

Memories of Nursing: Research Findings from an Oral History Study

Abstract (120 words)

Capturing the stories of nurses who practised in the past offers the opportunity to reflect on the changes in practice over time to determine lessons for the future. This article shares some of the memories of a group of 16 nurses who were interviewed in Bournemouth on the south coast of England between 2009 and 2016. Thematic analysis of the interview transcripts identified a number of themes, three of which are presented- defining moments, hygiene and hierarchy. The similarities and differences between their experiences and contemporary nursing practice are briefly discussed to highlight how it may be timely to think back in order to take practice forward positively in the future.

Key phrases and words: Memories, nursing in the past, oral history

Introduction

“Insight into what nursing is and what nursing can be will come from knowledge of what nursing has been” (Kalisch & Kalisch 1976:362). Learning from history is often discussed but rarely undertaken meaningfully; we can frequently spend time recreating wheels, ignoring the achievements and failures of others who went before us. However, if we take the time to listen, capturing and hearing stories of the lived history of individuals we can be amazed, inspired and stimulated by experiences from the past.

This paper highlights the value of oral history as a research method and provides the findings from Memories of Nursing (MoN), a joint project by nurse academics from Bournemouth University (BU) and a volunteer (a retired nurse academic, previous trustee at the home and skilled at interviewing) at the Retired Nurses National Home (RNNH), who came together to record some of the residents’ stories. The aim of the project was to produce rich and detailed accounts of “non-elite nurses who have no record of their lives in historical documents” (Beidermann 2001:61). The team wanted to capture stories from the professional lives of the group of ageing nurses, many who had practised before and during the Second World War and remembered the early days of the National Health Service so we could identify the changes that had taken place in practice but also, and possibly most importantly, learn from their experiences and consider the importance for contemporary practice.

Importance of History to Nursing

According to Boschma et al (2008:83), oral history is a “crucial methodology in capturing nursing’s past...[however] its potential for exploring changes in nursing and health care practice...is only in a very early stage”. Beidermann (2001) argues that nursing has struggled for acceptance and legitimacy as a profession in its own right; reflecting on the changes in practice and status over time can confirm its alignment with the characteristics of a profession (Blane 1991). Oral histories, and the project described here, explore and record the lives of nurses, having the potential to promote greater understanding, acceptance and legitimacy of nursing practice. Cushing (1996) highlights that recording an understanding of our nursing heritage helps to avoid the risk of the profession ‘being adrift without memory’ or in a state of rupture and dislocation (Nelson & Gordon 2004); it allows us to recognise that knowledge of nursing’s past can contribute to present and future practice (Furness 2002; Lait 2000). As so eloquently expressed by Birchenall (2003:324), history “signposts the path of change, showing footprints left by those who were in the vanguard...”

Although a number of relevant oral history accounts exist (for example Hemmings 1996; Hopton 1997; Leap & Hunter 1993), the number of autobiographical (Gluck 1985) oral histories of nursing that exist is more limited. However these would include the ‘Nurses Voices’ project at St George’s Hospital in London (<http://www.nursesvoices.org.uk>), the account of nursing during the Northern Ireland crisis (Manzoor, Jones & McKenna 2007) and the work of Mitchell & Rafferty (2007), Gates & Moore (2002) and Furness (2002). The MoN project intended to

contribute to this growing body of work and act as “an avenue for the integration of the past and the future” (Church & Johnson 1995:30).

Context of the Research- The Retired Nurses National Home, Bournemouth

The Retired Nurses National Home (RNNH) in Bournemouth is a home that provides residential care primarily for retired nurses and other health care professionals. It was established in 1937 specifically for nurses as a result of the recognition that many of them in the first half of the twentieth century dedicated their lives primarily to their work, living in hospital accommodation, earning small salaries and not owning their own property. On retirement, with fairly meagre pensions, many nurses struggled to pay rent as well as buying food and covering other expenses; this home provided a welcome haven for many. Times have changed and the rationale for living in the home is now different but it continues to provide a good standard of accommodation and friendly support. It is based near Bournemouth University and has had a link there for a number of years; it provided a natural environment in which to capture oral nursing histories as many residents were very willing to share their experiences from the past, often enjoying the opportunity to tell their personal story.

