured to us or gave us a practical demonstration. Mr. Willet used to have in his out-patient children and teach us to bandage, to put on splits, to make and apply plasters, bandages and so on. Sir Dyce would take us into the wards and give us a lesson on bedmaking, poultice making, or the contents of the doctors’ cupboard, or down to the bathrooms where he and Old Williams, the bath-

man, used to show us the best way to get the patients in and out of the bath and how to prepare special baths of various kinds.

Besides showing discontent for the fact that few sisters were actually involved in the training of future nurses, this quote points out the fact that often the tasks of medical and nursing personnel overlap showing the need of an adequate task distribution.

Anning (1966) records that in 1869, the Governors of the Leeds General Infirmary resolved that the duties of nurses should be strictly confined to nursing and that they must not participate in general cleaning or scrubbing the floor.

Seymer (1960: 163-165) also states that in 1879 a memorandum of instructions was issued, this directed the sisters’ attention to the list of duties e.g. bathing, dressing, temperature, pulse, etc. that they were responsible for instructing the probationers in their practical training on the wards. Rhodes (1984: 48) quoting Baly, comments that in this list of duties there is no mention of domestic duties but he gave the example of a probationers’ diary that thirty years later shows that a lot of time was expended on cleaning. This situation persisted until 1968 when a report on non-nursing duties was issued by the Department of Health and Social Security (DHSS, 1968: 22-23).

In the second half of the 19th century certain required details were the same everywhere; these details were questions which were put to every would-be probationer at the Nightingale School of Nursing in connection with St. Thomas’s Hospital. Billington (1893: 166) describes these details as follows:

1) Name in full and present address of candidate.
2) Whether single or widow? If a widow, name in full and former occupation of husband.
3) Age last birthday, and date and place of birth.
4) Height? Weight?
5) School or schools at which you were educated?
6) Of what religious denomination; name and address of clergyman or minister who knows you.
7) Are you strong and healthy? and you always been so?
8) If a widow, have you children? How many? And are they provided for during the term of training?
9) How have you been occupied during the last three or four years?
10) Name and address of your last employer (if any).
11) Give the full name, address and occupation of your father, or if not living, his former occupation and the present address and occupation of your mother.
12) Are you prepared to make payment? and whether at the
rate of £30 or of £52 if not, explain your circumstances, as far as may be necessary, to the matron.

13) The names in full, and addresses of two persons to be referred to (ladies preferred). State how long each has known you.

14) Name and address of candidate’s usual medical attendant

15) Have you read and do you clearly understand the regulations?

Supposing all these questions were satisfactorily answered, and that the hospital had a vacancy, the young woman, if she could afford to enter as paying probationer, entered on a six months’ course, and if she was not able to do that, she would enter for a month on trial.

One major contemporary claim was that nursing was becoming suitable for well-educated women, and that indeed more and more nurses were better educated. As Nettleton said (1972: 1615):

If you wished to become a nurse you needed a good education, which meant you probably went to a board school until 12 years and then to a private one for two or three years, usually your Vicar and Doctor would give references and then three months trial in the hospital to determine whether you were suitable or not.

Recruits to Chelsea Poor Law Infirmary in 1898 were expected to possess a fair education; at Manchester Royal Infirmary they were supposed to be ‘well educated’ women; at Bristol General, would-be nurses were asked to pass a preliminary examination in ‘general knowledge’ or else provide evidence of equivalent examination success, a practice favoured by several contemporary hospitals. Quite apart from essentials of reading and writing ability, the general impression about recruits is that character is more important than educational achievement (Maggs, 1978: 55).

Seeing this we must not forget that at this time the standard of entry was quite high, according to Nelson (1976: 40):

many nurses came into hospitals from upper—and middle—class homes (cultured background, in fact) and anyway, since the choice of profession was so narrow for all women, the level of natural ability and intelligence of the women coming into the profession must have been extraordinarily high.

If she is successful she will have to bind herself to the hospital in some such terms as these:
Having now become practically acquainted with the duties required of a hospital nurse, I am satisfied that I shall be able and willing, on the completion of my year’s training, to enter into service in a public hospital or infirmary, and I engage, in return for the advantages bestowed upon me, to continue in such service for the space of at least three years, in whatever situations the committee shall think suitable to my abilities, it being my intention from henceforth to devote myself to hospital employment. (Billington, 1893: 166)

The nursing courses varied at different hospitals, but if the trainee had attended lectures and passed examinations she would become a nurse in that hospital.

It is when this stage is reached that the profession begins to offer diverging courses for the future; for, with the certificate fairly won at the end of the third year, she may either elect to remain on in the hospital in which she has been trained (and many women feel a little honourable obligation to do so, after the trouble they had taken in learning their work), and in that case promotion to the rank of charge nurse would then probably follow soon.

Private nursing is the other course which lay open at the end of the three years’ training, and on this a lady of great experience writes:

Though it may offer better pay for the moment, and a change of scene, it has not the future to it that hospital work has. It is a very good experience for nurse for a short time, but after a couple of years it is often found more irksome than hospital work and less stimulating to the intellect. (Billington, 1893: 167)

b) General Nursing Council and Education

In December 1919 an Act to provide for the Registration of nurses was approved, and established the General Nursing Council, which made rules for the following purposes: for regulating the conditions of admission to the register and requiring that the prescribed training shall be carried out either in an institution approved by the Council in their behalf or in the service of the Admiralty, the Army Council, or the Air Council.

By 1920 a draft schedule for the approval of training schools had been adopted by the General Nursing Council. It contained six principles:

1) A one portal entry. This referred to a preliminary examination which all must take irrespective of the register being trained for.
2) There should be a general standard of nursing education in all schools.
3) A Preliminary Training School should be established, i.e. there should be a period of theoretical preparation before introduction into the wards.

4) The length of training to be prescribed.

5) Details of hospitals to be made available to the General Nursing Council.

6) A minimum standard of general education for entry to nurse training.

These principles are obviously concerned with professional control of education; ostensibly to raise and guarantee standards. They also constitute closure by the principle of exclusion of ineligible entrants, alternative routes and inferior training.

One year later, in 1921, the Education and Examinations Committee of the General Nursing Council prepared a syllabus of training to be compulsory for all training schools. For the first time it constituted a body of theoretical knowledge which all students of nursing had to study. The period of training was to be three years with theoretical and practical work throughout.

But this compulsory common training syllabus recommended by the General Nursing Council, was not accepted by the Minister of Health. The General Nursing Council eventually prepared an examination syllabus and agreed that the training syllabus should only be advisory. It seems that a common curriculum could not be imposed on institutions but a common syllabus could be examined. Those interested in producing registered nurses and maintaining their reputation implemented the ‘advisory syllabus’.

In 1921 the first academic nursing course was offered by the University of Leeds introducing a Diploma in Nursing, followed by London University which started a similar diploma in 1924. The latter has survived and was drastically revised recently giving it a longer duration with a distinctly nursing focus.

Monk (1923), in a pamphlet, said that in the old days women entering the nursing profession had no thought of salary it was their religion, their life. She said that it was necessary for a woman wishing to become a successful nurse to have had at least a secondary education, on which to build her general teaching of nursing because of the important advances that medicine had made. In the pamphlet she described the different work available for a nurse, and the entry standards for training and its duration:
**General Nursing Training**
The ground work for all the branches of the nursing profession is Probationary Training in General Hospital. Probationers are taken as a rule between the ages of 21 and 35, though some hospitals (and all children’s hospitals) accept suitable applicants from 18. Length of training: 3 to 4 years.

**Mental Nursing**
The certificates of the Medico-Psychological Association are granted to Nurses and attendants who have received training in an Institution for the treatment of Mental Disorder for no less than twelve months before sitting for the preliminary Examination, not less than two years before the intermediate, and no less than three years before the final examination.
Nurses possessing certificate of three years training in a General Hospital or Poor Law Infirmary are exempt from preliminary and intermediate examination and are eligible for the final examination after a further training of two years in one recognised institution.

**Fever Nursing**
Probationers are received at the age of eighteen. Three years’ training to become Staff Nurse if required examination is passed. The certificate is given at the end of third years.
The Fever Nurses' Association imposes the following conditions on membership:
   a) Two years training in Fever Hospital recognised by the Association and containing at least eighty beds.
   b) Passing of an examination controlled by the Association or recognised equivalent.

**Prison Nursing**
For HM Prison Nursing Service the three years’ General Nursing Certificate is required with Central Midwives Board (CMB) or Medico-Psychological Society Certificates in addition. The age limits are 24-35.

**Orthopaedic Nursing**
Orthopaedic Nursing offers opportunity to the probationer of 18-30. At the end of two years’ ordinary Hospital Training, the probationer may take Massage and Medical Gymnastic training for fifteen months, after which good posts can be held.
**Ophthalmic Nursing**
Probationers are trained for one to three years. Ages 19-30. For staff Nurses in Ophthalmic Hospitals three-year previous training in a General Hospital is necessary.

**Army and Navy Nursing**
Three-years training in a London General Hospital where men patients are received for medical and surgical treatment

**Nursing in India**
Three-years general hospital training
The CMB certificate. Some experience of tropical diseases.

**District Nursing**
The usual qualifications for District Nurses are: three years’ training in General Hospital or Infirmaries
Training in District Nursing no less than six month, including maternity Nursing. The CMB certificate.

**Health Visitors**
The qualifications required for the profession of Health Visitor consist primarily of the certificate prescribed by the regulations of the Board of Education, i.e. a two years’ course (for candidates without previous training or experience), or one year for fully trained nurses, women with a previous experience, or those with university degree. For obtaining a post it is extremely advisable to take, in addition, the CMB course (four months for fully-trained nurses, six to twelve for others).

Some time later the entrance requirements became again a target of the General Nursing Council who decided that no one should be permitted to enter nursing training, after June 1936, who did not possess the General School Certificate or equivalent, or pass a special test set by the Council. Otherwise, those candidates who, lacked intellectual capacity or educational attainment, would be eliminated. This move evoked opposition from hospital administrators who were afraid that it would cause a fall of recruitment. Because of this opposition, the first test was not held until November 1937 and it was abandoned two years later at the outbreak of war.

In mental nursing until 1945, there were two competing examinations for state registration: one under the Nursing Council, while the great majority of mental nurses held the qualifications of the Royal Medico-Psychological Association. The Medico-Psychological Association had been founded in 1841, and later ob-
tained a Royal Charter. They had published a handbook on mental nursing in 1855, started a three years training scheme and began to issue certificates. Recruits for such a training were as yet few, but from this beginning arose the special register for mental nurses established in 1919 by the Nurses’ Act.

In 1945 the GNC proposed that all qualified mental nurses should be registered by a statutory body and there should be only one qualification. Attempts to secure a compromise between the two examining bodies having failed. It was decided by Parliament that the Royal Medico-Psychological Association examinations should be discontinued, subject to some indispensable conditions, including complete protection for nurses already holding the Association’s certificate and of the training schools which the Association had recognised52. In this way the existence of only one examination for mental nurses and only one registration preserving the rights of the already recognised by the Royal Medico-Psychological Association was secured.

In January 1946, under the chairmanship of Sir Robert Wood, a Committee was set up by the Minister of Health (HMSO, 1948) to review nursing services. The committee had a wide-ranging brief which included the recruitment and training of nurses, the nature of the nursing task and the training required to prepare for it, and drop-outs.

Before the final publication of the Wood Report, according to Breviate Parliamentary Papers53 it was reported that, at this time, the average working life of the nurse was only nine to ten years, and that 9,000 were needed for the annual replacement before there could be any expansion. This meant that there was a great wastage of trained nurses. The system broke down primarily because of the 50 per cent wastage of student nurses during training. It made new requirements for recruitment necessary to change the situation of nursing.

On recruitment, it emerged that exactly the 54 per cent of student nurses failed to complete their training. Apart from marriage, the chief cause of wastage during training was the traditional code of discipline and control over personal life unsuited to a generation nurtured in modern ideas of freedom and relation between the sexes. It was argued that nurses in training had be accorded full student status and not subjected to an outworn system of discipline. The training

53 To Review the position of the Nursing Profession, see: A Breviate of Parliamentary Papers 1940-1954: 326-327
day should be reduced to approximately to the normal working day, and this involves the introduction of a 3-shift system.

Nearly half the nurses had received full-time education up to the age of 14 or 15, another 30 percent further education without reaching School Certificate standard and only 4 percent reached Higher School Certificate level and above.

The Wood Committee (HMSO, 1948), outlined the changes which were needed to enable nurses in training to be treated as students:

- First, if student nurses were relieved of domestic work and of repetitive nurses duties dictated solely by the staffing demands of hospital, a period of two years, based on a five days training week of 40 hours and allowing for six week annual holiday, would suffice for a general training more comprehensive and effective than that now given.
- Second, the course of training must be dictated by the needs of the student and not by the staffing requirements of hospitals.
- Third, the financing of nurse training should be independent of hospital finance and be drawn from public funds.
- Fourth, students should be under control of the training authority and not of the hospital except as necessary for teaching and care of the patients.

Student nurses should be responsible to the training authority, and not to the hospital. Their services would be needed for some time to come, but after a given date there should be no more admissions, and their duties should be transferred partly to trained staff and partly to the nursing orderlies who would replace them. Proposals were very advanced for this time, and they were not implemented. The hospitals and the GNC rejected them because, it meant an increase in the staff of the hospitals at a time that, as can be seen later, there was a critical shortage.

After the war, in 1945, the GNC asked the Minister of Health to return to the test of education as before the war, but the Minister refused because of a critical shortage of nurses. In 1948 the General Nursing Council engaged the National Institute of Industrial Psychology to design a suitable test which would select out unsuitable candidates for training, They had been tried out from some 2000 candidates entering training in that year, in anticipation of an eventual agreement by the Minister of Health to introduce it (White, 1985: 584). But the Minister studied the report on this experiment and decided in 1952 that he could not consider the institution of the test by the GNC.
By this time, as White (1985: 588) says,

there had been eleven years of open recruitment and many senior posts
had been filled by nurses entering the occupation without formal educational
qualifications. These nurses felt vulnerable to the possible challenge from
better educated recruits if a minimum standard of entry was reintroduced.
They argued that nursing was a practical occupation and should remain so.

In the Nurses Act of 1949, training allowances were to be paid by the hospitals,
the student and pupil nurses continued to be employees of the hospitals, the
content and standard of nurse training had to be approved by the Minister. The
finances for the Area Nurse Training Committees, however, were restricted to
funds for the salaries of the tutors and clerical assistance; those for research
were almost non-existent. The finances were nominally in the hands of the pro-
ession but the ministry cut it each year.

Probably the single most significant development of the Act of 1949 was the
growth of experimental forms of training, giving the Council the possibility of de-
veloping trial schemes of training and examinations to be undergone and passed
by persons as a condition of their admission to the register or, as the case may
be, the roll.

The GNC, and others in the nursing profession, continued to ask for the return of
the test until it was finally granted in 1959, to take effect from 1962. The GNC
set this level at two ‘O’ levels in the General Certificate of Education or the
equivalent of a score of 30 in their National Institute test.

In 1962 the GNC produced a syllabus that represented the first real revision of
what was considered appropriate knowledge for nursing and included the princi-
ple of integration of subject matter, the curriculum based on this new syllabus
had to be submitted and approved by the GNC before it could be implemented in
any school. The statutory body thus obtained a greater degree of control by what
amounted to a system of validation: powers additional to vetting the suitability of
training schools granted by the 1919 Act.

Two years later, *The Lancet*\(^{54}\) made proposals for the training of the nursing stu-
dent who aims at registration and these were for the first two years training giv-
ing service to patients only in the context of her own studies. The third year
should be spent in full-time service as a pre-registration student. She should re-
ceive an educational grant for the first two years; and in the third, as a full mem-

\(^{54}\) *The Lancet* (1964) Reform of the Nursing Education, June 20: 1375.
ber of the ward team, she should be paid two-thirds of the minimum of staff nurse’s salary. The educational requirements for admission to training for the register should be increased from 2 to 5 passes at ordinary level in the General Certificate of Education. And they hoped that the establishment of a degree course in nursing would not be long deferred.

The Platt Committee was set up by the Council of the Royal College of Nursing in 1961, it had a large membership of twenty three nurses, eight medical practitioners, five educationalists and one hospital administrator. This committee considered some experimental programmes to be run under the terms of the Nurses Act of 1949. One of the more interesting conclusions that they asserted is on page fourteen: “the principles of nursing can be taught as a university subject”.

The committee recommended the age of entry at eighteen years but that there should be discretion to admit candidates from the age of seventeen and half years. However, they left the door open to candidates leaving school at age seventeen or over with passes at advanced level in the General Certificate of Education, who should, if suitable in other ways, be able to proceed to nursing studies.

The minimum educational requirements for entry to the School of Nursing should be passing the General Certificate of Education at ordinary level in no less than five subjects. One of these must be English and in the others it would be preferable to include science. The committee, however, said that educational standards are not the only criteria; attitude and personality are vital factors in determining the students’ suitability and should be taken into account.

The course would occupy a period of three years, the first and the second year would cover academic study and controlled clinical experience, the third year would be spent in practical work as a full member of the ward team under supervision taking increasing responsibility for the nursing care of patients.

In essence the proposals from the Lancet Commission and the Platt committee were the same. Many of these recommendations were implemented as we can see in a pamphlet distributed by the National Health Service (HMSO 1965: 4-5) addressed to young people suitable for recruitment.

This pamphlet asks questions and gives the replies:

Would I be suitable for training? If you are 18 years old, and have two “O” level General Certificate of Education passes or Grade I passes in the Certificate of Secondary (one subject must be English or Welsh Language or Literature or History) plus a reasonable standard in five other subjects. If,
however, you have three or more GCE “O” levels or certificate of secondary education Grade I passes, including one in the subjects mentioned above, you will not need to produce evidence of a satisfactory standard in five others subjects. From January 1966 these requirements apply also to (RMN and RNMS students) If you do not have any educational certificates, at many hospitals you will be able to take as an alternative a standard educational test.

If I am not yet 18 what should I do until I am old enough to start training? You will be better to stay at school and take as good a leaving certificate as you can get.

If for any reason, however, you cannot do this, then you might care to ask your head teacher for information about the nearest hospital nursing cadet scheme or pre-nursing course. Some of the hospitals organise nursing cadet schemes for girls and boys who are 16 years and over. Cadets who are paid, work in a number of different departments in the hospital and attend classes for further education for one or two days a week. A pre-nursing course will last a year or more, embracing both general education and some nursing subjects.

If you have already left school, any job which enables you to know people or widen your horizons would be useful. You could also learn a great deal and maintain your interest in nursing by joining the St. John Ambulance Brigade or the British Red Cross.

The Salmon Committee on hospital nursing management (set up in 1963) and the Mayston Committee on community nursing (set up in 1969) sought a new hierarchy and divisional organisation for nursing with the blessing of the Royal College of Nursing. Salmon proposed that the status of each grade of nursing should be determined, not by the number of beds or the number or type of patients nurses in that position controlled, but by the type of decisions they made. One of the aims of the Salmon structure was “to improve patient care by introducing a clearer pattern of nursing administration and relieving ward sisters and charge nurses of some administrative work thereby enabling them to concentrate more on patient care and on teaching”. This presupposed a qualitative change directly affecting the contents of nursing work.

In 1969 the GNC issued a new syllabus which include some of Salmon’s ideas and became compulsory on the 1st January, 1971. This was not substantially different from that of 1962 excepting that in the preface it clearly affirms a total patient care approach.
In March 1970, under the Chairmanship of Professor Asa Briggs, a committee was set up by the Secretary of State of Social Services with the aim of reviewing “the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of a integrated health service” (HMSO, 1972). In this report there is a special interest in developing nursing education with particular emphasis on its quality:

The objective of education is to raise the quality of patient care. It is the quality of education which concern us, not the possession of more formal certificates. (HMSO, 1972: 93)

It further states:

We recognise the complexities inherent in balancing work in the clinical and other settings, but stress that basic education should fit a nurse to work in any field at the basic level of membership in a nursing team. (HMSO, 1972: 86)

In the same paragraph the importance of clinical practice is given, “Basic nursing skills can be learned thoroughly, we believe, only in clinical practice”(HMSO, 1972: 86). Thus importance is given both to an adequate theoretical training as well as to clinical practice but emphasised that basic nursing can only be learned through adequate clinical practice.

In regard to entry requirements to the profession, the committee also tries to cover most aspects saying

it will be necessary to recruit from applicants with different initial academic qualifications, ranging from average intelligence to the highest. (HMSO, 1972: 82)

The document goes on to express in detail the different aspects of entry:

we believe ... there must be a flow of entrants direct from school into nursing with completed sixth form experience or its equivalent and with similar academic qualifications to those of university entrants. For entrants with high initial academic qualifications, those universities ... will employ their own criteria for entry. (HMSO, 1972: 82)

The profession will also need access to a larger number of entrants who on the basis of present educational qualifications have at least four ‘O’ level passes or their equivalent. In this point the report makes some optimistic estimates about
the amount of girls and boys leaving the school with ‘O’ levels for the following

ten years.

In the report it was suggested that a proposed “Higher Certificate will appeal to

substantial numbers of these entrants and to those with ‘A’ levels. The training

for any qualification within the profession would depend not on initial academic

qualifications at entry but upon performance achieved during the course of nurs-
ing education: the relationship between secondary school performance and suc-

cess in nursing is still uncertain. While therefore, we wish to draw attention to

the need to attract candidates who have ‘done well’ at school, we believe that

nursing often appeals to people who have a high degree of motivation. Suitability

should not be determined by ‘O’ levels alone, we urge the Central Nursing and

Midwifery Council to promote and encourage further research on selection pro-

cedure” (HMSO, 1972: 82-83).

In sum and according to the report, selection procedures at the point of entry

should include:

1) a scrutiny of school performance and other related records;

2) a consideration of the applicant’s special interest bearing in

mind service to other people and ability to establish per-

sonal relationships;

3) a study of the reports of referees based on headings pro-

vided by the nursing authorities;

4) a planned interview in which consideration would be given

to all aspects of the applicant’s qualifications relevant to

nursing;

5) evidence provided by standard test of intelligence.

The report finishes with a recommendation saying that “it is essential that each

college of Nursing and Midwifery should recruit students with a wide range of

abilities”. Why is a wide range of abilities important? what kind of abilities? It is
difficult to understand, why this is specially applicable to nursing, and not to

other academic courses? They described new candidates in this part of the re-

port, as “people with average intelligence or more who, though they may have

few formal academic qualifications”. The report further adds that these people

should have a wide range of abilities to enter nursing. Nevertheless, is it possi-

table to apply this recommendation to any career?

A large number of bodies recommended to the committee that the age of entry,

subject to safeguards, should be lowered to seventeen. And in the summary of

recommendations it is said that the age of entry should be reduced from eight-

een to seventeen in two stages of six months, to 17 1/2 in 1973 and to 17 in

1975. To achieve this (HMSO, 1972: 85), strong arguments have often been
raised in the past, saying that some young women and men who have hitherto not been able to wait until the age of eighteen have taken alternative jobs have been permanently lost to nursing. They wanted to maintain continuity in the educational process and avoid diversion of enthusiasm into other channels.

The NHS itself recommended through its pamphlets to attend pre-nursing courses (HMSO 1965: 4-5). In the report it is said that no precise figures are available but about seven thousand cadets were in hospitals in England and Wales engaged in pre-nursing courses.

Sixty-six per cent of all hospital nurses and midwives in the survey carried out by the committee, had a job before they started nursing; to many entrants the period before entering to training school was simply an uncreative period of marking time. For the committee it was essential to establish measures to ensure that young students are not exploited as ‘pairs of hands’ as an effect of lowering the age of entry.

Whatever their initial qualification and whether they wished to be concerned primarily with community or hospital care, all entrants, once in the profession, entered in a common basic training, and this should provide a sound basic education in nursing leading to a basic Statutory qualification. This qualification is called the Certificate in Nursing Practice (Cullinan, 1972: 1562-1563; Collins, 1977: 86). The whole basic course will last a minimum of eighteen months. Those who wish and are able to train further can proceed to registration, a further eighteen months course should lead to a secondary statutory qualification, i.e. registration. There should be a higher certificate in a particular branch of nursing designed to attract a limited number of nurses with an academic bent (Collins, 1977: 86).

The Briggs report does not spell out how examinations should be structured and conducted and it recommends “that the education Boards should make a close comparative study of assessment and examination techniques in different professions where changes in procedures are still incomplete, and thereafter keep nursing and midwifery assessment under careful and regular review” (HMSO, 1972: 95).

The objectives of the examination and assessment system should be: to promote high standards of safe nursing practice in the interest of the patient; to compare the performances of the candidates in a similar setting, in interest of the individual nurse and in the long term interest of the National Health Service; to associate the testing situation with the learning situation in such a way that the student can gain educationally from the experience. There should not be one
single point at which student practice is observed and tested. There should be repeated observations.

With respect to teaching, at the time the report was issued, the shortage of nurse teachers was traditional in nursing. In the report we read expressions such as:

Few ward sister or charge nurses have had any preparation for teaching, and many of them object that classroom teaching is not realistic because things are not done in the same way as in the ward. (HMSO, 1972: 70)

This could be explained because the nurses felt themselves insecure in an arena like teaching were they had no experience; besides "some sisters are threatened by a knowledgeable student, or the one who uses initiative which is appreciated in an emergency only" (HMSO, 1972: 34), because they are all conscious of the lack of training and knowledge. The sisters have to overcome this feeling of insecurity by imposing strict rules of conduct on student nursing reducing their discretionality power. However, as some students would observe:

Training tends to destroy initiative, discretion and common sense dampens the enthusiasm which most nurses have to get to know and look after ill people. (HMSO, 1972: 34)

Thus the report proposed that health authorities cease to employ the staff of nursing education divisions, midwifery tutors and district nurse tutors who would be transferred to the new Colleges of Nursing and Midwifery and become employees of the Area Education Committees55.

All these proposals, however, raised many fears concerning matters in the Health Service, but in fact many of the proposals of the Briggs Report were implemented in the Nurses Act of 1979. In a document of the Department of Health and Social Services it is explained that these changes would have no negative effects:

It has been suggested that these proposals will leave health authorities with no responsibility for nurse training and with the consequent risk that they must lose interest in the subject. The government does not accept this. It is quite true that health authorities will cease to control the provision of nurse education and training but their participation will be essential. As the main employer of nurses, midwives and health visitors the National Health Ser-

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vice has a vital interest in their education and training and continuing and inescapable role in providing the clinical facilities within which education and training can take place. (DHSS Welsh, 1976: 1-2)

This 1969 syllabus was re-printed in 1975 but in 1977 an amended syllabus was issued in which a number of significant changes can been seen. Firstly, the time for study was increased with a minimum of 24 weeks.

Secondly, although section one retained its title, the introduction included the topic ‘Code of Professional Practice’ and a new sub-section entitled ‘Preparation for professional responsibility’, which includes an introduction to nursing research. A review of all syllabuses from 1923 to 1969 reveals that this is the first time that either the concept or the subject of research have been mentioned (Rhodes, 1984: 63).

The latest legislation to bring about a change in nursing education to date has been directive 77/452/EEC which reads:

> Concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

This directive, therefore, presents articles dealing with conditions which must be met for the mutual recognition of professional qualifications and of the right to practice in member states, which are included in the development of the syllabus of nursing in England.

The Wood Report (HMSO, 1948) made the recommendation that there should be a “common register” replacing the existing general register and the supplementary registers. The Nurses, Midwives and Health Visitors Act of 1979 created a unified statutory body for nursing and subsequently a single register became a reality.

For this reason the role and functions of three similar but different professions (Nursing, Midwifery, Health Visiting) are being defined and evaluated in terms of areas and job demands. The creation of a common core skeleton for a new education and training is not by any means a simple straightforward task. The variety of legitimate demands from these three professions, and also from diverse interest groups and representative bodies within each, needed to be canvassed in order that future perspectives could be, as it were, projected back in time to the initial legislative framework for the newly structured profession.
The purpose of the Act of 1979, was to replace the existing separate bodies responsible for the education training and regulation of professions by a single central United Kingdom Council supported by powerful national boards in each of the four British countries it would, for the first time, bring the professions under one umbrella, and for the first time, bring together the nurses, midwives, and health visitors of England and Wales, Scotland and Northern Ireland. The Act does not of itself make any change in the substance of professional education and training, but it paves the way for the professions themselves to initiate a new system of integrated training on the lines recommended by the Briggs Report when the substantial resources which such a change would require are available.

Never before had the subject been looked at in the context of an integrated health service. The main purpose of the Act was to establish a United Kingdom Central Council for Nursing, Midwifery and Health Visiting, and four national Boards. The Central Council was to prepare and maintain a central register of qualified nurses, midwives and health visitors and to determine, by means of rules, education and training requirements and other conditions for admission to the register.

The 1979 Nurses Midwives and Health Visitors Act was a step on the road to securing a unified voice for the professions in relation to the world outside and an important opportunity to ensure that each learned from the different perspectives of the others. The enormous variety of the professions, the long established separate status of midwifery together with the difficult period of transition being faced are factors to be acknowledged. Without doubt problems in size and diversity are greater here than for other professions in the health field.

The Briggs Committee outlined the need for change in the nursing profession, the government at that time recognised its validity and made space in the legislative programme for a new statutory structure which came into full operation in July 1983; the full task of reorganisation, however, was never completed; necessary adjustments to the pattern of educational preparation were not achieved.

Nurses, midwives and health visitors had acknowledged the need for a fundamental improvement in basic education, and the need for a complete restructuring of a complex and overlapping set of preparations, they had agreed strongly that the present arrangements in initial education were not appropriate for meeting health needs.

The council's strategy aimed at transforming the basis of educational preparation for nurses, midwives and health visitors in such a way as to provide:
a system of education geared to meeting future health needs,
a group of professionals able and willing to adapt rapidly to change,
a better relationship between education and service,
a simpler overall pattern of preparation, whilst maintaining and improving standards,
a greater degree of professional unity and constructive participation in health policy.

c) Project 2000 and Qualitative Changes in England

The Act of 1979 which set up the UKCC laid upon it the duty “to improve standards of training”. And the UKCC established a project in the summer of 1984 with the following terms of reference: “to determine the education and training required for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990s and beyond and to make recommendations”, this became known as Project 2000.

In the same year of 1984, a working group was set up to determine the kind of education required for the profession of nursing in the future, and to make recommendations. The Project 2000 Group recommended (Elkan, 1995: 386):

1) A new single level of registered nurse to undertake the work of the two levels of professional nurse which then existed.
2) A three year training, beginning with an 18-month common foundation programme followed by an 18-month branch programme, in either the care of the adult, child, mentally handicapped or mentally ill.
3) A reorientation away from the acute hospital setting towards the community provision of health care.
4) Academic recognition for professional qualifications
5) Stronger links between colleges of nursing and institutions of higher education
6) Students to be supernumerary for 80% of their time, with a 20% rostered contribution to service.

During the following two years the UKCC stimulated discussions for the identification of problems. In May of 1986 it published its major consultation report, Project 2000: a new preparation for practice, which contained a detailed analysis of the case for change. Between May and October of 1986 a large consultation of different professional members, the medical profession and other professional groups was undertaken.

To look further at the cost and manpower implications the management consultancy firm Price Waterhouse was engaged. As a result of all this work a strategy
for educational reforms was agreed. In 1987 the reform received the full support
of the Ministers of Health Departments of the United Kingdom and the recom-
mendations were accepted by the British government in 1988. The government
acceptance of Project 2000 proposals was conditional on agreement of two cri-
teria –widening the entry gate and deciding on the proposed support worker–.
The strategy had two principal elements:

- education and training reforms.
- proposals to improve manpower supply and retention.

