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PROFESSION OR UNION: WHO WILL CALL THE SHOTS?

LEARNING THE CONCEPT: NURSING IN CHRONIC ILLNESS

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YOUR RESPONSE TO NURSING PAPERS

IN APRIL, approximately 1000 copies of the first issue of *Nursing Papers* were distributed to the university schools and to other interested groups of nurses. The response to the journal as a forum for research and for the development of ideas and plans in nursing has been splendid. Many persons described the need for such presentations and for the subsequent dialogue among nurses with similar interests. Such great support has made us more courageous and at the same time resolute to continue our venture. My thanks to each of you for your good wishes and for your affirmation of *Nursing Papers* as one means of promoting our development, particularly in the university schools and their related community agencies.

Many persons have been generous in supporting *Nursing Papers* through personal contributions, while others have forwarded or have requested their organizations to forward the exact amount to cover individual copies.

Expenses for 1000 copies, April Issue, 1969	$600.00
Received from 47 individual and group contributions .	207.85
Balance	$393.15

With the cost of the present issue, we shall be approximately $1000 out-of-pocket.

The problem of finances must be attacked and it seems likely that we shall set up a subscription procedure in business-like fashion. However, a small select group, such as forty-seven persons taking out

medium-priced subscriptions, will not underwrite the development of a journal of the character and calibre which our university schools of nursing are demanding. If we need a forum designed for the small percent of nurses whose work is concerned with the future of our profession, — either in teaching, in the development of nursing services, in research, or in other ways, — could we undertake to finance the project through individual and school contributions at least for the time being? What other sources of revenue might be available in the future? I am approaching one of the publishing houses hoping to gain financial assistance on a permanent basis. Certainly, we are the major group purchasing or initiating the purchase of texts and reference books in the field of nursing. I feel sure we can count on reciprocal support from some of the publishers at a time when we require a means of continued communication to strengthen our own development. One might venture to predict valuable outcomes if our paper succeeds, — a greater number of Canadian authors in the nursing field! What suggestions do you have for long-term finances as well as for sources of revenue to sustain our (all of us) venture in 1969? We are looking to the Alumnae of our School at this time both for temporary backing and for volunteers to undertake the subscription service and distribution.

I would like to describe once again the idea behind the publication of *Nursing Papers.* We are seeking articles particularly from the faculty of university schools which describe a research study or the development of an idea or plan in nursing, in teaching, or in the provision of nursing services. It is important that the design of the study and its findings as well as the rationale of an argument or plan be presented so that readers will understand each part, the development, and the relation of one idea to another. We want readers to be challenged and to be critical in their response. Let us hear about your research concerns and endeavors, about the approaches you use in the teaching of nursing, about the new patterns of staffing you are trying, or about your plan to improve the quality of nursing care. We are in desperate need of articles.

Although all respondents seemed to enjoy the two articles in the April issue of *Nursing Papers,* we did not receive real assessment or appraisal of either paper. As the researcher responsible for evaluating the nursing program at Ryerson Polytechnical Institute in Toronto, I was hoping for responses to the design described in that issue. Many are concerned with evaluating the new educational programs across Canada and I believe each of us approaches the task with a different emphasis and study plan. What are other provinces such as Quebec,

Saskatchewan, Alberta, and British Columbia doing to evaluate their new educational programs? Here is an opportunity for us to explore and to discuss problems in evaluative research and to compare and contrast various methods. It would benefit all of us if we could share ideas and plans in this journal.

I think you will be challenged by the article on "Professions and Unions" in this issue of *Nursing Papers;* most of us have such definite ideas and opinions on the subject. Joan Gilchrist, the author, is presently completing requirements for the Ph.D. in Sociology at McGill University while working part-time on our staff. How do *you* view the future of our profession in relation to our bargaining and negotiating function?

Through the years, our staff has begun to accumulate valuable insights into the teaching of nursing in the Basic Nursing program, to identify the critical dimensions of nursing to be learned, and to translate such knowledge into tentative prescriptions for both teaching and curriculum structure. The first of such articles was presented in the April issue of *Nursing Papers*. Margaret Hooton, an Assistant Professor of Nursing with a M.Sc.(A) from McGill, continues in a similar fashion by describing the teaching of nursing in the care of patients with chronic illness. What do you think of the ideas in these two articles on the teaching of nursing? What notions or viewpoints have you arrived at in your program?

M. A.

PROFESSION OR UNION: WHO WILL CALL THE SHOTS?

