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# Education for community care

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## Introduction

Several different occupational groups are involved in managing or delivering services provided as part of programmes of community care. This necessitates a reappraisal of the content of professional education. One element in this concerns the delicate and contentious area of self-awareness. I have taken the example of three "isms"—racism, sexism, and agism—and argue that educators have a responsibility to help students to examine their own attitudes and values in these key areas. Of course, such awareness is important in most aspects of the "human service" occupations, not just in community care. But community policies and programmes are profoundly affected by the assumptions of those who plan and manage them, which strengthens the need for a sensitive appreciation of these issues.

In our society there is widespread evidence of institutional racism, sexism, and agism. The word institutional is used here to describe attitudes and practices that have the effect of treating certain groups as inferior in social status. These are not necessarily manifestations of individual arrogance or antagonism. Indeed, they are often at war with conscious and sincerely held protestations to the contrary. Professionals, obviously, are no more exempt from "isms" than any other citizen. But they have a special responsibility to unearth and seek to correct them since they are in positions of power and responsibility in which their behaviour can have a pronounced effect on the well being of the people concerned.

## Racism

Of the three "isms," racism probably engenders the greatest distress in individuals thus stigmatised and discomfort in those thus accused. Without doubt it is the most socially explosive. Lord Scarman's proposition that racial prejudice is "endemic in society" and that—its "destruction requires a determined and concerted effort throughout society, including an unwavering lead from those in positions of authority in public life" has far reaching implications for those who educate the professionals for community care.<sup>1</sup> Cheetham has drawn attention to the reluctance to accept the mote in our eye<sup>2</sup>:

"Although administrators and social workers can usually accept that they must deal with the consequences of the discrimination of other institutions, they are appalled by the suggestion that their own efforts are also tainted by racism. . . . The failure to understand the pervasive, subtle and often unintended effects of racism . . . may, paradoxically, be the result of well intentioned assertions that the achievement of equality rests on a refusal to perceive racial, sex or ethnic differences."

Various occupational groups such as teachers, social workers, and police are now offering race awareness courses in an attempt to set in motion a corrective process. There remains a dilemma for educationalists concerning the approach to teaching about other cultures, in addition to exploring racial attitudes. Some black people resent what has been called an "anthropological" attempt to understand others. There are dangers; for professionals to peer curiously at other people without reviewing their own assumptions as to what constitutes normal or desirable behaviour is likely to be counter-productive. (This is, incidentally, just as dangerous within and between our own home grown class differences.) Yet it is difficult to see the argument against increasing knowledge of other cultures if it is part of a package that includes increased self awareness. Certainly planning of community services without sensitivity to the prevailing mores of particular ethnic groups seems to be plain foolish.

In the development and planning of services for community care, we have to face the unresolved problem concerning the goals of assimilation, integration, or pluralism. The goal of assimilation seems, for the time being at least, to have been abandoned. It is unpopular among ethnic groups who wish to preserve their own identity and culture. For the moment, most of the talk is about integration or pluralism. Essentially, this is about living alongside or living together in a multicultural society. The issue is highly sensitive, socially and politically. A recent example from the sphere of education illustrates this. In Bradford, an Asian group was pressing strongly for separate school provision for their children against the wishes, indeed the values, of the Labour council. It is not difficult to see the strength of argument on both sides: Asian parents fearing the erosion of their standards in family life and religious observance; politicians fearing the social divisiveness that may result from children growing up in separate schools. Such issues will arise again and again. In part they reflect the wish of minority groups, or groups who believe themselves to be disadvantaged, to establish a separate identity or frame of reference that can facilitate community relations without the presence of the oppressor or, quite simply, in a social context in which they feel comfortable and at home. The former—the rejection of the perceived oppressor—may be more commonly found among young people; the latter—the desire to stay with the familiar—may be more common among elderly people and raises difficult questions concerning service provision for the old in our various ethnic groups.

We cannot predict how the tension between goals of integration and pluralism will be resolved. Cheetham writes,<sup>2</sup>

"In the struggle between a deep acceptance of differences and the moral problems of pluralism, there are endless opportunities for judgements which are, or are perceived to be, prejudiced. . . ."

The problem is raised here to illustrate a key topic within a multicultural society that those who educate for community care cannot afford to neglect. It has direct and immediate implications for services. Should we have separate health care facilities for Asian women? Should we foster the development of youth clubs for specific ethnic groups? What about day care for elderly people? We cannot approach these problems constructively without paying

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attention to the underlying problem of institutional racism, which, mirrored in our own professional attitudes, will subtly affect and sometimes distort the communications in which we engage with people from different ethnic groups.