The thirteen ‘demonstration district’ of Project 2000 implemented the reforms in
1989, currently, all but a handful of colleges have converted to a Project 2000
programme of training (Elkan, 1995). Since 1989, Project 2000 has been gradu-
ally phased in in England and Wales

The UKCC (1987) proposed a new division of labour with a single level of regis-
tered nurses, a more advanced grade of specialist and a support worker, ‘the
helper’. The training for both first and second level nurses was ended, although
the enrolled nurses in practice and in training must be recognised, and a stra-
egy developed for their conversion to first level if so desired.

The UKCC believed that the educational principle of shared learning should ap-
ply across many preparations for specialist practitioner and particularly in the
case of district nursing, health visiting, community psychiatric nursing, occupa-
tional health nursing, community mental handicap nursing and school nursing,
and prepared a syllabus of three years training beginning with an 18-month
common foundation programme, followed by an 18-month branch programme in
either the care of the adult, child, mentally handicapped or mentally ill

The course consists of 2300 hours of theory and 2300 hours of practice within a
156-week period. Each common foundation and each branch programme
should, normally, be 18 months full-time. Normally one third of this period, i.e.
six months, or no more than 20% of the course, will be designated as a rostered
contribution to nursing services. The broad philosophy which is being proposed
therefore is that initial 3-year education and training should be on a supernu-
merary basis and attract a grant.

Nursing is a practice-based profession and education must continue to be car-
rried out in practice settings; but to improve the standards in all educational set-
tings, the UKCC (1989), proposed that throughout their period of education and
training students should be supernumerary with the correspondent loss of em-
ployee status.
Supernumerary status meant that students could not be counted on to provide predictable contribution to service provision. No more than a 20% or 6 months will be designated as students’ rostered service. Nursing education staff has had reservations about the rostered service element of students’ courses, fearing students would be pulled into fulfilling service demands which had no value for their training.

The UKCC has also intended to review entry criteria for training that would be in keeping with the school’s policy and the guidelines and requirements of the UKCC, perhaps with greater emphasis on specifically designed courses for young people and on the development of appropriate courses within existing youth training and educational programmes.

The UKCC would be examining ways in which the entry gate to nursing education and training might be widened without sacrificing standards, considering as imperative to involve young people in health care careers at an earlier age than 17 and 1/2 or 18. The UKCC started to review the recruitment arrangements including advertising and the role of career service.

In the Nurse, Midwives and Health Visitors Act of 1983 there is reference to the age of entry:

Persons admitted to training at an approved training institution shall be no less than seventeen and one half years of age on the first day of the commencement of the course except that in exceptional circumstances related to specific courses the Council on the recommendations of a Board may agree to entry earlier but in no circumstances at less than seventeen years of age.

A specification to the educational requirements which should be fulfilled by the new persons admitted to training:

The minimum educational conditions for entry to training leading to qualification for admission to part 1, 3, 5, or 8 of the register subject to paragraph (2) of this rule shall be either:

a) a minimum of five subjects at ordinary level A, B or C grade in the General Certificate of Education of England and Wales, or Grade 1 in the Certificate of Secondary education;

b) and (c) contains the specific requirements for Scotland and Ireland;

c) other qualifications as the council may consider the equivalent to those set out in paragraph 1(a), (b) or (c) of this rule; or
d) a specified pass standard in an educational test approved by the council.

Training leading to a qualification the successful completion of which shall enable an application to be made for admission to part 1 of the register shall meet the requirements of the Nursing Directive. In this rule “Nursing Directive” means Council Directive No. 77/453/EEC concerning the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of nurses responsible for general care.

The education test which the UKCC has developed (the DC Test Series) should produce an alternative means of assessing suitability for preparation on an even larger scale. Professor Dennis Child, father of the DC Test, in 1988 addressed a speech to the National Directors of Nurse Education Group in Cambridge (Turner, 1988: 30) about the selection process. He listed the qualities which could be used in the assessment of potential nurses, these included social, physical, personal and intellectual qualities.

Dennis Child said that social attributes which include having a ‘caring’ attitude, understanding of other people, having sympathy with the sick and so on, have so far been unqualifiable by sociologists or social psychologists. He proposed that the most valid predictive criterion for ability to succeed in nursing training is intellectual ability. Professor Child made clear that this DC Test was aimed purely at establishing a candidate’s intellectual ability ‘and nothing else’. Furthermore, he does not believe to have “found a valid and reliable means of detecting those people with nursing ability” (Turner, 1988: 30).

In addition the 1983 Act established that many schools of nursing had for years set their own entry requirements at or about five O-levels. There is no guarantee that O-levels are infallible predictors but they provided evidence of intellectual attainment. Those without these qualifications have been given a chance, this has not necessarily been a success story, and the UKCC’s predecessor, the GNC, certainly had evidence that there was a correlation between low academic attainment (less than five O-levels) and failure to pass the centrally set examination or complete the training.

The Project 2000 reform and the government conditions for its acceptance draws attention to a ‘contradictory process’ where the average level of qualifications of entrants to nursing programmes fell slightly during the first year of the implementation of project 2000, whilst at the same time, the academic standard of courses rose. Attention is drawn to the fact that it is the older nursing students and those admitted to courses by passing the entry test (DC test), who have
been least successful academically. As Allen (1990: 43) said, “it is a strange logic that leads a profession to raise its academic standards at the same time as lowering its conditions of entry... Using such a diverse range of academic qualifications as a spring-board into diploma level education is like taking the beginners from the shallow end to the high diving boards. Far from being an incentive for excellence, it leads to fear and self-doubt”.

There is a great deal of concern that widening the entry gates means lowering standards. The UKCC does not believe that these two are synonymous; they argue that they are widening the entry gates in order to increase opportunity and improve recruitment, but in a controlled fashion so that standards are safeguarded.

This new programme of education should be academically credible, and should lead to a higher education qualification (UKCC 1986). Currently all colleges of nursing now have some kind of link with higher education, the full integration into higher education has by no means been achieved. The process, however, is moving forward.

3.2.2 Training and Education in Spain

In the 19th and beginning of the 20th centuries, nursing practice acquired legal status in Spain and the profession was institutionalised under three denominations: ‘practicante’, midwifery and nursing. The training was planned and certain regulations were established for everyday practice, with an importance given to subordination and service to another profession: medicine.

The Public Instruction Act of 9th September 1857, also known as the ‘Moyano Act’, became the starting point; article 40, paragraph 2, states that the regulations determine the practical knowledge needed by applicants wishing to become ‘practicantes’. In a Royal order of 26th June 1860, the requirements to become ‘practicantes’ were set as follows:

1) The art of bandages and other simple and common dressings in minor surgery.
2) Making bodily cures through the application of several soft substances, liquids and gases to the human body.
3) The art of practising general and local bloodlettings, vaccination, ear piercing, scarifications and cupping glasses and to administer to external skin irritants, issue and cautery.
4) The art of dentistry and pedicure.
The Royal Order specified that the applicants had to prove that they had carried out their studies through a correct enrolment, and practised their skills during a two-year period in a hospital with at least 60 beds and a normal occupancy of over 40 patients. The examination would last for at least one hour and the examining board would be formed by three professors from the Faculty of Medicine.

According to the Act, the ‘Practicante’ qualification was created within a context of well-defined activities, such as medical science assistant, with a technical orientation, following the therapeutical guidelines of the time, and after-care nursing. The accreditation of the knowledge remained under medical jurisdiction, although the activity was autonomous to a great extent.

As established by another Royal Order, dated 1 October 1860, barbers and those who did not have the qualifications of a ‘practicante’ were forbidden to make bloodlettings and perform minor surgical operations. Barbers and minor dentists had traditionally been assigned with these activities as well as with odontological problems.

Although ‘practicantes’ took over the odontological tasks developed by the barbers, the dentist-surgeon profession came to be regulated by the Royal Decree of 4th June 1875, only permitting intervention in the treatment of diseases of the mouth caused by the alteration of the teeth, including the necessary operations for their cure and, consequently, the ‘practicantes’ were forbidden to practise Odontology.

The studies of ‘practicantes’ and midwives were finally regulated by a Royal Order dated 21st November 1861. This included a more detailed programme and specified (article 19) that all applicants were required:

1) To be 16 years old.
2) To have passed a special examination about the subjects taught in elementary primary education. Proof of having passed this examination had to be produced in the Teaching College (“Escuela de Maestros”) by two teachers and the principal of the practising school.

As stated in Article 20, admission to the midwifery school would only be granted to applicants who fulfilled the following prerequisites:

1) Women over 20 years of age.
2) Married or widowed women. Married women had to produce permission from their husbands authorising them to carry out the studies. All had to produce certification from their parish priest guaranteeing their honest living and good habits.
3) Women who had completed their elementary primary educa-
tion. This was checked by means of an examination in the Female Teaching School in front of the Director, the Principal and one of the assistant teachers.

The studies were distributed in four semesters. The students who passed the four semesters in order to qualify as a ‘practicante’ or midwife were then admitted for a final ability examination; this was public in the case of the ‘practicantes’. For the midwives, the examination was held in front of an examining board made up of three professors. This test was both practical and theoretical, and covered all of the subjects studied; it lasted for one hour.

On 7th November 1866, the ‘practicantes’ studies were annulled, but were re-established by the Order dated 27 October 1868 (this annulment has been dealt with in another section).

A new regulation was passed on 16 November 1888 for the studies of ‘practicantes’ and midwives. Article 5 stated that the students also had to have some knowledge of the external anatomy of the body and the regions in which it is divided; the rules for the application of bandages and dressings and for minor surgery, except that of the dentists. Two of the academic years had to be spent in a public hospital with over 60 beds, acting as assistants to the medical team, and produce a certificate signed by the infirmary doctor or nurse stating the duration of the training and the quality of their service.

Special examining boards were created in order to test the practical knowledge of the applicants. The examination was oral, both theoretical and practical and covered subjects from the elementary/primary education and the subjects indicated previously in Article 5.

Article 12 specified that midwives were only authorised to provide health care in natural births, for which they were required to master the following: some knowledge of obstetrics, especially anatomy and physiology, childbirth phenomena, signs of premature or difficult births; precepts and rules to assist women in labour and to those who had recently given birth, the newly born babies with problems, first and urgent aid to asphyctic and apoplectic babies; and knowledge of how to baptise a new-born baby when its life was in danger.

Students were required to complete two years of training in a maternity unit as assistants in births, and produce a certificate by their tutors during the training scheme. In addition, their knowledge could be checked by a specially appointed tribunal who would monitored the final examination, with the same format as in the ‘practicantes’ examination.
The Royal Decree of 26 April 1901 established the requirement of having to pass an admission examination covering all the subjects taught in primary education, in order to carry out the ‘Practicante’ studies.

Subjects in the first year were: external anatomy of the body, topographical grid, uses of dressings and bandages, some elements of the medical subject (topical medication). In the second year, the pupils had to study operating techniques in minor surgery, some obstetric knowledge in normal childbirth, first aid in cases of poisoning and asphyxia. A minimum training of two years in a hospital was also required.

In order to be admitted to the first year examination, the students had to register 12 months in advance and had to produce a certificate of having trained in a hospital for a year. In the second year, only those students having passed the first year exam and with an additional year of training (with practical work on the subjects learnt during the course) were allowed to take the exam. After the second year examination, the students had to carry out a theoretico-practical exercise in order to qualify as ‘practicantes’ or midwives. This final test could be re-taken only after eight months of their first attempt.

The curriculum for each academic year was designed by the Faculty of Medicine of the Universidad Central (Madrid), and registration for training in hospitals had to be carried out in the Faculty of Medicine; this was also the procedure for the theoretical subjects. The certificates were issued by these same institutions. As to the training schemes, the certificates had to be issued by the hospitals which had to have a minimum number of 20 beds.

The obstetric speciality had to be certified by a hospital or maternity unit with at least six beds. For those ‘practicantes’ who wanted to assist in normal births and had trained in a hospital with no obstetrics department there was an examination designed with the contents established by the Royal Decree of 31st January 1902: pelvis anatomy, some elements of medicine, general knowledge of first aid for poisoning cases and asphyxia, some knowledge of obstetrics for normal births. In addition to the exam, a certificate had to be produced verifying that the student had assisted and practised for one year in a hospital specialising in births.

A Royal Order dated 22nd March 1902, re-organised the ‘practicante’ studies, and new instructions were given for the application of the immediately previous decrees. On 13th May 1902, a Royal Order finally established a training programme for ‘practicantes’ containing 78 topics.
These regulations were once more modified after the promulgation of the Health General Instruction in January 1904. Under title I, the following health professionals were acknowledged: doctor and surgeon, pharmacist, veterinarian, midwife, ‘practicante’, dentist, and in general other specialised professions, leaving the door open to future specialisms, such as Nursing.

A Royal Order of 10th August 1904 developed the contents of the General Instruction and re-organised the ‘practicante’ and midwife studies; the 1902 programme was kept, and article 11 established that women were also entitled to become ‘practicantes’, subject to the specifications in the decree.

The ‘practicantes’ students were also allowed to study in the Faculty of Medicine, both on an official and non-official basis\(^{56}\). In order to register, they were required to have completed their higher primary education and have passed an examination in a Teacher’s College. They also had to be 16 years old.

Attendance to practical work was compulsory; this was carried out by the official pupils in the colleges or infirmaries of the city hospitals. In the colleges, the training was supervised by an assistant in charge of the students and inspected by a Professor. To achieve the qualification, a final general theoretico-practical examination had to be passed in front of an examining board consisting of three lecturers from the Faculty of Medicine. This test was done after having completed successfully the two years of studies.

Similarly, the midwifery students could also carry out their studies on an official and non-official basis. For enrolment in the first year, applicants needed to be over 21 years of age, to have completed their higher primary education and have their husbands’ authorisation if they were married. The official programme was divided into two academic years: the first year covered the following subjects: anatomy, physiology, hygiene and general training on asepsy and antisepsy, especially of the feminine sexual apparatus; in the second year, the subjects were normal obstetrics, assistance in normal births, and assistance to the mother before and after childbirth.

Practical work in the obstetrics clinic was compulsory in both programmes; non-official students used to do this training in the obstetrics clinic of the Faculty of Medicine or in official maternity houses. The final theoretico-practical examination only entitled midwives to assist in normal births; this exam was taken after

\(^{56}\) Official students were able to enrol for tuition, classes and examinations, while the non-official students enrol only for examinations at the end of the school year.
having passed the two courses of the programme. Until 1896 all teachers of ‘practicantes’ were doctors, which would indicate an absolute medical control of their training; this was also evident in nursing and ATS training as well, until 1970’s.

a) First School of Nursing in Madrid

In 1880, the physician Federico Rubio Gali\(^\text{57}\) had created the Instituto de ‘Terapéutica Operatoria’ (Instituto Rubio), in the Hospital Princesa in Madrid; the institute’s capacity was 60 beds. In 1896, the first Nursing School in Spain was created in this Institute and received the name of ‘Santa Isabel de Hungría’. The regulation read: “with the aim of providing women with a decorous way of earning a living, offering them a chance to substitute nuns and ‘practicantes’ in hospitals, without any deficiency” (Criado, 1921: 2). Thirty students initiated their nursing studies in the Spanish school, 15 of them were resident at the school. Their ages ranged from 23 to 40. They were required to be able to read and write, to have some knowledge of mathematics, be healthy and vaccinated, and finally to have good manners and behaviour.

The studies consisted of three academic years covering both theory and practice; the course started on October 1st, and finished June 30th. At the end of the programme, the students would receive a certificate which qualified them as medicine and surgery ‘nurses’. Their mission was to assist doctors in operating theatres, in clinics and infirmaries; they also did 12-hour night shifts, attended conferences, cooked, cleaned, ironed and assisted the patients at any time (Alcón, 1986; García Lozano, 1993).

This new category of nurse would not be legislated for some time. This denomination first appeared in a Royal Decree on 19th April 1912: in this case, five scholarships were offered for a stay in England with a view to improving their professional skills: “five women dedicated to the study of the assistance to the ill in hospitals and clinics may apply for grants for their training in England”.

In the same year, 1912, the 5th National General Assembly of Spanish ‘practicantes’ was held, among the matters discussed was the intention of the nurses of the Rubio Institute to validate the nursing studies with those of the ‘practicantes’, and it was agreed that they would defend themselves against the nurses of the Rubio Institute and that the nurses would not be sanctioned as ‘practicantes’ until they had completed the full ‘practicante’ programme.

\(^{57}\) Rubio Gali, who had been the Spanish Ambassador to England (1860-1870), became familiarised with the British nursing model and imported it to Spain.
According to Criado (1921: 2), the 1st of February 1915 saw the inauguration in Madrid, by The Supreme Assembly of the Red Cross in the infirmary and hospital of San José y Santa Adela, of the first ever nursing course by the Red Cross. It was Queen Victoria Eugenia who promoted the creation of these studies.

In order to have access to this course, an application had to be made to the board of the Red Cross Dames, the applicant had to be Spanish, aged between 20 and 35 years, had to become a member of the institution and provide the services required by the Red Cross. They also had to pass an admission examination, and their physical status was determined through a medical check-up.

The diploma lasted two years, from October to June with a summer holiday break; once finished, a final examination was taken in front of an examination board, made up of a representative of the war ministry, three doctors and one civilian. The successful students were given a certificate by the war ministry, as the Red Cross was an institution created to assist in war. The nurses were then considered “war nurses” (García Lozano, 1993: 35). Thus the War Minister validated the qualification; later on the Red Cross training was acknowledged and nurses passed the final examination in the Faculty of Medicine as ‘practicantes’.

In a Royal Order of 15 May 1915 (Gaceta de Madrid, 21 May), the ministry of Public Instruction and Fine Arts, after assessment from the “Congregación de Siervas de María”58, authorised those people who proved to have the necessary knowledge to act as nurses, whether or not they belonged to a religious order. Based on a programme designed on the same date, the Order established in the first articles:

1) To join the programme, with the necessary skills to act as nurse, without having to belong to any religious community.
2) The practical skills and knowledge required in the programme could be previously acquired in clinics, hospitals and medical centres.
3) The sufficiency test will be both theoretical and practical. It will be taken in front of an examining board similar to that of the final exam of ‘practicantes’ of the Medicine College of Madrid, designated by the Dean.
4) The successful applicants will receive a certificate issued by the Dean of the Medical College. This document will authorise them to practise the nursing profession.
5) The examinations will be verified every year at the Medical College of the central university, at a time designated by the Dean.
6) The applicants will pay three pesetas for their records to be

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58 Female religious order dedicated to the care of the ill.
drawn up and a further ten pesetas to be paid to be able to take the exam, with an option to re-take it, should they fail, after a minimum period of three months.

The Royal Order also included a programme covering 70 topics. The first group had 12 subjects related to anatomy and physiology (skeleton, muscles, circulation and nervous systems, digestive apparatus, secretions, organs of the senses, hearing apparatus, gustative apparatus and the skin and its functions). Two topics touched on the so called “physical, moral and intellectual qualities needed in nursing and the duties and obligations towards the infirm whilst in their homes and the hospital wards”. A fourth group also touched on infectious diseases (infection and disinfection, health measures against infectious diseases, eruptive diseases, tuberculosis, and the transportation of infectious patients. Another subject covered the general rules which should be considered by a nurse when a legal action is required.

A five topic group covered first aid for cases of poisons, asphyxia, foreign bodies in the throat, esophagus or larynx, ears, nose and eyes, also accidents caused by the sun (sun-stroke, blindness), and freezing, somatic and local, and finally the care needed for those that have suffered, or are suffering from, fainting spells, convulsions or comas.

A subject was also given to the special care needed for the newly-born; and another for all aspects relating to death (certain death, apparent death and the duties of the nurse when a patient dies during their services).

Together with these 27 topics, there was a block designed to provide the future nurse with the knowledge, technical ability and necessary skills needed when faced by situations such as vomiting, diarrhoea, enemas and irrigations, digestive system, colic, jaundice and hydropsy, respiratory problems, dysphonia, and all related aspects of chest and side pains, etc.; pulse, heart beat, and cardiac-related symptoms, etc.; urine and bladder pains; delirium, brain disorders, apoplexy, head aches and back aches, etc. anaemia, haemorrhages, etc.; hygiene towards those suffering from fevers; contagious diseases relating to our climate e.g. the common cold; cleaning of the cavities of mouth, nose, rectum, vagina, and how to prevent bed-sores; measures in cleaning and sterilising of utensils used in surgery; how to administer medicines when the patient is unwilling; general anaesthetic, chloroform and ether, and how to administer in the cases of accident; methods of sterilisation; cauterisation against infection; continual bleeding; massaging and the administering for, muscle cramps, joints and fractures of the stomach wall, etc.; artificial respiration; treatment of burns; hypodermic and serum injections and how to administer; preparation and treatment of
septics and antiseptics; bandages mostly used for the head, neck, thorax, abdomen, etc.; accidents in patients, before, during and after surgery, (collapse, vomiting, pain, delirium, blood loss and urine retention) and how to treat; major symptoms of operations involving the head, neck, thorax, abdomen etc.; special vigilance towards those with problems of the ears, eyes, throat and nose; diets, excrement and urine; acute and chronic dermatological processes; and finally the care of the mentally sick and nervous patients.

From 1915, the professions of midwife, ‘practicante’ and nurse are acknowledged by the administration, each having its own regulations, and from that date on each had their own specific regulations drawn up.

In 1915, the school founded by Federico Rubio was awarded the title of “Royal School”. With this incentive and given the needs at the time, other schools and nursing bodies appeared. The following year 1916, the figure of Queen Victoria was used for the promotion of these studies. The queen had favoured the development of some of these schools and she was frequently seen dressed in a nurse’s uniform.

An outstanding factor in the first years of the training was its link to women’s emancipation. One of the objectives indicated, both in the manuals and documents in the schools, was the creation of an occupation for women. In 1917, other schools started being created, the second in Spain was the “Escuela de Santa Madrona” in Barcelona, set up by the “Montepío de Santa Madrona”59 , in April, with the idea of promoting the working women. The advertising leaflet, which included the syllabus, stated “This institution aims at providing women with new work orientations and welfare, and so a professional nursing course will be started on the 22nd of this month” (Alba 1917)60.

The situation remained unchanged until a Royal Order dated 7th October 1921 established a minimum syllabus for the diplomas of Medicine, Odontology, ‘practicantes’ and Midwifery. In the case of the ‘practicantes’ some of the contents were: anatomy, elementary physiology, antisepsis, asepsis, bandages and dressings, and minor surgery.

The syllabus for the midwives consisted of; anatomy, elementary physiology, antisepsis, asepsis, and elements of hygiene, and elementary obstetrics. The con-
ditions required to achieve this qualification were about to change: a Royal Order of 11th September 1926 established, as a requirement to enlist in the first course, the completion of the elementary education cycle, which—as before—was sufficient to have only completed primary education.

In 1923, a major event took place in the consolidation of contemporary Spanish nursing: by Royal Order of 23rd of May, the National School of Child-Care, associated to the Higher Council of Child-Care was given the task, among others, of the “preparation of women, baby-sitters, visiting nurses and child minders”. A Royal Decree of 16th November 1925 organised the school and the first course took place in October 1926.

To acquire the qualification of visiting nurse, the applicant had to complete two courses from October to February and from February to June. Any applicant who did not have the certificate of secondary education or a teachers degree, but wanted to continue the studies to become a visiting nurse had to take an admission test in front of the head professor.

After the proclamation of the 2nd Spanish Republic (1931-1939), a new regulation was passed on the 16th of June 1932 for the National School of Child-Care, the institution then developed a triple function: Technical school for professional orientation, Institute for child hygiene and Scientific research centre. The diplomas the school could issue were as follows: Visiting Child-Care Nurse, Child-Care Midwife and Child Minder.

The students of the visiting child-care diploma had to study the same subjects as the child-care doctors: Intra-uterine eugenemia and child-care for 1st childhood, child-care for 2nd childhood, social child-care and applied laboratory child-care in accordance with restricted programmes. The practical work was carried out exactly the same as for the child-care doctors.

Special attention was drawn to the exercises referring to the development of the personnel for social work and health collaboration purposes. This included intense and continuous training based on house visits. The figure of the visiting child-care nurse was considered as the link between the doctors and the children within their families and were seen as official/surrogate institutions.

The students in the child-care/midwife diploma had to study intra-uterine child-care in accordance with an adequate theoretical programme. The practical work was carried out in the quarters of the School or in collaborating institutions, under the surveillance of the teaching staff. It consisted of exercises of social work, obstetrics, and prophylaxis, by means of visits to children and pregnant women.
The theoretical knowledge in child-care consisted of an elementary course on Physiology and Hygiene for children. The practical work was intensive and carried out in the School (Nursery, Milk Drop – “Gota de Leche” –, Diet Laboratory), and covered all aspects related to child care in the first and second stages of childhood.

Finally, a new regulation was issued through a Royal Decree dated 19th September 1935 in which the objectives of the school, established in Art. 1, were outlined: “...adequate technical training for child-care nurses by means of special child-care courses; inform and spread information among nurses and health instructors about the high quality training given by the School”. This point is related at this time with the close collaboration among national child-care schools, Health institutions, and the School for Visiting Nurses and Health Instructors, during the Second Republic for the training of the different professionals.

Another institution significantly contributed to the process of socialisation of the nursing professionals, i.e. the National School of Health, which was created through a Royal Decree (9th November 1924), from the National Institute for Hygiene Alfonso XIII and the King’s Hospital. One of its functions was “to provide tuition and training to each of the care groups recognised, and those which would appear in the future, starting with ‘practicantes’, health nurses, disinfectants, and subordinated personnel used in prophylaxis against the pestilence and malaria”. This function was corroborated by the Royal Decree 12th of April 1930, which approved the regulation of the National School of Health, which explicitly set the following targets: “teach and train a body of visiting health nurses”, according to art. 4, “a programme will be set for the creation in Spain of a body of Visiting Nurses, this being a primordial need for the Spanish Public Health”.

The subjects for the nurses were divided into three terms, according to the following layout:

1st term: Bacteriology and Parasitology, Diet Hygiene and Nutrition, Traumatological Technique and Health Statistics.

2nd term: General Epidemiology and Epidemiologic Technique, Infectious Diseases and Parasitic Diseases. Private and Public Hygiene.

3rd Term: Immunology, Serology and Infiltrations, Health Engineering and Public Health Management, International Health Law.

Parallel to the start of the 1st course of the National School of Child-Care, on 24th February 1927, General Primo de Rivera signed a Royal Order, published
by the *Gaceta de Madrid* (no. 140) the following day; the Order appointed a Commission composed only of doctors (as commented before, the ‘practicantes’ and nurses training was completely dominated by doctors), for the elaboration of the curriculum for the nursing diploma in a 15 day deadline. From this date, the different nursing diplomas were to be standardised, thus avoiding the prolific nursing family which had grown under the protection of various patrons, religious and military congregations, and renowned doctors.

The ‘practicantes’ did not find this suitable, as they thought a branch of something which already existed was being re-created, and since the functions of the care professionals were broad enough, they suggested to the authorities of the country the creation of a “singular auxiliary profession”.

In May, the Minister of Public Instruction sent a report to the Medical College of Madrid to study the possibility of extending the ‘practicante’ diploma. The lecturers in charge of the matter suggested to the Minister the need to cancel the ‘Practicante’ diploma and the creation, instead, of the nursing body, respecting the rights of the former. This could be achieved by means of a minor transformation of the professional names, as the ‘practicantes’ would now be called qualified ‘male nurses’. This would also bring more culture, professional independence and a better performance, from which the patients would benefit directly. The example of the American female nurse is given as a professional with high prestige.

The ‘practicantes’ answered back by saying that they had always wanted a “singular diploma with different specialities”. In the end, the final report proposed not to create a new qualification and promote the already existing ‘practicante’ programme of studies.

The Royal Decree of 28 August 1928 established the requirements which had to present the institutions authorised to have a Midwifery School. These determined the subjects and the conditions needed in the applicants. This decree also permitted those women to follow the studies who wanted to acquire knowledge on an un-official basis, with a view to applying this knowledge altruistically and driven by charitable reasons. These students would only be issued a ‘Certificate of Studies’.

And finally, there was a third aspect contemplated by this Royal Order: the authorisation for the setting up of Midwifery Schools in all clinics of obstetrics and gynaecology which were run on state funds, or funds from the province or town and even from private entities. The following conditions had to be met: to have been in operation for at least 8 years, to be able to provide ser-
vice and have resources for 300 births a year. In exceptional cases, the schools could be established in obstetrics clinics with a number of annual births between 100 and 300. In any case, a certificate was required stating the number of births; if it was under 100, the Medical College had to decide whether or not that was a sufficient guarantee.

When the required conditions were met, the declaration of Practical School by the Ministry of Public Instruction and Fine Arts could be applied for. The Ministry then prepared a report on the conditions of the building, of the special materials, clinical personnel and teaching staff.

The duration of the diploma programme was two years. The first year covered the subjects of anatomy, physiology and general hygiene, general asepsy and special asepsy of the hands, instruments and dressings, disinfection of patients, preparation for operations, tidying up of the operating theatres, care and dystrophic births. The second year subjects were: special hygiene in newly born babies, assistance in obstetric operations, and diagnosis of pathological cases.

Applicants had to be over 20 years of age, and had to have completed their secondary education; they had to produce proof of their good behaviour and pass a health examination. For people under the age required and for married women, the authorisation of the parents or husband was required.

After completion of the two-year diploma, the students could ask to have a theoretical/practical test in the Medical College so that their Midwifery Certificate could be issued. To be eligible for the test, they had to produce a certificate stating they had completed the two-year studies and an extra one proving that they had assisted in at least 100 cases.

After the proclamation of the Second Republic, two Orders dated 3 November and 14 December 1931 modified the requirements needed to gain access to the ‘Practicante’ and Midwife Schools. Applicants were asked to have passed the admission exam in the National Institutes of Secondary Education, as well as the following subjects: Spanish language, French, and exercises of arithmetics and geometry, physiology and hygiene, calligraphy, special geography of Spain, general chemistry and physics, and natural history.

An order dated 23 February 1933 again made admission to these diplomas harder, establishing the requirement of completion of the first three years of the future educational curriculum, as well as some knowledge of physiology and hygiene.
The following year, an Order of the Ministry of Public Instruction, of 14 September 1934, stated: “All medical graduates would be able to gain the ‘Practicante’ qualification, should they meet the corresponding payment first”. This provoked a wave of protest, and after a few days, a new disposition, published on 5 October 1934, partially amended the previous order: “individuals who gained the qualification in this way would only be allowed to do their practice in one of them ‘practicante’ or medical doctor”.

Finally, an Order of the Ministry of Public Instruction, dated 13 December 1934, determined that, in order to initiate the studies of Auxiliary and Midwife, it was required to have passed all the subjects covered in the first three years of the high education cycle established in 1934, including the corresponding final exam.

Also during the Second Republic, and as a consequence of the reforms mentioned, especially for the ‘practicantes’, the first steps were taken for something which would have become real specialisation’s.

One of the areas which underwent major development was psychiatry, the ‘practicantes’ and the rest of the so-called auxiliary professions playing an important role in this move. An Order dated 16 May 1932 established the qualification of “Psychiatric Nurse”. This established two nursing “specialities” in both public and private psychiatric centres: on one hand, the medical and surgical auxiliaries, who –by means of the additional diploma in psychiatric nursing– cooperated with and assisted the doctors in medical and surgical tasks; and on the other, the psychiatric nurses (both male and female), who were in charge of the mentally ill, following instructions by the doctors.

In order to obtain this qualification, the corresponding examinations had to be passed; applicants were also required to have done practical and theoretical exercises in a psychiatric institution (official or private) for a minimum period of two years; they had to be over 22 years of age and have passed the necessary medical and psycho-technical check-ups. The ‘practicantes’ were eligible with only one year experience in a psychiatric centre.

