EDITORIAL.

JOB ANALYSIS

We are hearing a great deal these days about Job Analysis as being, for us, the open sesame to a New Order of Nursing. That one can hardly analyse before defining the "job" to be analysed seems to be overlooked by many.

The Working Party on the Recruitment and Training of Nurses having, in the Introduction to its Report, asked the question "What is the proper task of a nurse?" omits to answer it, although upon the answer to that question depends the whole of recruitment and training of nurses. Yet the Report does not hesitate to proceed to give details of the training deemed necessary.

That there is a very real need for an answer to this question cannot be gainsaid. Possibly the enormity of the task facing the investigator is one to make the boldest and even the most scientifically detached analyst quail. There is still a great deal of ignorance among the general public on the subject of nursing in spite of propaganda films, school talks and posters. Popular fallacies always die hard, and the one that nurses are expected to scrub floors is "an unconscionable time a-dying." It was an argument I heard first in 1923, and two young candidates lately interviewed told of the same story used to put them off. Where and how the story arose is intriguing. I would hazard a guess that some popular Edwardian novels about nursing had something to do with it. Wherever it came from it undoubtedly sticks like a burr.

That indomitable woman Florence Nightingale, who had never heard of Job Analysis, was not afraid of tackling the question as to the proper task:

> "A nurse must have a threefold interest in her work—an intellectual interest in the case, a (much higher) hearty interest in the patient, a technical (practical) interest in the patient's care and cure. She must not look upon patients as made for nurses, but upon nurses as made for patients."

And again:

> "Training is to teach a nurse to know her business, that is, to observe exactly, to do, to tell exactly, in such stupendous issues as life and death, health and disease. Training is to enable a nurse to act for the best in carrying out her orders, not as a machine, but as a nurse."

These extracts were quoted by Mrs. Seymer in the Florence Nightingale Oration delivered by her at the International Congress last year.

Let the Nursing Profession beware of being swept overboard by a scientific tidal wave and in the swirling torrent of facts and figures lose hold of its ideals, to emerge, washed clean maybe, but as a trade for technicians and operatives.

D. W.

DISEASES OF THE LENS—CATARACT.

The lens is composed entirely of cells (epithelial) which have retained their transparency. It is surrounded by a thin transparent envelope or capsule. Since it is avascular, inflammatory changes cannot occur. Degenerative changes cause a loss of transparency or cataract (partial or complete).

Normal growth of the lens occurs throughout life. The transparent lens fibres are formed from the single layer of cells underlying the anterior capsule. New fibres are formed around the older ones so that the centre (nucleus) is the oldest part of the lens and the cortex the youngest. This increase in size is offset by a shrinkage and hardening of the central part (which is called the nucleus). Thus the nucleus is hard whilst the cortex is soft.

If aqueous gains access to the lens fibres through an opening in the capsule, the soft fibres are absorbed, but not the nucleus. Thus it gives us a method of getting rid of the cataract in patients who have not yet formed a nucleus, i.e. under 35-40 years of age. If a hard nucleus is present it must be removed by operation.

Immature cataract—a partially opaque lens.

Mature cataract (ripe cataract)—cortex and nucleus entirely opaque. May absorb water and swell, becoming intumescent, with a tendency to produce secondary glaucoma.

Hypermature cataract—water is lost from the lens, which becomes smaller. Calcification of anterior capsule may occur (yellow patches). Cortex may liquefy—Morgagnian cataract.

TYPES OF CATARACT

(1) *Congenital*

Several types—e.g. blue dot cataract, lamellar cataract. Lamellar type the most common. Seen in children, usually reduces vision to 6/18–6/60. Really infantile rather than congenital, and may be due to defective calcium metabolism, associated with rickets, defective teeth, etc.

Opacification occurs in one layer of the lens which is laid down at the same time as the calcium deficiency occurs.

The cataract progresses very slowly.

(2) *Senile*

A senile degenerative change. Patients usually over 50. Usually begins with opacities in posterior cortex. Takes several years to mature.

(3) *Traumatic*

May occur at any age in any patient due to an opening being made in the lens capsule by injury.

(1) Direct injury (e.g. perforating wound).

(2) Contusion (indirect) causing a rupture of the capsule (post).

Aqueous enters through the perforation in the capsule causing the lens fibres to become opaque and swell up (complication 2nd glaucoma).

The process is very rapid and the lens may become opaque in a matter of hours or a few days.

(4) *Diabetic Cataract*

(1) True diabetic cataract in young patients (young adults).

(2) Rapidly maturing senile cataract.

previous page next page