Ethical Considerations

Engaging in such a project raised a range of potentially controversial issues as the participants could be considered as a vulnerable group on the basis of age and health. Considerations included the need to avoid coercive recruitment and protecting the best interests of the participant by recruiting only those informants that were fully able, physically and mentally, to usefully participate in the interview process and by keeping interview episodes brief enough not to tire the participant. Participants were invited to be involved as a result of suggestion by the home manager who acted as gate keeper and was very aware of the capacity and resilience of each resident. Indeed those residents who were approached welcomed the opportunity to tell their story and were delighted for it to be disseminated. The intention of the project was always to make the data available to researchers in the future, housing it in public archives accessible to interested parties. Therefore carefully considered procedures were developed in order to guide the project including risk assessment, intellectual property right assignment and the opportunity to either give permission to make their names available or not. For the purposes of this paper, interview numbers rather than individual names have been used to protect the few who preferred not to be named. Ethics approval was granted by the BU Research Ethics Committee originally in 2009 and was re-approved in 2015 when interviewing began in the second phase. All participants were invited to be involved, were given a Participant Information Sheet to explain the study and were asked to sign a consent form with the opportunity to withdraw at any time.

Research Method

Oral history is a research method in which the stories, narratives and/ or experiences of individuals with “something interesting to say” (Abrams 2016:1) are captured in recordings and then analysed. Abrams (2016) highlights that the term ‘oral history’ refers to both the process of

capturing the data and the product of the interview, that is the narrative of past events. Oral history can be regarded as a method that creates a new social history that can “counter the [dominant] hegemonic record” (Boschma et al, 2008:81) by empowering the narrator to freely express thoughts and ideas in a way that may not have previously been recorded (Reinharz 1992). It is increasingly a method popular in social sciences and health care as well as in historical research (Abrams 2016).

The Participants

In total there were sixteen participants (n= 15 females, n= 1 male). They completed their training between 1939- 1978, eleven trained in London, two in Scotland, two in Yorkshire and one in Birmingham. Although all of the participants resided in Bournemouth at the time of the interviews, few practised in the town but had relocated in order to benefit from the RNNH accommodation. Using a flexible topic guide that covered areas around motivation to become a nurse, experiences in training, after qualification while in practice and in further education, and particular memories of note, semi-structured interviews were undertaken, lasted approximately one hour and were transcribed in full.

Analysis and Findings

Analysis approach in oral history research will depend on the form of data collected, for example, a life story from one individual, narratives from a group or using texts from the past. Yow (2005) highlights the value of identifying classes or categories of people, events, and/ or the properties which characterise them in the analysis; a variety of analytic frameworks are implemented based on the disciplinary background of the researcher. In this project, each interview transcript was analysed using thematic analysis as described by Braun & Clarke (2006), highlighting patterns through a rigorous process of data familiarization, data coding, theme development and revision. An inductive approach was used to interpret the content of the data, building themes based on frequency, emphasis and depth of discussion.

Analysis of the interviews has led to a number of themes emerging three of which will be discussed here, including defining moments, hygiene and hierarchy; these are the most relevant to actual nursing practice. The transcriptions provided rich descriptions from the participants’ wealth of experiences that cannot be fully captured in this short paper. However more details can be found at the Memories of Nursing website (memoriesofnursing.uk) where interested parties can hear the actual words spoken by the nurses under these and other themes.

Defining Moments

Many interviewees highlighted how things that happened in their early years had helped them to feel that nursing was their career of choice, defining their direction for the future. These could be personal experiences, observing role models or as a result of family influence and the moments were described as ‘coat hangers’ as subsequent life events hang from them. Their

early years in training also influenced them once qualified, contributing to their values and approaches to practice.

One participant had her imagination captured through hearing stories and seeing photographs as a child:

“My mother had been a nurse and my father a teacher. I was drawn to nursing and with wartime Britain’s needs this was strengthened.” (MoN 5)

Some had personal experience as a patient that influenced them to be a nurse, whilst others observed nurses caring for family members and this had a significant impact, turning their attention to the profession as an opportunity for the future.

“I spent a lot of my younger days in hospitals, my father was a coal miner and he also rode a motorbike, so he spent a lot of time in hospital and I used to visit him. And I’d look at those nurses...” (MoN 11)

“When I was 14, I went into Aberdeen Royal to have my appendectomy and the nurses were so lovely to me. I said to myself, “Oh, I think I know what I’m going to do – I would love to be a nurse, I would love to do what they are doing.” (MoN 13)

Many recalled their early years in training and being thrust into positions of responsibility, often being “thrown in at the deep end” and “just being hurled into it, and you just had to get on with it” (MoN 14); this was sometimes seen as frightening especially in the early days.