Theoretical studies had to be adapted to the syllabus set by the Higher Council of Psychiatry and published in the same Order which regulated the requirements for the obtaining of the qualification. The syllabus consisted of 21 lessons: objectives of a psychiatric institutions, general nursing duties, assistance for the mentally ill, general care, surveillance of the mentally ill, medical care more frequently needed in a psychiatric centre, therapeutical and diagnostic methods more commonly used, observations and notes about the conduct of the mentally ill.
ill during their recreation time, special assistance for the mentally ill (transportation, admission and first care, dealing with aggressive and excited patients, etc.), notions on anatomy and general physiology (the nervous system exclusive), hygiene, some knowledge on general pathology, surgical diseases and their treatment, other diseases (TB, dysentery, pneumonia, diseases of the eye, ear, digestive and urinary diseases, etc.), anatomy and physiology of the nervous system, aspects related with the ‘normal spirit of man’, some knowledge of mental illnesses (causes, development, aim and clinical prescriptions), peculiarities in the assistance of the different clinical descriptions in mental disease, organisation for treatment in mental disease, prevention in mental disease, and finally, two lessons on the legal aspects referring to mentally ill patients.

The relation of the “psychiatric nurses” and the auxiliaries with the psychiatric nurse diploma was partially clarified and modified by an Order of the 31 December 1932, which specified that the auxiliaries who obtained this qualification were only able to practise as “Psychiatric Auxiliaries”, and the psychiatric nurses (male nurses) were not authorised in medical/surgical interventions. One of the reasons for this clarification was that the ‘practicantes’ did not seem to like the denomination of “psychiatric auxiliary”, which led to the subsequent change in the name. The so-called “nurses” (male) of the time used to carry out the most unpleasant tasks or those which required a great deal of strength (abundant references can be found in the professional press).

Although numerous official offers had been organised to cover positions of visiting nurses (female nurses) since April 1932, the creation of a specific school for this nursing branch did not take place until it was established by an Order dated 24 February 1933:

the organisation of a School of Visiting Nurses, dependent on the National Health School, is well advanced; the academic year will soon start, and therefore, we must work hard to contribute to an early functioning of such an Institution. This Ministry has considered convenient the appointment of the Managing Commission of the School, integrated by the Chairman, Sr. Gustavo Pittaluga Fattorini, Director of the National Health School, Sr. Sadí de Buen Lozano, General Inspector of Health Institutions, Sr. José García del Diestro y Escobedo, Director of the National School of Child-care, Sr. Manuel Fernández Criado, Director of the Red Cross Hospital, Sr. Manuel Tapia Martínez, Director of the National Hospital of Infectious Disease, Sr. Rafael Bergamín Gutiérrez, Ministry Architect, Srs. María Benevente de Bárbara, Nurse, and Sr. Alberto Ortega Pérez, Bursar of the School.
A letter dated 30 October 1933 stated: “as established in the State Budget, there are several positions of visiting nurses for TB clinics and Rural Hygiene Centres which urgently need to be covered; therefore, this General Direction has organised a course for 25 nurses, which will be taught by the National Health School in cooperation with other centres”. Among the requirements for admission were: “c) the applicants would have to be qualified ‘practicantes’, Midwives or Nurses; the nurse qualification must be issued by one of the following centres: Medical College, Red Cross head office, Health House of Valdecillas, Institute of Working Women (Santa Madrona), National School of Puericulture, and Rubio Institute”, which indirectly converted this qualification into a post-grade or speciality.

In 1934, the future school remained in a provisional situation, work was still being done in regard to organisation and implementation, as can be derived from the contents of the Order of 28 February 1934:

After studying the proposal by the Chairman of the Managing Commission of the National School of Visiting Nurses ... with a view to legalising the situation of those nurses who are being trained and educated abroad as instructors for the School ... this Ministry has decided that the Visiting Nurses who have qualified as such in foreign official schools of recognised scientific solvency will be able to validate their studies and thus obtain the corresponding certificate of visiting nurse issued by the General Health Direction, following an aptitude test.

Not all the difficulties were overcome, and finally the project for the National School of Visiting Nurses was taken over by the project for the creation of the National School of Health Nurses and Public Care. This institution was to cover the functions assigned to the first project and those of the School of Health Instructors, associated to the National School of Health.

In fact, an Order dated 19 January 1935 appointed a Managing Commission for the drawing up of the Regulation for the functioning of the School of Health Nurses and Public Care; the commission was formed by most of the people who had been designated for the drawing up of the Regulation of the School of Visiting Nurses.

The members of the Commission were the General Director of Health, the General Director of Charity Organisations and Public Care; Sr. Gustavo Pittaluga Fattorini, Director of the National Health Institute; Sr. Manuel Tapia Fernández, Director of the National Hospital for Infectious Disease; Sr. José García del Diestro, Director of the National School of Child Care; Sr. Salvador Pascual, Director of the Red Cross Hospital; Sr. Dionisio Herrero García, Professor of the
Medical College; Sr. Rufino Blanco Sánchez, educator and publicist; Sr. Mario González Pons, Director of the Head Office for Information and Unification of Public Care; and the Director of the Vallecas Hygiene Centre; Srta. María Benavente and Srta. Mercedes Milá Nola (Commission secretary), Visiting Nurses.

At the same time of issue of the above mentioned order, an offer was made with a view to covering some posts of health visiting instructors. A Nurse or ‘Practicante’ qualification – issued by the Medical Colleges, the Valdecilla Health House, the Red Cross, the Rubio Institute or the National School of Child Care – was required. In addition, two tests had to be taken, one consisted of a theoretical exercise about the function to be developed by the Health Visiting Instructors; the other was practical, and was determined by the examining board.

On that particular occasion, the successful applicants also had to complete a theoretical/practical course in Oviedo, under the orders and supervision of the Special Delegate of Health and Public Care of that province.

Meanwhile, on 18 July 1936, the Spanish Civil War broke out, which put an end to these projects. Among the events to be considered from that moment, we find a Decree signed by General Franco, on 7 October 1937, which aimed at improving the situation of the middle classes; the decree established the obligation of six months Social Service for women aged between 17 and 35, this becoming a compulsory condition in order to gain access to any official post or professional qualification.

During the Civil War period, the training and education of nurses, ‘practicantes’ and midwives was suspended in some centres, and some schools were even shut down. Other institutions remained relatively active but no examinations took place until the war was finished, in 1939. The education of nurses and voluntary personnel was of great importance during those years, given the numerous necessities, not only due to the number of war casualties but also to the existence of other care needs produced by the war. FET and JONS developed a series of

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61 In the decree for the development of the social service, dated 28th November 1937, Franco –from his military mentality– contemplates the obligatory male military service as the recognition of man dignity. Women had to be provided with something similar, the social service, with a 6 month duration and initially voluntary, later on it became compulsory, and in fact all women longing to become a public servant or develop any job related with to the State Administration, or obtain a professional qualification in a higher education centre or even have a driving license, had to produce proof of having completed the social service.
initiatives in order to make the most of the voluntary help, and also organised
nursing courses; this was an initiative by the Falange, which was authorised by
the Order of 21 April 1937. Later on, the Nursing Body of the FET y de las
JONS' was created, and was recognised by the Act of 3 January 1942, including
different categories in the existing Falange nursing personnel, such as organisa-
tion nurses, the Spanish Nursing Dames, hospital nurses, war nurses, and social
visitors; this last category was the substitute for the visiting nurses of the Na-
tional Nursing School of Child Care previously mentioned; all these qualifications
created by FET and JONS were to be validated later on by an Order dated 4
May 1945.

During the war the needs to be met were equal on both sides, but as one would
expect, those on the republican block were not so 'commented on'. The republic-
cans also implemented some training activities as far as it was possible and in
order to overcome their deficiencies and cover their needs; one example is the
Provincial Hospital of Valencia, where a training in nursing was carried out, with
17 lessons related to anatomy, physiology, moral qualities, nursing duties and
performance, etc.62.

When the war ended, the nurses had to re-validate their qualifications, and a
large number had to fulfil the Social Service established by Franco in order to
make their certificates effective. Some had to undergo the 'practicante' studies
to be able to carry out their practice; this meant the implied acceptance of the
differences between 'practicantes' and Nurses, which complicated things even
more for the subsequent legislation in this field.

An Order of 10 July 1940 established an obligatory admission exam for the
'practicante' diploma. Those students who had completed three years of high
education and the subject of physiology and hygiene in their 4th year, were not
compelled to take the exam. The demand of having completed previous studies
was not applicable to the nurses, which –together with the fact we have just
mentioned– posed problems for several years. The curricula in force in 1940
covered 133 topics for the 'practicantes' and 102 for the nurses, both subject
groups being very similar.

The specific legislation concerning the organisation of nursing schools did not
appear until 27 June 1952, when the Ministry of National Education put into
force a decree which organised the studies of the nursing diploma, establishing
that the admission tests or qualifications required for admission would be regu-

62 Hospital Provincial, l-24/c-6, file 26
lated by the Ministry of Education (Order of 4 August 1953); the Central Commission of Nursing Studies (CCNS) was then created as the assessing organ of the Ministry, to submitting reports about nursing education to adapt the nursing curriculum to changes in social and health conditions.

The Commission was presided over by the General Director of Higher Education, the vice-president was the Dean of the Medical College of Madrid; the rest of the members were: representatives of the ecclesiastic hierarchy, the General Direction of Health, the Female Section, Military Health, Red Cross, Health Auxiliary nuns, the Prevision National Institute, as well as three more representatives from the Ministry of National Education.

The Commission established that the school had to be managed by a director – a professor from the Medical College or a doctor – and have a school head and a secretary of studies (both positions had to be held by female nurses), teachers (doctors) for the different subjects, female nursing instructors, a clergyman and a bursar.

This legislation supported and institutionalised the subordination of the nursing profession to the medical one. The fact that the directors and teachers of the different subjects had to be – as stated by the law – medical doctors, relegated, from the very beginning, the nursing schools and professionals to a secondary position, with very few possibilities of intervention if the school management was not open or flexible.

Later on, an Order of 4 August 1953 dictated specific rules for the organisation of the curriculum, and set the following requirements for admission to the Nursing Schools:

1) Applicants had to be 17 years old the year admission was applied for.
2) Have passed the basic secondary education, have completed a teaching studies or reached the expertise grade of the Business studies.
3) Have the necessary physical and health conditions; these had to be verified through a medical check-up carried out in the school.
4) Be introduced by two people of recognised moral integrity.
5) Pass the School’s admission exam.

The students were resident in the school during the three years of the studies, if a trial period of three months was passed. At the end of this trial period, only the students who showed the necessary physical, moral, intellectual conditions and vocation were allowed to continue studying. At the end of each academic year,
an exam was taken in front of an examining board in the different Medical Colleges from which the schools were dependent.

b) A Common Syllabus for ‘Practicantes’, Midwives and Nurses

On 4 December 1953, the nursing studies were regulated again, but this time in conjunction with the ‘Practicante’ and Midwifery diplomas, aiming at following the orientation set by the Act of Health Bases of 1944, which established the unification of the health auxiliary professions.

The unification was achieved under the sole qualification of ATS; this denomination was imposed upon the professionals, who repeatedly rejected it, and so, one of the lectures in the First National Assembly of Nurses, held in Madrid in 1959, was devoted to the attempt to recuperate the title of ‘nurse’; the title of this paper was “The continuity of the ‘Nurse’ denomination”. The proposal did not succeed.

Within this normative, we find the transformation of the midwifery diploma into an ATS specialisation. There is also a willingness to integrate other professional practices in force as specialisations, in order to satisfy the needs of qualified professionals.

This unification decree established differences in the professionals according to their sex. As to female ATS professionals, the decree constantly referred to the conditions in the decrees of 27 June and 4 August 1952, which stated that female students had to reside in the school, whereas men were not required to live in the school, as they could carry out their studies in the schools –organised for them– in the Medical Colleges. The entrance requirements remained the same as those established in the Royal Decree of 4 August 1953.

A Central Commission of ATS Studies (CCEATS) was then created, constituted by the old Central Commission of Nursing Studies (CCNS), with the additional representation of the Professional Colleges, two professors from the Medical College, from the Official School of Midwifery, and from the Gynaecological Society. Despite the appearance of this new organism (CCEATS), the organisation of the schools was still subject to the 1952 decree.

Two years later, on 4 July 1955, rules were set for the new organisation of ATS studies, and the Ministry promulgated an Act after a proposal by the CCEATS.

Thus, several educational items were legislated, such as the student requirements, curriculum, examinations, etc. Let us remember that the regulations developed for the nurses had been validated for the new ATS situation, which demanded a specific set of rules for ATS compatible to the previous normative.
The organisation of the schools was not modified, therefore, the 1952 legislation remained in force. We should also add that on 6 July 1955 a new order was issued forbidding co-education in the nursing schools, which – together with the requirement of residence in the school – would be cancelled in 1976.

The ‘practicante’ qualification was then considered equivalent to the ATS one, as established in a Ministry Order of 29 March 1966. This did not apply to the (female) nursing diploma. The equivalence of the latter was long and hard to achieve, mainly due to the absence of admission requirements and due to the fact that on many occasions in the past, the nurses themselves had established the barriers; their equivalence was finally achieved in 1978 and only for those professionals whose qualifications had been issued by a Medical College and who had registered with a professional college (the corresponding certificate by the College had to be produced).

At the end of the 1950s, the first specialisations acquired legal status, whose regulations derived from the Decree of 4 December 1953; according to articles 6 and 7, the Ministry of National Education was authorised to create the specialities considered convenient and to issue the corresponding certificates. Since 1957, and as stated in the mentioned decree, the following specialities have been created:

Obstetric Assistance (Midwifery) in 1957, this disappeared as an independent study, and became a specialisation of the ATS. Physiotherapy was developed in 1957 as well, in 1962 Podology, and in 1980, both become separate diplomas63, carried out as University independent studies.


The legislation during the last period of the 1950s and 1960s does not offer practically any changes as to education, except for the regulation of the already mentioned specialities and attempts to effectively unify the ‘practicante’ and nursing qualifications.

One of the most outstanding nursing developments at the beginning of the 1970s concerning nursing was the new orientation proposed for the profession

63 In Spain, from 1977, a ‘Diploma’ is the first university degree. In England ‘Diploma’ refers to lower level studies unless postgraduate.
with the promulgation of the General Education Act of 4th August 1970. Resolution 2.7 indicates that the ATS schools were to become University Schools or Vocational Centres, depending on the nature and scope of their educational contents. This article was the basis upon which an important change in nursing education would lay its foundations.

This new legal framework on education favoured the questioning of the organisation of the practical work of ATS students; this organisation was developed in accordance with hospital needs, which triggered a conflict in the academic year 1971-72 which led to claims on criteria, curriculum and teaching hours. The health authorities accepted and implemented most of the claims (Guilera, 1986).

Despite these first important steps, it is only in 1976 that the professional ATS colleges saw the constitution of an Inter-Ministerial Commission for the Reform of the ATS Studies. All the areas related to nursing were represented in the Commission: University, Higher Education, General Direction of Health, INP, Union of Health Activities, ATS Council, Midwives, male and female ATS. Two doctors and two nurses were appointed as assessors of the Commission, representing the private schools and the National Commission of Nursing Schools.

The Commission started working and the following matters were discussed: professional profiles, number of professionals and employment posts, and estimations for a near future. The meetings of the commission were sometimes difficult, given the diversity of criteria and the difficulty in conciliating the different trends. Finally, reports and documents were drawn, giving legal shape to the University Schools of Nursing, with the qualification of Diploma in Nursing.

c) The Spanish Nurse and the University

The working groups completed their data and elaborated reports which would lead to the promulgation of the Royal Decree 2128, of 23rd July 1977, on the integration into the university of the ATS Schools as University Schools of Nursing. In the managing commissions created in the different schools to be integrated into the university, one aspect which had never been considered stands out, that is the participation of the students.

The organisation of the Nursing Schools did not undergo effective changes until 1977, with the enforcement of the decree for the creation of the University School of Nursing. According to the legal framework for University Schools (General Education Act, Decree of 17th August 1973, Order of 17th September 1974), these must have the following managing organs: a Foundation, a Foundation Commission, A Managing Board, a Head, and a Deputy Head.
Article 19, of the Decree 2293 of 1973, indicates that the management of the schools will be entrusted to a Foundation and its head, with the help of a managing board and other organs established by the university statutes or school regulations, as well as by the Foundation Commission, in accordance with the General Education Act. Article 21 establishes that the designation of the Head of the University Schools is made by the Ministry of Education and Science, among higher education lecturers; for this, the academic grade of doctor is required. Eventually, it would be the nursing professionals who would have access to these management positions.

The decree for the creation of the University Schools of Nursing exceptionally enabled the ATS Schools to admit students for the 1977-78 academic year according to the old procedure, specifying that the last ATS group would be that of 1990; from that year onwards, the qualified students would hold a Diploma in Nursing.

In July 1978, an open letter was sent to all nursing professionals on behalf of the Provincial Board of the College of Nursing of Valencia, which was published in a local newspaper (Levante 5 July 1978). The letter showed how high academic and ministerial (Education and Science) representatives wanted the ATS Schools to persist during the academic year 1978-79, that is to say, to permit the continuation of enrolment of students in ATS Schools, thus stopping the opening or transformation of the University Schools of Nursing. The representatives argued that there was a lack of adequate structures and not enough planning in the development of the new schools, thus trying to gain one more year to improve their functioning.

The Provincial Board of the College of Valencia, manifested in the letter total agreement with the new curriculum and their development, as well as the existence of a single School of Nursing, and proposed that telegrams be sent to the Ministry of Education and the Secretary of Universities with the following text: “Total repulsion to the continuity of ATS Schools, next academic year 1978-79. We support the total development of the University Schools of Nursing”. In compliance with the Decree, from the academic year 1977-78 onwards, only University Schools of Nursing were to be operative, and only those candidates having completed the Pre-University course would have access to the Nursing ‘Diploma’.

Once the Royal Decree for the integration of the Nursing Schools into University was published, with all the reactions it caused, another response was to be taken into account: the National Council of Nurses organised an Assembly of
nursing instructors. After studying the situation, they decided to create a Commission of Studies with the objective of elaborating the guidelines for the curriculum of the Diploma in Nursing. The document was sent to the Inter-ministerial Commission for the Reform of the ATS Studies, which had been created following the demand of the Professional Colleges. The document was approved on 31 October 1977, with minimum modifications (Blasco, 1986: 63), and published on 26th November under the title “Guide-lines for the Elaboration of the Curriculum of the University Schools of Nursing”. The commission took into account the recommendations of the European Council on this matter, as Spain joined this organisation in 1977.

The total minimum number of teaching hours was set at 4,600 hours for the whole three years, and at least 50% had to be dedicated to practical work. A detailed description of the subjects was made, stating the obligatory nature of 16 subjects. The optional subjects proposed by the universities were not to exceed the number of 4, including a compulsory subject called ‘Professional Ethics’.

The Nursing diploma had been integrated into the university and its curriculum had been published; it was then necessary to establish the teaching staff, especially for the tuition of subjects which could not/should not only be taught by nurses (anyway, nurses could not be employed as teaching staff, as they were not qualified to act as university lecturers). Therefore, by means of the Ministry Order of the 13th December 1978 and subsequent extensions, the Ministry of Education and Science enabled nursing professionals to act as teachers –on a temporary basis– despite their lacking the category of graduate or doctor; this situation was finally regulated since the Order of the 7th February 1984 on access to the categories of University Lecturer and University School Lecturer, meant that nurses could now become University School Lecturer, and progress further in their careers by taking a Doctorate.

The new denomination of the diploma revived the old denomination of nurse of not so long ago. Probably, this would not have been of much importance, but the collective already had several denominations, especially if we take into account the different orientation of the educational programmes and requirements of previous studies for ATS and the Nursing Diploma. The students of the latter were in a way considered an elite or were considered as such by the ATS group, especially due to the stagnant position of their profession at an academic level. ATS could not progress from an academic point of view unless they passed an examination after having completed a course aiming at overcoming their training deficiencies. The ATS qualification was not a higher education title, and therefore was educationally lower than the Nursing Diploma.
However, the recently qualified students of the Nursing Diploma entered the employment market and took on the same functions as the ATS professionals, for whom the validation of their qualifications was established in the Royal Decree of 11th January 1980, which derogated the resolutions 2 and 3 of the Decree 2128/23 July 1977. This decree set specific dates for the integration for the ATS Schools into University as University Schools of Nursing, made the ATS qualification equivalent to the Diploma in Nursing with the same corporate and nominative rights, the Ministry of Universities and Research being authorised to set rules for the levelling of knowledge for the academic equivalence of the ATS qualification to that of the Diploma in Nursing.

Parallel to the development of these events, the Spanish doctors started to be concerned when interpreting the intentions of the nursing collective, which led to the publishing of articles in several journals (De Lorenzo, 1980; *El Médico*). They thought that ATS professionals aimed at having access to the 4th course of the Medicine Degree through the validation of their studies, and were afraid of suffering an ATS invasion trying to gain access to the 4th medicine course. They had indeed made a very particular interpretation of the law on education of that period. As a result, activities were carried out against the reform which caused the nursing professionals to have doubts about their success and even think of regression. As a matter of fact, what happened is the most conservative medical groups considered the changes as threatening their power, and thus they tried to inhibit the professional progress of nursing.

Once the ATS studies had been integrated as University Schools of Nursing, the adequate specialities were not developed in accordance with the new qualification; on the contrary, a Ministry Order of 9th October 1980 authorised Nursing to follow the specialities which existed for the ATS collective. Some years later, a Royal Decree regulated the obtaining of the qualification of specialist nurse, containing the following nursing specialisations:

1) Obstetric Gynaecologist Nurse (midwives)
2) Pediatric Nurse
3) Mental Health Nurse
4) Community Health Nurse
5) Special Care Nurse
6) Geriatric Nurse
7) Management and Administration in Nursing

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Out of these, only the Obstetric Gynaecologist nursing speciality has been developed, as required by the European Union; without this demand, it probably wouldn’t have developed either. At present, the intentions of the government are unknown in this regard, and professionally, numerous questions arise: Is specialisation really necessary? Must the academic nursing structure be developed first? If there is no recognition in the employment world, is it really worth making an effort to obtain a specialisation? Etc.

A Ministry Order on the 15th July 1980 established the levelling course foreseen in the Decree of the 11th January 1980. The course was to have annual summons through the Spanish Open University, which meant the use for the first time of open educational methods, and with collaborating centres in the University Schools of Nursing, to provide personalised attention to any queries.

Two needs were to be met: make equivalent the qualifications of the professional groups affected, and level—as far as it was possible—the knowledge of all the nurses, even those with long years of professional experience.

The course was not accepted well, possibly due to the previous campaign for its rejection carried out by the nursing institutions, which demanded an automatic validation of the diplomas; the course continued for five years with several extra validation exams, the last one taking place in 1988.

After several years of finalising of the Validation Courses, those ATS which opted not to complete such a course, was ready in 1994; through the Professional Colleges, they required new editions of the course. The Ministry of Education and Science answered by a letter dated 21st November 1994, listing the different examination opportunities and the corresponding extensions, and stated that it was not their intention to set a new edition of the exam for the course.

Meanwhile, the Act on University Reform was passed in 1983, and so the process of reform of the Curricula of higher education started; the University Council promoted several working groups which elaborated projects about the different guidelines for the different curricula. One of the groups was the so-called Group IX, which was divided into sub-groups such as the Nursing group formed by representatives from the Ministry of Education and Science, the Ministry of Health and Consumption, the General Council of Colleges of Nursing and ATS, and the Council of Directors of University Schools of Nursing. Proposals were elaborated which led to the Royal Decree 1466/90, 20th December 1990, containing the Guidelines for the elaboration of the Curriculum which was to be applied.
One of the most important conflicts was how to respect the normative on the duration of the curriculum of the Spanish University, a maximum of 30 hours per week—15 hours for practical work, 15 for theory, with a minimum annual duration of 600 and a maximum of 900; this situation had to be compatible with the European Directive 77/453, which stated that the education of nursing professionals should be 4,600 hours.

After the appearance of the Nursing Curriculum in the Official National Bulletin in the form of a Royal Decree, with a duration of a maximum number of 215 credits (2,150 hours), numerous nursing organisations made a statement against it in the Commission of the European Community, as the Directive 77/453 had not been observed.

The response of the European Union was immediate and the General Director of the Internal Market of this organisation communicated to the informers that a letter dated 17th March 1993 had been sent specifying a deadline to the Spanish Government: the first stage of the infraction procedure for not adjusting the decree no. 1446 of December 20th, 1990, to the contents in Directive 77/453 had been initiated.

The Ministry of Education and Science offered a solution with a new Royal Decree 1267/10 June 1994 together with a correction of errors of the Decree, published on June 14th. This specifies that “the curriculum for the learning of clinical care in health institutions should include a minimum of 3,900 hours, in accordance with the educational programmes”. This left an open door to the establishment of equivalence in the value of the clinical practical hours, by assigning the practical work hours with time values, up to a total of 3,900 minimum hours (including hours devoted to theory) for nursing training in the European Union.

### 3.2.3 Research and Theoretical Knowledge

One of the most important elements to be developed by the members of a profession is education. The education should include research methodology and provide elements for research. Arcas (1990) believes that the deficiency of methodological education, together with the scarcity of sources, constitutes the most serious shortcoming in nursing, as professional development only takes place when there are new and varied data available from different sources.

Polit (1985) and Closs and Cheater (1994) pointed out that an early experience in research while still studying contributes to an increase in nurses who accept the professional responsibility of research; this early contact is decisive in the value given to research by post-graduates as an integral part of care. The inter-
est and dedication of these post-graduates has a lot to do with the learning atmosphere they were immersed in during their higher education as well as with the value given to research during their educational period.

Research, as it is acknowledged in the nursing curriculum of the University of Valencia, must:

- Be integrated within a global vision, as another component in everyday life, not detached or disconnected from the theoretico-practical contents.
- Promote experiences in the students –on an individual basis or as part of a group–; integrate the students into research groups formed by nurses with different levels of expertise and doctors who would help develop all aspects of research: data collection, methodologies, procedures, assessment techniques, resolution of problems, etc.
- Have quality and be accurate, trying to replicate analyses in order to obtain a contrasted basic knowledge, establishing laws through continuous verification, pooling efforts to build up a body of knowledge. This may require setting up international research networks to favour the development of coherent, universal and true foundations.
- Promote the knowledge of retrieval and use of information; information must be accessible, and nurses must be able to find the publications relevant to their research, distinguishing whether or not they are of any value; that is, nurses must be able to know how and where more knowledge can be found. Access to updated information is essential in research, and therefore it is necessary to use and analyse the information available, ascertaining its current value.

Until the 1860s, the objectives of nursing focused on disease, as medicine had done; at that particular time, it may be argued that a unique socially relevant service – different from medicine – started to emerge. One of the people who initiated the change was Florence Nightingale. Currently, it is generally accepted that nursing research started with Nightingale’s detailed observations of the effects of nursing actions in the Crimea War, which she was to use later to effect changes in health care.

In 1859, Florence Nightingale (1860: xxv) identified nursing as an art and a science, putting the emphasis on the importance of the inter-relation between the individual and the environment, thus becoming a pioneer in this holistic conception. She tried to structure the process of nursing care in the following terms:

the most practical lesson which can be given to the nursing staff is to teach them to observe, what to observe, how to observe, which signs show im-
Strt to improve a disease, which signs show its worsening, which signs are important, how negligence manifests, what type of negligence. (Nightingale, 1860: 104)

Florence Nightingale used to advise nurses to develop the habit of keeping records and notes of their observations in a systematic way and to use statistics to clearly expose their findings. She contributed to the birth of knowledge specific to nursing, thus strengthening the importance of nursing education, as the habit of significant observation can only be developed through education.

Although Florence Nightingale established the foundations of research in nursing, these were never transmitted as a part of the educational tradition, and research activities in nursing practically did not exist in England until the end of the Second World War (Smith, 1979: 320).

In addition to her contribution on observation, Florence Nightingale was able to establish general guidelines through statements such as “only nature cures”, “nursing must place patients in the best possible conditions so that nature can act on them” (Nightingale, 1860: 134), thus setting a first nursing model.

From that moment, theories started to arise in relation to the nursing activities developed through a totally scientific approach. From Florence Nightingale to the present day, we notice how nursing knowledge has been affected by the contexts where nursing activity has taken place, and the tendencies followed by the knowledge during each period.

Nightingale identified nursing knowledge as different from medical knowledge. However, nursing knowledge has been strongly affected ever since by medical knowledge, learning from many of the medical directives to continue its own development. This can be seen even nowadays, for instance in the structure and contents of nursing books: care for patients with urological problems, or care for patients with haematological problems, etc., or in the denomination and structure of certain professional associations, such as the Association of Urological Nursing, or the Association of Reanimation and Anaesthesia Nurses.

Under the influence of the medical model, nursing incorporated the empirical tendency as a paradigm for the development of its own knowledge, possibly in the search for certain levels of objectivity which would provide nursing with the validity and reliability needed to become a science. This, together with the use of specific instruments, led to the division of the aims of research into smaller units, which ought to facilitate their analyses, as was done in medicine and other scientific fields; at the same time, special attention was placed on the control of the question in research.
This leads to the use of a scientific methodology, and research is now considered an essential element in the development of nursing and its establishment as a science within the general area of health sciences. Therefore, the Nursing Care Process (NCP) (i.e. the application of the scientific method in the detection of health problems in individuals and/or communities) becomes a working tool for nurses together with the establishment of nursing care. The application of the NCP as a working instrument has led to the implementation of one of the points in the Briggs Report (1977), i.e. “Nursing should be a research-based profession”.

Parallel to the development of the NCP, and since the appearance of Nightingale’s conceptual model, research has been carried out on the description of the conceptual framework in which nursing develops and through which nursing becomes an autonomous profession, as a specific field of knowledge which has to grow and varies depending on the elements which form the framework.

During the first decades of the 20th century, several nurses have brought into the profession research methods used by other professionals in other scientific and educational fields. One of these nurses is Deborah Mac Lug Jensen; her book *Students Handbook on Nursing*, published in 1929 by the Nursing School at Yale University (USA), described a system of problem-solving through data drawn from the description of patient cases. This mainly helped prepare Public Health students. The study included a series of analyses, based on questions such as: “Why did the patient go to hospital?” “What did the patient do after hospitalisation?” “How can the professional nurse help the patient in these matters?” These three questions precede the current components of the nursing process, i.e. data collection, planning, and intervention.

In 1902, Lavinia Dock presented a report about what was called ‘the experiment’, carried out with nursing students and initiated by Lillian Wald, which provided free nursing care to students and to ill people in their houses. In 1927, Jean Broadhurst and her colleagues submitted a research paper on hand-washing procedures.

These studies, together with a few other isolated cases, constitute the only experience in nursing during this period, when unfortunately not many references are found, maybe due to the underestimated social role of women. They are American analyses, and they must have contributed –to some extent– to the progress of nursing in Europe. The different social rules and the subsequently improved situation of women facilitated an early integration of nursing in the university curricula with the creation of the first nursing chairs.
From 1930 onwards, a period can be identified which is characterised by a search for solutions to problems derived from education, which are soon incorporated into university studies. ‘Supply and demand’ studies are also carried out in hospitals, drawing conclusions about staff policies and functions.

When the analysis by Esther Lucille Brown was published, in her book Nursing for the Future in 1948 (also called the Brown Report), most of the American nursing students were already familiar with some problem-solving methods, such as case-study and written care plans. The book meant a great push for the development of nursing, as it set three major challenges for the profession:

1) Nursing Schools had to become a part of the university.
2) The term nurse (both male and female) had to be given to nursing graduates.
3) An adequate salary had to be established for nursing professionals.

The need to educate nurses in the university and thus acquire a level of knowledge typical of higher education, as well as the demand for an adequate salary in agreement with the professional service, required from the nurses to be responsible for their nursing care and the quality of that care. Given the lack of resources for qualitative analysis and measurement, the development of quality control methods started, which was considered to be a new step in the nursing progress (Benavent et al., forthcoming).

