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**Dame Sheila Quinn DBE in interview with Sir Gordon Wolstenholme
Oxford, 2 December 1996**

GW Sheila, I am particularly grateful to you for coming from Southampton today, to Oxford, to be interviewed in this way, because it's very high time, to say the least, that there should be some nursing input into our already pretty large archive of medical and scientific history. And I couldn't have asked for somebody more distinguished to come and be the first nurse to be interviewed. You have, as I may remind you, been President of the Royal College of Nursing, you've been Director General and Vice-President of the International Council of Nursing. You've received quite the most prestigious nursing award that the world has to offer; and in addition, among other things, you have been President of the Standing Committee of Nurses in Europe. Now, nevertheless, looking at your past history, you started out by getting a BSc in economics at London University. What was it after that, that turned you towards nursing?

SQ Well, actually, it was the other way round, Gordon. I actually started nursing in a provincial nursing school in Lancaster, quite near my own home, towards the end of the war, which was why I stayed near at home in a comparatively safe area. It wasn't until I'd become a sister tutor in a London training school that I felt the need to have done something perhaps more intellectual, having had two years postgraduate at the Royal College of Nursing. So I decided, while I was working as a principal tutor, to take my degree in economics, in my spare time.

GW In your spare time.

SQ Yes. I got it in 1957.

GW I hadn't realised that came so late. You got your SRN in '47, isn't that right?

SQ That's correct.

GW Where had you done that early training?

SQ At the Royal Lancaster Infirmary.

GW In Lancaster, is that?

SQ Yes, one of the old voluntary hospitals with two hundred and fifty beds.

GW And then your midwifery in Birmingham?

SQ Midwifery in Birmingham and Halifax – part I in Birmingham, part II in Halifax, yes.

GW And then got your post, as a very mature, really a mature person, in the sense that you were about twenty seven or so when you came to the Prince of Wales.

SQ Well, I did ward sister's work before then. I went back to my own home after midwifery to do a night sister's post in Blackpool. And then I had one of the most fascinating jobs of my career, I think, in Manchester, where I went to learn from Mr Graham Bryce, at that time, about chest surgery, and opened one of the very early chest surgical units with him, in Daveyhulme, in Manchester. And that, I simply loved.

GW How long did that last?

SQ I suppose it was two to three years, I forget just how long. And it was after that that I did my ward sister's course at the Royal College of Nursing, which fired me with a desire to do more about it. And I then came down to London, to the Prince of Wales Hospital, first as a night superintendent, and then I went on to day duty as a ward sister, and from there to the Royal College of Nursing to study for nurse tutor.

GW Yes. I hadn't realised that. This makes much more sense than, if I may say so, your CV does because there seemed to be a very sudden jump into the Prince of Wales, and to a very responsible position. But, in fact, you worked your way up to it.

SQ Yes. I think probably my CV just mentions certain ward sister posts, because it gets too long and bulky otherwise.

GW Yes, of course. And then your work at the Prince of Wales General was becoming a sister tutor, largely?

SQ Well, I did two years as a night superintendent, which I loved. I loved nursing the patients at night. There's something very special about it. And then I went for the two year course at the Royal College of Nursing, which was when I met one of my great friends, Catherine Mary Hall, and went back to the Prince of Wales then to work, first as a tutor, but because of circumstances at the time, I rapidly became the principal tutor there, and stayed for a few years.

GW Looking back, you said the night duty was particularly agreeable, because of the responsibility, I suppose, of feeling that the buck does really stop with you.

SQ That's right, yes.

GW Who were the main medical people there in those days?

SQ The one I remember most, of course, is Mr Dickson Wright, who had some beds at the Prince of Wales as well as at St. Mary's, Paddington. I remember him mainly because he was the person I used to see most at night. Other surgeons tended to finish in the day, but Mr Dickson Wright would appear anything up to three, four o'clock in the morning, so he was one of my trials, from the time point of view.

GW And expect to have a daytime service in the middle of the night.

SQ That's right.

GW That must have been very enjoyable, and very, very instructive.

SQ Mmm.

GW And I suppose your next move was into the International Council of Nursing [ICN], is that right?

SQ Yes. It was while ... this is where I think the BSc economics came in. Having done two years at the Royal College of Nursing, I went back into a preliminary training school to repeat the same syllabus every eight weeks. And this, I thought, 'There's no way I can cope with this very long.' So I decided to do studies in my spare time. I chose something completely outside nursing, which was economics, and I specialised within that in sociology. And I met the most fascinating professor from Oxford. I used to come over here for tutorials once a week, because I hadn't got time to go to evening classes, working. And I did it in the normal three years. But, as I finished, the International Council of Nurses advertised a new position for a nurse with a degree in economics or sociology, to help nurses throughout the world to negotiate for their own conditions of work and salaries.

GW It's an extraordinary title. It's social and economic welfare, if I remember rightly.

SQ That's correct. Very American, don't you think?

GW Well, yes. I couldn't imagine what it really meant.