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TODAY some of the most crucial problems concerning the character of nursing practice are being solved by unions, by hospital associations and by government. Professional or otherwise, unions conceive the answers to these problems to be amenable to inflexible, rigid and isolated statements of what "each side" in negotiations with employers will or will not do under certain similarly inflexible, rigid and isolated circumstances. The same type of solution is often sought by professional associations attempting to give people definite predetermined "guidelines" upon which the solution to professional problems in work situations are to be based. What are the logical consequences of this for nursing?

Neither union nor professional association individually or in concert, as each is presently constituted, appear to be capable of reversing the insidious erosion of the individual and collective nurse's power in her job relationships, a crucial requirement of a professional service. Who then is to call the shots? This paper presents some aspects of the situation to be considered in deliberations among nurses as they answer this question.

In their individual and group relationships with employers, nurses are attempting to find methods of negotiation and bargaining which allow them to retain their professional aspirations, fulfill their perceived obligations, and acquire social and economic security. A variety of arrangements have been utilized, but to date these have required that a false and, in my view, a dangerous dichotomy exist between general staff nurses on the one hand and management nurses on the other. This is true even when the bargaining function is under the

aegis of, or a separate arm of, the professional nursing association. Since such an organization represents all members of the profession and purports to have an intimate concern with all things which affect nursing participation in health services, the tacit acceptance of this dichotomy is an inherent contradiction. But an even more serious conceptual error is made when responsibility for remuneration and those things called working conditions are conceived to be a function of any organization other than the professional association. For it is inconceivable that these can be artificially separated from "professional" matters and remain an important part of the professional ethos.

Unions operating under antiquated labor codes developed for non-professional workers see no need to challenge laws which require these separations. Professional associations are of similar bent and are not sufficiently strong to exert pressures in those places which are the seats of law-making and change. In either case the general philosophy, the framework within which contracts are negotiated, and the specific items negotiated are those of a typical union.

The concept of collective bargaining in nursing is now relatively well established and it is time to review the entire situation and the context within which it exists with a view to determining future action, including the new structural arrangements which will ensure the delivery of a high quality of nursing care in the amount required. Decisions of this sort are often taken in conformity with the perceived power structure and with vested interests rather than according to what will best serve the evolving purposes of the professional organization.

In selecting among alternative courses of action, I see two main aspects of the problem which we have before us. One is the appraisal of our profession within the context of society and the other is an assessment of the ramifications of the union movement.

Let us look first at the trade union. Management and unions come to grips in two arenas, the corporation and society at large. Management, as a functional group, exercises little social initiative — the desire is to stand pat. The corporation is operating in an ideological framework which it and its predecessors largely created. Its creativeness, self-esteem, daring and drive are largely concerned and consumed in the business arena, not the societal one. This complacency with the social framework may likewise be imputed to the unions. Their objectives are quite compatible with the present system — higher minimum wage, shorter working hours, better overtime pay, improved social security and so on. In short, there are no revolutionary or radical designs. Unionism betrays no sense of direction and is

content to drift. Its challenge to management control is more apparent than real. It has voluntarily integrated itself within its society. This spares the country from divisive political contests but at the same time scarcely leads to change. Moreover, Chamberlain says,

> Most labor economists who have undertaken research to establish whether unions have been able to provide differential rewards for their members over the employees of unorganized establishments have concluded either in the negative or in a very much qualified affirmative.[1]

Further he suggests: "The notion that union power is so monolithic that it sweeps all before it is more supportable by prejudice than by impartial analysis".[2]

What then have unions done if most wage increases are the result of changing economic conditions alone? They have influenced the forms of remuneration; i.e. various fringe benefits. This matters little to management. There is virtually no dispute, however, that the unions' representation of members in the grievance process provides a major benefit. The effectiveness of union power seems largely confined to its success in securing equitable treatment for its individual members. Then why all the union-management conflict? In the area of wage determination and in grievance handling, the union is looked on as insurance. Economists in general have maintained that the union's non-economic contribution is by far its most important function. Yet is it also true that perhaps the union can remain as a viable organization performing day-to-day protective functions only because members believe it also provides them some insurance against unfair wage decisions? There is a growing conviction that union power has had a remarkably minor effect so that the union's exercises have been largely uneconomic and perhaps somewhat unsocial. Economists are convinced that unions will be driven into other sorts of activity, such as political activity, where they can have a more potent influence than at the bargaining table, through promoting legislation dealing with employment measures, public expenditure, and a number of forms of social change. Most of to-day's labor leaders, on such a stage, would feel exposed and uncomfortable. Surely it is in such an arena that an organized profession will select its coalitions and engage its opponents.