Important recommendations in this study were: hospitals had to have sufficient staff to allow nursing students to be considered students and not hospital personnel, and every effort had to be made in the development of nursing research, which required the participation of the academic staff.

These claims, which first arose in the USA in the 1940s, affect us even today. All these problems were advanced and resolved in the United States, and as we have seen in other chapters, they were similar to the problems in Europe, in particular to those of the British and Spanish nurses.

The awakening of research in nursing dates back to 1950, according to several scholars (Polit, 1985; Smith, 1979; Blasco, 1986; Maanen, 1990; Shaw, 1993). From its beginning, slow but continuous progress was made, which required changes in education and in the attitudes of the nurses in order to accept the responsibility of research. Zilm (1993: 1663) refers to the work prepared by Spekenbrinken which established that the first Nursing department in a university in Europe was that of Edinburgh, in Scotland, founded in 1956 and therefore the
oldest in Europe; the consolidation of nursing research in universities was to progress slowly but surely from this particular moment.

We could add that the theoretical development and the formal separation of nursing from medicine started in the 1950s. During this decade, the intellectual atmosphere favoured this development, and emphasis was put on the analysis of nursing concepts and frontiers; parallel to this accelerated evolution, some features started to shape nursing as a science.

During the 1970s, nurses were beginning to question nursing as a scientific discipline; the ‘fortunate’ absence of consensus favoured the discussion, and as a consequence a greater theoretical and academic development took place. In the 80s, nursing was identified as a discipline by the scientific community, with the corresponding acceptance of concepts, scope and frontiers of the nursing paradigm, which foresees a future of its total acceptance as a science with a defined body of knowledge based on practice (Benavent et al., forthcoming).

All this progress would not have taken place without spreading the knowledge generated. Nowadays, the results of scientific activity are spread through different media and systems, especially through written articles in scientific journals and books. Some authors believe that a research is not concluded until the results are known by the rest of the scientific community which is concerned with the subject of the research.

Today, scientific articles constitute one of the most important means of communication among scientists; in nursing, scientific papers have several objectives: firstly, to spread advances in the different nursing fields; secondly, to instil in them a didactic nature; thirdly, to expose the research to the critical evaluation of colleagues; and lastly, to permit the review of the results of the previously published research. Other relates feature are the personal promotion and the professional stimulus received by the authors.

The daily production of scientific articles is 6,000, which means that every two years scientific knowledge doubles (Saba, 1989: 189). Currently, 10,000 journals of health sciences are published on a yearly basis, with a production of over 600,000 articles per year, without including publications which may have a more or less related content, such as essays on psychology, biology, sociology, anthropology (Icart et al., 1991: 16).

According to Price (1972: 45):

the continuous duplication which takes place approximately every 15 years and which has led to the present scientific era, is responsible for the pecu-
liar contemporaneity which enables us to affirm that most of the science is current and that most of its generators live today. According to this law, if we affirm that the number of scientists doubles every 15 years, during such an interval there would be as many new scientists as there have been during all previous eras. But the scientists who coexist in a certain period are not only those who have appeared in the last 15 years; they have appeared over a period of 45 years, between the age at which a person would start researching and retirement age. Therefore, for each person born before the 45 year period, there is one born in the first duplication period, two in the second, and four in the third.

This law seem to applied in the work of Maanen (1989: 918): starting with H. Peplau, the author establishes a chronology of nursing authors (she stresses how she has used the theoretical concept in nursing, including in her list those contributions which have been recognised in her country of origin). The list is not exhaustive, but it is sufficiently expressive: in the first 15 years (1950-65) and starting with Peplau, we find 7 theoretical contributions; in the following 15 years (1966-1980), we find another 7, which added up to the previous figure makes 14, and finally for a third period (1981-90), there were 9, which totals 23.

According to Maanen (1989), the concentration of theorists in the USA took place between 1955 and 1980, whereas the first European contributions date from the end of the 1970s following the influence of the Americans, which coincides with the chronologies made by different authors concerning the start of theoretical nursing in Europe (there is one of such chronologies in England but not in Spain). The readers may get the impression that this part of the research is talking about theorists and theory development instead of article-publishing, but theorists could be considered the forefront of the profession; they stimulate to publish, as they must expose their ideas writing articles in journals. They are the catalyst for new research articles and more writing. And the growing number of theorists could be considered the thermometer of the growth of research in a profession and of the publication of articles.

Therefore, we can consider that what is valid for science in general is also valid for nursing, possibly in a more particular way as far as the nursing process is still in its first stages. According to Price (1972: 46):

the function of growth and its regularity help us explain the feeling we get that most of the greatest scientists live today and that most of the scientific contributions have been made in the times of the present generation.
These words were valid for science in general terms in the 1970s. In nursing, the greatest contributions will be possibly made in the near future, although it is commonly accepted that numerous theoretical aspects have already started to crystallise: some of the contributions Maanen refers to are in a paradigmatic situation, and in a developing status for the constitution of conceptual frameworks, models and theories. In Price’s (op. cit.) view:

The principle (referring to his previously quoted words) is even more evident if we underline that in the period covered from the next decade to the end of the following one, there will be as many researchers and works as in the total of the previous eras.

The changes which nursing has undergone in England and Spain in the last two decades, both at an academic and professional level and as to the evolution of the health system, have defined a favourable framework for the progressive incorporation of nursing professionals in activities of generating and communicating scientific knowledge.

We must take into account that at present it is impossible to quantify the totality of the nursing scientific production developed in both countries, as there are no complete data bases gathering research projects in nursing (finished or under way), and that there are numerous projects whose results do not go beyond the place where they were carried out.

One way to determine the scope of scientific production in nursing and the preparation of professionals for the contribution to the development of the discipline is to study the articles published in nursing scientific publications which are then accessible to the rest of the nursing scientific community. These articles do not constitute the totality of the scientific production in nursing in both countries, but they constitute a good representation of the level of preparation of the professionals in the development of the discipline, and of its scope, through a tangible result, i.e. written evidence accessible to the rest of the scientific community. This way, one of the basic demands of scientific knowledge is met.

The articles which include an analysis of the scientific production in nursing are quite recent in Spain. The authors’ major concern is to describe the main traits of scientific production in nursing, for which several elements were established which were later treated statistically. The elements ranged from internal structure of the articles (abstract, sub-titles, presentation) to quality, research area, subject of research, instruments, place of research, designs, number of authors, academic qualifications, etc.
If we follow the comments made by the authors, we can get an idea of the capacity of nursing professionals to produce scientific knowledge; Mompart (1990: 21) comments on two research projects on the scientific production in Spanish nursing which had not been published at that time (one was to be published later; Icart et al., 1991); in her opinion, both underline that the number of articles published “doubles and even triples from year to year”, and the problem is observed of the lack of continuity in the works started and finished, as well as the lack of recommendations for future work on the subject.

Since 1990, there has been a successive production of articles which analyse the capacity of professionals to contribute to the development of the discipline: works by Icart et al. (1991) (previously mentioned), Cabrero and Ricart (1992), Torra (1995). Some of them analyse a specific segment of production, such as Martínez and Martínez (1992), who focus on scientific production in primary care, and Puerto and González (1993), who analyse the scientific nursing production in oncology.

Ricart’s article (1994) has a slightly different content but it is in the same line. He analyses the literature references which are used by the authors in the research papers published in a 2 year period in three Spanish journals. This author notes that the use of specific and recent bibliography is somehow smaller in the Spanish scientific nursing literature than that in journals like Nursing Research (American) and Journal of Advanced Nursing (British) in 1990; however, he mentions that there is an increasing development at the moment.

Possibly, one of the elements which dynamised scientific production in Spain, after the incorporation of nursing in the universities in 1978 and as has been the case in other countries, is that there is a gradual approach between the scientific production of professionals associated with the university and the assigning of more resources and larger budgets by the Administration; in turn, the resources are linked to the quality of research.

This situation is not new in England where – since 1986 – the quality of research of the different university departments, including nursing, is analysed. Tierney (1994) analysed the results obtained by the University Financing Council in Research Assessment Exercise. This consisted of a survey through which 29 departments were assessed, with a 1 (none or virtually no excellence sub-area) to 5 scale (some international excellence area or different national sub-areas); 19 departments were rated as 1; others received a 2; 2 departments reached a 3; and, finally, only 3 departments got a 4. None of the nursing departments was able to reach grade 5.
Tierney describes that those departments in the oldest universities – which at the same time are the newest departments – have a higher number of researchers and got the best rates in the survey. The lower rates corresponded to department in newer universities which originated from the disappearance of the binary system of Universities and Polytechnics in England, many of which were more concerned with academic and educational matters than with research and had a reduced staff, which seems to have caused the low rates obtained in the assessment.

These ideas are supported by Smith (1994): who describes what he calls the “uniqueness of nursing” as a combination of factors: they range from difficulties in finding funds and time, to lack of experience, a great number of new institutions and a low practical level. Smith considers that each of these factors is not relevant in itself, but when combined, result in low quality levels in nursing research; in addition, he compares several nursing journals (a new journal, and two with several decades of experience) with a medical journal, and concludes that nursing should not be afraid of being compared to medicine, there are specific areas where nursing must develop but medicine can also learn from nursing. In the author’s view, the current research levels must be considered as a benchmark for the improvement of the future.

In Spain one of the most reiterated objectives and priorities, since the establishment of Associations and Colleges of ‘Practicantes’, Midwifes and later Nurses, is to have their own fora and especially means of publication of their research, such as journals, bulletins, etc. This objective is registered both directly and indirectly by the successive norms which developed the creation of the professional colleges; this is the chronological order:

Item i in article 5 sets the aim of the Colleges in the Orders of 1929 and 1930: the colleges must develop all the charitable and cultural aims foreseen in their particular regulations (one of those cultural aims was the publication of journals).

In the same Orders, article 13 established as a college duty that the secretary of each college had to register in strict detail all the members; a list would then be provided annually to the General Direction of Health, Provincial Inspection of Health, and medicine sub-delegations, and the modifications to the list would have to be published in the Official Bulletin of the corporation. The Bulletin was the communication organ of the colleges (obviously for those who had it), and included all the aspects previously mentioned as well as those related with scientific communication.
The Order of 8 March 1941 (article 1) established that until the approval of the new statutes, the colleges had to continue functioning in accordance with the statutes approved by the Order of 22 December 1929 as to all the areas which had not been modified by other regulations or by the Order, and so the publication of the college bulletins was guaranteed.

Item g in article 4 of the same Order established as the exclusive function of the General Council of the Official College of ‘practicantes’ the publication of a bulletin including scientific, professional and legal works of interest to the ‘practicantes’.

Later on, the Order of 18 March 1942 (item j, article 5, Chapter 5) described the functions of the colleges as follows: promote and develop the charity work, cultural activities, etc., which may be of interest to the Class (this reminds us of previous regulations). Article 23 stated that the agreements adopted by the colleges had to be published in the Official Bulletin of the Council if they contained references to general measures affecting the Class; this function had been exclusively assigned to the General Council and is again reiterated by the Order of 26 November 1945, which established in article 3 that the function was exclusive of the Council: the Council shall publish a bulletin including scientific, professional and legal works which may be of interest to the Class, to which all Spanish health auxiliaries registered in a college will subscribe.

The Order of 21 June 1951 established the Statutes and Regulations of the Midwifery Colleges. Item 6 in article 6, Chapter I, describes as functions all those scientific and cultural aims which would be found relevant.

Article 12 in Chapter II, in the same regulation, established the duty of the secretary of the Managing Board of each college of keeping a record of the adequately registered midwives, which would be annually submitted to the college members, the Health provincial inspectors of the provinces covered by each college, and to the rest of the college members, the General Council, and the General Direction of Health; the modifications – if any – had to be published monthly in the Official Bulletin. Therefore, this communication organ was both used as a registry and for tax purposes, and also as a way to circulate knowledge among the members.

Item h in article 6 of the Regulation of the National Council of Health Auxiliaries, developed by the Order of 29 March 1954, established a task which is exclusive to the National Council, that is, the publication of a Bulletin containing as many official news and reports which could be of interest to the professionals. The Bulletin had to be distributed to all the college members. In addition to the bulletin, each of the sections – individually or in joint schemes with the other sections –
could publish a journal with scientific, literary, and socio-professional contents, of interest to the group.

Item 0, in the same article, states that –under the direction of the Health Authorities and the Medical Body– the study will promote the initiatives for the improvement of the public health and the care techniques in the assisting of the ill, stimulating personal efforts.

This norm also included an appendix with the Moral Code which established certain moral duties for health auxiliaries (article 3): the professionals should be aware of their responsibilities, always trying to increase their knowledge, keeping up to date in science. Both in this appendix and in the regulation articles, independence from the doctors was not determined, and the auxiliaries were only encouraged to update their educational activities and not their research.

Later, the Spanish college organisation subscribed in 1973 the nursing code of the International Nursing Council. The section ‘The nurse and the profession’ says: “nurses contribute actively to the development of the shape of nursing knowledge”. The only way to achieve this active contribution and development is research. The assumption of this code involved a quality change in this line, which would later result in irreversible changes as to professional autonomy and development through research, because it implied the recognition of nursing research as something different from past activities, even in the opinion of the nurses themselves, something worth working on. This would eventually lead to irreversible changes; the consideration of nursing by the patients changed dramatically, and the aspirations and demands changed as well in terms of autonomy. Changes are still occurring, especially as far as research is concerned.

In the college regulations, there is no further reference to the development of informative media, bulletins, journals, etc., as from this moment, the highly important college function of distribution of scientific, literary and socio-professional materials is taken for granted. And therefore, all those colleges which have funds available publish journals or bulletins.

In the Deontological Code of Spanish Nursing –published in 1989– we find two articles which represent a commitment to research and professional development; article 70 reads:

The nurse will be aware of the need of being up to date by means of staff development schemes and through the development of the knowledge on which his/her professional practice is founded,

and article 73 reads:
The nurse must try to research systematically in the field of his/her professional activity, aiming at improving the nursing care, discarding incorrect practices, and extending the field of his/her knowledge.

Both articles implicitly promote the creation of journals for publishing the results of research, as the advances which are not communicated are not really advances, since they are not integrated in the corpus of scientific knowledge of the corresponding professional group, in this case nursing.

### 3.2.4 Responsibility to Maintain Professional Standards

One of the things that worried Florence Nightingale was the question that patients were asking themselves: “does that nurse live up to her profession?” and the British nurses answer this question in the ethical code saying that the claim to professional status must be substantiated through the maintenance of competence at all levels by continued research and improved methods of nursing care, adapting it to changing needs and new techniques of care.

The professional authority of nurses is based upon their training and experience, they have particular forms of knowledge and skill that are not shared by other professions.

These ideas are expressed in the Code of Professional Conduct for the Nurse, Midwife and Health Visitor published in 1983, saying in point 2 that a nurse must be accountable for her practice and take every reasonable opportunity to sustain and improve her knowledge and professional competence;

and completed it with point 6 saying that:

at all times act in such a way as to promote and safeguard the well being and interest of patients/clients for whose care she is professionally accountable and ensure that by no action or omission on her part their condition or safety is placed at risk.

In the 2nd edition of this code, published in November 1984, these two points were transformed into three, although the contents remained the same:

1) Act always in such a way as to promote and safeguard the well being and interests of patients/clients.

2) Ensure that no action or omission on his/her part or within his/her sphere of influence is detrimental to the condition or safety of patients/clients.
3) Take every reasonable opportunity to maintain and improve professional knowledge and competence.

The Spanish professionals have also been concerned with fighting obsolescence and keeping up to date. This is shown in article 3 of the Code of Conduct, published as an annexe to the College Statutes of 30 de Julio de 1954, which says that Health Assistants:

need to be aware of their responsibility, trying to always gain knowledge and catching up with the related latest scientific advances.

This is perfectly established in articles 60, 70, and 71 of the 1989 Deontological Code of Spanish Nursing:

Art. 60. Nurses shall be responsible for constantly updating their personal knowledge, thus trying to avoid situations which may put at risk the health or life of the patients.

Art. 70. Nurses must be aware of the need to keep up to date through ongoing training and an overall development of the knowledge on which their professional practice is based.

Art. 71. Nurses must assess their own educational needs, seeking appropriate resources and being able to manage their own training.

**Comparative analysis**

The Spanish nurse, including in this denomination; ‘practicantes’, ATS, and nurses from 1857, was always more prescribed and more medically and bureaucratically controlled than English nurses in their development. From the very early days English nurses influenced nursing education; in Spain until the 70s the control was in the hands of the doctors. In Spain the validating authority with one exception was the medical faculty. The one exception being the War Ministry (Table 4.) for a short time. This domination of nursing training by the medical faculty lasted until 1977. In England the validating authority was hospitals until 1919 (Table 5.), then Statutory bodies.

Since its institutionalisation both in England and Spain, the nursing profession has been characterised by the commitment to train staff after completion of their studies, to update, and thus optimise the care standards. Possibly, one of the mistakes which has also defined the training is the close link with medical technologies at the expense of nursing; however, this is only a tendency from which nursing has also learned.
Nowadays, training, research and care standard maintenance are included in the articles of the nursing code of conducts of England and Spain, which strengthens the commitment of both professional groups.

In the field of the education of nurses, the number of similarities between Spain and England are very large: both training systems were based on practice; this aspect evolved and – at present – both the theoretical and practical contents are equally important in both countries.

Basically, the professionals started the development of their studies as dependent on the doctor, although in the case of the Spanish ‘practicantes’ there was some autonomy in their practice given the special health organisation of Spain and scope of the work of these professionals.

It is also interesting to note that both in England and Spain women had to meet additional conditions for acceptance in comparison to men, such as authorisation by the father or husband, and references from a doctor or a church minister, about their good behaviour and manners. This was in line with the ideas at that time, when women held a subordinate position in society.

The training of the ‘practicantes’ in Spain covered medical and technical aspects, whereas in England the training of the nurses was directed to a greater extent to the satisfaction of the patient’s needs. This is an important difference in the educational profile which gradually changed with time, as – given the demand of the health systems– the professionals were asked to be prepared for both things. From the very first moment, the English nurses had a say on their training, whereas in Spain this control has been achieved only recently, and had always been in the hands of the doctors.

The current training in both countries is quite similar, although experience in the Erasmus65 scheme of the European Union indicates that Spanish nurses cover a larger number of medical/technical activities; e.g. intravenous drug administration needs a special qualification for nurses in England, while in Spain it is taken as a routine practice.

In Spain, the syllabus which had to be applied in all schools was obligatory at a national level and established by the Ministry of Education. The development of the syllabus was done by the teaching staff; until recently, the doctors were re-

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65 Erasmus is a section of Socrates which is the European Community action programme for co-operation in the field of Education. Erasmus section focuses on higher education.
sponsible for that task. At present, the process of elaboration of the new syllabus has been initiated by university organisations, and the University Council has created a commission for that purpose consisting of members from the nursing teaching bodies and members from the General Council of Nursing Colleges. The drafts have been made available to the public. All the social sectors, including professional organisations, nursing associations and unions, can suggest changes which may be included in the elaboration of the final document containing the new syllabus.

At the beginning, in England syllabi were developed by the teachers of the different schools of the country, each school having its own syllabus. But in 1920, GNC attempted to apply one single syllabus to be followed by all the centres; this initiative did not succeed until 1962, possibly due to the different types of existing nurses. Numerous hospital-schools found it difficult to adapt to the new arising needs. For a period of time the GNC and UKCC set the syllabus and held state examinations. A system of central professional control which had not been achieved in Spain. At present, curricula are developed by institutions and validated by UKCC for Nurses, Midwives and Health Visitors, a professional organisation with several missions, one of which is to validate the curricula for all the nursing schools in England. This constitutes one of the most relevant differences between England and Spain, where academic validation, as distinct from the professional, comes from the universities.

But the most outstanding difference observed concerns the examination set by the professional body in England, GNC or UKCC for Nurses, Midwives and Health Visitors. The successful applicants were able to practice after signing up in the registry. Such an exam does not exist in Spain; passing the different exams and theoretical and practical tests of the university degree enables the graduates to carry out nursing practice, validating the NCP, because is included as a regulation, like in England: Rule 18.

The existence of different types of nurses, with different scopes in their work, training, and even a registration on different parts of the nursing registry, is another divergence from the Spanish system.

Spain has implemented a homogeneous training for all ATS, later on nurses, since 1954. Prior to this, there had been two types of professionals differentiated by their sex: 'practicante' (male) and nurses (female).

In England, the number of basic different training programmes have been recently reduced to four through Project 2000, and the four models provide an 18 month common training. Therefore, from a situation with numerous types of
nursing training there has been a reduction to four, which shows certain similarities between England and Spain and a tendency toward a single core type of nursing training. Until very recently, the training of different specialist in Spain was carried out as post-basic training, in England, basic training had ‘specialist outcomes’.

Another similarity refers to the process followed in both countries as to the level of access required for nursing studies. Once the suitable associations were organised both in England and Spain, the idea was to raise the access standards, this being the target to accomplish, later attempting to integrate the studies into the university. This objective has been hindered by several obstacles, especially in England, where the hospitals were fed with student-employees, and the idea of raising the standards could be interpreted as a measure to dissuade the recruitment of new labour. In addition, raising the standards could increase the pressure to regard nursing as a profession; this has, in turn, a repercussion on the economic cost of the nursing services.

Another possible and important element which may have caused the nursing access standards to rise could be the development of the national health systems in both countries: 1944 in Spain and 1948 in England. Possibly, such systems conditioned and supervised the development of the access standards to their own growth and development.

On the other hand, there is sufficient evidence of the fact that nurses who sat on the GNC and who should have taken the decision to press for the increase of standards in the GNC, were people that had entered nursing training without qualifications (White, 1985). All these elements were possibly taken into account when the GNC considered raising the admission standards.

Recently, access to university in Spain and to similar levels in England, as far as nursing studies are concerned, represents a new converging point between both countries, as the studies previously completed condition the age of access. However, as shown in Table 4, admission standards were raised by some training centres in England, and consequently – since 1962 – numerous schools kept admission levels higher than those really required. The same happened in Spain (Table 5), where the demand for training places in the ATS schools – greater than the supply – caused the standards to be raised to a higher level than it would have been required under normal circumstances. Currently, nursing in Spain has one of the highest admission standards for university access. For example, in the University of Valencia, out of 43 careers that could be chosen by
students, the nursing career is the 4th in ranking of the standard level for entrance (data from the University Registration Office).

The length of studies is similar in both countries (three years); this was achieved by the English nurses during the last century (Table 4), and by the ATS in Spain in 1953, as shown in Table 5.

In both countries, research is an important subject during the studies, which constitutes a step toward the homogenisation of nursing in both places, leaving behind the routine training of the first stages included in the chronology of this paper, and developing similar dependent strategies in the two countries, leaving every day routine tasks to achieve new areas with new challenges and wide objectives.

With all these similarities and differences, we can state that there is a high level of coincidence in the evolution of the English and Spanish nursing systems, and that both countries have widely covered the indicator “Skill-Based Theoretical Knowledge”.

3.3 Nursing Natural History of the Professionalisation

Table 6. summarises the history of the nursing profession in England and Spain, offering information on the sequence followed in the development of nursing in both countries. The table makes one think about some elements which are analysed in the study of the professions and apparently confirms that there is a typical sequence of events, in the terms established by authors like Caplow (1954) and Wilensky (1964).

Regarding the contents of the table and since there have always been patients and health providers, we could state that nursing has always been a full time job, though it is difficult to determine the timing of the technological and organisational transformation which placed nursing in a position to evolve from an occupational point of view; this is not the subject of this investigation, though. For our purposes, we can accept that nursing in England and Spain started to be a full time occupation in 1850, as this is the date from which our analysis starts.

Secondly, we can take into consideration the dates when nursing training was initiated in both countries, with the establishing of the St. Thomas’s School of Nursing in 1860 in London (England), promoted by F. Nightingale with the support of the public, and the Colleges of Medicine in 1857 in Spain, which opened new avenues for the training of nursing precursors, ‘practicantes’ and midwives, within the reorganisation of health studies. For Spain, the table includes the ap-
pearance of the different training centres which have led to the existence of the present nurses (male and female): the Nursing School of Dr. Federico Rubio Gali (1896), the Schools of Health Assistants (1952) and finally the University Schools of Nursing (1977).

Third, the sequence covers the establishment of the first professional associations: the British Nurses Association in England (1887), and the ‘Practicantes’ Union in Spain, whose first references dates back to 1883.

The pressure and political agitation caused by these and other associations had their effect, after a long period of time, when nursing obtained the support of the public authorities and the protection of the association by law in both countries, which led to the creation of the General Nursing Council in 1919 in England and the Professional Colleges in 1929 in Spain A fourth step had been taken in the sequence of the professionalisation process.

In this regard, as shown in Table 6, we find in Spain that the professional colleges (the first one being that of the ‘practicantes’ set up in 1929) would pool later on all the existing nursing professionals (nurses and midwives) who – in 1954 – joined the ‘practicantes’ under the denomination ‘Colegios de Auxiliares Sanitarios’, later called ‘ATS and Nursing Colleges’ (1978).

The categories that existed before ‘nurse’ indicated the type of professional. Such is the case of the ‘practicante’, which was the denomination used for a practitioner of medical techniques. In addition, the ATS as a health aide to the doctor, who had inherited the practical/technical aspects of the ‘practicantes’, while the term ‘nurse’ had been hardly ever used. The present recovering of the name ‘enfermero/a’ (nurse), in Spain, implies the identification of the real dimension in the performance of the nursing professional, who also benefits from tradition and recognition.

And finally, the sixth step in the sequence has recently been achieved by nursing in both countries: in England in 1983 with the Code of Professional Conduct of Nursing, Midwifery and Health Visitors of the UKCC, and in Spain with the Deontological Code of 1989.

If we do not count the fifth step of the sequence – only applicable to Spain and without chronological significance –, we will observe that the process in both countries is practically identical; there is only a small chronological difference when at times England is ahead of Spain, and vice versa.

In their analyses, Caplow (1954) and Wilensky (1964) refer to a specific Northamerican culture; in our case, our reference is made up of two different cul-
tures, that is, Spanish and British, which also seem to meet their expectations in terms of sequences in the professionalisation process. This may suggest what both authors indicate, i.e. the professionalisation process is practically unilinear and thus its application universal.

3.4 Nursing Attitudinal Autonomy

In this next section will be seen the progression of nursing from completely dependent task-orientation, to the patient need centred, nursing process approach, that could provide to nurses a very important area of autonomy in their work with people. In this, it is possible to understand the role of the development of nursing knowledge as well as to see how nurses rejected time and again, the possibility of dropping routine tasks, because of tradition, in the training of nurses, and girls commitment to the role of the stereotypical woman.

3.4.1 Nursing Knowledge and Work: from Routine to Dependency

According to Borenham (1983: 695), knowledge provides the work performed by the professional a special characteristic: “the work of ... professionals ... by its very nature its not amenable to mechanisation and rationalisation”. Freidson (1984: 11) further states that professional workers are “expected to exercise judgement and discretion on a routine, daily basis in the course of performing their work”; judgement in face of daily problems, and discretion deciding what should be done is a recognised and legitimate part of their work.

Oppenheimer (1973: 214) saw professional work as work in which there is discretion and judgement by the worker. Her/his work is not readily standardisable; in it levels of training are required. The opposite of professional work is routine and lack of discretion.

Rhodes (1984: 49) quoting Medvei and Thornton, gives evidence that the nursing and medical tasks often overlap in the past. The following, from the same source reveals from the other side the domestic tasks that the nurse, had to carry out:

How does the work now compare with the work then? Well, of course, nursing as you understand it now (1902) was utterly unknown. Patients were not nursed then, they were ‘attended to’ more or less; but there was only one nurse in each side of the ward and the work was very hard-lockers, lockers-boards, and tables, of course, to scrub every day.
It seems from both quotations that the nurse spent as much time in carrying out medical tasks and domestic tasks as forming part of the daily ward routines.

In 1890 *The Lancet* Sanitary Commission\(^{66}\) made a report on the duties, pay, diet, and recreation of hospital nurses. Of the information elicited, mostly from private inquiry, was selected the following notes, which are anonymous:

... after a hard night, have beds to make, washing of patients, dusting, and breakfast to prepare and to give each patient. [...] 

   A rule obtains in some institutions of imposing household drudgery upon nurses. It surely is a very bad economy that employs a valuable expert as a mere housemaid. Why must these ladies be asked to expend their last bit of energy to sweep floors, scrub lockers and lockers boards, clean brasses, and even keep lavatories in order, to clean lamp globes, and polish head boards? (*The Lancet*, 1930: 1091)

In this quotation it can be noted that there was a clear perception of the value of nursing work and also a consideration that the time spent in domestic tasks was a waste of time for valuable experts.

### 3.4.2 Routine and Discipline Training

In the early 1930s The Lancet set up a Commission of Enquiry which concentrated almost exclusively on the difficulties of attracting recruits to nursing. It spent a considerable portion of its time on the need for changing terms and conditions, specially living conditions for the student nurse. The problem, viewed by doctors, was one of adjusting nurse training giving more personal freedom for students, reducing the rigidity set up by Miss Nightingale.

Against the introduction of a standard curriculum for the General Nursing Council, *The Lancet* Commission found much testimony of protest from some senior nurses and notably ward sisters; they said that the vocational spirit which inspired former generations of nurses has been dimmed, although early fears in this respect were unfounded. They senior nurses and ward sisters attribute that “the preservation of the vocational spirit the routine work of has been severely criticised from outside the profession and is stated to have prevented many girls

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from entering the hospitals. This factor is the routine work of the probationer, occupying nine to ten hours a day\textsuperscript{67}.

Speaking about the exploitation of the student labour the commission said:

... a large section of the nursing profession, specially ward sister, remain convinced of the value of a strict discipline, which is designed to plant and foster in the probationer certain qualities and habits. Among these are un-critical obedience; punctuality; loyalty to superiors and to the institution served.\textsuperscript{68}

Vera Brittain (1985: 316) a nurse during the World War I, noted in her comments the kind of discipline that nurses had to suffer at that time

discipline must exist, of course, but self-discipline voluntarily accepted is always better than discipline dictatorially imposed from above. Some regulations are necessary to the smooth running of a hospital service, but the imparting of confidence to the sick matters more than the number of buttons on a coat, and the conquest of fear in one patient alone was higher value than a hundred newly-polished sterilisers.

Davis (1976: 276) expressed the concept of routinisation of work as considerable emphasis on rule-following, on standardised and routine activity, and on a clear nursing hierarchy with firm allocation of supervisory responsibility. On this basis it is clear that the process that nursing work followed was at that time, a process of routinisation.

The Medical Society of London analysed the shortage of nurses and stated that “the employment of untrained or partly trained women to perform simple nursing duties under the supervision of the trained staff was now widespread in institutions for the chronic infirm and in some special hospitals and sanatoriums where the shortage of trained nurses was most acutely felt”. For this kind of new nurses it was suggested that such ‘nursing assistant’ should be given a “practical training of two years mainly in wards for the chronic sick, should not be made to pass examinations”... They recommended that they should “not be formally enrolled or admitted to any form of state register”\textsuperscript{69}.

\textsuperscript{67} The Lancet (1932), The Lancet Commission on Nursing. (February 20): 415-417; 473-475; 532-535.
\textsuperscript{68} The Lancet (1932), The Lancet Commission on Nursing. (February 20): 415-417; 473-475; 532-535.
\textsuperscript{69} The Lancet (1937), Sick nursing: Past, present and future. (October 16): 906-908.
The Athlone Committee (1939), whose final report was pre-empted by the outbreak of war, relied heavily on the work of *The Lancet* team in its own interim report. It saw its special task as being concerned with securing an adequate service for the hospital and, though it stressed the importance of a career in nursing comparable to that for women in teaching, it is nonetheless significant that it was firmly against raising the age and educational requirement for entry into nursing lest these exacerbate the problem of supply of nurses.