SQ Well, I tried to change it to social, social welfare, but they said, 'No, it's not that. It is, yes, the social life of the nurse, but most importantly, the economic conditions, the salaries around the world,' so that's why it had that name.

GW That must have been an extraordinary experience because the ...

SQ It was.

GW ... because the contrast in different parts of the world, between the fully professional nurse, and those who were just dogs-bodies, must have still been very obvious.

SQ It was, yes. This is quite true. I didn't expect to get the job. I was surprised when I did. But within six weeks of actually starting there, there was a crisis in Jamaica, and I was called out to try to help them in Jamaica. I think it was a question of the blind leading the blind. But I survived that, and the nurses did as well. There was a general strike, and the nurses were trying to hold out, and had got real problems there. But I was there two or three weeks. When I got back, of course, I felt I'd got an idea of some of the problems. But in something like four years, I was travelling in nearly fifty countries, and not just going through them, but I used to spend two and three weeks in each, trying to talk to the nurses about their own conditions, and sometimes living with them, deliberately, so I could see what it was like. And then talking with government, and trying to persuade government there's a need for negotiating machinery, and the nurses as well. And then I used to teach them how to negotiate. We used to run seminars. But I remember, even a sophisticated country like New Zealand, they hadn't any negotiating machinery, and I remember the nurses saying to me, 'We can't, because it's in regulations. We're not allowed.' And I said to them, 'Regulations can be changed. It's not a law.' And, in fact, of course, they had it within a few months after that.

GW Does this mean that these were people who always were employed, in some way, directly or indirectly, by the state?

SQ Very largely so. Particularly, of course, in the developing countries. You'd have your mission hospitals and the small hospitals where they were in a different situation. But largely the state were educating their own nurses in one way or another, and employing them. And, of course, that led to problems for the nurses, like ... they were inevitably married, and they had children, and for the first two years, or three years of their contract they had to go out into the rural areas, and they could be two hundred miles away from their families, with very difficult transport.

GW If I may intrude a personal reminiscence, it is that in the war, I was supplying medical supplies to the medical services of about twelve different nations. And it was a terribly instructive and interesting and amusing, sometimes, to see the difference between the level of acceptance of responsibility by the nurses, of the different countries. The Canadians, in my experience, were far and away the most competent, and more competent than many of their officers, medical officers. South Africans were pretty good too. But coming to almost the bottom of the scale were the British, who had been so controlled, by having to be in by ten or whatever, and in their training, of course, I don't mean after qualification. But they hadn't had the experience of self-discipline and self-reliance that so many of the others had developed. And it seemed very sad because they would get very panicky if the situation became other than routine. And I wondered if you found, yourself, major differences, going around the world, of this acceptance of responsibility by the different ... in the different countries?

SQ Oh yes, I did, very much. I remember, you know, looking back, really being quite horrified with my low level of knowledge when I did graduate as a registered nurse. I mean, it's then you began to start learning, and you learnt a lot from the medical profession at that time. I was always being asked, you know, 'Who are the best nurses in the world?' And, of course, you assume that the British are the best nurses in the world. And I used to say to them, 'No, this isn't so.' There's a tremendous caring instinct, almost, certainly training of caring for the patient. For basic nursing care, there is nobody any finer than the British nurse. But when it comes to education, and the level of knowledge, and the ability to take decisions by themselves, I think this is something we've only been learning over the last decades. It certainly didn't exist at that time.

GW So recent? In the last decade?

SQ No, decades. I would say twenty or thirty years, probably.

GW But, after all, this is the, I suppose, surely the most, the most caring of all professions, that without discipline and training that caring really doesn't register, does it. It's fundamental to the relations with the patient.

SQ Well, it is. And I think it's here where you get the difference between, or you should get the difference, between a trained nurse and a very caring auxiliary, because your auxiliary nurse, without the knowledge, will care very, very well at what she feels is necessary or what she's told to do. But you need the education and the knowledge of the trained nurse to know what that patient wants, to build up the relationships with the patient, and then to pass on the knowledge that is required to the auxiliaries and care workers that are with you, and are terribly important.

GW Do you think that the development of the use of auxiliaries and other people in nursing, who are not fully trained, has diluted the profession?

SQ Well, I think you've got to look back at the situation we had, that was an apprenticeship situation. You know, in this country, we're so used to the nurses staffing the wards, you know, ninety per cent of the ward staff were student nurses, and very experienced. I remember being left in charge of a ward for about three weeks, because somebody was off, and I was just into my second year. Well, it was crazy. I mean, we all got by, and nobody died because of it. I don't think, anyway. And we used to have our ward maids in those days, and that was all. We did the cleaning as well as the nursing, which can't have been terribly good for cross-infection. Though we didn't seem to have much. But I think it was inevitable it was going to happen, because we had to move from that apprenticeship system, and there were dire warnings about what would happen if we tried to in this country, of the terrific shortage we'd have, and the patients wouldn't be looked after. And, in fact, when we took that step, not that long ago, and Project 2000 really moved in, you haven't really heard any screams about the shortage on the ward because of the loss of students. There are shortages for other reasons. And, of course, what we had done in the meantime was, really, try to train the nursing

auxiliary, because until that point in time, she might have been trained in some hospitals for two or three months. I know they certainly were in Southampton, because we appointed a tutor specially to do that. But I think that situation was few and far between. Now that we've got care assistants, who are the nurse's assistant, not just general assistant to the ward, and the nurse really can plot the patient's care, and train that care assistant or auxiliary to really work, probably in more depth than they used to before, to take some nursing responsibilities, always under the care of the trained nurse, rather than just doing, say, a bedpan round right across the ward, and that type of thing. So I think it's inevitable we've had to dilute the trained nurses. But we've got more trained nurses on the wards now than I ever remember, you know, in my time.

