we tell our kids, aged eight and five? Tom, we decided was able to cope with it straight. Catherine was too young to really understand, and as it turned out this was a sound judgement, for Catherine became bewildered, bemused, and frightened by the environment she was to enter during the next few days.

I wasn't in the lowest risk group for open-heart surgery, so I decided to try and make a living will. I asked to see those on the anaesthetics team and they duly visited me the night before my operation. Unfortunately it was evening visiting time. The curtains were drawn and we entered into a prolonged and animated discussion about the details of my possible demise. No, I didn't mind their plans for my heart if it stopped; it was my brain I was concerned about. "So, if I throw a clot up top, exactly how will you determine the degree of cerebral activity conducive to maintaining life support? And surely if I blow a pupil you will turn me off?"

I despaired of being left in a vegetative state. Such was the nature of our protracted and animated conversation.

No, we didn't reach full agreement with regard to all my wishes, but I met these sincere and caring people, and I trusted them as I held their eyes and shook them by the hand. As they left, they opened the curtains and I suddenly became aware of the silent, solemn whanau, visiting their loved ones in the room I shared with five others, three on the same surgical list as myself.

Eventually, I became the recipient of quintuple coronary artery grafts. I remember this time well. I was fortunate enough to be visited by a number of mental health nurses, friends who listened to my fear, who shared my humour, who counselled me spiritually, who even played me music.

. . .As I began the slow and painful journey of recovery following major cardiac surgery, I longed for a nurse fully equipped to recognise the interface between mental health and physical health. . .

The nurses caring for me were superb, but far to busy with my physical care, having neither the time nor the skills to "nurse the whole person".

After surgery, there was the slow, arduous path to recovery. The knowledge that coronary artery bypass surgery was a massively invasive technique took on new meaning for me in the light of actual experience. The bright lights and high staffing ratio of CCU, essential for my close monitoring, became quite torturous for me. I simply could not sleep. On my third day post-operatively, I spat the dummy big time. Climbing from my bed, and with two concerned nurses in my wake, clutching at all the drips, drains, monitors, and other apparatus attached to me, I staggered from the unit, down the full length of the corridor to the darkness of the television lounge, where I collapsed into a "lazy boy" chair and slept for 10 hours straight.

I spent eight days in hospital post-operatively. Surprisingly to me, my objectivity as a nurse (when conscious!) remained acute. I would do secret, "nursey" things to ensure the patency of my intravenous line and adjust my own drip rate. There was an obvious staff shortage and a great deal of pressure on beds. One evening, the young, new graduate nurse caring for me, sat at my bedside and cried, as much from sheer physical exhaustion, as from fear that in her haste, she had made a mistake with my drug regime — two panadol for goodness sake. Poor thing!

Whilst I retained my nurse identity, I began slipping into classic sick-role behaviour. When faced with immediate threat earlier in my hospitalisation, I had been assertive and forthright in exercising my right to be informed. Now I was becoming passive, compliant, unquestioning.

As a mental health nurse, I often act as an advocate for clients about their rights. Looking back on that time, I badly needed a nurse to act as an advocate for me. A nurse who could approach the consultant physician as he whisked through his ward round and say: "I think it would give Mr Stabb considerable peace of mind if you could spend ten minutes with him somewhere privately and fully inform him. He has many questions to ask." A nurse fully equipped to recognise the interface between mental health and physical health. But the nurses caring for me were overstretched and ill-equipped, both because of time, and for some, the skills to fill that role.

And then it was home to community care, far inferior to the care I had become accustomed to at Waikato Hospital.

Physically well and returning to work three months later, I underestimated the impact my experience was to have on me. Post–traumatic stress syndrome is not to be taken lightly. I became seriously depressed — me? A tough old "psych nurse", immune to mental illness!

Despite the love of family and friends, life appeared so pointless and my own death so attractive, I actually began to plan it. With the help of straight talking from family and colleagues, and the care of an excellent GP, I was able to recognise I needed professional help. After two miserable months, and with good psychiatric and psychological help, I recovered from the deep depression that had enveloped me. Over 70 percent of post-cardiac surgery clients suffer post-traumatic stress syndrome.

It's 16 months on now and each day I celebrate my love of family life and my passion for my work. My experience has changed many things for me and about me personally. It has also reinforced my professional beliefs that the core components of mental health nursing skills should be central to our nursing education programmes. As I began the slow and painful journey of recovery following major cardiac surgery, I longed for a nurse fully equipped to recognise the interface between mental health and physical health — a nurse who could provide me with comprehensive care. This is surely the nurse envisaged in the shift from hospital-based programmes to tertiary education programmes in the early 70s.

I have, over many years, raised my concerns about the lack of understanding of the importance of mental health nursing skills within the comprehensive programme. The strategic review of undergraduate education, commissioned by the Nursing Council, did little to allay those concerns. And they are shared by many mental health nurses.

To all those making decisions about the future direction of nursing education, the Nursing Council included, I say: "Please come out here, to the coalface of care. Talk to the real people who actually do the business. Talk to the students in training, talk to the new graduates in practice, talk to service users. Don't survey them. Visit them. Talk to them in the places they work. Please look to the true nature of nursing and base decisions on the evidence of your own eyes and ears."

As a mental health professional, I've long had fears about mental health nursing education. My experience as a consumer amplifies those fears. There is little need to commission research. The information is everywhere — in our hospitals, in our psychiatric units, in non-governmental organisations, in community health services and among service user groups. If all that evidence was gathered, it would provide a compelling case to change the way we educate nurses. If that change occurred, we could honestly be called comprehensive nurses. ❑