We are witnessing in North American society simultaneous and grandiose expansion plans of all traditional professions, a spectacular proliferation of new professions and the increasing professionalization of business life.[3] Veblen's sixty year-old dream of a professionally run society has never been closer to realization. Sociologists and historians

have now made valuable studies of individual professions, but these have by and large lacked discussion of the organic relationship of each discipline to the community at large. As Whitehead has said, "each profession makes progress, but it is progress in its own groove . . . (serious thought is restrained) within a groove. The remainder of life is treated superficially with the imperfect categories of thought derived from one profession."[4]

It is clear that practitioners of a profession have not been interested in viewing their work in the light of an interplay of values from a variety of disciplines. Apart from an awareness of the tremendous manpower requirements that a developing technology and an exploding population have enforced upon the professions, and of the rocketing costs of professional services which have alarmed even the most affluent society, we all seem to be oblivious to the existence of a professional problem. Administrative demands increasingly divert professionals from their real work, while demands for their services are made not only by an ever expanding clientele, but by business and government, both of which have come to depend upon the advice of professional consultants. The closer the professional moves toward the center of societal life, the more functions he is called upon to perform. Lynn has noted:

> Because the professionals have been no more willing than the general public to face up to the predicament in which their triumph has placed them, they . . . have guarded their exclusive rights of performance . . . For all their intellectual vitality and daring receptivity to new ideas, the American professions are enormously conservative when it comes to changing the club rules . . . Such conservatism is clearly irresponsible in the America of the 1960's . . . Our professional institutions are an important stabilizing factor in our volatile society, thereby helping to maintain world order. Yet, at the same time that they help to bridge the gulf between nations, the professions erect "No Trespassing" signs between themselves and other professional groups, especially the newer ones. And if they help to keep our society steady, they do not blaze new social pathways — at least not as often as they should . . . More than anything else, our professionals need to liberate themselves — Just as their colonial predecessors did — from monopolistic notions of who should do what job and narrow-minded conceptions of their obligations to the community at large.[5]

Professional associations evolve as a means to control standards and entry into the professions and to diffuse professional knowledge. Their original intent is to be democratic in character, with whatever implications or assumptions this has for the people involved.

To know a professional is to know of his or her organized profession, associations or societies, for these, like the institutions in which

they work, determine much of the professional's behavior. There is clear evidence that such organizations make the professional a conformist and a conservative to a considerable extent. Some associations, and especially one like the American Medical Association, have gained steadily in political power. "They have become oligarchic rather than democratic in character"[6] despite what "seems" to be and is verbalized as, true democratic process. In terms of recognized institutional and political power in society, nursing is one of the least powerful professions. In terms of its practice and development it has used the model of another profession, medicine, to an inordinate degree.

Most descriptions of the nursing role are of two types: narrow and technical or general and vague. These, combined with our lack of many characteristics constituting the "professional syndrome", will keep us in the shadow of other older professionals, dominated by them in regard to the nature of our contribution to society. We lack the right to make major policy decisions within our health institutions and have not challenged the prerogative assumed by others to define the nature of disease and health and to determine how health and nursing services ought to be distributed and paid for. Moreover, if our development as an organized profession continues to follow that of most other professions, then our vested interests, our institutional inheritance, and our oligarchic processes will preclude a participation in society which would "blaze the new social pathways" needed for today and tomorrow.

As one of the "new professions" if not new occupations, we have an opportunity to avoid these mistakes. To accomplish this we must be prepared to view our work and our role, not only in substantive terms through the esoteric nature of the service which we deliver to individuals, organizations or government, but also with an awareness of our place in the society, with knowledge of social forces which impinge on our services, and with a realistic interpretation of what we believe we must do and are able to do in the context of not only maintaining, but moving the social order forward. Our conception of our obligations to the community at large must develop through the identification and interpretation of broad horizons. We must be willing to investigate, initiate, and run counter to predetermined ideas of the "right" road to our objectives. We must unite to promote solidarity and gain through the power it provides a greater voice in the affairs of man, but we must not seek specific, personal, or conservative solutions to dynamic problems by viewing them within a narrow framework. We must find ways to alleviate the oligarchic tendencies

of our associations in action, something which other professions have not done.