GW Yes, because one took it ... one never knew all the different colours of uniforms, and just what they were.

SQ No. No. We really have more now.

GW But, of course, a high proportion were students at one level or another.

SQ That's quite true. And now, of course, they are on for experience only. And, of course, the care assistants, remember, are being trained now with NVQs – the National Vocational Training, which is a good thing.

GW Did you have an enormous struggle to achieve the change for a more academic approach, if you like, for nursing?

SQ Oh yes. I remember, in my second year, coming down to a student nurses' conference at the Royal College of Nursing, and standing up and demanding student status for the student nurse, and commenting about the hours we work, the amount of night duty we put in, and so on. So that must have been about 1945. And I forget just how many years back it is now that Project 2000 really moved in properly. It can only have been, actually, completely working for the last two to three years. And we had terrible struggles in that time. Yes, we got a bit more in the way of ... they moved over to a block system, and we got a little more training here and there. And some of the schools were very, very good indeed. But there was tremendous variation across the country. And then, suddenly, it seemed to happen, well, it didn't happen overnight, but in a way, we felt as if it had, because we had been struggling for so long to get it. And, finally, student status, Project 2000 was agreed, and then it got moved in very fast indeed. I think, perhaps, too fast.

GW And taking on a university degree, which I remember Elizabeth Hockey and others being quite involved in, at Edinburgh, particularly. Of course, that was strongly criticised by many medical people, wasn't it.

SQ It was, yes.

GW I mean, that was not really the role of a nurse, to be clever.

SQ No.

GW But, nevertheless, if you are going to have the student nurse treated as a student who is being really trained for her job, you can't have it both ways, can you? You can't have her doing all the work as well.

SQ You can't. It just isn't sensible, I think. I mean, those of us who had degrees in the early days, had to take it in something other than nursing, because, you know, there was no such thing. It was places like Edinburgh and Glasgow, and Manchester, Professor J McFarlane in Manchester, and another. Those, I think, were the early pioneers. But, of course, now we have ... even before Project 2000 started, we had a large number of universities with degrees for nurses. We'd already ... with the early ones of, you know, Edinburgh and Manchester were doing up to doctorates. But it, it still required that sort of general move to ... to move away from the apprenticeship system. And, of course, now the student is a student alongside other university students. He or she is on a grant, which isn't means-tested, actually, for nursing. But, otherwise, it's a grant rather higher than for other students, because we don't have the same long holidays. Because of the amount of practical work required, the long vacations are very much cut down in that respect. So that is why they get a slightly higher grant. But they're not employees any longer. They, when they are in the wards - whether for experience or actually taking responsibility - for about twenty per cent of their time, largely in their third year, they are, of course, then accountable through the ward sister to the hospital authorities. But otherwise, they are like any other university student. But when Project 2000 moved in, it was a three-year programme, and, of course, not everybody was doing degrees, and still aren't. It was a three-year programme leading to a Diploma of Higher Education, as well as Registered Nurse. That was important, that diploma, because it meant that it gave us the credits to go on, if people wished, to degrees later on, because we'd never been able to have credits before. There are a lot of very real differences. One that I regret, and I'm probably, in this country, in the minority on that, but I know that, internationally, I'm not. I'm very much in the majority there. And that is the way that the programme was developed. You remember, before Project 2000, you actually started life as a general student, nursing student, or you went in for paediatrics, and perhaps moved on to take your general for eighteen months after, or mental health and so on. And I suppose it was the speciality lobby, if we hadn't compromised, I doubt we'd have got the whole thing through at all. So, you know, the true British compromise. So we have a situation now, where, out of the three-year programme, there is an eighteen-month common programme, common to all, which is fine. But after that, you move into the programme of your choice, probably made when you started, when you were interviewed in the first instance, now I believe you can move across, if necessary, now. You either did adult nursing for eighteen months, or children's nursing, or learning for people with learning difficulties, or mental health. And, of course, we ran into problems there with the Nursing Committee of the EEC, who really challenged us, and saying, 'You're not meeting the EEC directives. You, in fact, only have an eighteen-month training'. We got round it by saying, 'Well,

it is only the nurse with the adult programme that works with the EEC directives, as a nurse responsible in general care,' so the other programmes, of course, didn't come into Europe. But one thing that we still don't go along with the rest of the world, is that we still believe in this training in specialities at basic level. Now, you wouldn't do that in medicine. You'd do your general medical training first, and then decide what to do. And the rest of the world does that in nursing. You take your general training, and then at postgraduate level, often at degree level in the country, you'd take mental health or children's nursing, or whatever. We're still on the old system. And I believe we're going to have to change. But maybe I won't see that.

