The concept of nursing*

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The author contends that with the acceptance of health care as a universal human right has come a variety of national, provincial, state, and local systems for providing health care. An international network of rapid communications makes peoples everywhere aware of the variety of systems and the fact that some systems other than their own show better results, as measured by, for example, the infant mortality rate, or the incidence of venereal disease. Traditional roles for doctors, nurses, health educators, social workers and others are in question.

To meet the needs of the people, health educators, physicians, social workers, nurses and all other categories of health personnel must constantly evaluate their roles and be ready to modify them for the common good and modify the programmes that prepare them for their work. While the roles of doctors, nurses and others are, necessarily, in these rapidly changing times, in a fluid state, some health workers must provide a 24-hour service that helps human beings with their essential daily activities when they lack the strength, knowledge, or will, to carry them out unaided and to work towards the development of a healthy independence. This intimate and essential service is, in the author’s opinion, the universal element in the concept of nursing.

The most successful preparation of nurses will, the author argues, always include whatever gives them the broadest possible understanding of humanity and the world in which they live. It will also provide an opportunity to see expert nursing care given and to have the satisfaction of seeing the care they themselves give, hasten a person’s recovery, help a person cope with a handicap, or die in peace when death is inevitable.

Introduction

Since I have been asked to discuss ‘the concept of nursing’, I must assume that there is still in Great Britain, as there is in the United States of America (USA), a question about the role nursing plays, or should play, in health services.

During a period of rapid change, it may be unrealistic to expect a global answer to this question. John Kenneth Galbraith (1977) contrasts the stable ideas of the 19th century with the unrest of the 20th century, calling ours The Age of Uncertainty. The social scientists tell us that we must learn to tolerate ambiguity. In spite of this, nurses must, of necessity, establish worldwide guidelines based on a definition of nursing, for we are organized internationally and we seek agreement among member nations on nurses and the general nature of their preparation. The International Council of Nurses (ICN) has made recommendations to the International Labour Office (1976), during its recent study, that involve professional and auxiliary nurses as defined by the ICN. Actually, the ICN has, throughout its existence, made recommendations on the nature of nurses and nursing.

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Some national nursing organizations have spent a great deal of time, effort, and money on studies designed to provide working definitions of nurses and nursing – geopolitical units have enacted legislation to control the preparation, function and licensing of nursing personnel. All of these demand definitions.

**Different definitions of nursing**

As long as international, national and local organizations and governments define nursing and nurses differently, and as long as nursing personnel are prepared for their work differently and accorded different rewards and roles in health services, we will, almost certainly, continue to discuss the concept of nursing.

Another reason that nurses find the concept of nursing a subject of perennial interest is that their self-image is often at odds with the public’s image and what nurses do is at odds with what nurses and the public think they should do. In fact, there are so many facets to the topic of the concept of nursing that it is hard to choose the most important. I could compare, *ad infinitum*, the nurse’s concept of nursing with the physician’s, or I could compare how nursing is seen by the rich and the poor, the learned and the ignorant, the well and the sick. Any of these would be a more manageable discussion than the one I am attempting, but, because I assume that you expect a more general discussion with emphasis on the views I hold after nearly 60 years in ‘the profession’ of nursing (entertainers more modestly call their vocation ‘the business’), I have arbitrarily chosen to consider the following questions: Is there a universal concept of nursing? What are some of the more significant definitions of nursing? What kind of an education will most likely produce effective nurses?

**Is there a universal concept of nursing?**

Before trying to answer this question, it is necessary to ask whether I am searching for the public’s concept, the concept of other health providers, or the concept of nurses? The answer is that I am not trying to answer any of these questions definitively, but rather to identify the common elements, if they exist, in representative ideas about nursing.

It is always tempting to go back to first principles, or to see what dictionaries and encyclopedias say. In those I have consulted there is little disagreement, although the order of priority of the various meanings may differ. A medical dictionary, for instance, gives suckling an infant as the first meaning, caring for the sick as the second, and that of the ‘nursemaid’ as the third, while a more general reference gives the meanings in the reverse order. Here is what Funk & Wagnalls’ (1977) dictionary has to say: ‘(Treating nurse as a noun) 1. “A female servant who takes care of young children.” If she suckles an infant “A wet-nurse, if she doesn’t, less frequently a dry nurse.” 2. “One who suckles a babe.” 3. “A person who cares for the sick, wounded or enfeebled, especially one who makes a profession of it.” 4. “One who fosters projects or promotes,” Also, 5. “One of various sharks, as the nursehound …” and, 6. [in entomology] “A sexually incomplete bee or ant, etc., whose duty it is to care for the young.”’

Meanings of ‘to nurse’, ‘nursing’, and ‘nursed’, the verb, follow the meanings assigned the noun. Some modifiers and synonyms include ‘to operate carefully’, ‘to preserve from injury or damage’, ‘to clasp or hold carefully, caressingly, to fondle’. Other dictionaries stress caring for ‘tenderly’ and ‘cherishing’. Some nurses and doctors have suggested that the traditional (or dictionary) meaning attached to nurse and nursing is so far removed from reality, as they see it, that it would be desirable to get a new title for the person they conceive of as the nurse. Whether or not today’s nurses like it, however, the dictionary definitions represent public opinion and we must reckon with it. The terms ‘nurse’ and ‘nursing’ have many meanings and conjure up different pictures in people’s minds, even the minds of nurses themselves – and why not?