In the Nurses Act of 1943, a second grade of qualified nurse was created “It shall be the duty of the General Nursing Council for England and Wales ... to form and keep a roll of assistant nurses subject to and in accordance the provisions of this Act”. The assistant enrolled nurse, a title later changed to State Enrolled Nurse, created two distinct grades of nurses with no progression from one to the other.

The separation of an intermediate stratum of semitrained nurses from untrained nursing assistant was formalised in 1958 with the establishment of an educational programme for the state enrolled nurse status and the development of a new nursing grade, nursing auxiliary, defined as one who is engaged wholly or mainly in nursing duties but has no recognised nursing qualifications and is not a student nurse or pupil assistant nurse (Bellaby and Oribabor, 1980).

In 1948, the Wood Committee (HMSO, 1948), appointed without consultation with the nursing profession, was set up to provide a comprehensive review of the nursing profession before the introduction of the National Health Service. It carried out empirical studies making some recommendations such as removing domestic chores from the tasks of the student of nursing and the strict discipline providing a full student status. With the removal of the domestic tasks the committee felt that the training could be completed in two years. The committee viewed the enlargement of the schools and these should be financed and staffed independently of the hospital itself. Such changes would entail the appointment of nursing orderlies to cope with domestic work in the hospitals.

The nursing organisations, General Nursing Council and College of Nursing reacted rapidly; they said that the student nurse status was acceptable, reduced length of training with increase of contents was less so, and put a strong opposition to the removal of the student control from the hands of the matron and stressed that the matron as head of the training school had the last word in the selection of a student. Note especially the comment “The elimination of so called
‘repetitive duties’ on which the reduced training is based would result in robbing the student nurse not only of the ability to nurse but of satisfaction in nursing”.\(^{70}\)

The Wood Committee attacked the relevance of routine work in nurse training, and instead stressed a more academic syllabus. Its recommendations were to do with a reorganisation of nursing work and a new type of nurse, a 3-year training has less to do with a complex content of work, and more to do with fulfilling the service needs of the hospital and creating a humble and disciplined character in the nurse (Davis, 1977: 487-488).

Things continued in the same way and the students continued complaining, as *The Lancet*\(^{71}\) said:

> Over and over again, students declared themselves dissatisfied with the lack of method in teaching on the wards. Their responsibilities and duties varied with the exigencies of ward routine rather than their own skill. Supervision and methods varied from ward to ward.

Virginia Henderson’s words fully describe what she thinks about the nurses of the time:

> Nurses are not bookish people. Nursing is a taxing job physically, mentally and emotionally, and there is little time for the practitioner to discuss or analyse her work in the way that, say teachers might do. Furthermore, the nature of basic nurse education has been until comparatively recently, designed to inhibit rather than to encourage the critical and inquiring mind. There are still many people both in nursing and more particularly in medicine who would not regard it as any part of the nurse’s function to reason why; she is there to obey, to show respect for her superiors and above all get on with the job. (Quoted in Grosvenor, 1978: 81)

In 1964, as the end of the process initiated in the post-war era, the Royal College of Nursing developed a policy in relation to training which was changing the initial strategy of subordinating training to service. The Royal College set up the Platt Committee (Royal College of Nursing, 1964) which affirmed the need to separate education and training from service, and grant full student status. In section I of the Platt report (Royal College of Nursing, 1964: 5), they quoted the


\(^{71}\) *The Lancet* (1961), A nurse is a nurse is a nurse. (May 7): 1021-1022.
Nuffield Provincial Hospital Trust Report, under the title of “The work of nurses in hospital wards”, in which they referred to the position of student as follows: “student nurses were student in name only. Their alleged status is still far from identical with their actual status; indeed if student status exists at all at the present time it is only as an attitude of mind on the part of these students themselves”. Ten years later the Platt Committee considered that this description was still valid for the student. In 1968, following Davies (1977: 489-490), the Royal College of Nursing condemned with vigour the consolidation of the student as employee. The Platt report recommended also a new grade of auxiliary worker to reconvert the existing nursing auxiliaries and ward orderlies into this new grade, and the enrolled nurse should undergo a two year training on apprenticeship lines.

In 1966 the Salmon Report on senior structure meant a formalisation of the stress on discipline, hierarchy and routine identified earlier, it also referred to the ‘sapiential authority’ of medical staff over the nurses on matters of medical treatment and put it in the job description saying that the nurse was to “receive and carry out the orders of the medical staff”. With this in mind, it is clear that the subordination still remained, although the sapiential authority is only in matters of medical treatment.

3.4.3 Exercising Judgement and Discretionality

Many of the things stated by the Platt report were assumed by the Briggs report. This report, quoting the comments of Davies (1977: 489), “begins by identifying the distinctive role of the nurse as ‘care’, this is sharply distinguished from the ‘cure’ task of the doctor and the idea that nurse should be in any sense a ‘junior medical assistant’ is firmly rejected. We learn that ‘care’ draws upon a number of different areas of expertise, the physical, psychological and social needs of the patient provide scope for a broad knowledge base for the nurse. It quickly becomes apparent however, that ‘care’ is very broad indeed”. This implies an acknowledgement of the wide field of nursing expertise.

Nevertheless the 1972 Briggs report questionnaire put in evidence that domestic chores are still part of the nursing task, as noted in (HMSO, 1978: 39):

forty percent of hospital nurses and midwives had carried out at least one duty in the last week which could have done more appropriately by domestic staff,

and a later paragraph says that the
shortage of staff, whether of domestic staff or other professions, should not be made an excuse for the persistence misuse of nurses and midwives.

Although the nurse’s function is complementary to, and not ancillary to that of the doctor, the notion that she carries out his orders, at least in some spheres, is not questioned.

It has been argued that it is not the nurse who carries out the doctor’s orders, but the patient. The nurse accomplishes neither more nor less than the function defined by Virginia Henderson (1960: 3): “the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death), that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible”. Evidence of this is that the chief feature of the work of nurses now is the educative component, teaching the patient the treatment and techniques to administer as necessary. In all cases where possible, if the patient is unable to perform the treatment, then the nurse, will perform it for him. In other words the nurse assists the patient to comply with medical prescription and to cope with other activities of living.

As Bosanquet (1973: 82) described, in the practice of nursing much effort was dedicated to reducing or eliminating the area of discretion of students and nurses by routine and discipline. The style of supervision of some trained nurses meant that they would check on performance before, during as well after tasks had been done. These efforts to limit discretion reflect a lack of confidence in the standard of their junior staff. It will never be possible to eliminate discretion entirely, even if desired and one might argue that it is not rather it is a desirable characteristic in qualified nurses. But if discretion is not nurtured all the time it will be lacking when is needed. For the safety and comfort of the people being attended by the nursing profession nurses should be able to exercise discretion and total initiative. The presence or absence of discretion will affect the quality of the work done.

An explanation of this attitude of reducing or eliminating discretionality, is offered by Davies (1976: 279) saying that, the first and most obvious is that “the training of nursing is a process of socialisation which transforms current work practices into valued work practices”; in the second place, she argues that “nursing is a female occupation and that like all the female occupations had a certain propensity to routine”, and in the third place, that routinisation of work in particular has been noted as “a solution adopted in situations of high turnover”. The familiarisation of newcomers is facilitated where procedures can be relied on to be identi-
cal and where channels of reporting and limits of responsibility are set. In fact, the last point has been adopted, and at present it is being developed by a large part of the nursing services in England and Spain.

Otherwise, one main feature of the changes seen over the past years in hospitals has been to make the discretionary element even more important. During that time a good deal of drudgery has been eliminated. With this, discretionality is continually increased by the introduction of new technologies and therefore more technical contents.

Rhodes (1984: 22) comments on the concept of ‘technical’ by Jamous and Peloille:

> It is a means of production that can be mastered and communicated in the form of rules. By codifying knowledge and creating a more technical process of production, a potential for outside control is brought into play. This potential, however, may never be fulfilled because an established profession can prevent the organisation of work on technical lines, yet, at the same time, utilise scientific technology.

This process is followed in nursing.

Nursing knowledge is becoming codified, and comprises a new scientific technology (understanding by technology the technical language of an art or science72. (Casares, 1984)). This new technology is the nursing process that formally sanctions nurses to collect data, diagnose, plan action and evaluate its effects. Central to the Nursing process is the diagnoses. Following Johnson’s view (1972: 57):

> The diagnostic relationship is used as a control mechanism both within an occupation and in relationships with other allied occupations, for whatever the problem (mechanical, physical, psychological, or social), actions, (plans, therapy or policy) stems from diagnoses and the diagnostician assumes an authoritative role.

Diagnoses in nursing are unique to each patient individual problem, and the treatment applied after diagnosis is also unique to each patient. The individual character of the diagnosis makes it impossible for any member of another profession to be able to take over control of the case, precisely because the nature of the problem which the diagnosis refers to is specific to nursing.

Control of work content means autonomy, and autonomy is acknowledged as an important feature of the concept of profession by theorists from all schools and it is crucial to the usefulness of the nursing process model. Rhodes (1984: 28) quoted Hall’s statement in reference to autonomy:

"Autonomy is also part of the work setting, in that the professional is expected to utilise his professional judgement with at least relative confidence that only another professional will be in any position to question it."

And Parry and Parry (1977: 826) had already said that “professions have a strong capacity to thwart the process of rationalisation because they come to dominate and control the organisation within which they work”. As a consequence, professions have been able to manipulate the division of labour among supporting occupations in a manner which suits their interest. In reality, established professions enhance indetermination by utilising more modern technology; and support technology from the security of their indeterminate function in the central process of production from which others are excluded.

In spite of attempts in England to introduce such innovations as the ‘nursing process’ and ‘primary nursing’ with their emphasis on greater autonomy for nurses and systematic individualised care for patients, task allocation has not completely disappeared as a method of organising patient care. Staffing the task system requires a hierarchy of skills provided by those with specialist training and a formal qualifications (registered and enrolled nurse); those in the process of obtaining those qualification (learner nurses); and those not seeking or in possession of nursing qualifications (auxiliaries). Organising work in this way reflects the earlier influence of division of labour and scientific management theories (Gibbs, MaCaughan and Griffiths, 1991: 243). Similar difficulties happened in Spain at this time to remove the traditional organisation of the work that followed the scientific management theories.

In 1983 Statutory instruments of the Nurses, Midwives and Health Visitors Act specified that only first level nurses were to be allowed to devise and assess care plans within the scope of the nursing process (Porter, 1992: 723).

As Baly said (1984: 11), when this system is better understood it should lead to the substitution of the scientific method for folklore, the prescribing of care on a personal basis, and should go some way to meeting the requirement of a profession that builds up knowledge by the continual follow up of research.

Experimental Nursing Homes have been opened and are managed by nurses who prescribe care and call the general practitioner when appropriate. Only
eight years passed between the two next quotations but their diversity of thinking are obvious. The first comes from Davies (1976: 277) who wrote:

the creation and maintenance of work complexity requires control over the development of knowledge about the occupation. Nurses are reliant on medical staff and, to a lesser extent, social scientists to create nursing knowledge. Few nurses themselves are engaged in research activity and the lack of explicit nursing research findings in nursing journals affirm this argument.

The next quotation from Baly (1984: 11) evidences how fast the nursing profession was evolving in the way its own paradigm was to be understood:

... the fact that nurses are now prescribing care, there is a considerable body of research being built into nursing practice, although until nurse training is on a more heuristic basis these findings are not likely to be widely used. Supporting this idea, I note that nursing is changing the paradigm of analysis from the medical and sociological to nursing paradigm increasing the space in nursing journals to study nursing problems and models rather than the sociological and medical models so favoured in the past.

In addition, Form (1976: 413) further said that “the increasing mobility of nurses has been related with the passing of the minor tasks to new occupations placed in the lowest steps of the health hierarchy”. Seymer (1969) in her writings quotes the opinion of one of the early probationers who said: “Progress was slow in regard to organised teaching. When I entered the school in 1867 there were a few stray lectures given, some antiquated medical books and a dummy upon which to practice bandaging: the taking of temperatures, pulse and ordinary test for urine being strictly the work of the medical students” (Seymer, 1969: 43). Note that certain techniques were reserved for students of medicine. Was this because they were of a diagnostic nature or that they were relatively novel and enhanced indetermination? Here can be see the strategy of dependency being practise by doctors, although the techniques which in 1867 were entrusted to medical student were subsequently passed onto nurses. The nursing profession now, is doing the same with the routine tasks of work. A new era is beginning in which nursing resources are considered valuable resources. In another context, in reference to the United States of America, Ball et al. (1992: 14) write:

With registered nurses earning salaries of 35,000 dollars to 60,000 or more, hospitals cannot afford to waste nursing skills on administrative or routine clinical tasks that don’t require a nurse’s education and expertise. Upon examining their daily activities, we found that nurses frequently spent much of
their time performing routine, repetitive, technical tasks rather than performing those professional duties for which their education and experience had prepared them, specifically providing primary patient diagnosis and treatment.

One could understand this quote to be a forecast of the future of the nursing profession. Things like these begin to occur in England and Spain under the name of ‘multi-skilling’, ‘skill-mixed’, and ‘patient-centred care’.

3.4.4 Dependency as Strategy

But what is a strategy of dependency? Davies (1976: 273), begins by saying that a group in an organisation can, under certain circumstances, create dependency for others and thus enjoy power. What is relevant is not necessarily the possession of an esoteric body of knowledge highly valued in the society at large, but rather a hold over some strategic resource vital to the overall functioning of the organisation, a resource which is not easily transformed into a routinised activity where the job occupants are readily substitutable.

And Davies in the same paper, further added some elements which constitute dependency:

The creation of dependency requires persuasion on two counts: first that the work to be performed is of value and second the alternative performances are unavailable or inadequate. An occupational group must thus manipulate both its recruits and its work content. The number and type of recruits must be controlled and the training laid down. Nobody must be allowed to practise without having undergone the required training, which creates simultaneously a scarcity and a uniformity of practice. Along with such recruit control, attention must be paid to the nature of the work done. It must be clearly delineated from adjacent occupations; ideally, routine work should be off-loaded to those in a lower status occupations while the group in question avoids itself becoming the recipient of such a strategy. The work content should also remain obscure to the outsider and not become a matter for obvious rule-following routines. (Davies, 1976: 275)

*Project 2000* on nurse training seems likely to reduce considerably the proportion of registered nurses within the nursing workforce. In 1988, Colin Ralph, the Chief Registrar of the UKCC, admitted the inevitability of such a reduction. An
indication of this trend is the 18% reduction in the number of student nurses in Britain during the 1980s (Porter, 1992: 724).

Thus one proposal from the Project 2000 is for a new grade of helper to undertake specific tasks in support of, and under the supervision of, qualified nurses (Gibbs, Gibbs, MaCaughan and Griffiths, 1991: 247), and remove completely all the routine tasks to be performed by the students, thus becoming supernumerary in the wards.

This favours the settlement of the idea of the relationship between the nurses and the patient or a group of patients through NCP, where the professionals themselves have at times caused more problems than the Managers and Health Care Planners of the Health Administration, partly due to their resistance to change and unawareness, and to the inertia of their acquired knowledge during their nursing training.

However, the NCP and its application also represents power for the nursing professionals. Its analysis permits one to establish which routines – for instance task allocation of the work – can pose difficulties for professional development. Although power is needed, the development of this methodology by the professionals will act as the engine for the changes and their application.

Therefore, a generalised application of NCP will lead to the final progress from a routine-based practice to a professional practice based on the educational philosophies adopted by the UKCC and the Spanish Nursing Schools, validated in the English curriculum by Rule 18 (1983 and 1989) and in the Spanish curriculum by the order of directives of the nursing curriculum (1990), both legal regulations.
4 POWER AND AUTONOMY TODAY

4.1 Overview of the Research on Power Indicator

Once the indicators for the traits theory and the theory of the natural history of professionalisation had been established and analysed, they needed to be developed for the latest and most updated theory, the power or autonomy theory, if the indicators were to permit the comparison between England and Spain in terms of professionalisation in nursing.

The development of the power indicator has been a very complex one. The scarcity of studies has prompted an extra effort to delve deeper into this specific and most important indicator. Instruments capable of indicating attitudinal autonomy or power levels have been only researched by Hall (1968) and Forsyth and Danisievicz (1985).

Hall’s instrument concentrated on only one dimension; autonomy from employing organisations; Forsyth and Danisievicz took into account two dimensions: attitudinal autonomy from client and from organisation. In this research it was decided to use Forsyth and Danisievicz’s approach because it was thought to be more comprehensive in their development of Hall’s theory of power and, in addition, in line with this investigation.

The decision was made to devise and administer a questionnaire to four groups drawn from both, health science students and professionals, because if, as supported by the theory, power is the critical variable in the professional phenomenon, the power profile of medical doctors and medical students – the former practising the latter preparing to practise in a ‘true’ profession such as medicine – ought to differ in a patterned way from the profiles of those preparing to practise or who are practising nursing, if nursing is not also thought to be a true profession.

The answers given by Spanish doctors and Spanish medical students were thus used as a parameter in the comparison of the answers of nurses and nursing students both in England and Spain.

The working hypothesis used in this case for the application of the questionnaire was that there would be no difference between the attitudinal autonomy of medical and nursing groups in England and Spain.
4.2 Sample Description and Methodology

The number of subjects to whom the questionnaire was to be administered practically coincided with the number used by Forsyth and Danisiewicz in their 1985 research, the idea being to have a reference in the sample analysis, as certain parts of their research were going to be replicated. In their analysis there were 136 students of nursing and 80 students of medicine. In the Spanish sample, the questionnaire was administered to 134 nursing practitioners and 76 practitioners of medicine, and also to 147 nursing students and 78 medical students. All the students were in their final year. For the English sample, the questionnaire was administered to 121 practitioners of nursing and 134 nursing students, all of them final year students.

4.2.1 Sample and Location

For the data collection in the case of the nursing students, the proportion was established in accordance with the number of 3rd year students at each of the Valencia Nursing Schools. As several centres were accessible, it was decided the sample would be made up of students from all of them, aiming at having a more varied sample, thus eliminating the bias involved in sampling from one centre only: obtaining the sample from one centre would have meant having almost all of the students of the school. In the process, the number was rounded either up or down, and the questionnaires were randomly distributed to third-year students.

Table 7. Spanish Schools of Nursing. Sample Distribution

<table>
<thead>
<tr>
<th>School</th>
<th>3rd-year students</th>
<th>Surveyed</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital General</td>
<td>100</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Hospital La Fe</td>
<td>50</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Ntra. Sra. Desamparados</td>
<td>150</td>
<td>47</td>
<td>32</td>
</tr>
<tr>
<td>Universitat de València</td>
<td>168</td>
<td>53</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>468</strong></td>
<td><strong>147</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

238
The questionnaire was also administered to sixth-year medical students from the Faculty of Medicine of Valencia, with a total of 636 students during the academic year 1994-95. It was not distributed in other centres, as access was not gained. The sample was drawn by distributing 78 questionnaires among the attendants to an exam in May 1995.

With regard to the medical and nursing professionals, the questionnaires were distributed among the different wards in the following hospitals: Hospital Clínico, La Fe, Hospital Provincial, Peset Aleixandre and Hospital Sagunto, and in several primary care centres of the Valencia province, with the idea of having a diversified sample. The English sample was obtained similarly, trying to achieve variation and eliminating the bias involved in sampling from one centre only.

The centres were selected depending on access facilities, and questionnaires answered by final year nursing students were collected at the following schools: Homerton School of Health Studies at Cambridge University, Faculty of Health Care and Social Studies of the University of Luton, School of Nursing and Midwifery Studies at the University of Wales in Bangor, and Faculty of Health Care and Social Studies at Leeds Metropolitan University.

In turn, the professionals samples were obtained from the following centres: Addenbrooke’s Hospital, in Cambridge, Stoke Mandeville Hospital in Aylesbury, in Wrexham (Wales), St. James Hospital in Leeds, and several primary health centres.

4.2.2 Questionnaire Design

Forsyth and Danisievicz (1985) developed their questionnaire from previous works by other authors. There is no evidence that this study had been replicated previously. Their questionnaire was translated into Spanish for its replication in Spain.

The Spanish questionnaire (Appendix 2) was handed out to a small group of medical and nursing students and professionals in order to check if the translation was suitable and did not cause linguistic problems nor difficulties in its interpretation, as there could have been cultural aspects not familiar in our context.

Four questions were added to the questionnaire (Questions 23 to 26) to investigate aspects related with clients autonomy which – in contrast with questions 1 to 11 – aimed at analysing the particular features of the conflict between professionals and clients from the perspective of the professionals and their consideration of the client’s rights (the questions were also included in the English version
and did not pose any interpretation difficulties in the questionnaires collected. The full questionnaire is attached to Appendix 1 (English) and 2 (Spanish).

In Forsyth’s and Danisievicz’s (1985) questionnaire, some of the statements are positive, some are negative. The statistical analysis of items 1, 3, 4, 6, 7, 8, 9, 10, 11, 16, 18, 20, 21, 22 was scored reversed.

Eleven Likert-type items (1 to 11 of the questionnaire), operationalised client autonomy – conceptually defined as the relative autonomous attitude that individuals express with regard to their clients or potential clients (Forsyth and Daniesievicz, 1985: 69) –, in terms of decisional independence and conviction of one’s knowledge. Each item scored from one to eight, according to the respondent’s intensity of agreement or disagreement with the item; the higher the sum of item scores, the greater the autonomy from the client. The idea was to respect the original questionnaire in order not to modify the reliability and comparison.

Like the client autonomy scale, the autonomy from the employing organisation scale also consists of Likert-type items (12 to 22 of the questionnaire) that operationalise the concept in terms of submission to organisational administration – conceptually defined as the relative attitude autonomy that the individuals express with regard to the institution they work at (Forsyth and Daniesievicz, 1985: 69) –, the perceived importance of organisational loyalty, and the respondent’s willingness to bend organisational rules.

Four Likert-type items were added (23 to 26 of the questionnaire), to the original questionnaire to analyse how the client is considered in his/her own autonomy to make decisions about his/her affairs. Client autonomy from professionals could be conceptually defined as the relative attitude autonomy that individuals express with regard to the respect of the freedom of clients to make decisions in relation to their own affairs.

### 4.2.3 Data Collection Procedure

In Spain the questionnaires were attached to an introductory letter indicating the research objectives as well as the instructions to fill them in. Each questionnaire was directly handed out to the respondents after having asked them to participate, provided they had some spare time. Confidentiality was assured to all of the participants. A few minutes later, the questionnaires which had been completed were collected.

In England the process was somewhat different, as the questionnaires were distributed in the organisations, universities and health centres, and the participants
were asked to return them by mail; 600 questionnaires were delivered and 255 complete questionnaires were returned, that is, 42.5%.

4.2.4 Statistical Treatment

The statistical analysis comprised a descriptive study of each item with the calculation of different measurements of central tendency and dispersion, such as standard error, variation coefficient, range and order percentiles 10, 25, 50, 75 (see Tables in Appendix 3). Kruskall-Wallis was used to distinguish genuine differences among the samples and random variations of different samples of the same population. Mann-Whitney was used to ascertain whether or not there were differences among the samples.

The function of the significance tests is to determine whether or not two or more groups compared in terms of different measurements (measurement of central tendency and dispersion, like standard deviation, variation coefficient, range and order percentiles 10, 25, 50, 75) could be considered as coming from the same population.

The value of such tests is explained by their Power and Efficiency: Kruskall-Wallis test makes the scores into ranks instead of dichotomising them over and under the mean value, thus permitting the establishment of the direction of the significance. On the other hand, Mann-Whitney is an alternative to t-Test, which does not require nor restrict the suppositions involved in utilising the latter.

The statistical calculations were done on a Macintosh II SI computer through FileMaker Pro 2.1 and Statview SE + Graphics software.

Significance levels were set in terms of:

- \( p > 0.05 \) Non-significant. Cannot be distinguished among groups.
- \( p < 0.05 \) Significant. Can be distinguished among groups.

4.3 Results

Significant differences were found in the answers given in the three question groups which are related to autonomy from clients (questions 1 to 11, see Table 8 and Appendix 3) and autonomy from organisations (questions 12 to 22, see Table 9 and Appendix 3); and in the answers of the third group of questions, which referred to the autonomy of clients from professionals (questions 22 to 26, see Table 10 and Appendix 3).
Strikingly, some mean values obtained in the questionnaire seem to be rather low; for instance, for questions 1 to 11 and 12 to 22. Apparently, there is no specific reason for this, but in any case, it was something established by the sample. Perhaps the length of the Likert scale used for the answers (1 to 8) which is longer than usual, may have conditioned the choice.

### 4.3.1 Autonomy from Clients

The statistical treatment of the answers to questions 1 to 11 of the questionnaire (Appendix 3), was first carried out for the whole six groups in order to determine whether or not there were significant differences among them by means of the Kruskall-Wallis test; the application of this test ruled the null hypothesis out and indicated the presence of highly significant differences $p = .0001$.

Afterwards, the six groups were analysed by means of Mann-Whitney U, two at a time (Table 8), and each group was contrasted to each of the five remaining groups.

By using Mann-Whitney U the following results were obtained: the Spanish nurses, doctors and students do not support the difference, and the three groups could be considered to have the same attitudinal autonomy from clients.

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Score</th>
<th>Group</th>
<th>Mean Score</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>0.6081 NS</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.2318 NS</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0001</td>
</tr>
<tr>
<td>English Nursing Students</td>
<td>54.127</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0018</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0054</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0001</td>
</tr>
<tr>
<td>English Nursing Students</td>
<td>54.127</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.0001</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.2474 NS</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>English Nurses</td>
<td>55.653</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>English Nurses</td>
<td>55.653</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>0.6528 NS</td>
</tr>
</tbody>
</table>

Non Significant = $p > 0.05$
In addition and based on the sample, the results obtained from English nurses and students cannot support the difference, and the two groups could be considered to have the same attitudinal autonomy from clients.

In the analysis the answers given by the English nurses and nursing students to questions 1 to 11, were compared to the following groups: Spanish nurses, medical students, nursing students and doctors. The null hypothesis was rejected and highly significant differences were found among the groups $p = .0001$ in each of the cases.

The analysis of the answers given by the Spanish students to questions 1 to 11 were analysed and compared with the other groups. This comparison rejected the null hypothesis and indicated the presence of highly significant differences among the groups.

### 4.3.2 Autonomy from Organisations

The statistical treatment of the answers to questions 12 to 22 of the questionnaire (Appendix 3) –relative to aspects of autonomy from organisations– was initially carried out for the answers of the six groups as a whole, in order to establish the statistical significance by means of Kruskall-Wallis. Its application ruled the null hypothesis out and indicated the presence of highly significant differences $p = .0001$.

Furthermore, the six groups were analysed with the Mann-Whitney U test, taking them by pairs and comparing each group with each of the five remaining ones as can be see in Table 9.
The results obtained for the answers given by the sample were as follows: among the Spanish nurses, the English nurses, the Spanish medical students and the Spanish doctors, based on the sample present cannot supported the difference and the groups could be considered to have the same attitudinal autonomy from organisations.

The analysis of answers 12 to 22 (English and Spanish nursing students compared with the answers by each of the following groups: English nurses, Spanish nurses, Spanish medical students and Spanish doctors) reject the null hypothesis and indicate the presence of very highly significant differences among the groups, $p = .0001$ in each one of the cases. It could also be stated that the difference cannot be supported by the results obtained by the two groups – English nursing students and Spanish nursing students – since it could be considered they have the same attitudinal autonomy from organisations.

### 4.3.3 Clients’ Autonomy from Professionals

In questions 23 to 26, both nursing and medical students and professionals from England and Spain were asked about their attitude as to some rights of the patients which may condition their professional autonomy.

Their answers were analysed by means of the Kruskall-Wallis test with a view to determining significant differences. The application of this test rejected the null
hypothesis and indicated the presence of very highly significant differences among the groups, \( p = .0001 \) (Appendix 3). Later, the six groups were analysed through Mann-Whitney U, taking them in pairs and comparing each group with the five remaining groups as can be seen in Table 10 below.

The results obtained from Spanish nursing and medical students – based on the sample – cannot support the difference and both groups could be considered to have the same attitude about clients’ autonomy.

The comparison of the Spanish nursing and medical students with the English nurses and nursing students rejected the null hypothesis and indicated the presence of very high significant difference between the groups, \( p = .0001 \) in every-one of the cases.

The results comparing English nursing students with English nurses – based on the sample – cannot support the difference and both groups could be considered to have the same attitude to client’s autonomy.

By means of applying Mann-Whitney U, we found that the answers given by the English students to questions 23 to 26, compared with the answers of the Spanish doctors and nurses, rejected the null hypothesis and indicated the presence of significant differences, \( p = .0465 \) with the Spanish doctors, and very highly differences with the Spanish nurses, \( p = .0001 \).

Table 10. Attitude from Client’s Autonomy. Mann Whitney U (Q 22-26)

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Score</th>
<th>Group</th>
<th>Mean Score</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>0.0478</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.754</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0001</td>
</tr>
<tr>
<td>English Nursing Students</td>
<td>54.127</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0001</td>
</tr>
<tr>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>Spanish Nurses</td>
<td>39.157</td>
<td>0.0966</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.4706</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.2374</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0085</td>
</tr>
<tr>
<td>English Nursing Students</td>
<td>54.127</td>
<td>Spanish Nursing Students</td>
<td>44.925</td>
<td>0.0011</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.0465</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.0002</td>
</tr>
<tr>
<td>English Nurses</td>
<td>55.653</td>
<td>English Nursing Students</td>
<td>54.127</td>
<td>0.6108</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>English Nurses</td>
<td>55.653</td>
<td>0.1316</td>
</tr>
<tr>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>English Nurses</td>
<td>55.653</td>
<td>0.001</td>
</tr>
<tr>
<td>Spanish Medical Doctors</td>
<td>40.382</td>
<td>Spanish Medical Students</td>
<td>40.872</td>
<td>0.1051</td>
</tr>
</tbody>
</table>

*Non Significant = p > 0.05*
And finally, when the comparison was established between the answers to questions 23 to 26, in the case of the Spanish nurses, and the answers given by the Spanish doctors to the same questions, the null hypothesis was rejected and significant differences were found between Spanish nurses and Spanish doctors: $p = .0478$, this being more outstanding in the case of $Z$ corrected by ties, that is, $p = .0213$ (Appendix 3), and very highly significant differences were observed between Spanish nurses and English nurses, $p = .0001$. 
5 DISCUSSION

5.1 Nursing Attitudinal Autonomy

Based on the literature, both nurses and nursing students from England and Spain were expected to be the two groups with the lowest level of autonomy from clients, but autonomous from the organisations. In any case, the most favourable forecast was that they would show the same level of autonomy as doctors and medical students in both sections.

Nevertheless, the result was unexpected, as the Spanish and English nursing students and English nurses showed a higher level of autonomy from clients and organisations than the other three groups, Spanish nurses, Spanish doctors and Spanish medical students. It could be stated that Spanish nurses, Spanish doctors and Spanish medical students have the same attitude toward their clients.

On the other hand, the English nursing students and the English nurses belong to the same group, as their answers were similar and no differences between them were found as to their expressed level of autonomy from the clients (which was higher than in the other four groups). The Spanish nursing students were more autonomous than the Spanish nurses, doctors and medical students, but less than the English nursing students and nurses.

In the analysis of the answers given to the second question group (12 to 22), no differences were found between the English and Spanish nurses, and the Spanish doctors and medical students. Both the English and Spanish nursing students stood out regarding autonomy from organisations and showed a more autonomous attitude than the other four groups, could be that practitioners experiences could have affected their attitudes.

Maybe this result is a consequence of the present emphasis of nursing schools on promoting professional independence and autonomy, setting some distances from other professionals. This may be having an intense effect on the promotion of attitudinal autonomy from clients.