GW Where does midwifery fit into this?

SQ Well, midwifery, for many years, has always seen itself as a separate profession. It is not nursing. It is a profession that's as separate as ...

GW But don't you have to take your core general nursing first?

SQ Well, I certainly did, and then I did my midwifery on top of my general nursing, a year in all. But not any longer. And, of course, the EC directives, again, have a separate midwifery programme, and separate directives and so on. So the midwifery programme has changed tremendously now.

GW I wasn't aware of that. And this is agreed in Europe, that it can be midwifery all the way through, from the first place?

SQ Yes. Because in the early part of that programme, they do what is called their 'nursing part', so they learn nursing, as much as is required.

GW Which isn't necessarily midwifery, do you mean? Or is it?

SQ Well, it's only seen ... nursing as part of midwifery, only what is required for the midwife, because the midwife is an independent professional. And again, we found that we were ... I'm not really so well informed on the midwifery profession, obviously, but I do know from my European experience, that the midwives in Europe tend to have a two or a three-year programme. And in places like Belgium and France, they were very independent practitioners, whereas our midwives had been brought up in a very different way. And we had to improve our training, which, by this time, was a two-year midwifery training, which could stand alone, and there was an agreement with Europe that there would be one year supervised practice after that, in order to come into line with the directives. And I do think it's fair to say, and I'm sure my midwifery colleagues would agree, that over the last decade or so, or perhaps even longer than that, the midwives really have been seen as independent practitioners. Many of them do work in hospitals, you know, alongside the obstetricians, but there are many, also, that are working as independent midwives, completely. I think doing a very good job.

GW Were you involved in the formation of those directives?

SQ Very much so, yes. Yes. Yes, I was. That was, you know, before they came into being. So that was ... I came back to this country, from the International Council of Nurses, in 1970, and from then I was immediately into Europe, because, of course, I'd been in the centre of Europe, more or less, in Geneva, and in contact. And we took ... oh, it was about seven years to negotiate this.

GW It wasn't until '73 that we and others went in, so ... you started with only six countries, did you? Or was it ten from very early on in your ...

SQ Well, it was a very interesting history from the nurses, because while I was still in Geneva, there was an existence, an organisation that was then called the Western European Group, and it was mainly the francophones, getting together to discuss matters, particularly on nurse education, which was one of their big problems. This group became enlarged to be the European Nursing Group, in which we then belonged. And the President was then a very famous Belgian lady, and she was living in Brussels. She was the directrice of the Edith Cavell School, and knew the people in Brussels very well, and began to realise that the directives for nursing were, at that time, being drawn up, with not a nurse in sight, of course. I think there was the odd doctor around, but certainly no nurse around. So she came to me in Geneva, and said, 'Look, we've got this problem. We badly need ICN's help, you know. Can you come and talk with us in our various meetings?' And I couldn't go myself, but one of my staff, who was a New Zealand nurse, joined that group, and we managed to get in to Brussels. But, of course, we had problem, insomuch that they would only talk officially with the six, at that point in time. However, we went ahead, and we persuaded the Commission that they needed what is known as a 'Liaison Committee in Nursing', and fortunately, by that time, by the time we got to that stage, we were an acceding country, with a year to go.

GW '73?

SQ Yes. So then we were able to move in. I became the negotiator for the UK, and a member of the committee. And I worked very closely with the Department of Health, with Dame Phyllis Friend. We used to be in Brussels at the same time, you know, she was in the government, in their committee, and they knew where we were meeting, and, as you can imagine, the phone was picked up in between if we had problems. We had a very close relationship. We came out with not a bad directive. I think there were many things in it we'd have liked changed. And it was very much a basic directive. We managed to keep hours out of it, and no quantitative situation ...

GW Ah. Because the ... on the medical side, one of the very first things was 5,500 hours of training, or something.

SQ Oh, we got that. We got a 4,800. They wanted 3,600 and we fought like mad to get ... and we got our 4,800. But once having got that, we said, '4,800 or three-years training', because some were doing academic years, you see. And once we got that, between them, and it was just in sort of three

sections – sociology, nursing, biological sciences – and they had to cover these subjects within them. But how much care they gave to each subject was up to the country. For example, on community nursing, on what was then called ‘home nursing’, some of the countries just didn’t do any at all, and couldn’t, whereas we were well away on that.

GW And within the countries of the Union, as it is now, is there a reciprocity? I mean, on recognition of ...

SQ Yes. From that ... once the medical directives were agreed, we moved in straightaway with the nursing, two years after the medical were agreed. We had ours in 1979. And from that date ...

GW And do nurses move around in Europe?

SQ Not as much as everybody thought, and we did think they would move.

GW And not the doctors either.

SQ No.

GW Nothing like.