As with other emerging professions, ours is one in which members are not homogeneous with respect to the amount of knowledge and community orientation they possess and, at the same time, the knowledge on which occupational performance is based is not highly developed. Thus our codes are but vague generalities and hard for the individual practitioner to apply in concrete situations. Our profession needs to increase its effectiveness in the functions of self-determination, self-control, and to re-determine the goals of socialization and education of the members. Involved in this is the association's right to assess and negotiate its working conditions, to assist in all ways in strengthening its professional schools, and to gain prestige and support from the general public who provide the pressures in response to which legislators act. While these concepts are familiar, accomplishment has escaped us. To do this well means the engagement in some conflict with elements both inside and outside of our occupational group. But in such social situations, competition and conflict often have positive as well as negative functions. We can no longer avoid such confrontations, and we must be much better prepared to engage in them than we have in the past.

In summary, these appear to be the crucial issues:

1. The focus of union activity, and the weight of union power, is likely to shift from the bargaining table to those things which affect the social order much more profoundly, but which, at the same time, will be protective of the integrity, prestige, and economic status of the occupational group. In short, to those things which we view as professional concerns. Should not *all* professional nurses have the right and indeed the obligation to determine the future of "Nursing in Society"?
2. Unions, in an economic sense alone, have dubious effects in the long run upon the earnings of the group they represent. Rather, this is more a function of the total economic situation in the community and the relative prestige and power of the occupational group.
3. The status of an individual accrues primarily from his occupation. Where the occupation is a profession, or viewed as such by society, the prestige, integrity, and social power of the profession is a function of its solidarity and its strength in defining its own practice and in identifying the type, quantity, and scope of service as well as the structure through which the

service will reach the public. Ultimately, the power of a profession may be viewed in relation to its ability in defining social change.

4. Public acceptance of expert advice and care is based upon the image it has of the profession. The public image of even an emergent profession is far different from that of a union under whatever guise the latter seeks to function in meeting perceived challenges. Simplified, this means that a union is perceived as self-interested while a profession is seen to be inherently service-oriented.
5. In emerging professions members are not homogeneous with respect to knowledge, social orientation, and capability of changing basic tenets. Statements of intent to the public and to themselves are only vague generalities. These must be made more meaningful to both the practitioners and the public.
6. The profession must reassess its place in the social order. It must seek new and perhaps unconventional answers to problems which are both ancient and contemporary. In this, it must seek to present viable alternatives before the membership, and before the public. We must climb out from under the oppressive blanket held firm by other more powerful professions.

In my view, evolving a structure which promotes the integrity of, and thereby strengthens, the professional association while at the same time promoting a viable means of meeting the economic, social, and professional needs of nurses, is necessary if nurses are to take their place in society as a profession. Any arrangement which attempts to solve only the readily perceived problems commonly associated with the term "collective bargaining" is no longer tenable. The interactions among parts of the social order will not permit real success within such a narrow framework, be it union or professional association.

FOOTNOTES

1. Neil W. Chamberlain. "The Corporation and the Trade Union," in Edward A. Mason (ed.), *The Corporation in Modern Society*. New York: Atheneum, 1966, p. 132.
2. Ibid, p. 133.
3. Neil W. Chamberlain. "One Life of the Mind in the Firm", *Daedalus*. Winter, 1969, pp. 134-146.
and Michel Crozier. "A New Rationale for American Business", Daedalus. Winter, 1969, pp. 147-158.
4. A. N. Whitehead. *Science and the Modern World*. Cambridge, 1925, pp. 275-276.
5. Kenneth S. Lynn. *The Professions in America*. Beacon Press, Boston: 1963, pp. 12-13.
6. James Howard Means. "Homo Medicus Americanus," in Lynn. op. cit. p. 51.

LEARNING THE CONCEPT: NURSING IN CHRONIC ILLNESS

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IT HAS BEEN POINTED OUT on numerous occasions that one of the nursing skills needed in many areas is the minute-by minute assessment of the patient's state and the consequent adaptation of nursing care. Regardless of the patient's illness, he usually passes from a form of self-sufficient independence, to helplessness, and then to a gradually re-gained autonomy. One of the distinguishing features is the time taken by the patient to progress through these phases. A surgical patient, depending on the type of surgery he has undergone, moves through these phases over a period of days or weeks. An obstetrical patient, as has been described in a recent article, advances through all stages in a matter of hours.[1] A patient with a chronic illness may require weeks, months, or even years and in the end may still not regain a measurable degree of autonomy.