Another influential aspect may be the special idealism of the students during their training years, which might be encouraged by this atmosphere of promotion of professional independence and autonomy in the nursing schools.

Special attention needs to be paid to the data obtained from the answers given by the English nurses, with values well over the mean score of the Likert scale.
This was significant, as it evidenced the independence and autonomy tradition-
ally held by the English nurses in relation with the patient.

However, a review of the data provided by Forsyth and Danisievičz (1985) in
their analysis supports the idea that the nursing students only display one of the
dimensions (autonomy from organisations) of the autonomous attitude and not
two (lacking autonomy from the client). This confirms their hypothesis: the power
of the students who were preparing for what – in Etzioni’s (1969) words – was a
semi-profession, could show one of the dimensions of autonomous attitudes and
not two.

This could be argued if we take into consideration the data provided by Forsyth
and Danisievičz. These authors, however, used procedures for the analysis of
the variance of the mean values of the autonomous attitudes in eight groups of
students from different occupations which claimed professional status, in the two
autonomy dimensions.

The data in the analysis of Forsyth and Danisievičz (1985) indicate the presence
of statistically significant differences among the groups (p = .0001). The result
only indicates objectively that there were differences among the eight student
groups and consequently among the occupations for which they were training,
without indicating the differences in any direction. This result could be expected,
since normally there would be significant differences when comparing autonomy
from client and organisation in eight different student groups.

Forsyth and Danisievičz compared the mean score for each group to the aver-
age mean values of all the groups, assigning each group to a different category
(profession or semi-profession) depending on the score (above or under the
mean values). With this result, Forsyth and Danisievičz generalised and ac-
knowledged Law and Medicine as true professions, as these students scored
higher than the mean value for both autonomy dimensions. Likewise, the nursing
students and the students of the remaining occupations studied with a score un-
der the mean for one or both dimensions were assigned to the category of semi-
profession.

It could be argued that without a more detailed analysis aiming at establishing
group differences and comparing each of the so-called semi-professions with
those recognised as true occupations, the authors should not have generalised
and assigned their chosen categories. Therefore, the study of Forsyth and Dan-
isievičz should be replicated in the same terms or the data should be re-
assessed in order to determine – by confrontation of each of the semi-
professional occupations with medicine or law – which are the ‘true’ professions.
If significant differences were found then, the semi-profession category could be assigned to the less autonomous groups.

If this procedure were applied to the present analysis, and a classification of profession and semi-profession categories was made, in particular to the mean scores of each group for questions 1 to 11 and 12 to 22, in the present study, the results would show an average mean score of 46.553 for questions 1 to 11 (attitudinal autonomy from clients), and therefore only the English nurses and students would be over the average.

Regarding questions 12 to 22 (attitudinal autonomy from the organisations), the average mean score was 34,072 and therefore the Spanish and English nursing students would be over the average.

Another feature which has not been taken into account yet, is that the rest of the groups (Spanish nurses, Spanish doctors, and Spanish medical students) showed an identical level of autonomous attitude for both dimensions; this should be underscored, as no significant differences were found among them, which suggests the existence of an identical outlook in the nursing and medical professionals in Spain.

Table 11. Mean Scores of all the Groups

<table>
<thead>
<tr>
<th></th>
<th>Spanish Nurses</th>
<th>Spanish Medical Doctors</th>
<th>Spanish Nursing Students</th>
<th>Spanish Medical Students</th>
<th>English Nurses</th>
<th>English Nursing Students</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions 1-12</td>
<td>39.157</td>
<td>40.382</td>
<td>44.925</td>
<td>40.872</td>
<td>55.653</td>
<td>54.127</td>
<td>46.553</td>
</tr>
<tr>
<td>Questions 12-22</td>
<td>32.388</td>
<td>31.934</td>
<td>37.224</td>
<td>30.09</td>
<td>32.347</td>
<td>37.388</td>
<td>34.072</td>
</tr>
</tbody>
</table>

This survey seems to be effective in the comparison of different groups (medical and nursing students, doctors, and nurses), permitting the observation of national characteristics in the comparison (should there be any) and/or data on the international trends of the autonomous attitudes and the power of nursing professionals.

The answers to the last four questions (23 to 26 of the questionnaire) referred to clients autonomy showed a change in the dominant paradigm among professionals, from the paternal attitude to client autonomy.
The results for answers to questions 1 to 11 showed the level of professional autonomy from clients, and at the same time, the autonomy of the clients themselves was shown in answers to questions 23 to 26. This is not contradictory, as the rights do not actually collide; it would be unfair to suggest that this was in contradiction with a particular right or duty. ‘Collision’ can only occur in a particular situation of professional/client conflict.

When interpreting the results, one understands that professional autonomy can be practised without affecting autonomy of the client. Both the professional and the client have rights and duties in real situations, and usually without conflict. The denial by the professionals of the practice of autonomy by the clients would be unfair and therefore could be legally prosecuted in some circumstances.

Both, professionals and students are respectful of the autonomy of the client, with high scores in the answers (very near to ‘completely agree’). The average mean value of the answers is 29.822, and the maximum score which could be reached for those particular answers was 32.

Finally, in the analysis of the answers to the last four questions, the most homogeneous groups were the Spanish medical and nursing students. On the other hand, both the English nurses and nursing students obtained the lowest mean values, and their comparison with other groups provided high significant levels. It could therefore be stated that the Spanish nurses and doctors, and the Spanish medical and nursing students are more respectful of the autonomy of the client. However, if the scores obtained – which are very similar – were analysed, this fact would not be so important and the difference could be of a purely national nature.

The comparison between the English and Spanish nurses and nursing students on the one hand, and the medical students and doctors on the other, in terms of attitudinal autonomy enables the drawing of the conclusion that there are no differences between the groups; in any case, there is greater autonomous attitude in the English and Spanish nursing students in both dimensions (clients and organisations).

The results obtained display differences between the nursing students and the nurses at a national level. By comparing the Spanish nurses and nursing students to their English counterparts, minimum differences can be established on a national level, but in attitudinal terms, the data are similar, which means that the homogeneity is high in both countries.
5.2 Historical Indicators

The development of this study has questioned some of the statements made in the literature on professionalisation, as there is little analysis of professionalisation in nursing and a lack of comparative analyses. There has been repetitive quoting of sources and in the application of concepts which needed to be updated; e.g. Etzioni’s concept of nursing as a “semi-profession”, proposed in the 1960s, which is still widely quoted by present day scholars.

In this study, different professionalization indicators have been analysed, drawn from three sociology schools: traits, evolution, and power or autonomy, to study the evolution of nursing in England and Spain from 1850 until the present day. This analysis indicates the presence of important similarities in the professionalisation processes and highlights some cultural differences. In the previous section (V.1.) it was already discussed the indicator referring to power and autonomy. The discussion will now focus on the historical indicators.

The indicators may be somewhat subjective, as it is practically impossible to avoid some subjectivity when they are applied, although this only affects certain aspects or moments. Subjectivity may be eliminated as a result of the use of validated studies, and therefore any problems posed to reliability can be overcome by observing progress in the achieving of each indicator over time.

It is necessary to acknowledge that professions and professionalisation theories are applied and analysed from the perspective of men. Doubts may arise as to whether or not this is the most suitable approach when studying occupations such as nursing (mainly a female job). However, as demonstrated by authors such as Holden and Littlewood (1992), and Wilkinson and Kietzinger (1996), nursing – as well as other occupations mainly carried out by women – are completely integrated within the male tradition in terms of achieving a professional status.

Freidson (1983) argues that the professions need to be studied as historically individualised cases. It has been done so, but at the same time we have tried to avoid the consideration of nursing as a prototype of the concept of profession. It has also permitted us to compare two cases from a historical point of view: nursing in England and in Spain as individualised processes; one case against the other, and not against a general concept, such as the concept of a profession.

Likewise, our experience suggests that the sequences established by Caplow (1954) and Wilensky (1964) in the development of a profession could be applied to other cultures (Table 6.). The necessity of replicating studies and analysing
whether or not the conclusions proposed by these authors can be generalised, as in the work carried out by Forsyth and Danisievicz (1985), should also be taken into consideration.

Indeed, this also applies to our analysis, whose limitations must be acknowledged: it is one of the first comparative analysis in this field and, therefore it may include all the faults involved under such a circumstance. The significance of the conclusions of this study need to be understood strictly in what they say, as they need to be contrasted or refuted by means of new analyses. Consequently, this study should be replicated and tested by carrying out more research, particularly on the contemporary scene and the issue of professional autonomy, maybe using other methods.

At the beginning of the study, a number of questions were posed related to the professionalisation process. Some of them can be answered in the following pages.

The study began as an exploration of the professional development of nursing in England and Spain. There was an assumption, given cultural differences, that there would be a degree of non-homogeneity in the nursing occupation/profession between England and Spain, despite Florence Nightingale’s international promotion of a nursing model. However, the data suggest that the English and Spanish nursing patterns have a high degree of homogeneity both at present and through time, and even as far as professionalisation is concerned, as both seem to have undergone a similar process. Being aware of the numerous details which are different in both countries, we attempted to find similarities which would enable a comparison.

The data may suggest that nursing is very similar in both countries, having a unique quality and a high level of coincidence, despite the differences and the delayed assimilation of the nursing idea offered by Rubio Gali (1896), which was inspired in the British model (section III.2.2), and the very disruptive situation caused by the Spanish Civil War (1936-39), which entailed the continuation of inadequate nursing models for a longer time in Spain.

On that basis, at present, it may be argued that today it is desirable to consider the possibility of achieving a greater level of convergence and homogeneity, given the recent changes in nursing in both countries and the continued growth of the European Union.

This European dimension is causing important changes and it is expected to trigger further transformations in all fields in the life of European citizens. In the health systems, changes are affecting nursing, an occupation traditionally con-
templated from a patriarchal perspective and subordinated to the doctors, thus creating an obligation to be obedient which – as we have seen – regulates the relationship of inferiors to superiors (section I.3).

This is why nurses are held responsible for the problems which may arise if orders are not fulfilled in perfect discipline: this intensified in Spain after the Civil War, and the failure to obey was considered a lack of morality and even a crime, which made nurses become simple intermediaries between patient and doctor.

When nurses started playing their role going beyond execution of the mere orders given by a doctor, and theorising about the content of nursing, they found a woman’s job with well-defined limits imposed by male-medical power within the health systems. The organisational structure displays the thought of men, and within that structure men hold powerful positions as a result of the patriarchal relationships established over time. The current situation does not seem to be a gender problem but a hierarchical one, where men hold the dominant positions.

In health organisations, as well as in other fields, there is usually a boss, with clear and distinct power. Men are described in such a way that it seems that winning is essential to them. And so, they prevent others from being successful. Numerous studies have been written on the aggressive part played by men alleging biological reasons or cultural and environmental conditions as reported by Tannen (1994), Stokes, Irwin and Peeples (1995) and Primeaux (1996), among others.

A tendency has been observed in organisations mainly composed of women, for instance in nursing, where men still hold the highest posts. It is difficult to understand why women allow their male colleagues to hold large percentages of important positions in their organisations. This also applies to many other occupations, although it is less noticeable due to the smaller presence of women.

Possibly, women are assumed not to be able to have a career similar to that of a man, as they marry, have and bring the children up; whereas men – who have always had the power – keep holding it and therefore have kept their privileges in the public and domestic spheres. The more power the greater the need to preserve it. This applies to physicians and nurses as professional groups, as well as to the relationship between them. Nowadays the situation has changed (not without problems, as when somebody has had the power, it is difficult to take it away without coming across some resistance).

But let us analyse those elements which are changing or which may make the situation change. Firstly, changes in terms of the theory of organisation: authority changes to co-operation, conflicts and hostility in the relationship authority-
obedience to a relationship based on trust, providing solutions to the conflicts which may arise through sharing ideas and collaborating.

It can be stated that current organisations based on authority and obedience will find it difficult to survive and will gradually be replaced by organisations based upon co-operative relationships with a minimum or non-existing division or distinction, thus shifting from pyramidal to horizontal structures. The democratisation is noted as well in the evolution of the nursing profession; in the 1850s probationers in England, and ‘practicantes’ and midwives in Spain came from the upper social classes. Nowadays, if the requirements for entrance are fulfilled it is possible to follow nursing studies without any social barrier.

In addition, women have also played secondary roles instead of fighting for leading positions, valuing more the establishment of co-operative links. Stokes, Irwin and Peeples (1995: 37), in their description of a female managerial style, state that women oppose an ethical awareness to a primary one directed to self-interest, thus recognising the importance of other individuals in any action aiming at decision-making, as the latter should occur in a co-operative and participatory way.

All this shows that there have been some changes and that organisations are moving from authority to participation, or male-dominated organisations to organisations with a more feminine way of thinking, communicating and performing, this is reflected in the attitude score in tables 9, 10 and 11.

But what does all this mean in nursing terms? Nursing has been a subordinated activity based on a natural-seeming relationship of authority and obedience. But this is changing; on the one hand, there are new ideas of co-operation between medicine and nursing, acknowledging the value of nursing; on the other, doctors are more aware of the fact that medicine and nursing need to work hand in hand in maximising the benefit of their common subject, that is, the patients. They need the nurses, as they are not with the patients all the time. This has contributed to a re-definition of the relationship between doctors and nurses in terms of collaboration.

The differentiation of the work of medicine and nursing was not a mere occupational division but a question where sex played a major role as a way to keep the power threatened by nursing, represented by nurses collection and interpretation of data on a particular patient, and their application of treatments when the doctors were absent. At present, this has made the medicine/nursing relationship develop in a collaborative framework, rather than based on subordination and obedience. The NCP provides nursing with a degree of autonomy and inde-
pendence. The process is highly complex and is still undetermined and uncertain, which may imply difficulties in its regulation. Its resolution will probably come as a result of expertise of the nurse practitioner (section III.4.2 and III.4.3).

The differentiation, promoted by the development of the NCP, possibly prevents nursing from being taken over by new paramedical professions, as it happened in Spain in the past. By using their influence and power, Spanish doctors tried to constantly extend their actions to nearby fields which they considered theirs, trying to validate the ‘practicante’ title (1930’s), or to get medical students to develop ‘practicante’ duties in 1930, and to eliminate odontology as a ‘practicante’ function (19th Cent.) (section III.1.1). This succeeded to a certain extent. All this illustrates how competition is a source of monopoly-type legal restrictive elimination of competitors and produces exclusive control over an activity.

The aim is to monopolise those areas with the highest level of complexity and/or technical specialisation, areas which result in a lack of determination or uncertainty, whose domain the speciality belongs to. The loss of the odontological functions of ‘practicantes’ shows how an activity can be granted to others by society because of the greater power, in this case, of the medical profession.

The work of the ‘practicantes’ was not clearly defined in many areas, which allowed doctors to take over easily, as they were also familiar with duties of the ‘practicantes’. Nowadays, it will be much harder for doctors to work out strategies for the invasion of nursing territories, provided that the NCP is adequately developed.

One needs to add that – presumably – there will be a medium-long term transformation of the scope of the medical profession, if woman doctors (at present, there are more women than men in the medical faculties in Spain) are strong enough (section I.3). Their growing presence within the profession will inevitably lead to the reduction first and ultimately to the elimination of the masculine ethos.

The homogenisation between English and Spanish nursing may be facilitated by one of the immanent principles in the Treaty of Rome (1957) which is the free movement of workers within Member States. The citizens of the Community must not be considered foreigners in any of the regions of the Community as far as work is concerned. All citizens are entitled to develop their own capacities in all States of the Community. Despite this statement, professionals whose occupations have not been harmonised through a directive have limited freedom of action.
The major development has been achieved in the field of health professions, and identical criteria for the training and the recognition of qualifications have been set in medicine and medical specialisations, general care nurses, veterinarians, midwives and odontologists.

In the field of technical professionals (engineers, architects, etc.), despite the efforts made until now by the European Community, the suitable directive projects have not been passed yet. The existing differences among the Member States as to educational requirements, and the different professional skill provided by each qualification, have impeded the harmonisation process. At present, free movement is permitted for all those wishing to practice their health profession on a freelance basis; this has been in force since 1st December 1990. Those wishing to be employed have been able to do so since 1st January 1993.

Regarding this issue, an European compensation system for employment supply and demand was created – the European Job Offer and Request Service (SEDOC) – in 1972 with a view to making feasible the idea of a European social space, now transformed into the European Employment Services (EURES), that is, a job-centre at a Community level. The compensation system fosters the feasibility of the Community priority in the occupation of the available jobs; however, this theoretical preference is being questioned, as in practice the Member States have frequently employed labour from third world countries, the reason being the lower cost and less concern as to employment conditions.

In this regard, a distinction should be made between the Right to Settle (develop the profession on a regular basis) and Service Provision (sporadic practice). The procedures are slightly different in each case. As to the right to settle, we must point out that those nursing professionals wishing to practice in an European Union country will have to comply with the same requirements which rule the activity of the native professionals of that particular country, and in order to register with the professional college or corresponding professional institutions, they will have to submit not only an application form but also a certificate issued by the corresponding authorities of the country of origin specifying that the applicant has not been disqualified either temporarily or permanently in his/her professional practice. These documents must be issued at least three months before submission.

The procedure to be followed by those professionals wishing to settle in a Community state will depend on the country chosen; one should not forget that the professional will have to practice his/her career in accordance with the regulations in force in the receiving country. For the different Member States not to ex-
cessively delay the granting of settlement permits, the Directive establishes that the procedure must finish within a maximum deadline of three months after the submission of the completed documents. The deadline will be extended in cases of outstanding issues which may have an effect on the subsequent professional development of the applicant.

As opposed to the right to settle, the service provision also allows a temporary professional practice. As a particular feature of this option, the professionals do not need to register with the corresponding professional college or organisation. The visiting nurse, in this case, is compelled to submit a certificate proving that he/she is legally qualified to act as a nurse in the Member State where their practice takes place, together with a certificate by the authorities of the country of origin stating that the applicant holds the required titles or qualifications, a written letter justifying the reason for their service, and the address where they will be lodged during their stay in the country. In emergency cases, these documents will be submitted immediately after the provision of the service.

But, as stated in the Rome Treaty (1957), Community Law is superior to the different legal systems of the Member States and even to their Constitutions; in the event of legal clashes Community law will prevail over internal law. With all this, we can gather that articles 7 and 14 of the Statutes for College Organisation (1974), will be applicable to Spanish nursing professionals – as far as obligatory college registration is concerned – when their services are provided on an occasional basis and in Provincias different from those where they are established.

Another highly interesting subject resulting from the supremacy of Community Law can be found in article 48 of the Treaty of Rome; the article states that discrimination should not occur on the grounds of the language spoken by a worker. The usefulness of such a norm can be easily illustrated in the Spanish State (and this could also apply in other European Union States), as in recent years and in certain Spanish autonomous communities the knowledge of the local language has prevailed when trying to get a job in the public sector. Therefore, if a person feels discriminated against due to language in his/her own country (this may sound paradoxical), the case could be brought before Spanish courts, based on the non-discrimination principle in the Treaty of Rome.

In purist terms, we must say that there are no recognised nursing specialities within the Community, although from the Spanish perspective midwifery may be considered as such. In other Member States, midwives have historically been regarded as professionals independent from nursing, and therefore their profes-
sion has been legally treated as autonomous and independent and not as a specialisation.

In the case of the Spanish midwives, the discussion must be placed on time perspective: in 1857, a new health staff category appeared, that is, the ‘practicante’, a male assistant to the doctor. The situation then reversed completely and certain functions, traditionally carried out by midwives, started being practised also by ‘practicantes’, such as assisting at normal labour. Therefore, the ‘practicantes’ defended their new role as necessary; the midwives could not do much to stop them, as they did not belong to any organisation which may have been able to fight for their cause and, at the same time – as women –, they did not have any power, let alone political power. This was the first defeat of this group in Spain.

It would be worth studying why this traditional and independent speciality became a medical specialisation. However, we need to focus on our research and try to understand why midwifery has taken so long to develop as a speciality in Spain, and why it only happened after the pressure exerted by the European Union. Maybe another defeat was in store for the nursing profession, especially with technological development in the obstetric field and the drop in the birth rate; it seemed there was very little space for midwives and obstetricians/gynaecologists to work together. The strong competitors – holders of the political power – could have well caused the final disappearance of midwives, and the Spanish birth rate did not help either (section III.2.2). Possibly history has been very near repeating itself, once again, as in the last century, when doctors managed to interrupt the training of ‘practicantes’ and midwives because they thought themselves qualified to carry out their duties (section III.1.1). Possibly one of the reasons is that in Spain nursing specialities have traditionally been ‘medicalised’ and the physicians have not had any difficulty in extending their working scope over the field of nursing.

The European Union is not likely to harmonise in the short term the nursing specialities, as reaching the agreement of all the Member States is a rather complicated process. As a paradigmatic case, we must point out that the English attempt to create and harmonise a nursing specialisation in oncology has been recently rejected, alleging that in the rest of the countries, this specialisation does not exist and therefore its regulation is not needed at a European level.

The fact that certain specialities may not be recognised in other countries should not prevent their development in each Member State; however, the specialities should not be taught until the nurses can benefit from the creation of a truly pro-
professional career. The reason is obvious: it would be a ‘fraud’ to get the professionals to train in onerous specialisations as to time and cost which would not improve their social and professional status, as is the case in Spain.

Regarding the free settlement and service provision, one cannot dispute that there will be a progressive disappearance of all barriers blocking the free movement of professionals in Europe; as Hamer has said (1992: 32), nursing acts as an important case study in this regard, as some of the directives which regulate the profession were passed in 1977, which enabled professionals to freely seek employment.

However, if a legal harmonisation in the field of health and in relation to the workers does not occur, covering areas such as functions and responsibilities at work, salaries, promotion system, etc., that has been mentioned – together with the linguistic problems – will not make possible the achievement of a real movement of professionals. The Maastricht Treaty (1992) could have helped in this regard, but it excludes the harmonisation of the laws which deal with these areas.

The aspects which have contributed to the establishment of different occupational/professional structures in Spain and England – once the analysis of the data supplied has been finished – can be determined, as there are numerous different situations (though similar in essence) which stimulate the occupational/professional structures in both countries. History is made by men/women and each man/woman is different and has his/her own peculiarities. All of them together, their peculiarities and the different events which occur in the occupation itself and in women’s situation in society, prepare the professionals in particular and society in general to carry out and accept the changes. The situation of female nurses (the social group which includes most of the nursing professionals) is also modified.

Women’s work has not been valued independently, on its own, but has always been considered as dependent on the work of men; her salary has been considered family salary and not a woman’s salary (section I.3.3). This also applies to nursing, and we cannot define the position of nursing without analysing the relationship between the role of nurses and the position of women. The idea of a family salary earned by the man and the salary of the woman as additional earnings remain – according to Oakley (1993: 9) – as the basis of the tax and national insurance systems in many countries.

The strict social control of the nurse as a woman carried out by the midwives in English hospitals and the mother superiors of the female religious communities
in Spanish hospitals conditioned the nurses not to think about salaries but to consider nursing, religion and life from a lay perspective in England, and from a religious one in Spain. Nursing training was similar to that in a religious order, with numerous comparisons and metaphors, such as the family in which the doctor represented the father, the nurse played the part of the mother and the children were the patients. The metaphorical sense used involves all the elements of a model of male dominance, reinforced by mother superiors and matrons and the strict and iron-like control of the nurses. All this strengthened and promoted the permanence of the patriarchal model in nursing.

Nurses must be seen in the context of two forms of work division, first in the sexual division of labour, where women serve others, developing those activities considered more suitable to them; such chores had always been unimportant to men, as ‘serving’ is not a dominant value nor a socially appreciated thing. Second, the division of work in health care, where the professionalisation of nursing takes place by following a patriarchal model and the care and service provided by the nurse is not considered an important value. Therefore, we find an outstanding contradiction, as care is necessary and extremely important in the follow-up of the patients (in the absence of the physician) but it is something which is not socially valued.

Nursing was considered a specialisation of housework, equivalent to the chores carried out within the family, something which could be done without expecting any economic reward, which – together with the values of service taught during training – could lead to bad working conditions and low salaries. The permanence of housework in nursing relates this occupation to the household and therefore with the concept of women. The abandonment of household chores implied an important change in nursing because – until then – the development of housework in nursing prevented the intellectual and professional development of the nurses (section III.2.1. and III.4.2).

All this can be applied to England, as domestic chores only stopped being done in nursing in 1968, presumably coinciding with certain currents which promoted a greater development of the skill and knowledge of the nurses. In Spain, although housework was not intrinsically linked to nursing, the religious orders would do most of the work, as there were very few nurses. This reduced the nursing presence and, together with the iron-like patriarchal structure, affected the intellectual evolution of the nurses until the 1970s, when progress was first made in women’s equality. The ‘practicantes’ only dealt with technical work, and nothing which could be considered ‘domestic work’ was done by them; in fact,
sometimes they would only turn up in the nursing wards to carry out technical
activities.

Later on, both ‘practicantes’ and nurses became ATS professionals; their union
was considered adequate, especially with the birth of the SOE, but underlying
this unification idea was the search for efficacy: by joining both functions in a
single professional, the access of women was facilitated, and the new graduates
would have to do the ‘secondary’ jobs such as feeding or washing the patients.
This – which was obviously against the technical reputation of the ‘practicantes’ –
would somehow prevent men from entering the nursing world. In fact, in many
cases, the ‘practicantes’ defended their acquired rights and kept only the techni-
cal functions of their jobs, refusing to perform otherwise.

These situations fostered subordination and constrained the autonomy of the
‘practicantes’. Definitions of the ATS work are found as perfectly matching the
paternal metaphor of the family “protecting the doctors (husbands) from the less
interesting jobs (the care of the home) which gives them more time for concen-
tration on their work” (Miranda, 1956: 45).

Currently, the evolution of both English and Spanish nurses is taking more fa-
vourable directions, that is, serving but without being servants. Nursing may be
then losing the femininity which constrained it in the past. As a matter of fact,
what is changing is the social concepts, especially those referring to women. In
addition, other changes are taking place in the professional demography and the
organisations.

It might not be necessary for women – and particularly nurses – to organise a
revolution. Maybe if they did, they would just be described with adjectives not
quite appropriate. Perhaps if the problem or problems were identified, things
would then change and actions would be taken. Probably, conflicts would come
along but there would be attempts to avoid regression in the normal flow of
events.

In this regard, numerous measures have been taken in the European Union
which should not be forgotten and which affected England since the origins of
the EU. Such measures are at present having important repercussions in Spain
since the country joined the EU in 1986. The EU has supported the idea of an
equal role for women in society from its first steps in 1957. Article 119 of the
Treaty of Rome constitutes a policy of equality of opportunities, especially equal
pay, without discrimination based on sex: “Each Member State shall –during the
first stage– ensure and subsequently maintain the application of the principle
that men and women should receive equal pay”. This search for equality goes
even further, and so the agreed Charter of Fundamental Social Rights of 1989 incorporated many points that put the emphasis on the advance in equal opportunities for women, like the right to equal treatment, to a fair wage, to social security, to vocational training, to good health and safety at work.

The data supplied in this study, constitute the answer to the question of which elements have contributed to the establishment of different occupational professional structures, as without the participation of all the factors, we would fail to understand the occupational/professional structures in both countries.

Among the factors which could be identified in the historical data, we find ‘war’ as an element of change in the dynamics of women and nurses. Armies are male organisations which tend to confirm the social dominance of men; women have only played secondary roles in them until just recently. During war periods, the figure of the soldier is praised, with a subsequent strengthening of the figure of man in society, and in turn society subordinates everything to the authority which emanates from the soldier figure (Horne, 1993: 124-125).

On the other hand, wars seem to create inconformity with previous situations and accelerate changes at all levels, especially as in the situation we are analysing and during different conflicts women were assigned new activities traditionally developed by men. Such activities made women experience new opportunities without restrictions or social inequalities; everybody – men and women – collaborated and worked equally in achieving a common end, that is winning the war. The successful development of certain industrial activities by women (from ship construction to munitions production in England) constituted a step forward towards the integration of women in industry in equal terms. This broke with numerous existing rules, for instance the fact that married women were to stay at home; during the war, even nursery facilities were available for working women.

Could things go back to normal after the war? Could women tolerate social differences based on sex after all that? The answer was negative. This was reflected in English nursing with the creation of the GNC after the Great War and in the development of university nursing departments after the Second World War. The evolution could have been greater had there been less obstacles posed by the professional organisations (section III.1.5). On the other hand, in Spain the events and wars previous to the Civil War evidenced the need of secular nursing services, and some attempts were made to meet the demand which the religious orders could not satisfy during the cholera epidemics and the Morocco War (section III.1.1).
The Spanish Republic (1931-1939) constitutes the opportunity missed by the Spanish nursing profession; it meant the secularisation of civil life and the state. At that particular stage, the secularisation of nursing and a subsequent progress toward professionalisation would have been feasible, had the Civil War not put an end to this democratic period of Spanish contemporary history.

Undoubtedly, the long impasse produced by the Spanish dictatorship caused women to return to their traditional role in a patriarchal society, with deep religious roots and a revival of the sexual division stereotypes prior to the Republic, which lasted until the 1970s.

Needless to say that nursing activities in military hospitals and battle fields were absolutely important in the development of events and the social appreciation of nurses. However, working in battlefields and hospitals was part of the nursing role. If the change in the social consideration of women had not occurred, possibly the merit of the performance of the nurses in itself would not have been able to achieve their professional evolution.

Another contributing factor in the development of the nursing professional structures was the existence of remarkable personalities, in particular Florence Nightingale, who made the most of the opportunity to create an occupation for women, i.e. nursing, whose principles are still alive in both English and Spanish nursing (section III.2.1). Likewise, the contribution by Rubio Gali was outstanding in introducing Florence Nightingale’s ideas in Spain (section III.2.2).

Indeed, nursing – as we know it today – would have not developed unless the professionals themselves had believed in the uniqueness of their relationship with society, exerting pressure for the implementation of laws for the protection of the public and for the elimination of unqualified competitors. It is also necessary to admit that the development of medicine and the growth of hospitals have contributed to a great extent to generate needs for a better trained nurse in a framework where the doctor was absent and was dependent on her in the achievement of his goals.

Women’s right to vote and their subsequent political representation would – from that moment – hinder their political segregation and discrimination, this being another factor for the establishment of the nursing organisational structures. In addition the role played by the Spanish and English monarchies should be not be forgotten, as their female members would often wear nursing uniform, thus guaranteeing their royal patronage and giving prestige to this occupation in the eyes of society.
The circumstances in which nursing personnel in England and Spain tried to professionalise their occupation are difficult to specify with accuracy; one of these circumstances was the acknowledgement that nursing science can be something unique and different, which takes place when nurses start realising there is something more meaningful in their work and try to discover everything which is inherent to their activity. From the moment nursing activity and its inherent elements are identified, i.e. knowledge, decision-making, etc., nurses will start demanding independence from other professionals and autonomy, both from employers and patients. This situation appears earlier in England; in Spain, however, due to special circumstances already mentioned, i.e. the Civil War and the subsequent dictatorship – with a peculiar vision of women and religion –, the process was delayed. There was indeed a claim for autonomy and responsibility. Autonomy for development in terms of analysing and giving answers to social needs, and responsibility for self-regulation and establishment of mechanisms to live up to the public’s expectations, providing suitable health services, as the demand increased for better health care in line with population growth and better standards of living.

The research data obtained suggest that, as a consequence of the demands, the progress of nursing in professional and social terms in England and Spain is partly the result of the evolution in society of the idea of social equality between men and women. Another consequence is that the vision and ideas about health are changing together with the places, scope of work, and activities developed by nurses. Hence, the conditions required for a successful development exist; nurses only need to continue giving adequate answers in accordance with the health and social needs, both in England and Spain.