SQ And our main ... the stupid thing is that we were always moving between Ireland and UK, and, of course, the major part of the figures you get now are still Ireland and UK. And they only went into sort of the twenties, with Denmark and Netherlands, I think I’m right in saying. Otherwise it was very small movement indeed. It’s getting a bit better, but not a great deal really.

GW Is there unemployment in nursing at all, in Europe?

SQ There was, of course, in some of the southern countries. And I remember that Denmark was the only Scandinavian member at that time, and they were very concerned about people moving in, because they were afraid that they would come in prepared to accept poorer conditions than the nationals, and would bring unemployment with them. It didn’t happen. But, yes, we were still recruiting nurses, if you remember, from Spain and Italy, in particular, in those days.

GW Yes. And if I may go back to the ICN, the International Council of Nurses, for a bit, because you would have this head of this division of social and economic welfare for about three or four years, I think.

SQ Mmm.

GW And then there was a little gap, I think, and then you became executive director. Or was there a gap at all?

SQ Well, there was a ... I had it for four years, and then they decided to restructure and make the nurse advisers, as we were called then, capable of doing education, etc., and not having any speciality. I think the social and economic welfare lost out a bit, because it was a particularly specialised field, and I think my colleagues at ICN would agree with me, at that time. Well, at that time, I became the deputy executive director, and we made the move to Geneva. We were in London until then. And that was a terrible upheaval, because there was only one other staff member went with me. Other people either moved on or retired.

GW You set up the office?

SQ I had to set up the office in Geneva, and all the investments and everything like that. And, of course, working not just in a different language, but with completely different ways of working with people like banks, and accountants and so on. It was an interesting experience. And it took us, you know, a year or two to settle down. And then the executive director became ill and had to retire, and I was appointed executive director then.

GW And the board, which I presume is the governing body ...

SQ Yes, that's correct.

GW ... was always international? Is it guaranteed to be representative of different parts of the world?

SQ It wasn't early on. It became guaranteed just about the time that I was appointed executive director. So we have people from each area of the world now. And then, finally, three at large that can be appointed as well.

GW Areas being regions? WHO [World Health Organisation] regions?

SQ They were more or less the WHO regions, yes, with the exception of Israel.

GW And in that capacity as executive director, were you automatically connected with WHO?

SQ Not automatically, I suppose. But even when I first joined ICN, the relationships with WHO, particularly with the nursing division, which was very strong then, were very close indeed.

GW And good?

SQ Very, very good. And there was always one member of ICN doing work with them. I remember, I was working with WHO soon after I went to Geneva to take the first travelling seminar on nursing into Russia. It was fascinating. It was with Lyle Creelman, who was then the chief nurse, and the chief nurse of Canada. And that was a fascinating experience. I took ... there were some twenty nurses from developing countries, ostensibly to learn about

the Russian system. And I think they were somewhat surprised to discover, you know, the Nigerian and the Ghanaian chief nurses running rings round anybody. They were super people.

GW That was - I can't think when that would be - that would be?

SQ About '67, I think it was. Something like that.

GW '67 or '70, or thereabouts. And did you stay in Russia long, with this group?

SQ I think we were there about two months. It seemed an awfully long time. I do remember sitting in the Austrian airport, waiting for the plane, with Lyle Creelman, the WHO Chief Nurse, and Dr Helen Mussallem from Canada, and we were all, obviously, getting quite worried. And then Helen said, 'I've only got one paper. I think we'd better go and get some more. We're going to be there a long time.' And I said, 'Helen, it's still today's papers. It's not going to help next week.' But it was quite an experience.

GW But then medicine, in Russia, in those days, was almost wholly left to the women, wasn't it.

SQ It was. And I remember, so well, at one seminar, that we were introduced to an eye specialist, a very capable woman. And it was explained that she'd started as an auxiliary and came in the upper third, so she was allowed to train as a nurse. And she did so well as a nurse that she's become a doctor and a specialist. And there was a pause for us to comment. And the only thing I could come up with, 'How very interesting.'

GW It's like Cicely Saunders, I suppose, really, of Russia.

SQ Yes.

GW Did you get any encouragement in that visit? I mean, did you feel that you were getting anywhere? And did you feel that they were appreciating what ... their insight into international or ... standards of nursing?

SQ I think, only from a few people. I think the Russian nurses and doctors that we met in the hospitals and the community, simply could not take it in, or didn't really believe it was happening. But there were some of the government officials ... one or two of the really well-known doctors that were moving around the world, that, yes, we were able to talk to them, and, you know, they expressed their hope that some day it would happen. And when I was working with WHO again, three or four years ago, the big pan-European nursing conference, which we held in Vienna, there was a Russian doctor from WHO, who was working with us, and he'd brought along with him his chief nurse, and they were starting in Russia. And now, of course, there's a big movement in Russia, they're really taking strides.

GW Because they must need them desperately now.

SQ They do. And, you know, they've a lot of our own people going over now. Professor June Clark, for example, I know is putting a lot of work in in Russia, really helping them with university studies. But, on the whole, I think it's still the doctors that are, more or less, the powers that be. But they really are trying to help the nurses to get on their feet.