As we now review our procedures for increasing the number of students from ethnic minorities we can be sure that, if we have not already faced up to the educational challenge in combating racism, we shall have to do so as our black recruitment is increased. This can be painful, but the presence of students from other ethnic groups will be of great value in helping us to examine realistically our policies and practices for community care.

### Sexism

The next "ism" concerns the place of women in community care. Women take the main responsibility for providing the informal care that enables millions of men, women, and children to live outside institutions. A substantial number are cared for within the family; in 1976 a quarter of women between 50-64 were caring for a disabled person in their home. Millions more people are supported in crucial ways in their own homes by relatives, neighbours, and friends, mostly women. Of course there are also men who carry onerous responsibilities for informal care. But, in general, informal care is carried out by women. Is there anything objectionable about that? There are three issues to be addressed before that can be answered. Firstly, what is the status of such activity in our society? Secondly, how acceptable is this role of carer to the women concerned? Thirdly, what are the economic, physical, social, and emotional consequences of performing it?

Firstly then, what is the status of such activity in our society? Professor Parker, of Bristol University, has made a helpful distinction by abstracting from the notion of caring the element of "tending"—that part of caring that requires direct physical contact. If the social status of tending is considered in relation to economic reward then there can be no doubt that it is way down the ladder. Those who are paid to tend in the social services, such as care assistants in old people's homes, are paid as unskilled manual workers. Even though economic reward is imperfectly associated with social status, those activities associated with family and household work—whether they involve tending or the more diffuse aspects of caring—have never been ascribed high instrumental status; that is, the high level of skill and organisation required to perform them competently has rarely been acknowledged. They have, however, been ascribed high expressive status. Conventional wisdom (usually male) has praised highly the part women play in maintaining a stable and secure home. It would be cynical to dismiss this as a mere tactic to keep women safely at home and prevent competition outside. In fact, there is widespread social ambivalence—a combination of denigration and idealisation—about the value ascribed to domestic type activities.

The second issue concerns the acceptability of the roles of caring and tending to the women who perform them. If the analysis of social ambivalence is correct it is not surprising that women reflect it. In particular, if expressive aspects of the caring role are perceived as associated with a desirable feminine image to reject them is an act of rebellion or desperation. There are, of course, wider aspects of this dilemma, which pervades all dimensions of life, including motherhood. The focus here, however, is on those caring tasks performed for dependent adults, mainly elderly, or for children who do not have a normal expectation of independence. Obviously, as individuals with different aspirations and needs, women will vary in their response to the "call to care." A combination of a sense of duty, associated in this sphere with the female role, together with a real sense of satisfaction and fulfilment that such activities can bring, means, however, that many women accept it without too much resentment or conflict, up to a certain point. Behind that qualification, however, lies what is probably the single most pressing policy issue in community care—namely, the exploitation of such women, upon whose unpaid services the policy is totally dependent. Evidence on this point and growing awareness of the extent of the problem have become apparent in the past 15 years,

since when campaigns about caring for the carers have been initiated by various influential groups.

This awareness has been reflected in the content of professional education in the field of social work. To teach a course about social care of elderly people without taking this theme as central would now be unthinkable. Some of the most valuable evidence has come from the Equal Opportunities Commission, which in a series of low key reports has played an important part in raising our consciousness. The most recent of these, *Carers and services*, reanalyses survey data gathered for other purposes to examine whether health and social services do respond differently according to the carer's sex.<sup>3</sup> They are commendably cautious, stating that "the study is exploratory and the commission would not wish to make exaggerated claims as to its typicality." Nevertheless, "the study does suggest . . . that the pattern of health and social services provision tends to reinforce women's caring role, by assuming that it is appropriate for women to carry a heavier burden of care than might be expected of a man in comparable circumstances." Their findings are not dissimilar to others, and they shock by their cumulative implications.

The third issue concerns the economic, physical, social, and emotional consequences for the women concerned. Women who give up work not only lose financially at the time, but their pension rights and re-entry to work may be affected.<sup>4</sup> Married women are still ineligible for the Invalid Care Allowance, although this is the subject of legal dispute at present. The physical and mental health of many carers has been shown to be at risk.<sup>5</sup> We should not need research to accept that damage may be done socially and emotionally when the burden of care overwhelms, but there is such evidence, including, sadly, some concerned with the abuse of elderly people by carers.<sup>6</sup> The past few years has seen a sudden alarming explosion (a threefold increase in five years) of private residential care for elderly people, facilitated by the social security allowances payable since 1982, which are now being curbed. We do not know why this explosion has occurred. The market has met demand rather than created it, even though its swift response may have stimulated it. Who are these elderly people, and why, against all we have heard of their desire to stay in their own homes, have these people chosen (or have they, rather than their relatives, chosen) to enter residential care? To what extent is this the carers' response to the intolerable demands made on them, or which they fear will be made on them, by a society that does not share the task? Those who work in the helping professions must, during their education, examine their assumptions (for assumptions lead to action, or lack of action) about the part of women in the informal aspects of community care.