The answers are dependent on the lack of regulations in nursing in England; in Spain, steps are now being taken in order to abandon strict regulations by law and to open the door to negotiations among professions. The different proposals presented for the enactment of a new law have not been successful, even though the last Spanish regulation of functions dates back 23 years.

This situation weakened nursing, giving opportunities for the creation of new categories of workers in the health arena. This would not be a problem if the 1960 and 1973 regulations were not in force in Spain, which entails disadvantages in the negotiations between professions (section III.1.1).

The development of the legal regulation of functions in Spain has followed the paternalist pattern, warning and acknowledging that doctors know more and, therefore, should be obeyed. This emphasis shows the weakness of the physi-
cians: as they were not with the patients at all times, nurses had to know the problems which could arise, thus participating in the diagnostic process and medical treatment. Then, the problem had to be based on the hierarchic relationship resulting from the transformation of the traditional gender relationship which implied the subordination of the nurse to the authority of the doctor.

Besides, the setting up of associations of a public nature grouping professionals related to the same activity is the clearest and most precise manifestation of the special, essential and unique relationship established among the individuals who receive a service and the professionals who are permitted to create an association, as this corroborates the public and essential nature of their service.

Both in England and Spain, the conflict between professional associations and unions – in terms of competition – would be licit as to the achievement of the unions, but would be unfair for the public because if the unions had won, some of the elements which are currently covered by the professional organisations, UKCC in England and the colleges in Spain, would not had been covered.

Regardless of this conflict with the unions, another conflict was started on the onset of the nursing professional associations in England and Spain, i.e. if nursing had special characteristics and influenced the life of people in both countries did it need special regulations to protect both the occupations and the public? Indeed, although it was difficult to achieve, the recognition of the occupation, and subsequently of women, constitutes an important step forward in terms of autonomy, not only at a professional level but for women as individuals. We must add that this recognition took place prior to that of other occupations which would take far longer to achieve such a status, e.g. dentists or accountants.

Possibly, one of the elements which delayed this social recognition was the internal disagreement of the occupation itself, as both groups (in England and Spain) were more interested in finding differences than similarities. Until very recently, there were fourteen different training programmes in nursing in England, all of them trying to defend their specific traits, this leading to numerous difficulties in the unification of all the associations within the same layout. This diversity made the internal relationships within the organisations very difficult, due to the co-existence of different interests.

Something similar happened in Spain with the nurses, ‘practicantes’, and midwives, which was to aggravate the situation with the arrival of the ATS. Each group would think of the others as their opposition, which impeded being able to work with unified criteria. This situation was partly solved by the conversion of all those categories into a single one in 1977, that is, university nursing. Perhaps
this will also occur in England in the next few years, as the different nursing classes have already been reduced to four, which could be used as the basis for the establishment of more homogeneous criteria.

One of the effects of the patriarchal society on the nursing professional organisations was their internal sexual division. In Spain, the ‘practicantes’ would not mix with the nurses. Perhaps if they had not tried to associate in college organisations, the Spanish professional nursing scene would have been quite different. Given their condition of men, the ‘practicantes’ managed to develop the organisations where later on nurses would participate, obviously with less power and representation, this causing a troublesome relationship.

The distribution by sex was perfectly assumed and established from a social point of view, and accordingly when the unitarian new category of ATS was created each of the new professionals registered with the corresponding college section. In England, the sexual division materialised in the creation of a section of the registry for men, which would not amalgamate with the general registry until the 1960s, this putting an end to the differentiation by sex.

Another noteworthy peculiar feature is the clear definition of the monopoly among the different parts of the registry in England and the temporarily established monopoly between ‘practicantes’ and nurses, with the threat of intrusion between both professional groups.

Finally, the differentiation was clear between professional nursing associations in Spain and England: the Spanish organisation only consisted of professionals, the State acting as a referee in defence of the interests of the public in any situation or self-regulation which may affect the individual in need of a nursing service. On the other hand, in England the State compels to an outside representation as members of the organisation, that is, non-professional members, in order to defend and represent the rights of the public. This, in the long term, however, could damage the autonomy of the organisation, as the decision-making could be conditioned by non-professional individuals who have a voice and a right to vote on professional matters, thus affecting the self-government of the organisation.

Democracy is the guideline followed in the election of the managing members of the Nursing Colleges and Nursing Councils in Spain. This grants freedom of action in the self-governing of the professional organisations of Spanish nursing. This is not the case in England, where the Secretary of Health has always had the possibility of appointing part of the organisation’s representatives, either in the GNC or the UKCC for Nurses, Midwives and Health Visitors. However, he
does not issue decrees and orders which affect detailed control or even the name e.g. ATS.

As to confidentiality, the first codes both in England and Spain offer a clear vision of the social role of nursing and its social position of subordination, including the advice not to criticise doctors as superior men, reinforcing the obedience of the nurses. Professional secrecy places nurses in a powerful position, this prompting medical doctors to adopt an active role of aggression against their power, as they believe they are supposed to hold the information which belongs to them which they do not want to share with anybody. Female nurses are considered by biased individuals as gossippers, and negative pictures of them promote a lack of trust. The idea was to use such pictures to damage their reputation and thus achieve their professional discredit.

When asked, nurses were forced to lie in order to protect themselves from the power of physicians. Nurses should be trained to use information as a source of power, and this was impeded through attitudes aiming at repressing their performance as information sources. This involved important dilemmas, as nurses were asked to be frank and at the same time to allege ignorance, which seems rather paradoxical in the sense nursing ethics.

Likewise, there was the dilemma of protecting either the patients or the medical doctors, as the pressure put on the nurses to allege ignorance in front of the patients could also imply malpractice. Therefore the situation of nurses was a rather delicate one and not protecting the patient could put them in a very compromising situation.

All these situations were undoubtedly rooted in the traditional power and authority relationship between the sexes, and the gender was determining in the staking of positions, especially as a result of the physicians fear not to be able to control the situation for having been absent. Fortunately, this subordinated relationship is giving way to collaboration and constructive criticism to the benefit of patients and medical and nursing personnel as well.

It is necessary to add that, since the 1960s, the users of the health system are more and more against the position they have held over time within the patriarch relationships, and have found the perfect ally in the nurses, as they have historically been closer to the needs of patients than to the needs of medical doctors, and so nurses just need to re-discover their past. The alliance between nurses and patients will lead to quick positive changes in the health systems (Baly, 1982; Oakley, 1993).
Analysing comparatively these two countries within the EU, the influence of the regulations of the European Commission on the professionalisation of nursing must be taken into account. Therefore, it is necessary to study the legal regulations and the recognition of titles (qualifications) in the different Member States of the EU.

Although some countries require a medical certificate, to be admitted to educational programmes, a good behaviour letter, and to have passed an admission test, we shall focus on the analysis of two requirements which are common to all countries, and which are considered as part of an indicator in this research, i.e. minimum age at beginning of training, and the educational level required to start nursing studies.

As to age of admission, applicants must be 17 or 18 years old before starting studies. Regarding the educational level and previous qualifications, the Directive specifies ten years of basic education, but the general trend is to demand 12 years, which is equivalent to having completed secondary education. Within this category, three groups of countries can be distinguished:

1) Countries which require the applicants to have completed their secondary education, or 12 years of education, prior to starting studies; this is the case of Spain, France and Portugal.

2) Countries which do not require the applicants to have completed their secondary education: this group includes Member States which, to gain access to nursing studies, only require them to have completed primary education and part of the secondary cycle. This is the case of Denmark, Italy and Germany, where nursing studies are equivalent to the level of vocational studies, and are validated as a second cycle of secondary education.

3) Countries with a different requirement level: this covers those countries which acknowledge several qualifications in the Community Directive, or where the same qualifications can be obtained through different educational avenues and thus the level required varies, e.g. United Kingdom, Holland, Luxembourg, Ireland.

In England, the idea promoted by Florence Nightingale of ‘doing’ and not ‘studying’ has probably been a handicap in the development of nursing. F. Nightingale built up a whole philosophy about observation in *Notes on Nursing* (1860), pos-
sibly without noticing that many of the ideas commented on, need to be taught with dedication, as she does with her book, by reading and making the readers see things which otherwise would not be recognised. In her books, she criticised the poor observation skills of women, why do nurses not notice details which are obvious to her? Possibly by reading, Nightingale gained part of the knowledge which allowed her to make such statements in her written works, as well as an exceptionally higher cultural level for a woman of her time.

Only by means of a guided education can one develop a purposive observation of the many different sides of reality. This skill cannot be developed through mere practice, especially today when nurses are faced with highly complex situations. A nurse cannot just learn to observe through practice, first she/he needs to know about the phenomena to be observed and the elements to be identified.

In addition, Nightingale could not have developed her ideas without a solid education and training which enabled her to recognise the deficiencies in health care in terms of ventilation, noise, diet, hygiene, etc., questioning why things were done in a particular way depending on the context; for instance the situation of Scutari and others later on. She could not have done any of that without her mathematical background, which she gained through the study of books. But she simply accepted the domineering ethos of her time; women were to do only female work, activities which had been introduced and inculcated by practice generation after generation, nursing was among these activities, possibly as the acceptance of the dominant male ideology which determined what had to be or not to be taught.

Access to knowledge has been denied to women until recently, as it constituted – in essence – an instrument of the patriarchal hierarchy. In this regard, we could say that the universities have actually been patriarch hierarchies themselves which are now undergoing a transformation process, from authoritarian attitudes to collaboration, as it is the case of the health systems.

Training and education are pivotal elements of the professionalisation process, and therefore a necessary point of analysis. Why does nursing need theory? Theoretical knowledge is power (Borenham, 1983), and theory in nursing is a source of autonomy, and as other occupations, nursing is following the same process of theoretical development, although with a certain degree of delay.

The best exponent of this theoretical development in nursing is the creation and development of its own-language, such as the diagnostic taxonomy through which, as a part of the NCP, nursing is obtaining advantages in autonomy, as
the base for action and for developing an arena of reference and communication for all nurses.

Along with this, the abandoning of training based solely on practice; practice that was and is as invisible as housework. Woman’s work and nursing activity are becoming more socially visible, especially in nursing with the initiation of a climate of establishing a price for nursing work, and of learning from journals as the best support for the spread of theoretical nursing knowledge. At the same time, the abandonment of routine practices organised on the basis of medical decisions is taking place. The NCP broke with this kind of thinking and with those that replicate the family structure in the health centres, developing instead the concept of care of the nursing theory.

The low nursing standards in Spain and England could have been due to the idea that any woman could become a nurse (even without training, like housework). In England, there have been numerous attempts to determine –by means of tests– the elements of femininity which, according to the patriarchal ideology, a nurse had to have; the emphasis was put on the aptitudes and personality as determining factors of the quality of care. The improvement in the standards could have entailed short-term changes in the structure of the health system and the social role of nursing, derived from the prestige involved in such improvement itself.

But what prevented admission standards from rising? As we have just mentioned, firstly, the improvement in the standards could have entailed short-term changes in the structure of the health system. Secondly, the social role of women as subordinated individuals in a patriarchal society, and thirdly, the fear of not achieving sufficient recruitment (which had not been solved by the long-term reduction of standards) in the competition implied for nursing studies with other female occupations. In fact, the shortage caused the standards to drop, and trying to increase the number of nurses could have been the wrong policy.

In the 1970s, many young people tried to gain access to the medical colleges, longing for prestige and possibly a good salary, even though the admission standards for university entrance were very high. We can only understand the tendency to drop the standards in nursing based on the female condition of the nursing personnel and the low confidence in their physical and mental abilities in the past. Could be argued that high standards were not seen to be necessary for nursing.

In both countries, after decades of constant growth of hospital beds and personnel needs, with the subsequent increase in professional costs, the shortage pro-
duced the appearance of assistants. But isn't the professional shortage a consequence of organisational deficiencies or problems in the identification of objectives and/or task assignment?

At present, it is commonly accepted that nurses should not scrub floors and their mission has nothing to do with housework. If the domestic chores had been eliminated before, possibly not so many qualified nurses would have been needed. In order to eliminate housework, nurses were required to develop alternative functions, which lead to the existence of a vicious circle, as it was not possible to carry out alternative duties to domestic work when the nurses were already busy doing housework in hospitals (section III.2.1.).

Administration probably foresaw an increase in nursing salaries and applied the task division of the work, thus trying to reduce costs, creating cheaper categories within nursing. In fact sometimes unqualified staff was employed to replace nurses, and these attempts are still found at present. The non-existence of regulations establishing the specific functions of the profession may have weakened nursing as a whole.

As it could also be foreseen, the organisational bases of the future were being built with the development of staff categories which permitted a great flexibility and adaptation to the new tasks and posts at work. The division of work in tasks does not ensure authentic nursing care; the assisting categories can do and as a matter of fact do part of the job in a mechanical way, but nurses must be present not only to control the evolution of the treatment of the patients but also to provide solutions for the problems of treatment in terms of care, thus proving their efficiency as qualified nurses. We should not forget that nurses are becoming a main component of the health team to which the actions of the other team members relate, in accordance with the continuity of health care which is only supplied by the nurse and extended to the rest of the health professionals through her/him.

Nowadays, English standards are undergoing a paradoxical process which has been identified by different authors (Allen, 1990; Elkan, 1995), that is difficult to understand. The idea is to raise the academic standards together with a relaxing of admission to the nursing degree, which in turn would imply the fall in the admission standards. This is a conflicting issue, as the lowering of the admission standards would not facilitate the maintenance of the academic standards; in the case of Spain, this only leads to a high rate of drop-outs (those students who arrive in college with low educational records are more likely to drop out, according to data from the follow-up commission of the Nursing School at the University of
Valencia). This is even more difficult to understand if we consider that links are being established between the nursing schools and the university.

Nursing studies need to gain further social prestige and, at the same time students need to prove their sufficient intellectual capacity by means of admission standards, identical to those of other university degrees, and no differences should be observed between entrants to nursing and that of any other discipline in higher education.

It is necessary to take into account that the educational proposals launched by the different committees which were set up in England for the analysis and solution of the nursing situation were advanced for their time. Some have been implemented just recently. The reason why they were not applied before is the fact that they questioned the social system accepted by nursing itself, also because of the conflicts among the committees or due to internal problems in the nursing organisations.

In Spain, the evolution of the standards has been gradual, until nursing was considered a university career in 1977. Sometimes their development was dependent on the regulations, and sometimes it was conditioned by the supply and the demand of university seats.

However, we cannot forget that nursing education in Spain was subject to a complete medical domination up until the 1970s (and therefore immersed in a patriarchal teaching model where the study contents sometimes had very little to do with the present nursing subjects at the university. Nursing training has since evolved from mainly practical contents to a balance between theory and practice.

Since the 1970s, training and education are more and more in the hands of the nurses, which provides the curriculum with a very different emphasis. Changes that took place in practical terms meant the development of the profession with more rigour, method and order.

Throughout the EU, students show two different types of status: in general, students have all rights and duties, but in some countries they are employees with a specific salary. Curiously, the German nursing legal framework specifies that a qualified nurse must be substituted by 5 students. The countries where students are employed on a salary basis are: Germany, Denmark, Ireland, and, until recently, England.

However, after assessing the situation of the student as employee, the tendency is towards student status, as the former position has certain disadvantages,
such as the fact that clinical learning is based on the urgent needs of the service and not on the student’s needs; that is, the student’s obligation to provide a service comes before their accomplishment of learning aims, this having negative repercussions in their practical training, and the fact that subjects are not organised depending on the links between theory and practice.

The existing regulations as to nursing studies entail a series of more or less defined characteristics which are reflected in the regulated curricula in different countries:

1) Duration of studies: the basic nursing studies usually last 3 years or 4,600 hours, but there are some exceptions, such as 2 years of vocational studies or 2nd nursing grade in Greece, and 3 and a half years in Denmark, the upper level in Greece, or the Verpleefkundige A level and 4 years of Higher Professional Education in Nursing (HBOV) in the Netherlands (the 4th year corresponds to the specialisation/first degree in the UK and Ireland).

2) The distribution of theory and practice established by Directive 77/453/EEC: this sets the duration of the studies at 4,600 hours, and does not specify the theory/practice relation. Directive 889/595/EEC supersedes the latter, balancing the time devoted to theory and practice, and specifies that a third of the education will consist of theory, half of the duration of the programme will be devoted to clinical practice, and the rest to various activities, the student being free to choose in some countries.

Although a variability margin and some error is accepted in these data, there is a defined group of countries whose distribution shows clear differences, practice being more dominant than theory in Germany, Denmark, The United Kingdom, and the Netherlands. Maybe this is due to the fact that in the first three countries the students are also employees, and in the Netherlands to the fact that the studies are actually considered a service, to the extent that the studies description is ‘education in service’.

The intervention of public authorities in the academic scene is reflected in the need to pass a final external examination, this being an essential requirement to gain the qualification and title. The examination can be organised by the profes-
sional associations or by the state administration, and is regulated at a national level in some countries.

The examination is compulsory in England, Germany, Denmark, Italy, The Netherlands, France, Luxembourg and Ireland. The last three countries do not only require a final exam set by the state administration, but also to pass tests at the end of each year. All these examinations are duly regulated in the corresponding legal framework.

After the analysis of the data, regarding nursing education in Europe, one comes to the following conclusions:

There is great variability among the different countries as to their educational structure, and even within countries there is no uniformity among the different school types. In this situation, one wonders whether or not – with all these entrance requirements – the final meeting point will be the same, or if on the contrary each country and even each school is educating future professionals with a totally different concept of the profession to each other, Spain and England are close in this matter.

Therefore, even if one accepts that there are differences resulting from peculiarities which, however, do not point to a difference in levels, it is important to reach unity in the criteria for both the progress of the profession and the free movement of professionals. Therefore it may be argued that it is important from the professional perspective to:

- Require an educational level equivalent to that needed to gain access to university, that is, to complete higher education.
- Achieve student status in all countries for the pupils so that they can work properly and thus accomplish their learning objectives.
- Draw up curricula aiming at balancing theory and practice, establishing modules to facilitate their integration.
- Unify criteria in relation to the content of the course.

Although in other countries we find some type of university training, only Spain requires of all its professionals to hold a university degree (equivalent to the first educational cycle in university or undergraduate studies) in order to be able to practice. Holding a university degree should be an element to be considered as regards to free movement and the recognition of professional titles granted in other countries.
After having analysed these data, one feels unable to affirm that the European Union regulations constitute a professionalisation element, but they could be considered as a harmonising element for the establishment of the base for future professionalisation.
REFERENCES

6.1 Bibliographical References


Royal College of Nursing (1964). *A Reform of Nursing Education* (Chairman: Sir Anthony Platt). London: Royal College of Nursing.


6.2 Nursing Legislation

6.2.1 Spain

Decreto 8 de Julio de 1822. Código Penal.

Decreto de 8 Junio de 1823. Ejercicio Libre de las Profesiones.

Decreto de 20 de Julio de 1837. Ejercicio Libre de las Profesiones.

Real Orden de 28 Mayo 1838. Colegiación Obligatoria de los Abogados.

Real Decreto de 10 de Octubre de 1843. Regula la Docencia de la Cirugía Menor-Prácticos en el arte de curar.

Real Orden de 29 de Junio de 1846. Crea el título de Ministrante.

Real Decreto de 19 de Marzo de 1848. Código Penal.

Real Decreto de 19 de Marzo de 1848. Reales órdenes y decretos no incorporados en el texto del Código Penal, y de la Ley provisional dictada para su ejecución en la presente edición reformada. (Edición reformada de 1850).

Ley Orgánica de Sanidad de 28 Noviembre de 1855,

Ley de Instrucción Pública de 9 de Septiembre de 1857

Real Orden de 26 de Junio de 1860. Estudios para Practicantes

Real Orden de 1 de Octubre de 1860. Prohíbe a los barberos y a quien no tuviera título de practicante a sangrar y ejecutar operaciones de cirugía menor.

Real Decreto de 21 de Noviembre de 1861. Reglamento para la enseñanza de Practicantes y Matronas.

Real Orden de 6 de Julio de 1864. Crea un Comité con el fin de que se instruya y organicen secciones de enfermeras y voluntarios civiles para el socorro de heridos en los campos de batalla.

Real Orden de 10 de Marzo de 1865. Regula la enseñanza de Practicantes.

Real Orden de 28 de Mayo de 1866. Dispone las medidas para no admitir como Practicantes en los hospitales a los que no hayan cursado los estudios necesa-

Real Decreto de 7 de Noviembre de 1866. Reforma los estudios de la Facultad de Medicina. Crea los Facultativos de 2ª Clase.

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Decreto-Ley de 21 de Octubre de 1868. Se deroga el decreto publicado de 7 de Noviembre de 1866.

Orden 27 de octubre de 1868. Practicantes


 Real Decreto de 4 de Junio de 1875. Regula la profesión de Cirujano Dentista.

 Real Orden de 6 de Octubre de 1877. Que los títulos de Practicantes no habilitarán ya en lo sucesivo para el arte del Dentista.

 Real Decreto de 16 de Noviembre de 1888. Reglamento para la Carrera de Practicantes y Matronas.

 Real Decreto de 24 de Mayo de 1895. Reforma el Reglamento de 16 de Noviembre de 1888 para la carrera de Practicantes y Matronas.

 Real Decreto de 12 Abril 1898. Estatutos de los Colegios de Médicos y Farmacéuticos.

 Real Decreto de 26 de Abril de 1901. Modifica y amplía las prescripciones del Real Decreto de 16 de Noviembre de 1888. Reglamento para la carrera de practicantes y matronas.

 Real Orden de 21 de Marzo 1901. Desarrolla estudios de odontología.

 Real Decreto de 31 de Enero de 1902. Fija contenidos de examen para habilitar a los practicantes en partos.

 Real Orden de 22 de Marzo de 1902. Programa para la carrera de practicante.

 Real Orden de 13 de Mayo de 1902. Programa de la carrera de Practicante.

 Real Orden de 6 de Octubre de 1902. Crea comisión de trabajo para el estudio de la colegiación.


 Ley de 12 de Enero de 1904. Instrucción General de Sanidad Pública.

 Real Decreto de 10 de Agosto de 1904. Reorganización de los estudios de las carreras de practicantes y matronas

 Real Orden de 22 de Enero de 1910. Prohibición de practicar la odontología a los Practicantes.

Orden de 27 de Diciembre de 1910. Reorganización de los estudios para la obtención del título de odontólogo.

Real Decreto de 12 de Abril de 1912 en el que se ofertan cinco becas de estancia en Inglaterra para el perfeccionamiento profesional.

Real Orden 15 de Mayo de 1915. Programa para la enseñanza de la profesión de enfermería

Real Decreto de 23 de Octubre de 1916. Colegios provinciales de farmacéuticos.

Real Orden de 6 de Diciembre de 1917. Colegios provinciales de médicos.

Real Orden de 7 de Octubre de 1921. Cuadro mínimo de materias para las carreras de medicina, odontología, practicantes y matronas.

Real Orden de 23 de Mayo de 1923. Crea la escuela Nacional de Puericultura.

Real Orden de 3 de Julio de 1923. Prohíbe la práctica de la odontología a los Practicantes.

Real Decreto de 9 de Noviembre de 1924. Crea la Escuela Nacional de Sanidad.

Real Decreto de 16 de Noviembre de 1925. Reglamento de la Escuela de Puericultura.

Real Orden de 11 de Septiembre de 1926. Requisitos para los estudios de practicante.

Real Orden de 24 de Febrero de 1927 Nombramiento de la Comisión para la elaboración de los programas de la carrera de enfermera.

Real Decreto 1552/1928 de 28 de Agosto. Fija los requisitos que debían reunir los establecimientos en que se autoriza la implantación de Escuelas de Matronas determinando la enseñanza a seguir y las circunstancias que debía acreditar el aspirante.

Real Decreto Ley 1596/1928 de 8 de Septiembre. Aprobando el proyecto de Código Penal que se inserta y disponiendo empiece a regir como Ley del Reino el día 1 de enero de 1929.

Real Orden de 11 de Noviembre de 1928. Asigna a los Practicantes las funciones de prevención y defensa de las enfermedades evitables.

Real Orden de 23 de Octubre de 1929. Distribuye impuestos entre los Practicantes.
Real Orden de 22 de Diciembre del 1929. (Ministerio Gobernación). Estatutos para los Colegios Oficiales Practicantes en Medicina y Cirugía.


Real Orden de 27 de Mayo de 1930. Describe actividades de los estudiantes de Medicina.

Real Orden de 27 de Mayo de 1930. Describe las funciones de los Practicantes en las enfermedades de transmisión sexual.

Real Decreto de 12 de Abril de 1930, Reglamento de la Escuela Nacional de Sanidad.

Real Orden de 7 de marzo de 1931 (Ministerio Gobernación). Carnet de practicantes.

Real Orden de 20 de Marzo de 1931 (Ministerio Gobernación). Practicantes y Matronas. Redacción del art. 7 de los Estatutos de los Colegios Oficiales de Practicantes.

Real Orden de 22 de Abril de 1931 (Ministerio Gobernación). Practicantes y Matronas. Redacción del art. 7 de los Estatutos de los colegios oficiales de Matronas.

Orden 3 de Noviembre de 1931. Practicantes y Matronas. Normas de Matrícula de primer curso de Practicantes y Matronas.

Orden de 14 de Diciembre de 1931. Modifica requisitos para los estudios de practicante y matrona.

Orden de 16 de Mayo de 1932. Enfermero Psiquiátrico.

Circular de 16 de Julio de 1932. Aprueba Reglamento de la Escuela Nacional de Puericultura.

Ley de 27 de Octubre de 1932, Promulgando el Código Penal de 1870, reformado según la Ley de Bases de 8 de septiembre de 1932.

Orden de 31 de Diciembre de 1932. Clarifica el acceso a los estudios de enfermero psiquiátrico.

Orden de 21 de Febrero de 1933 fijando las asignaturas del Plan de estudios del bachillerato que han de cursar los que aspiren a obtener el título de Practicante o de Matrona.

Orden de 24 de Febrero de 1933. Crea la escuela de Enfermeras Visitadoras.
Circular de 30 Octubre de 1933. Concurso provisión de plazas de enfermeras visitadoras.

Orden de 28 de Febrero de 1934. Reglamento de la Escuela de Enfermeras Visitadoras.

Orden de 14 de Septiembre de 1934. Concede a todos los licenciados en medicina la facultad de obtener el título de practicante y enfermero previo pago correspondiente.

Orden de 5 de Octubre de 1934. Aclara la Orden de 14 de Septiembre de 1934.

Orden de 13 de Diciembre de 1934. Orden resolviendo instancias presentadas solicitando aclaración sobre las asignaturas que deben cursarse en los Institutos Nacionales para matricularse en la Facultad para Practicantes y Matronas.

Real Orden de 19 de Enero de 1935. Crea comisión para el desarrollo del Reglamento de funcionamiento de la Escuela de Salud Pública.

Decreto de 19 de Septiembre de 1935. Reglamento para la Escuela Nacional de Puericultura.

Orden de 24 de Abril de 1937. (Gobierno General). Falange. Cursillos de damas enfermeras

Decreto de 7 de Octubre de 1937. Establece el Servicio Social obligatorio para las mujeres de edades comprendidas entre los 17 y lo 35.

Orden de 21 de Abril de 1937. Autoriza a Falange Española Tradicionalista y de las J.O.N.S. para impartir cursos de enfermería.

Orden de 22 de Diciembre de 1939. Nombramientos del Consejo General de Colegios Oficiales de Practicantes.

Orden de 10 de Julio de 1940. Examen obligatorio para el acceso a los estudios de practicante.

Orden 8 de Marzo de 1941(Ministerio Gobernación) Practicantes. Normas para funcionamiento de los colegios.

Orden de 21 de Mayo de 1941. Normas para la obtención del título de enfermera.

Ley 3 de Enero de 1942. (Jefatura del Estado). Enfermeras. Crea el cuerpo de Falange Española Tradicionalista y de las J.O.N.S.
Orden de 18 de Marzo de 1942 (Ministerio Gobernación) Practicantes y Matronas. Estatutos de los Colegios Oficiales de Practicantes.

Ley de 22 de Noviembre 1944. Sanidad. Ley de Bases para su organización.


Decreto de 23 de Diciembre de 1944. Promulgando el Código Penal.

Orden de 4 de Mayo de 1945. Valida las titulaciones creadas por Falange Española Tradicionalista y de las Juventudes Obreras Nacional Sindicalistas (FET de las JONS).

Orden de 26 de Noviembre de 1945 (Ministerio Gobernación). Sanidad. Aprueba: Reglamento y Estatutos del Consejo General de auxiliares y de los Colegios provinciales respectivamente, y los Estatutos del Consejo de Previsión y Socorros Mutuos.

Orden de 20 de Enero de 1948, por la que se aprueba el Reglamento de Servicios Sanitarios del Seguro Obligatorio de Enfermedad.


Decreto de 27 de Junio de 1952.Organiza los estudios de enfermería.

Decreto de 4 de agosto de 1952. Establece el régimen de residencia para las estudiantes de enfermería.


Orden de 30 Julio de 1954 (Ministerio Gobernación). Aprueba los Estatutos de los Colegios Provinciales de Auxiliares Sanitarios.


Orden de 6 de Julio de 1955. Prohibición de la coeducación en las escuelas de enfermería.

Decreto 18 de Enero de 1957 por el que se establece la especialización de Asistencia Obstétrica (Matronas) para los Ayudantes Técnicos Sanitarios Femeninos.


Decreto 1153/1961, de 22 de Junio por el que se crea la especialidad de Radiología y Electrología en los estudios de Ayudantes Técnico Sanitarios.

Ley 22 Julio 1961, num. 56/61 (Jefatura del Estado). Derechos políticos profesionales y de trabajo.


Real Decreto 727/1962, de 22 de Marzo (Ministerio Educación y Ciencia) por el que se crea la especialidad de Podología en los estudios de Ayudantes Técnicos Sanitarios.


Decreto 168/1963, de 24 de Enero, que desarrolla la ley 79/1961, de 23 de Diciembre, de Bases para una revisión parcial del Código Penal y otras Leyes especiales.

Real Decreto 22 Octubre 1964, núm. 3524/64 Escuelas de Ayudantes Técnicos Sanitarios. Especialidad de Pediatría y Puericultura.


Real Decreto 3524/1970, de 22 de Octubre (Ministerio Educación y Ciencia) por el que se crea la especialidad de Neurología en los estudios de Ayudantes Técnicos Sanitarios.

Ley 14/1970, de 4 de Agosto, General de Educación y Financiamiento de la Reforma Educativa.

Real Decreto 3192/1970, de 22 Octubre (Ministerio Educación y Ciencia), por el que se crea la especialidad de Neurología en los estudios de Ayudantes Técnicos sanitarios.

Real Decreto 3193/1970, de 22 Octubre (Ministerio Educación y Ciencia), por el que se crea la especialidad de Psiquiatría en los estudios de Ayudantes Técnicos sanitarios.

Real Decreto 203/1971, 28 de Enero (Ministerio Educación y Ciencia), por el que se crea la especialidad de Análisis Clínicos en los estudios de Ayudantes Técnicos sanitarios.


Orden de 26 de Abril de 1973, por la que se aprueba el Estatuto del Personal Auxiliar Sanitario Titulado y Auxiliar de Clínica de la Seguridad Social.

Orden de 17 de Septiembre de 1974 por la que se desarrolla el Decreto 2293/1973, de 17 de Agosto regulador de las Escuelas Universitarias.


Decreto 2233/1975, de 24 de Julio, por el que se crea la especialidad de Urología y Nefrología para Ayudantes Técnicos Sanitarios.

Orden de 1 Abril de 1977 (Ministerio Gobernación) Ayudantes Técnicos Sanitarios. Organización Colegial


Orden de 31 de Octubre de 1977 (Ministerio Educación y Ciencia) Escuelas Universitarias de Enfermería. Directrices para la elaboración de los planes de estudio.