GW Does their system allow for a nurse to become a person of responsibility within a clinic?

SQ Yes, I think it does now. I think so. But it'll be a long time before they really get it, you know, spread across the country.

GW These duties that you had as executive director, inevitably became international politics, in a way. But were there rewarding aspects of the ... I mean, you'd had the many visits to all those many countries, in the earlier capacity. But, as executive director, were you more directly concerned with the national associations of nurses?

SQ Well, to a certain extent, yes. And a large part of planning invariably took place with, with getting the quadrennial congress together, you know, we had 12,000 in Montreal. And in between we had a major meeting that wasn't so big, it was only two or three hundred. So, yes, a lot of your time was taken up with that. But I still travelled a great deal. And I got, you know, tremendous pleasure from going back to the countries that I'd seen in the early days. New Zealand was one example. Australia was another that had moved in...

GW New Zealand nurses, I should have said earlier, were among the better, most outstanding ones.

SQ Yes. They're very, very good indeed. But they were very tied on their conditions of work. They had no real negotiating machinery with government, but they got it. And a great pleasure in seeing a country like Jamaica, the way that they moved, and the University of the West Indies, the place the nurses have taken within that.

GW You certainly met spectacularly competent nurses from the West Indies.

SQ Oh, very, very much so.

GW Was that your first experience of a strike by nurses?

SQ Yes, it was, in Jamaica. Yes, it was. I met one or two after that, and, of course, met them again in the Scandinavian countries.

GW And did they withhold their nursing services altogether, in Jamaica, then?

SQ No. There were sort of warring factions, with one group really wanting a complete strike, and the other group trying desperately hard to hold the nurses together, because the doctors were out and, you know, life was difficult. But they were very responsible about it in Jamaica.

GW One would imagine so, I must say, because I certainly have met wonderfully competent people there.

SQ I get worried sometimes ... in Scandinavia. Again, they're very clear about what they're doing, they've got wonderful conditions, and education for their nurses, but they have had one or two rather nasty strikes, in which they start limiting labour, and withdrawing, and limiting the number of people. And I find that difficult to live with, as a British nurse.

GW Certainly. On the medical side too.

SQ You know, I get ... you have to be tolerant, and you have to understand it is their country, and this is the way they work here. And they do try to make sure the patients are not ... don't suffer from it, but I think, sometimes, it's inevitable. And then, on the other hand, you see situations in the African countries which ... I got to know West Africa particularly well, and I used to feel desperate for some of those nurses. India was another. I remember staying for a few days in a tiny little village, and I was staying with the nurse/midwife, who was an auxiliary, really, not a fully trained nurse. And there was a small group of them, must have been about seven or eight, and they lived in this tiny little house, and they had a bed, and that was about it. And the rain was coming through - appalling conditions. And every day, they were doing a trek of about twelve miles through jungle, you know, to find the little villages, or their group of patients to care for. And they were fantastic people. They cared so much about their work. And they cared about ... it was a vocation to them. And again, in Africa, you saw them, again, trekking for miles, to go and see their patients, living apart from their families, seeing them once every year or so ... having to let their babies be brought up by, you know, part of the extended family. And I remember people like Docia Kesseih in Ghana, and Koforola Pratt in Nigeria, two of the finest nurses you'd find in the world, both trained at St. Thomas', of course, in this country. And I remember Koforola's fight when she went back to Nigeria, because she was a trained nurse from St. Thomas' and she'd been a ward sister at St. Thomas'. She went back to Ibadan, and she was only allowed to take a staff nurse post, because she was Nigerian ... because it was the white nurses who were the ward sisters in Ibadan. And she fought a very bitter battle with what was then the colonial government, of course. And, being Koforola, she beat it, and she became a ward sister. She then, of course, eventually became the chief nurse of Ibadan, and chief nurse of her country, and minister of health for the State of Lagos. And they're wonderful people you meet.

GW Some justice in the world.

SQ Oh yes.

GW We're mentioning ward sisters. I suppose the commonest complaint of doctors is, of course, especially of my generation, is that, 'Where is the ward sister now?'

SQ I do agree with you. Until quite recently there was a ward sister. But because of the way that patient care has developed, you know, remember, our patient charter requires every patient to have a named nurse, and so you get a nurse responsible for a group of patients, really responsible, not to the ward sister for that care, but directly to the doctor for the care of her patients. And, in many respects, that's really good, because, you know, we had the old task-orientated system, which wasn't very good for the patients. But what I do feel sad about, even a year or two back, that the ward sister never really knew all her patients. She was never around because she didn't like to interfere with the nurse who was responsible for that bay. Now, I regret we don't always have the nurse in charge of the ward. There are situations where it is the manager who is not a nurse, or it is a nurse who is a ward manager, and it's not quite the same thing.

GW Of course, with the change in the studentship of nurses, it couldn't have stayed as it was, in any way, because that was her main role, was bringing up these people in the right way, wasn't it.