“I went on the medical ward and I was just seventeen and a half and I sort of remember walking down the wards, you know rather in fear and trepidation...” (MoN 10)

Others remember taking early responsibility particularly on night duty:

“[It was] night duty. But I was given responsibility; I felt I was given responsibility very early.... I was trusted.” (MoN 9)

As a result of responsibility being thrust on them early, the transition from student to qualified nurse was manageable:

“It was not too difficult at all because you were looking forward to wearing your long cape and feeling more like the bee’s knees... all the way through, we were taking, obviously we were supervised, but we were taking a lot of responsibility. So you grew into it, which was okay.” (MoN 4)

Some also remembered particular patients who had made an impact on them. Some of these were because the clinical situation was unusual such as nursing a 20 year old man with an aortic aneurysm:

“And there was no treatment, (but) you know we were encouraged to spend any time we could in with him in between visitors because obviously he was a frightened young

man just waiting for this thing to burst. And so you know you did have the compassion amongst some of them and that was lovely.” (MoN 8)

Other memories were due to emotional impact:

“...if there was a terminal side to what you saw was happening, you made that extra effort. I suppose getting to sit with dying patients was a huge privilege and also when people had died you went afterwards to see the family, you didn’t just leave them high and dry, that was the sort of relationship you had...” (MoN 17)

There were also success stories, for example, when a new drug was released and the doctor admitted:

“there’s only one thing I can try’, he said, ‘I’ve never used it before’, and he explained to them about vincristine and said it would work in 48 hours or it wouldn’t work and it was just before Christmas. And I went in on Christmas morning and the night staff nurse had a long face and said ‘come and see Mandy’. And I went along to her bed and the curtains were drawn round and the sheet was over her and of course my heart sank and all of a sudden there was a ‘boo!’ ... it was wonderful; you know we just hugged..” (MoN 8)

These (and other memories not able to be reported here due to word restrictions) focus on how the participants chose to become nurses and how there were touch points in their careers that made a significant impact. They talked about many of these experiences as though they were yesterday, they were fresh in their minds, focused on people important to them and many had been very influential in the satisfaction they derived from nursing.

Hygiene

Many of the participants trained and practiced before the routine use of antibiotics and therefore the importance of hygiene was discussed frequently. The impact of contagious diseases in the era before antibiotics featured significantly as they saw children and adults dying of infection and this clearly had a considerable impact. The importance of hand washing and hygiene came early on in training and cleaning was seen as part of nurses’ duties; many described in detail how they learned to damp dust, deep clean and disinfect bins. Learning the importance of hygiene at an environmental level was also part of their training; this quote includes both the environmental and ward based issues:

“(In PTS- preliminary training school) we went out on trips so they took us to places like sewage farms, water purification plants, so we had to understand the whole sort of background of health, the whole concept was of understanding what contributed towards health – it was hygiene, it was learning also as we went on to the wards as a junior nurse that it was very important for cleanliness and cleaning and laying the dust” (putting damp tea leaves on the floor to then sweep up all the dust with the tea leaves) (MoN 17)

This participant described the anxiety that infection caused in the ward setting before antibiotics:

“If by any chance you had an infection on your ward and certainly if somebody had had straight forward surgery and by any chance they got a bit of an infection in their wound, well really just about the heavens fell in, it was terrible, it was dreadful...” (MoN 10)

Another returned to nursing practice later in her life and found things were not always at the same standard as she recalled from her training days, identifying the need for safe practice in terms of hygiene:

“When I returned to nursing ... I was so surprised with the lack of attention and the hygiene and even with less respect for the patient in times such as washing and dressing. “ (MoN 5)

Finally a participant recalls her first exposure to penicillin:

“amazingly, when I was up in Durham, the very first penicillin was allowed to be allocated to our hospital for children. And we had a wonderful paediatrician. It was rare this stuff, you know I can remember the smell of it, very, very smelly stuff this penicillin. It was a sort of golden colour...” (MoN 3)

Capturing these memories of nursing practice in a very different time provides opportunities to reflect on the impact of antibiotics, usually but not always for the better.

Hierarchy

Status was raised in a number of interviews; the hierarchy that existed in the health service was mentioned by a number of participants. This related to students/ staff nurses/ sisters/ matrons within the nursing community and between doctors and nurses. For example “I mean doctors were doctors and nurses were nurses, you know” (MoN 8) was a common comment. It is worthy of note that other health professional groups were largely absent in the discussions.