Real Decreto 1856/1978, de 29 de junio, por el que se aprueban los Estatutos de la Organización colegial de A.T.S..

Constitución Española, 28 de Diciembre de 1978.

Orden de 13 de Diciembre de 1978 sobre habilitación de títulos para impartir docencia.

Real Decreto 111/1980, de 11 de Enero, sobre homologación del Título de ATS con el de Diplomado en Enfermería

Ley 8/1980, de 10 de Marzo, del Estatuto de los Trabajadores.

Orden de 15 de Julio de 1980, por la que se establece un curso de Nivelación de Conocimientos a efectos de la convalidación académica del título de Ayudante Técnico Sanitario por el de Diplomado en Enfermería.


Orden Ministerial del 9 de Octubre de 1980, por la que se regula que los Diplomados en Enfermería puedan realizar las especialidades reconocidas para los ATS.


Ley Orgánica 1/1982 de 5 de Mayo, de protección civil del derecho al honor, a la intimidad personal y familiar y a la propia imagen.

Real decreto de 24 de Julio de 1889, ordenando la publicación en la Gaceta de Madrid de la edición reformada del Código Civil (1983).

Real Decreto 137/1984, de 11 de Enero sobre Estructuras Básicas de Salud.

Orden de 7 de Febrero de 1984. Regula el acceso a las categorías de profesorado universitario.
Orden de 14 de Junio de 1984. Desarrolla las funciones de los Técnicos de Formación Profesional de segundo grado de Laboratorio y Radiología.

Orden de 28 de Febrero de 1985 por la que se establecen los órganos de dirección de los hospitales y dotación de su personal, regulando la provisión de cargos y su puesto correspondiente.

Real Decreto del de Marzo de 1985. Reglamento de hospitales.


Ley Orgánica 14/1986, de 25 de Abril, General de Sanidad.

Real Decreto 992/1987, de 3 de Julio, del Ministerio de Relaciones con las Cortes y de la Secretaría del Gobierno, por el que se regula la obtención del título de Enfermero Especialista.

Ley Orgánica 3/1989, de 21 de Junio, de actualización del Código Penal

Real Decreto 1466/1990 de 20 de Diciembre. Directivas para la elaboración del plan de estudios de enfermería.

Orden de 20 Noviembre de 1991 de la Conselleria de Sanitat i Consum, por la que se establece el Reglamento de Organización y Funcionamiento de los Equipos de Atención Primaria en la Comunidad Valenciana.

Real Decreto 1267/1994, de 10 de Junio, que modifica el Real Decreto 1497/1987, de 27 de Noviembre, por el que se establecen las directrices generales comunes de los planes de estudios de los títulos universitarios de carácter oficial y diversos Reales Decretos que aprueban las directrices generales propias de los mismos.

Corrección de erratas del Real Decreto 1267/1994, de 10 de Junio, que modifica el Real Decreto 1497/1987, de 27 de Noviembre, por el que se establecen las directrices generales comunes de los planes de estudios de los títulos universitarios de carácter oficial y diversos Reales Decretos que aprueban las directrices generales propias de los mismos.

6.2.2 Great Britain

Midwives Act, 1902 (2 Edw. 7, c. 17)

Nurses Registration Act, 1919 (9 &10 Geo. 5. Ch. 94)

Nurses Act, 1943 (6 & 7Geo. 6, c. 17)
Nurses Regulations, 1945 (S. R. & O., 1945, No. 638)
Nurses Act, 1949 ((12 & 13 Geo. 6, c. 73)
Nurses Act, 1957 (5 & 6 Eliz. 2 Ch. 15)
Nurses (Amendment) Act, 1961 (1961, c 14)
Nurses Act, 1964 (1964, c. 44)
Nurses Act, 1969 (1969 c. 47)
Trade Union and Labour Relation Act, 1974 (1974 c. 52)
Nurse, Midwives and Health Visitors Act, 1979 (1979 c. 36)
Nurse, Midwives and Health Visitors Act, 1983 (1983 No. 667)
Nurse, Midwives and Health Visitors Act, 1992 (1992 c. 16)

6.2.3 European Community Directives

Council Directive 77/452/EEC of 27 June 1977 concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of this right of establishment and freedom to provide services.


care, including measures to facilitate the effective exercise of the right of establish-lishment and freedom to provide services, and amending Directive 77/453/EEC concerning the co-ordination of provisions laid down by law, regulation or admin-istrative action in respect of the activities of nurses responsible for general care.

Treaty Establishing The European Economic Community. Rome, 25 March 1957
<table>
<thead>
<tr>
<th>Examination and requirements of enrolment</th>
<th>Age</th>
<th>Duration</th>
<th>Professional Board / Examination</th>
<th>Examining Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>1861</td>
<td>21-35</td>
<td>1 year</td>
<td>Certificate of proficiency</td>
<td>Independent Body</td>
</tr>
<tr>
<td>1887</td>
<td>3 years</td>
<td>3 years</td>
<td></td>
<td>Independent Body</td>
</tr>
<tr>
<td>1893</td>
<td>3 years</td>
<td>3 years</td>
<td></td>
<td>Independent Body</td>
</tr>
<tr>
<td>1889</td>
<td>Essentials reading and writing ability. Examination on basic knowledge or equivalent examination.</td>
<td>3 years</td>
<td>Independent Body</td>
<td></td>
</tr>
<tr>
<td>1919</td>
<td>Nurses Act creating the General Nursing Council (GNC); it issues rules on: examinations and conditions for admission to the register</td>
<td>3 years</td>
<td>Examination prescribed as a condition for admission to register</td>
<td>GNC</td>
</tr>
<tr>
<td>1920</td>
<td>Draft Schedules for approval of training schools: – length of training to be prescribed – minimum standards of general education for entry to nurse training</td>
<td>3 years</td>
<td>Examination prescribed as a condition for admission to register</td>
<td>GNC</td>
</tr>
<tr>
<td>1921</td>
<td>General Nurse training – Secondary education</td>
<td>21 - 35, hospital accept suitable candidates from 18</td>
<td>Preliminary, intermediate and final</td>
<td>GNC</td>
</tr>
<tr>
<td>1923</td>
<td>Mental Nursing – Secondary education</td>
<td>3 years</td>
<td>Passing of the examination controlled by association or recognised equivalent</td>
<td>Medico-Psychological Association</td>
</tr>
<tr>
<td>Profession</td>
<td>Duration</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever Nursing</td>
<td>3 years</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Secondary education</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prison Nursing</td>
<td>3 years</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Secondary education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedic Nursing</td>
<td>19 - 30</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmic Nursing</td>
<td>19 - 30</td>
<td>1/3 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army &amp; Navy Nurse</td>
<td>3 years</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing in India</td>
<td>3 years</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Nurse</td>
<td>3 years</td>
<td>GNC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1936 GNC. No one should enter to nursing who did not possess the General School Certificate or equivalent or passes special test set by the Council. 3 years Examination prescribed as a condition of admission to register.

1939 Test was abandoned at outbreak of the World War II. 3 years GNC.

1945 GNC asked the Minister to re-establish the test of education. 3 years GNC.

1959 Demand for the return to the test system, the Health Minister acceded. 3 years GNC.

1962 The test takes effect 18 3 years Passing of the examination controlled by association or recognised equivalent.

* In this period many schools of nursing have for years set their own entry requirements at or about five O- levels.

1983 Five subjects at ordinary level A, B or C grade in the GNC of secondary education, or a specified pass standard in educational test approved by the Council. 17 and 171/2 Passing of the examination controlled by association or recognised equivalent. UKCC for Nurses, Midwives and Health Visitors. Academic validation at Diploma level by Universities.
### Table 5. Historical Development of the Skill-Based Theoretical Knowledge Indicator in Spain

<table>
<thead>
<tr>
<th>Examination and requirements of enrolment</th>
<th>Age</th>
<th>Duration</th>
<th>Professional Board / Examining Board</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1860</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **1888** | | | | | 2 years | a) elementary education
b) Theoretical and practical about the contents of the studies of (M) and (P). | Medical Faculty. |
| **1896** | | | | | 23 | 3 years | Nursing (N): be able to read and write, knowledge of mathematics, be healthy and vaccinated, good behaviour and good manners. | Medical Faculty. |
| **1901** | | | | | 2 years | Theoretical and practical; each year with accreditation of one year training. | Medical Faculty. |
| **1904** | 16 (P) | 2 years | Theoretical and practical; each year with accreditation of one year training. | Medical Faculty. |
| | 21 (M) | 2 years | | Medical Faculty. |

**APPENDIX 2**
1915 (N). Application to Red Cross: Spanish nationality, admission examination and a Medical check-up. 20-35 2 years Final examination. War Ministry act as validating authority.

1926 (P) Elementary education cycle ('Bachiller elemental').

1928 (M) Elementary education cycle ('Bachiller elemental'). Proof of good behaviour. Parents' or husband's authorisation.

1931 (P) and (M) studies, have passed the admission exam in the National Institutes of Secondary Education.

1933 (P) Have completed the first three years of the future educational curriculum plus Physiology and Hygiene.

1936/39 Civil War

1940 (P) Obligatory admission exam; those students who had completed three years of high education plus Physiology and Hygiene of fourth course were not compelled to sit the exam.

1953 Ayudantes Técnicos Sanitarios (ATS) Pass school admission exam. Be introduced by two peoples of recognised moral integrity. Medical check-up carried out in the school. Have passed the elementary high educational cycle. Trial period of three months. Females were resident at the schools.

1977 'Diplomado en Enfermería' Pre-University Course. 3 years Examination at the end of each academic year. University.

1990 'Diplomado en Enfermería' Pre-University Course. 3 years Examination at the end of each academic year. University.
Table 6. Natural History of the Nursing Professionalisation Indicator

<table>
<thead>
<tr>
<th>England</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The emergence of a full time occupation.</td>
<td>1850</td>
</tr>
<tr>
<td>1850</td>
<td>1850</td>
</tr>
<tr>
<td>2. The establishment/founding of a training school and concurrent facilities.</td>
<td>1857 Faculty of Medicine: ‘Practicantes’.</td>
</tr>
<tr>
<td>1860 St. Thomas’s School of Nursing.</td>
<td>1857 Faculty of Medicine: Midwives.</td>
</tr>
<tr>
<td>1896 Nursing School Dr. Federico Rubio Gall.</td>
<td>1896 Nursing School Dr. Federico Rubio Gall.</td>
</tr>
<tr>
<td>1970s University Studies</td>
<td>1970s University Studies</td>
</tr>
<tr>
<td>1977 University School of Nursing.</td>
<td>1977 University School of Nursing.</td>
</tr>
<tr>
<td>3. The establishment of a professional association.</td>
<td>1887 British Nurse’s Association.</td>
</tr>
<tr>
<td>1887 British Nurse’s Association.</td>
<td>1883 ‘Unión de Practicantes’.</td>
</tr>
</tbody>
</table>

Prolonged period of political agitation directed to obtain the support of the public power

<table>
<thead>
<tr>
<th>England</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930 ‘Colegio’ of Midwives.</td>
<td>1930 ‘Colegio’ of Midwives.</td>
</tr>
<tr>
<td>1953 ‘Colegio’ of Nurses.</td>
<td>1953 ‘Colegio’ of Nurses.</td>
</tr>
<tr>
<td>5. Change in the name of the association</td>
<td>1850 Nurse</td>
</tr>
<tr>
<td>1850 Nurse</td>
<td>1857 ‘Practicante’ and Midwives</td>
</tr>
<tr>
<td>1915 Nurse</td>
<td>1915 Nurse</td>
</tr>
<tr>
<td>1952 ATS</td>
<td>1952 ATS</td>
</tr>
<tr>
<td>1977 Nurse</td>
<td>1977 Nurse</td>
</tr>
<tr>
<td>1983 United Kingdom Central Council Code for Professional Conduct of Nursing Midwives and Health Visitors</td>
<td>1989 Deontological Code of Conduct</td>
</tr>
<tr>
<td>1989 Deontological Code of Conduct</td>
<td>1989 Deontological Code of Conduct</td>
</tr>
</tbody>
</table>

APPENDIX 3
Attitudinal Autonomy

Attitudinal Autonomy Instructions and Questions

Instructions: The following questions indicate your beliefs about the desired relationship between you and your (future) clients (patients) and the organisation (institution, firm) in which you (will) work. You are asked to answer questions as if you were already putting into practice your occupational skills and knowledge in an organisational setting (institution, firm).

The possible answers form a continuum from one extreme at the left to the other extreme at the right. Demonstrate the relative strength of your belief or feeling by filling in the one box that comes closest to describing your view of that question.

Remember, answer the questions so that you demonstrate how you would like your relationship with the organisation you work for and your clients to be.

AUTONOMY FROM CLIENTS QUESTIONS:

1. I try not to let the feelings and speculations of clients (patients) sway me from holding with decisions I believe to be in their best interest.

2. Clients are usually very knowledgeable about professional matters and therefore should participate in decisions made on their behalf.

3. Giving clients what they want does not necessarily serve their best interests.

4. Clients often don't understand the complexity of decisions I make in their best interests.

5. I think my colleagues ought to be more flexible in allowing their clients to participate in decisions made in their regard.

6. In order to serve my clients effectively, it is important that they surrender their judgement to mine.

7. In my relationships with clients I discourage their attempts to dominate the situation.

8. Rather than alter my approach, if a client expresses disapproval of my services, I often recommend he/she seek help elsewhere.
9. Ultimately my concern is in making technically sound rather than popular decisions about clients.

10. I know my work and expect my clients to respect the decisions I make on their behalf.

11. I believe independence from clients is the hallmark of expert service.

AUTONOMY FROM ORGANISATIONS QUESTIONS

12. I shouldn't allow myself to be influenced by the opinions of those colleagues whose ideas do not reflect the thinking of the administration.

13. I believe I should adjust my occupational practice to the administration's point of view.

14. Typically the administration is better qualified to judge what is best for the client than I am.

15. Personnel who openly criticise the administration of this organisation should be encouraged to go elsewhere.

16. This organisation should not expect to have my whole-hearted loyalty and support.

17. I believe it's important to put the interests of the organisation I work in above everything else.

18. It should be permissible for me to violate an organisational rule if I'm sure that the best interest of the clients will be served by doing so.

19. In case of doubt about whether a particular occupational practice is better than another, the primary test should be what seems best for the overall reputation of the organisation.

20. I should try to put what I judge to be the standards and ideals of my occupation into practice, even if the rules and procedures of this organisation discourage it.

21. I believe that administrators and boards of directors (advisers) should facilitate my work rather than direct it.

22. My colleagues and I should try to live up to what we think are the standards of our occupation even if the administration or immediate community doesn't seem to respect them.
CLIENT AUTONOMY QUESTIONS

23. Clients must receive information about their access to health services and the necessary requirements to use those services.

24. The clients must be advised whether the prognosis, diagnosis and therapeutic applied can be used in a teaching or research project and that, in no case, will be dangerous for their health. In every case a signed authorisation from the client will be necessary.

25. The client and relatives must be addressed in understandable terms, with complete and continuous information about his process both oral and written, including diagnosis, prognosis and alternatives forms of treatment.

26. Clients can choose among the options offered by the attendant medical or nursing staff. Consent from the client for the carrying-out of any intervention will be necessary.
APPENDIX 5

Actitudes y Autonomía Profesional

Autonomía Profesional, Instrucciones y Preguntas

Las siguientes cuestiones ponen a prueba tus creencias acerca de las relaciones deseadas entre tú y tus futuros pacientes y la organización en la cual puedes prestar tus servicios.

Las posibles respuestas forman un continuo desde un extremo en la izquierda a otro extremo a la derecha. Demostrarás la fuerza de tus creencias y sentimientos completando los cuadros que consideres más próximos a describir tú visión de las preguntas.

AUTONOMÍA CON RESPECTO A LOS CLIENTES

1.- Trato de no dejar que los sentimientos y especulaciones de mis clientes (pacientes) me influyan en el mantenimiento de decisiones que creo son en su mejor interés.

2.- Los clientes normalmente conocen mucho acerca de los asuntos profesionales, y por eso deberían participar en la toma de decisiones que les afecten.

3.- Dar a los clientes lo que ellos quieren no necesariamente sirve en su mejor interés.

4.- Los clientes a menudo no entienden la complejidad de las decisiones que yo tomo en su mejor interés.

5.- Yo pienso que mis compañeros deberían ser más flexibles en permitir a sus clientes participar en las decisiones tomadas en su beneficio.

6.- Para servir a mis clientes eficazmente, es importante que ellos supediten su juicio al mío.

7.- En mis relaciones con los clientes yo les desanimo en sus intentos de dominar la situación.

8.- Más que alterar mi enfoque, si un cliente expresa desaprobación de mis servicios, a menudo le recomiendo que busque otra ayuda o trate de ajustarse a mi criterio.
9.- Me preocupa en definitiva, que mis decisiones sean más bien técnicamente correctas que populares.
10.- Conozco mi trabajo y espero que mis clientes respeten las decisiones que yo tomo en su beneficio.
11.- Creo que la independencia respecto a la influencia del cliente es el sello de un servicio experto.

AUTONOMÍA RESPECTO A LA ORGANIZACIÓN

12.- No debería dejarme influenciar por las opiniones de compañeros que no reflejen las ideas de la administración.
13.- Creo que debería ajustar mi práctica laboral al punto de vista de la administración.
14.- Normalmente la administración está más preparada que yo para juzgar lo que es mejor para el cliente.
15.- El personal que critica abiertamente la administración de esta organización debería ser animado a abandonarla.
16.- Esta organización no debería esperar tener mi lealtad y apoyo de forma incuestionable.
17.- Creo que es importante poner el interés de la organización donde yo trabajo por encima de todo.
18.- Debería serme permitido violar las reglas de la organización si estoy seguro que hacerlo redundará en el mejor interés de mi cliente.
19.- En caso de duda acerca de si una práctica laboral es mejor que otras, lo mejor para la reputación de la organización debería primar por encima de todo.
20.- Debería tratar de obtener lo que consideraron los estándares y los ideales en mi práctica habitual, incluso si las normas y procedimientos de la organización me desaniman a ello.
21.- Creo que los administradores y consejeros deberían facilitar mi trabajo más bien que dirigirlo.
22.- Mis compañeros y yo deberíamos tratar de obtener lo que pensamos son los estándares de nuestro trabajo, incluso si la administración o comunidad inmediata no parecen respetarlos.
AUTONOMÍA DE LOS CLIENTES

23.- Los pacientes deben recibir información sobre los servicios sanitarios a que pueden acceder, y sobre los requisitos necesarios para su uso.

24.- Los pacientes deben ser advertidos de si los procedimientos de pronóstico, diagnóstico y terapéuticos que se le apliquen pueden ser utilizados en función de un proyecto docente o de investigación, que, en ningún caso, podrá comportar peligro adicional para su salud. En todo caso será imprescindible la previa autorización por escrito del paciente y la aceptación por parte del médico y de la Dirección del correspondiente centro sanitario.

25.- Hay que dirigirse al paciente en términos comprensibles, a él y a sus familiares o allegados, información completa y continuada, verbal y escrita sobre su proceso, incluyendo diagnóstico, pronóstico y alternativas de tratamiento.

26.- Los pacientes pueden elegir entre las opciones que se le presente el responsable médico de su caso, siendo preciso el previo consentimiento escrito del usuario para la realización de cualquier intervención.
APPENDIX 6

Statistical Treatment of Attitudinal Power

AUTONOMY FROM CLIENTS (QUESTIONS 1 TO 11)

Statistical Treatment of Answers

<table>
<thead>
<tr>
<th></th>
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</thead>
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<td>76</td>
<td>147</td>
<td>78</td>
<td>121</td>
<td>134</td>
</tr>
<tr>
<td>Mean</td>
<td>39.157</td>
<td>40.382</td>
<td>44.925</td>
<td>40.872</td>
<td>55.653</td>
<td>54.127</td>
</tr>
<tr>
<td>Std. dev.</td>
<td>10.244</td>
<td>10.631</td>
<td>9.015</td>
<td>9.065</td>
<td>9.554</td>
<td>8.34</td>
</tr>
<tr>
<td>Std. error</td>
<td>.885</td>
<td>1.219</td>
<td>.744</td>
<td>1.026</td>
<td>.869</td>
<td>.72</td>
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<tr>
<td>Minimum</td>
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<td>20</td>
<td>24</td>
<td>18</td>
<td>33</td>
<td>27</td>
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<tr>
<td>Maximum</td>
<td>76</td>
<td>63</td>
<td>71</td>
<td>60</td>
<td>76</td>
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<td>47</td>
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<td>&lt;10th%</td>
<td>13</td>
<td>8</td>
<td>14</td>
<td>7</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>10th%</td>
<td>24.9</td>
<td>26.1</td>
<td>34</td>
<td>30</td>
<td>43.6</td>
<td>43</td>
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<tr>
<td>25th%</td>
<td>32</td>
<td>32</td>
<td>38.25</td>
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<td>6</td>
<td>14</td>
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Kruskall-Wallis (Questions, 1 to 11). All the groups.

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<td>H</td>
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## Mann-Whitney U (Questions 1-11), per subject groups

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<tr>
<td>Z</td>
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| Group 1 | Spanish Medical Students       | 78  | 8822   | 113,103  |
| Group 2 | Spanish Nurses                 | 134 | 13756  | 102,657  |

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<td>Z</td>
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| Group 1 | English Nurses                  | 121 | 21646,5 | 178,897  |
| Group 2 | Spanish Nurses                 | 134 | 10993,5 | 82,041   |

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</table>

| Group 1 | Spanish Nurses                  | 134 | 24776,5 | 184,899  |
| Group 2 | English Nursing Students        | 134 | 11269,5 | 84,101   |

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313
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<td>134</td>
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<tr>
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<td>Medical Doctors</td>
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<tr>
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<td></td>
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| U                           | 4334                     |
| U - prime                   | 15364                    |
| Z                           | -8,106 \( \ p = .0001 \) |
| Z corrected for ties        | -8,11 \( \ p = .0001 \)  |
| # tied groups               | 39                       |

<table>
<thead>
<tr>
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<th>English Nursing Students</th>
<th>Number</th>
<th>( \Sigma ) Rank</th>
<th>Mean Rank</th>
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<tbody>
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<td>134</td>
<td>17565</td>
<td>131,082</td>
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<td></td>
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<td>76</td>
<td>4590</td>
<td>60,395</td>
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| U                           | 1664                     |
| U - prime                   | 8520                     |
| Z                           | -8,101 \( \ p = .0001 \) |
| Z corrected for ties        | -8,105 \( \ p = .0001 \) |
| # tied groups               | 40                       |

<table>
<thead>
<tr>
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<th>( \Sigma ) Rank</th>
<th>Mean Rank</th>
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<tbody>
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<td>Spanish Medical Students</td>
<td>134</td>
<td>18009</td>
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<td>78</td>
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| U                           | 1488                     |
| U – prime                   | 8964                     |
| Z                           | -8,678 \( \ p = .0001 \) |
| Z corrected for ties        | -8,683 \( \ p = .0001 \) |
| # tied groups               | 36                       |

<table>
<thead>
<tr>
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<th>Number</th>
<th>( \Sigma ) Rank</th>
<th>Mean Rank</th>
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<td>16472,5</td>
<td>122,929</td>
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<td>121</td>
<td>16167,5</td>
<td>133,616</td>
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<p>| U                           | 7427,5                   |
| U – prime                   | 8786,5                   |
| Z                           | -1,155 ( \ p = .2479 ) |
| Z corrected for ties        | -1,156 ( \ p = .2476 ) |
| # tied groups               | 35                       |</p>
<table>
<thead>
<tr>
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<th>Mean Rank</th>
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<tr>
<td>English Nurses</td>
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<td>121</td>
<td>15166.5</td>
<td>125,343</td>
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<td>76</td>
<td>4336.5</td>
<td>57,059</td>
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\[
\begin{align*}
U &= 1410.5 \\
\text{U - prime} &= 7785.5 \\
Z &= -8.183 \quad p = .0001 \\
Z \text{ corrected for ties} &= -8.187 \quad p = .0001 \\
\# \text{ tied groups} &= 44
\end{align*}
\]

<table>
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<th>Number</th>
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<th>Mean Rank</th>
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</thead>
<tbody>
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<td>English Nurses</td>
<td>Medical Students</td>
<td>121</td>
<td>15518.5</td>
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<td>4381.5</td>
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\[
\begin{align*}
U &= 1300.5 \\
\text{U - prime} &= 8137.5 \\
Z &= -8.619 \quad p = .0001 \\
Z \text{ corrected for ties} &= -8.624 \quad p = .0001 \\
\# \text{ tied groups} &= 40
\end{align*}
\]

<table>
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<th>Group 1</th>
<th>Group 2</th>
<th>Number</th>
<th>Σ Rank</th>
<th>Mean Rank</th>
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<td>Medical Students</td>
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<td>78</td>
<td>6169.5</td>
<td>79,096</td>
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\[
\begin{align*}
U &= 2839.5 \\
\text{U - prime} &= 3088.5 \\
Z &= -.45 \quad p = .6528 \\
Z \text{ corrected for ties} &= -.45 \quad p = .6525 \\
\# \text{ tied groups} &= 32
\end{align*}
\]
AUTONOMY FROM CLIENTS (QUESTIONS 12 TO 22)
Statistical Treatment of Answers

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<td>10th%</td>
</tr>
<tr>
<td>25th%</td>
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<td>50th%</td>
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<tr>
<td>75th%</td>
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<td>90th%</td>
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<td>&gt;90th%</td>
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Kruskall-Wallis (Questions, 12 to 22). All the groups.

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<td>H</td>
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<td>Group</td>
<td># Cases</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------</td>
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<tr>
<td>Spanish Medical Doctors</td>
<td>76</td>
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<tr>
<td>Spanish Nurses</td>
<td>134</td>
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<tr>
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### Mann-Whitney U (Questions 12-22), per subject groups

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<td>134</td>
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**U** 5078  
**U - prime** 5106  
**Z** -0.033  
**Z corrected for ties** -0.033  
**# tied groups** 32

<table>
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<th>Σ Rank</th>
<th>Mean Rank:</th>
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**U** 4664  
**U - prime** 5788  
**Z** -1.305  
**Z corrected for ties** -1.306  
**# tied groups** 38

<table>
<thead>
<tr>
<th>Group 1</th>
<th>English Nurses</th>
<th>Number:</th>
<th>Σ Rank</th>
<th>Mean Rank:</th>
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<tbody>
<tr>
<td>Group 2</td>
<td>Spanish Nurses</td>
<td>134</td>
<td>17112</td>
<td>127,701</td>
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**U** 8067  
**U - prime** 8147  
**Z** -0.068  
**Z corrected for ties** -0.068  
**# tied groups** 37
<table>
<thead>
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<th>Number</th>
<th>Σ Rank</th>
<th>Mean Rank</th>
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<tbody>
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<td>1</td>
<td>Spanish Nurses</td>
<td>134</td>
<td>20496,5</td>
<td>152,959</td>
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<td>2</td>
<td>English Nursing Students</td>
<td>134</td>
<td>15549,5</td>
<td>116,041</td>
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U: 6504,5
U - prime: 11451,5
Z: -3,899  p = 0,0001
Z corrected for ties: -3,901  p = 0,0001
# tied groups: 39

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<th>Number</th>
<th>Σ Rank</th>
<th>Mean Rank</th>
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<td>Spanish Nurses</td>
<td>134</td>
<td>16238</td>
<td>121,179</td>
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U: 7193
U - prime: 12505
Z: -3,904  p = 0,0001
Z corrected for ties: -3,906  p = 0,0001
# tied groups: 40

<table>
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<th>Population</th>
<th>Number</th>
<th>Σ Rank</th>
<th>Mean Rank</th>
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<td>147</td>
<td>18293,5</td>
<td>124,446</td>
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<td>Medical Doctors</td>
<td>76</td>
<td>6682,5</td>
<td>87,928</td>
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U: 3756,5
U - prime: 7415,5
Z: -4,006  p = 0,0001
Z corrected for ties: -4,009  p = 0,0001
# tied groups: 36

<table>
<thead>
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<th>Number</th>
<th>Σ Rank</th>
<th>Mean Rank</th>
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<td>Spanish Medical Students</td>
<td>78</td>
<td>6570,5</td>
<td>84,237</td>
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U: 3489,5
U - prime: 7976,5
Z: -4,828  p = 0,0001
Z corrected for ties: -4,831  p = 0,0001
# tied groups: 39
<table>
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<th>22506,5</th>
<th>153,105</th>
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<td>English Nurses</td>
<td>121</td>
<td>13539,5</td>
<td>111,897</td>
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| U                | 6158,5                   |
| U - prime        | 11628,5                  |
| Z                | -4,331 p = .0001         |
| Z corrected for ties | -4,334 p = .0001       |
| # tied groups    | 38                       |

<table>
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<th>Spanish Nursing Students</th>
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| U                | 9744                     |
| U - prime        | 9954                     |
| Z                | -.154 p = .8774          |
| Z corrected for ties | -.154 p = .8773       |
| # tied groups    | 38                       |

<table>
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| U                | 3329,5                   |
| U - prime        | 6854,5                   |
| Z                | -4,165 p = .0001         |
| Z corrected for ties | -4,169 p = .0001       |
| # tied groups    | 32                       |

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| U                | 3168                     |
| U – prime        | 7284                     |
| Z                | -4,778 p = .0001         |
| Z corrected for ties | -4,781 p = .0001       |
| # tied groups    | 37                       |

320
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| U                      | 5455,5  |
| U – prime              | 10758,5 |
| Z                      | -4,508  |
| p = .0001              |
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| p = .0001              |
| # tied groups          | 36      |

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| U                      | 4569,5  |
| U – prime              | 4626,5  |
| Z                      | -0,073  |
| p = .9417              |
| Z corrected for ties   | -0,073  |
| p = .9416              |
| # tied groups          | 30      |

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| U                      | 4246,5  |
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| p = .2335              |
| Z corrected for ties   | -1,192  |
| p = .2332              |
| # tied groups          | 37      |

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| U                      | 2699,5  |
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| Z                      | -0,956  |
| p = .3391              |
| Z corrected for ties   | -0,957  |
| p = .3388              |
| # tied groups          | 32      |
**AUTONOMY FROM CLIENTS (QUESTIONS 23 TO 26)**

Statistical Treatment of Answers

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**Kruskall-Wallis (Questions, 23 to 26). All the groups.**

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### Mann-Whitney U (Questions 23 to 26), per subject groups

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| U - prime | 12073,5 |
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| Z corrected for ties | -3,474 | p = .0005 |
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| U | 4249,5 |
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</tbody>
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APPENDIX 7

Main abbreviations used in this study

ATS Ayudante Técnico Sanitario
ANTC Area Nurse Training Committees
BMA British Medical Association
BNA British Nurses Association
BOE Boletín Oficial del Estado (formerly Gaceta de Madrid)
CCEATS Central Commission of ATS Studies
CCNS Central Commission of Nursing Studies
CMB Certificate of Midwives Board
DC Dennis Child (Test)
DHSS Department of Health and Social Studies
EAP Equipo de Atención Primaria
EEC Economic European Community
EURES European Employment Services
FET de las JONS Falange Española Tradicionalista de las Juntas de Ofensiva Nacional Sindicalista (1933)
GCE General Certificate of Education
GNC General Nursing Council
HBV-O Higher Professional Education In Nursing (Netherlands)
HMSO Her Majesty Stationery Office
INC International Nursing Council
INP Instituto Nacional de Previsión
INSALUD Instituto Nacional de la Salud
NCP Nursing Care Process
RCN Royal College of Nursing
RMN Registered Medical Nurse
RMNS Registered Medical Nurse Student
SATSE Sindicato de Ayudantes Técnicos Sanitarios de España
SEDOC European Job Offers and Request Service
UGT Unión General de Trabajadores
UKCC United Kingdom Central Council
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