SQ Yes. Well, now, of course, they'll go in with their lecturer as responsible for looking after them. But I feel sad when I see people who have been in a hospital and, you ask them what's happened, and something's gone wrong, and I say, 'Well, weren't you able to talk to the ward sister?' And they say, 'Well, we never saw the ward sister all the time we were there,' or, 'We noticed her at the desk, but she never actually came, came in; never saw her.'

GW This is very sad, from a patient point of view, but it's also from a medical point of view, because there's certainly, in my generation, which is a long time ago, owe eighty per cent, perhaps, of our confidence in training to the ward sisters. They were very fearsome at times ...

SQ This is quite true. But, I mean, she ruled the junior doctors with a rod of iron, didn't she. And knew her patients.

GW And if you could do something with her blessing and get away with it, sort of thing, you knew you'd survive.

SQ Perhaps she'd cover for you ...

GW Yes. And I think that doctors terribly miss this role in their training.

SQ I think this is so, and I've got a feeling that there must be times when the nurse does. But, not being in the wards these days, I wouldn't know. But I can only tell you that I've had experience, over the years, in an independent hospital, and I have been so impressed with the way that ... all right, you might have your own nurse looking after you, but you see the floor sister, you

know, at least once a day, and she's absolutely clear about what's going on on her floor. I'm not so sure that I could say that for every one of our ...

GW NHS ...

SQ ... floors in the NHS. I know it, perhaps, is the modern way of life, but I do heartily dislike the way that the patients are spoken to in the NHS these days. A nurse is supposed to ask a patient how she would like to be addressed. I so often hear, 'You don't mind if I call you Mary, do you?'

GW No. Oh yes, I agree.

SQ And if you're somebody just going in. And I do hate to see a very elderly person called by her first name, and probably with visitors in the ward. There's one I remember particularly. All right, they've got their tape on, and you've got to check carefully with drugs, so you check not only the name, but the date of birth, but with visitors there? And I remember being in a ward visiting somebody, a couple of years back, and a relative sitting next to somebody across, and it was his mother. His mother must have been well into her eighties, and he said, 'Mother never let us know how old she was.'

GW Mmm, I hadn't thought of that point.

SQ I think there's something, a lack of sensitivity. All right, we're living in a modern world, but this sort of thing bothers me. And I can only tell you that if I went into that independent hospital, I would never be addressed as anything but by my correct title, whether it's Mrs or Miss, or whatever. But the moment I go into a GP surgery, and the tannoy goes out, which says, 'Sheila Quinn, please'. And when you see some of the elderly ladies getting up because a young nurse has called them like that, it's lack of dignity, and I think it's time we thought hard about that kind of thing.

GW I suspect that the pendulum has gone as far as it's going to go in that direction.

SQ I hope so.

GW It might well come back quite a long way. You wrote a book one time on, among several, on the 'Past and Present of the International Council of Nurses'¹.

SQ Yes.

GW Now, I'd like you just to put an epilogue in the way of a future for that organisation, and for nursing in general, and its status and situation. If I may mention, you have succeeded me as chairman of Action in International Medicine, and I think you know that I've honestly tried to get nurses more and more involved in this from the beginning.

¹Dame Sheila Quinn '*International Council for Nurses, Past and Present*' (Harrow 1989)

SQ Yes.

GW I haven't succeeded, really, apart from yourself, and Muriel Skeet, perhaps. I mean, I really haven't succeeded in getting either nurses or midwives actually seriously involved. I deeply regret this. How do you think we might move forward in our own organisation, in this respect? And how do you feel that this will fit in with, particularly with the developing countries and their development of nursing?

SQ I think we will only move forward in getting the nurses really involved, and I'm thinking in terms of nurse leaders, because they're the people that bring the others with them. I think we'll only do that when we demonstrate that we are really wanting to work with nurses on equal capacity. If we've got a project in a developing country, we've got to make sure that it's not just the doctors running it and involving the nurses at another level, but that there's a real partnership going on. If we can get that in any one project that we can demonstrate, then I think we will have them with us. Because I've talked with my colleagues, both internationally and nationally, and there's a very strong feeling, still, that we're medically orientated, so I think it's up to us to do something about that. But where nursing is going, I certainly think, internationally, the International Council of Nurses is making a tremendous impact now. It's really grown up, and it gets help from various international organisations in the way of money. But they've been doing regional workshops around the world on important things like the regulation of nursing, because there are still so many countries without a nursing law or act, and we've have had a lot to do with that. And they've not just gone in and done one lot with a group of people and come out, but they have made sure they've had at least two from each, or they've had a range, you know: one from government, one from a hospital, one community, and so on, and bringing them together for about two weeks, and then letting them go back and, perhaps, two years later, bringing the same people back again to see what it is they've done. We've done the same thing with economic welfare, and we've done a lot in the same way on community care. So I think the International Council of Nurses has really made its name with the international organisations. And I think the national organisations, like a small association, say in somewhere like Zaïre, relies tremendously on ... if it needs something to work with its government and hasn't an entrée itself, or isn't getting too much notice taken of it - and I'm only using Zaïre as an example, not that anything specific has happened there - they would write to ICN and they'd say, you know, 'Please can we have your policies?' And they've done some very, very good ones that can be used by the developing countries. Or one of the nurse consultants will go over, and they will negotiate with the government, and take the nurses from the country with them, and get it across. And they're doing a lot to bring up the standard and the status of nursing in those countries, just as, I think, we did a lot for them in the old colonial days, we left people like Doccia Kesseih and Koforola Pratt, as chief nurses in their country, and withdrew the counterparts. And WHO has done a lot as well. I think it's ... really, when you're looking at ground floor level and get worried about what's happening in our own National Health Service, but the Americans will be equally worried about theirs, or the Canadians about their