The doctor’s self-perception of status was described succinctly:

“It was a bit different but... Doctors, like doctors always are, thought they were the bee’s knees, you know.” (MoN 16)

The relatively lowly position of student nurses was highlighted:

“Well we were student nurses, we were down here, so it didn’t affect us at all, you hardly ever spoke to a doctor. You were just too busy doing all your routine stuff. When the consultant came in, the ward was closed, and you had to tippy toe around. You still had to work, but you mustn’t make any noise at all, you mustn’t drop anything or you were terrified, you know?” (MoN 14)

A nurse who trained in London in 1941 describes her memories of hierarchy where there was “a tremendous reverence about doctors who were always called sir and you always put your hands behind your back when you saw a doctor” (MoN 3). She went on to describe how matron was

respected but also feared, especially if you were found to have broken a thermometer. She developed a creative way of dealing with this when called to the matron's office:

"I developed a scheme that when I went in, knock, knock, knock, 'come in nurse', you know and I used to mentally, as she was haranguing me about my ineffective ways of dealing with things, I would mentally, I have to tell you, strip her nude in my imagination and plonk her in a bath with five inches of water as we all only had. And she used to have me staring at her, not knowing that I was getting over this amazing situation in this manner." (MoN 3)

Hierarchy wasn't only on the wards but existed in the arrangements in the dining room:

"The sisters were up one end and the staff nurses were in another bit and the PTS were all down the one little bit all huddled up together.... so very much a hierarchy." (MoN 10)

The status increased as they progressed in their careers but the picture painted through the participants' words remained a hierarchical one, aligned to a military approach of command and control.

Discussion

Although this study is not a comparative project, with no attempt being made to explicitly link the experiences of the participants to those prevalent in contemporary practice, there are some aspects from the themes that align with modern nursing. These will be discussed under the headings compassion, safe practice and relationships and will identify some of the concepts currently being highlighted in the nursing literature that have similarities or contrast with earlier times.

Compassion

The participants of this research highlighted how early life experiences had influenced their choices to become a nurse especially at a time when career opportunities for young women were somewhat limited (just one interviewee was male and he trained later). They appeared as compassionate and empathetic individuals who were affected by the plight of their patients.

Although not always expressed as compassion, participants recalled the important relationship they developed with their patients and commitment they felt to them and to their families as defining moments. In more recent times, and following the focus on quantitative targets as identified by Francis (2013), the return of compassion and the qualitative characteristics of excellence in care has emerged as critically important. Indeed the Chief Nursing Officer of England developed a strategy that included care, compassion and commitment (Cummings 2013), highlighting the continued importance of values in nursing.

However some suggest that nurses today lack the caring approaches of those in the past and that it is essential that nurses start to revisit it as a central focus for practice (Chambers & Ryder

2009). Indeed Curtis (2015) confirms the importance of compassion in contemporary nursing practice and proposes that small acts of kindness can make all the difference. This begs the question as to whether there are aspects of care today that make it more difficult to maintain the human kindness that was described in the participants in this research. There can be little doubt that the conditions in hospital have changed dramatically over the past half-century. Acuity levels have increased, throughput is very rapid, the interplay of long term conditions as a result of longer life spans have added complexity and the use of technology to record events, both in detail and contemporaneously in a litigious society, all mean that pressure has increased considerably. Our participants practised in a somewhat simpler environment of care although pressures would have existed in relation to differing elements of the context, especially for those who were active during the war. Have we maintained compassion effectively or is this something we need to revisit to learn from the past?

Safe Practice

The MoN participants had a real sense of duty in protecting their patients and took this seriously, having been schooled thoroughly in the importance of cleanliness from the start of training. Ensuring the environment of care was clean and safe was something introduced very early in training to many. The issue of protecting patients, especially in relation to infection/communicable diseases, continues to be as important in nursing practice now as then but the world has changed with the advent of antibiotics and improved quality of life/ infrastructure. Nevertheless, with the arrival of healthcare-acquired infections and antibiotic resistance, and the challenge for science to produce creative ways of addressing this, hygiene and safety has changed from worrying about tea leaves on the floor and damp dusting to much more sophisticated ways of maintaining safe practice.

Kirstin and Monson (2012) define hospital-acquired infections (HAI) as infections developing after 48 hours of stay at any healthcare facility which were not present or incubating at the time of admission. HAI have been associated with increasing medical costs, length of stay, complication rates, and worsening overall morbidity and mortality. Research has yet to find the solution to prevention of HAI although basic hygiene is seen as an important aspect with good hand washing and clean environments essential features. In relation to antibiotic resistance, WHO (2016) suggests that this happens when microorganisms change when they are exposed to antimicrobial drugs, often attributed to overuse or misuse of these medications. Ventola (2015) highlights that the rapid emergence of resistant bacteria is occurring worldwide, endangering the efficacy of antibiotics, which have transformed medicine and saved millions of lives. Therefore, despite having made significant progress in therapy a number of decades ago, bacterial infections have again become a threat.