From a teaching-learning viewpoint, one is concerned that the student learn how to assess, set objectives, and make appropriate adaptations in the methods she establishes for the achievement of her objectives. To care effectively for patients, the student needs to nurse them in the different phases of their illness. This goal can be readily achieved for the surgical or obstetrical patient because of the numbers of such patients, the rapidity with which they pass through the phases of their illness or need for care, and their hospitalization throughout. The patient who has a chronic illness receives care in a general hospital only until he has advanced through the acute phase or during

an exacerbation of his illness. Because of the fragmentation of location where care is available, the student will see the various aspects of care of persons with chronic illness in widely separated experiences. To become involved in the whole concept of nursing in chronic illness, with its range of possible combinations of relationships, the student needs to unify the "bits" which make up such nursing by experiencing them in one situation within a brief time period, — necessitating rapid alteration of methods and strategies of nursing. Following on from this notion, the question then becomes one of identifying the essentials to be learned about the concept and the experiences which will facilitate such learning.

In this paper, I wish to discuss the experience Basic Nursing students have in the Fourth Year of their university program here. To assist students to acquire depth in understanding the patient's universe and skill in helping him cope with the problems of chronic illness, they have an experience with patients who are being treated for tuberculosis in a sanatorium. The two questions raised earlier will be discussed. First, I will describe the essentials to be learned, which were derived from our own cumulative experiences in nursing the chronically ill as well as from the literature. Secondly, I will outline the structure which is evolving within which students learn.

Initially a diagnosis of tuberculosis with subsequent hospitalization is accompanied by shock and drastic change from a person's usual routine of living. Not only need the student learn to appreciate the magnitude of this wrench, but also to understand the struggle the patient is undergoing in trying to retain a place for himself within his family, occupation, and his social life. Compounding the dilemma is the highly regulated, bureaucratized, and frequently impersonal conditions of the institution that tend to segregate him from his former way of living. This situation and the care he receives gradually result in a mutual disengagement between the patient and his former social ties. In our present way of caring for the patient with tuberculosis, the student needs to allow this disengagement to occur and to accept the accompanying mourning. In coping with this situation the patient's reactions fluctuate unpredictably, ranging from aggressiveness to the medical staff, family and other patients, to rather tense calmness and sullenness. In adapting her nursing care the student learns to recognize cues which indicate the patient's need to verbalize the bind he feels between his ambitions and his obligations to his family on the one hand, and the demands placed on him by the medical therapy regime on the other. This conflict consumes tremendous amounts of energy and soon the student appreciates the periods of exhaustion and

apparent defeat. Accompanying this crushed feeling is an apparent lack of interest in the very condition that has precipitated the patient's present situation. Therefore, the student learns not to promote discussion of the disease process and therapy until the patient exhibits signs that he is becoming concerned about these topics. When this occurs the student proceeds to help the patient acquire the understanding and necessary skills to combat the illness. This latter phase is not dissimilar to that displayed by patients in the acute phase of any illness.

As the patient's confinement continues, he becomes more aware of the long-term implications of his illness. Because the course of the disease process and its response to therapy is unpredictable and time-consuming, the patient can view the process as endless. His life and existence may become meaningless due to the cumulative effect of social deprivation and seeming lessening of life's purpose. Accompanying this sense of futility are a variety of patient reactions which necessitate modification of nursing care. Generally speaking, she sees that the patient is less dependent on her for interaction and more dependent on his fellow patients. She concludes that further explanations of disease and therapy and assistance in the activities of daily living are not effective means of nursing intervention at this time. During this phase the patient has considerable difficulty making any decision related to his life in the future. The student learns not to force the patient in this process, realizing that time to him is unlimited. Thus, the student paces her expectations to the changes in the patient. However, she is constantly alert to cues indicative of his readiness to move forward from this phase of illness.

As the patient's state of health improves, consideration needs to be given to what the patient will do when he leaves the institution. For most patients some degree of adjustment in their former way of living is necessary. Sometimes the patient has no home. At other times he has to secure different employment or learn a new skill in order to change his occupation. The greater the adjustment required of the patient, the more energy is needed to motivate him into assuming a more active role in planning for his discharge. The student sees that the family is very important at this stage in stimulating the patient and in sustaining his efforts. She also learns that the nurse assists in the patient's rehabilitation by mobilizing and co-ordinating the activities of the health team members to guide the patient and his family in their search for an acceptable plan. Thus, through involvement in the care of the patient at this phase of his illness, the student learns that preparation and rehabilitation is a co-operative effort of all persons concerned.