own. But we've all got our own problems, which we try to handle nationally where you can, but also, our quadrennial meetings, the next one being next June, really talk these main issues out, and try to get strategies on them, and policies which are useful to people, not just words.

GW You may remember that when I first wrote to the ICN about Action in International Medicine, or AIM, they told me, when I went to Geneva, that my letter had appeared on the board table, and when they read it, they actually burst into applause and said, 'At last, somebody is remembering us, and doing something about it.' And so it's so frustrating that we haven't, so far, really succeeded ...

SQ Absolutely, yes. Yes.

GW ... in getting going together.

SQ Yes, it's quite true.

GW But I have found nurses rather backward in coming forward, I must say. When you speak to them individually they're so impressive, and so full of enterprise and enthusiasm and intelligence, but the years of traditional waiting to be asked...

SQ Yes, is still there.

GW ... is still there.

SQ Yes.

GW And I suppose we need a few really obstreperous women.

SQ Well, I think our own Royal College of Nursing, you know, has done an awful lot for nursing in this country, as indeed has the United Kingdom Council for Nursing, Midwifery and Health Visiting. And they do speak out. I think particularly the general secretary of the Royal College has been very, very vocal, and has done a lot for nursing, but there's a long way to go.

GW There's just one little - well, not so little - problem that ... last time I was in Salt Lake City, I went to this famous paediatric intensive care unit. And they said that every single child that was born alive, they could keep alive. And they were getting, of course, tiny weight premature babies, many of whom were irrevocably damaged, especially with lungs, and in many other ways, and yet they were obliged to put all their care and attention into this. And the nurses that we met, privately, were really in despair about this. And I wondered, how does one approach such an enormous problem, because it's not only nursing, it's not only medical, and it's not even just biological and medical in its widest sense. It is a national one, or an international social problem.

SQ Well, I think the debate has started in this country, hasn't it, you know, around five hundred grams. And so I think where that debate is going on, there is discussion with the doctors and nurses. I find in intensive care baby units, there is a great teamwork between doctors and nurses. It isn't so in every country, I'd accept. But you've got the same thing at the other end of the scale. You've got nurses feeling very, very strongly about patients being kept artificially alive in some circumstances, or resuscitated in certain circumstances, and it's only with dialogue and understanding between the ... particularly the two professions of medicine and nursing, that I think you're ever going to solve these problems.

GW I suppose medicine has had its own way for so long, that nursing really has to be much more of an equal partner to, to influence decisions in these major problems ... this, and abortion, and euthanasia and so on.

SQ This is true. And when I, as I've done quite a bit of consultancy in the Middle East, as you know, and there again, you can see our own nurses, or nurses from New Zealand and Canada and so on, working and feeling desperately frustrated in that situation, because of the ethos, you know, of the citizens of the country coming in with ... quite different ... and the doctors expect the nurses to do as they're told, rather than express opinions and you can see the problems starting again in these countries.

GW Just one last question, and this is on gender, because, of course, more male nurses, certainly in this country, have come into it. And I remember that in Jordan, the professor, dean of the university, had to adopt all the nurses to protect them and their reputation, to get middle-class girls into nursing. This has been a major change, hasn't it. But in some countries, it's still a major problem, isn't it.

SQ What?

GW Women can only be nursed by women.

SQ Well, it's the same in many of the Middle East countries, although it is changing. But, you know, we've only ... still got only about ten per cent of men in the profession in this country. It hasn't changed much over the years. But I think that three of the finest nurses that I know at this age, that I've personally worked with, have all been men: Richard Wells on AIDS and cancer; Robert Tiffany, cancer nursing; Trevor Clay. They're three nurses of the finest you'd find anywhere in the world.

GW And they would fully recognise this.

SQ Oh, absolutely.

GW Well, I think that time is running out, or we're getting close to the end. Is there any more that you would wish, particularly, to put on record?

SQ I really don't know. Except, I think, with having spoken with Dame Catherine Hall just before her death, I think the thing that sticks in my mind, with her, was her absolute commitment to nursing. I remember Trevor Clay, he would express an opinion of somebody, of a nurse, 'Do they burn for nursing?' And I think I'd like to put on record, 'Yes, I do burn for nursing. I believe in it.'

GW I believe you. Thanks. Thank you very much indeed. I much enjoyed, as I expected to, this talk with you.

SQ Oh, I've enjoyed it tremendously.

GW Good. Thank you.