### Agism

What of the third "ism," agism? There is confusion in our perceptions of aging. This is made the more difficult because so much of the attention of both the personal social services and the health services has been focused on the problems of aging, whether individual or social. Although both services could, and to an extent do, make provision or offer services that might be regarded as preventive, rather than curative, most of the pressing pre-occupations of those who offer or manage services are with the frail elderly, of whom the severely mentally infirm are some of the most tragic examples. The effect of this may be to reinforce stereotypes of old age as profoundly dependent, lacking in initiative and zest for life, and taking much and giving little. Indeed, the backlash to concern about carers is the reinforcement of the image of elderly people as burdens. This has dangerous social consequences, not least when the word burden spreads insidiously into the vocabulary of politicians—"can we really afford the burden of pension increases?"

The truth is many sided. The increased number of frail elderly people, many physically and mentally infirm, is there for all to see. Many old people are forced into physical dependency by their physical frailty when their sharpness of intellect and strength of will is unimpaired. How we then respect and help to preserve that sharp intellect and that strength of will is a challenge to all who work in the

helping services. If those who practise have an image of aging as inherently, rather than specifically, dependent policies and practices evolve that do not respect the strengths that old people have; thus the strengths are eroded and increased dependence encouraged. This is not to deny a real problem that goes beyond the attitudes of the professionals. The place of very old people in our society, and the value ascribed to them, is very uncertain. What do they have to give us? What is perceived as valuable to transmit from generation to generation is profoundly affected by many factors, such as technological change. It is not agist to acknowledge and respond to the extreme dependence of some very old people nor to acknowledge that many very old people have an uncertain status in our society. It is agist to depersonalise our responses to very old people so that we have lost the individual in the stereotype. To correct this prevailing tendency is hard, particularly because of deferential attitudes that mask the individuality of so many old people to the professionals.

Education for the human service professions involves some

examination of attitudes and behaviour, both those of the helper and those of the persons it is hoped to help. The first can be quite painful since it requires the learner to look at his or her own beliefs and values, often deeply held. A better understanding of the other person, whether derived from sociological or psychological insights, may speed the process because the discovery of alternative views and feelings may act as a catalyst for change.

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# Contemporary challenges in education for the caring professions: education for nursing, midwifery, and health visiting

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## Diversity of roles in nursing

The "greater nursing profession" encompasses many roles as expressed in the *Report of the Royal Commission on the National Health Service*<sup>1</sup>:

"Within nursing there are many levels of skill and different roles. . . . Nursing is an immensely varied profession. In hospitals, nurses work in acute, long stay, children's, psychiatric, maternity, and other specialised units. Outside hospital there are health visitors, home nurses, midwives, and nurses working in clinics and in general practice, as part of the primary health care team. Nurses work in administration in the NHS and health departments, in education and research, the armed forces, voluntary organisations such as the Red Cross, occupational health and international agencies. There is a great deal of overlap in the knowledge required in many branches of nursing."

This diversity of roles, however, encompasses many different competencies and models of care. The nurse in an intensive care unit needs to combine a high level of technological competence with individualised care that supports the patient, who is experiencing

not only physical but psychological and spiritual trauma. By contrast, the psychiatric nurse uses the skills of person to person interaction as a therapeutic tool. Much of the work of nurses in the area of mental handicap lies in the use of education strategies for social skill training. The paediatric nurse needs to be able to integrate therapeutic skills with care that will facilitate and maintain normal human development. Midwifery and health visiting have been identified as separate professional roles. The midwife assists the mother in a normal human function that is only potentially related to pathology (which the midwife must be able to recognise). She is a practitioner in her own right and has considerable decision making autonomy in her area of competence. She spends a high proportion of time using health education skills. The health visitor has a major concern with primary prevention and uses skills of health education, counselling, and social advice. The role of the health visitor is in the domain of health, but she uses knowledge and skills from the disciplines of education and social work.

## Commonalities and interfaces

The nursing curriculum has thus to be designed to prepare for a diversity of roles and models of care. We have to question what commonalities exist in the knowledge and skills needed and to what extent there is a core curriculum or foundation course that, desirably, should be common to all. At what stage should specialisa-

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