The NHS has responded to these challenges in creating a specialist workforce, the infection control nurse, whose role it is to prevent infection rather than to cure. In looking back at the time when many of the participants trained and practiced, preventing infection was the priority and much time and effort was devoted to cleaning the environment of care so similarities

remain despite a divergence of emphasis in the intervening period. Therefore, although there has been apparent progress with the use of antibiotics, it could be argued that by introducing specialist infection control nurses, responsibility is seen as being transferred to the specialist and away from those on the front line. All nurses delivering direct patient care have a responsibility for safe, effective and evidence based practice in their engagement with patients, families and relatives; this remains a priority for high quality care.

Roles and Relationships

Many participants were given responsibility early on in training and their careers and generally they accepted and even embraced this, although at times it was seen as frightening; their relative status was low in the early stages of their careers. The status of nurses has increased over the years generally but many would argue that hierarchy still exists in the NHS, nurses have just moved up a few rungs beyond the care assistant and domestic staff levels. Responsibility levels have greatly increased in certain spheres of nursing practice; Triggles (2015, online debate), asks 'Are nurses the new doctors?' and highlights that medicine has been revolutionized over the years with new drugs and treatments, leading to an overhaul in the functions of health professionals, in particular, the demarcation between doctors and nurses. "What was once the preserve of doctors - prescribing drugs, ordering x-rays, referring patients and diagnosing - is now also done by many senior nurses who have had extra training" (Triggles 2015 online). As the law does not prescribe which tasks are suitable for particular healthcare personnel (Scrivener 2011), there is much scope for extended practice and with this, perceived higher status. Much basic nursing care is now devolved to care assistants and the registered nurse is often responsible for overseeing the quality of care rather than delivering it directly. Specialist nursing roles, advanced and consultant practitioners have extended the level of responsibility and authority for a section of the nursing workforce, perhaps similar to the status the ward sister had in the past. However, the profession seems to have learned from its mistakes. Senior nurses were promoted away from the bedside making it was more difficult to ensure people were cared for kindly and treated with the respect they deserve. With, the introduction of the consultant nurse role in 1999, McSherry et al (2005) recognized the ground breaking move to return the highest level of clinical nurse to the world of direct patient care, for 50% of their role, challenging previous practice. Now, in ideal practice environments, the most senior clinical nurse leads from the front, with leadership, education and research as key dimensions of the role (McSherry et al 2005).

Limitations of the Study

This qualitative study was conducted on only one convenient site, the Retired Nurses National Home in Bournemouth, although the participants had all trained and mainly worked in other parts of the country. By virtue of the research approach, the data is constructed by the participants' memories which may have only been partially complete and accurate, a feature recognized and accepted in the literature on oral history. Also there were a number of different interviewers involved and therefore the topic guides would have been used somewhat

differently and interview style may have varied. However in analyzing the data collected, it was identified that the majority of the same issues were covered in each interview.

Conclusion

The NMC Code of Professional Standards of Practice and Behaviour for Nurses and Midwives (NMC 2015) identifies four key principles expected of registered nurses and midwives in the UK: prioritise people, practice effectively, preserve safety and promote professionalism and trust. Comparing these standards to the characteristics of the research sample, it is clear that there is considerable alignment between what the profession expects in the twenty first century and the priorities articulated by the participants in the project, primarily from the middle of the last century.

Many aspects of contemporary UK nursing practice remain similar to those of the participants-wanting to make a difference, caring about people, wishing to protect them and accepting considerable professional responsibility. However the status of nurses has increased generally and more particularly in areas where specialist practitioners have taken on roles leading the care delivery to patient groups. But there are two particular essentials of high quality care that have emerged as areas of concern in the recent past- compassion and basic hygiene. From the experience of the participants in this study, we need to remain focussed on the drive to maintain compassion in practice both strategically and on the front line, and learn from our predecessors how to uphold a strong commitment to safe, high quality care.

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Questions for reflection

Have we maintained the compassionate basis of nursing or is this something we need to revisit in order to learn from the past?

With hospital acquired infection and antibiotic resistance being ongoing problems in contemporary practice, how safe is our practice really?

Has the distance from the direct care of the patient by qualified nurses made it more difficult to ensure people are cared for kindly and treated with the respect they deserve?