Any discussion of the structure within which the students learn the essential aspects of nursing in chronic illness needs to consider their experiences antecedent to that in the sanatorium. In an acute care center they nurse patients with multiple sclerosis, spinal cord injuries, and long-term renal conditions. In an out-patient chest clinic they work with patients who come for diagnosis, follow-up medical care, and assistance from the public health nurse and social worker concerning tuberculosis. Through visits to the homes of patients, students are able to see some of the ways that the family and the individual cope with the problems of chronic illness. These experiences enable the student to observe the patient's shock that occurs with diagnosis, the helplessness during the acute phase of his illness and the degree of autonomy as he recovers. Due to the fragmentation of time and place there is discontinuity in the student's concept of chronic illness. A short concentrated experience at the sanatorium with patients in different phases of the same illness in one setting allows the student to compare patient's reactions, bring together the knowledge previously acquired to make appropriate nursing responses and thus see nursing in chronic illness as a continuous process.

In the sanatorium, patients are assigned to a ward depending on the severity and phase of their illness. Because of the limitations of the clinical setting the students are divided into three groups. One group cares for patients who are in the initial, acute phase of illness. Since these patients need care with which the student is familiar, she does not require a long experience to learn to care for them. The other groups commence their experience with patients who have been in the sanatorium for some time. Some of whom are preparing for discharge while the discharge of others is still indefinite either because their recovery has not sufficiently advanced or because they have no suitable home to which to go. These patients require care with which the students are not as adept. In fact, they feel quite useless at first because the patients appear so self-sufficient. They have difficulty obtaining information from the patients and many times are not sure of the kind of information they need. During the acute phase of illness the student can easily identify the information she needs to know, but in this phase she has few leads. She is confused about what to do and she needs guidance to develop ideas. Because of these complexities, the major part of the students' experience is devoted to caring for this latter group of patients. The rotation is designed so that one-third of the time is spent with the acutely-ill person and two-thirds with patients who have been in the sanatorium for some time.

Throughout the experience, discussions are held daily with the Director of Nursing about the care of the students' patients. The focus of these conferences is to pool information about the patient, his family, home, and occupational status. For the most part the Director of Nursing is able to provide relevant information because of the many roles she has assumed in relation to her position. Thus she acts as a model for the students in terms of knowing the patient as an individual and in using this information to help him. At the same time the physician, occupational therapist or psychiatrist may be asked to join the discussion. In these sessions students can see the nurse acting as the motivator and co-ordinator of activities beneficial to the patient. The sessions allow the students to talk over their successes, to seek help with their difficulties, and to share their frustrations. They learn to adapt their nursing intervention so that it is relevant to the particular phase of the patient's illness.

The sanatorium is located in the Laurentians approximately 60 miles from the city. The location of the institution separates the student physically from her family, friends and normal social life. When she leaves for the ten-day consecutive experience she does not view this as a long time period and so does not make any plans to bridge the separation. Thus, unexpectedly and not by choice the student finds herself in a situation not unlike that of the patient in that she experiences some of the isolation he is feeling. Due to the concentration of the learning experience, the student has little opportunity to pursue activities other than those centered around life at the sanatorium. Her daily activities closely resemble those of the patient even to the adoption of some of the same routines to pass the time of day. Frequently the student spends a large portion of her time with a patient and gradually becomes absorbed in his life. This helps her appreciate the timelessness and the monotony he feels. The very proximity of the student residence to that of the patients' contributes to her awareness of the values, norms and customs of the sanatorium community. This modified "total immersion" adds to the student's understanding of the problems facing the patient both while in the sanatorium and when the time comes for him to return to his former community.

Through this experience the students are able to tie together many different kinds of knowledge they have acquired during the year. They have the opportunity to spend time with the patients and to think through and test out their ideas so that their knowledge and ways of nursing become more relevant to the needs of the patient.

In this paper I have attempted to outline those aspects of nursing in chronic illness which student nurses need to learn and to show the structure that is emerging for our students to accomplish this purpose. Although the paper deals mainly with the care of patients who have tuberculosis, I feel that many aspects of it can be generalized to patients with other chronic illnesses.

FOOTNOTES

1. Moogk, H. "Learning to Nurse Patients in Labour," *Nursing Papers.* Montreal: School for Graduate Nurses, McGill University. (April, 1969), p. 6.

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