**Different functions of nurses**

Even so-called ‘professional nurses’ function differently in Western and Eastern Europe, in India and mainland China, and in North and South America, and, within all countries, the nurse functions differently in the country and in the city. In Canada, which I believe is singularly blessed by cooperative relationships among health providers, the work of a nurse in an outpost of the Indian Health Service, where the nearest doctor may be hundreds of miles away, is so different from the work of a nurse in an Ottawa hospital that it can seem inappropriate to give both of them the same title. Not only does the work of nurses differ, but so does their preparation for nursing. From country to country, and within countries, it differs.

While the ICN, representing nurses in 84 countries (in 1975), defines the term ‘nurse’ to imply that nursing is a profession, a small proportion in even economically favoured countries are prepared professionally according to most concepts of professions (McGlothlin 1964). There is a marked trend toward college education for registered nurses, but practical nurses, nurse’s aides, attendants and orderlies, or auxiliary nursing personnel, outnumber professional
nurses even in the USA where the movement toward higher education for nursing is most marked. The public, by and large, is, I believe, unaware of the increasing numbers of collegiate programmes. Most people would express amazement were they told that in 1976, 19,861 bachelor’s degrees, 3,437 master’s degrees and 62 doctoral degrees were awarded in nursing programmes in the USA.

Another condition that makes a universal concept of nursing untenable is the uneven distribution of healthcare providers. In the Western world, nurses (that is RNs) exceed physicians in number, but this is a recent development in a number of countries and, in some parts of the world today, there are more doctors than nurses (International Labour Office 1976, Djukanovic & Mach 1975). The ratio of nurses to doctors and to other health providers affects what nurses do and therefore the concept they and the public have of their roles.

Because nurses, or those performing the function of a nurse, come from all classes of society in most countries and are poorly, moderately, or well-educated, the public image of the nurse is confused. The public image is influenced by the fact that most nurses are women, the majority are not well-educated, are not from the most privileged social class and are not well-paid (International Labour Office 1976, National Commission for the Study of Nursing Education 1970). Margaret Mead (1949), the anthropologist, generalizes that the public’s concept of women’s work is that it is ‘easy’ compared with men’s work and in a materialistic and affluent society the value of any work is related to the price paid for it. It is clear from the definition of nursing in dictionaries that nursing as an occupation is still confused in the minds of some persons with one of our least valued and poorest paid occupations—that of domestic service.

While it is possible that the privileged members of society in the USA under-rate nursing and the status of the nurse and the underprivileged over-rate nurses and nursing (Simmons & Henderson 1964), it is safe to say that each person doing the rating is, in the last analysis, influenced by whether he or she has had a good or a bad experience with nursing. A woman who has good maternity care from a nurse-midwife, a young boy who has seen a nurse from a hospice effectively help his mother through a terminal illness, or an inhabitant of a remote region of Canada or Australia who sees public health nurses dealing with all sorts of health problems under the most difficult conditions, are people who have the image of the nurse as a professionally competent and compassionate worker. By contrast, a man who finds nursing personnel in a hospital saying that they are not allowed to give him the simplest information, as, for example, the thermometer reading or that of the blood pressure apparatus, or the man who in a nursing home finds a sick and disoriented parent alone and tied in a chair while nearby nursing personnel drink coffee in the kitchen, are people who are likely to see nurses as unprofessional, incompetent and callous.

Legal barriers

The public and probably the majority of doctors worldwide have conceived of the nurse as the physician’s assistant. To the average doctor in the USA all health providers are ‘paramedical’ except dentists, who seem always to be considered in a class by themselves – just why, seems irrelevant to this discussion. While Canadian doctors and nurses have officially agreed on a collaborative rather than an assisting role for the nurse, I have not seen comparable official positions reported for other countries (Canadian Nurses Association 1972). The extent to which nursing can serve a client, or patient, who is not also under the care of a physician, is far from settled in the USA. Until it is clear that they can do so legally, it is hard to get rid of the concept of nursing as dependent upon medicine.

Medical and nursing practice Acts in most countries must be modified if legal barriers to an independent function for the nurse are to be removed. The National Joint Practice Commission in the United States has reported a study by Virginia Hall (1975a), an attorney, in which she comes to an interesting conclusion. Since medical Acts prohibit the practice of medicine by persons other than physicians, Mrs Hall suggests that, rather than revising all nursing practice Acts, medical practice Acts exempt nurses from the prohibition against the practice of medicine. Were this suggestion taken and generally known it might radically alter the public concept of the nurse.

That nurses are now, and have been for many years, diagnosing disease, treating minor ailments and carrying out radical measures in emergencies is generally recognized, but this is nothing more than the corner druggist, or indeed the average person, does when medical help is physically or economically unavailable. The roles of medical providers may be clearcut in legislative controls, but human needs have always overridden legal barriers and, with the present emphasis on self-help, it will be increasingly difficult for doctors to claim sole right to the functions of diagnosis, prognosis and treatment. While it may not be possible here to support this conclusion convincingly, I nevertheless venture to state that the concept of nursing held by nurses themselves, by physicians and other health providers and by the public are all blurred. Definitions by the ICN of nursing and the two grades of nursing personnel might be said to represent the official worldwide concept (International Nursing Review
1975), but it would be interesting to see how many nurses and representatives of the public know and subscribe to these concepts.

If there is any consensus among the people of the world, I venture to suggest that most people, including nurses, would agree that, of all health providers, nurses render the most intimate personal service and that this service is the most constant factor in health programmes since the nurse is the only category of worker available on a 24-hour, 7-days-a-week basis. Perhaps the quality people most often seek in the nurse is that of a comforting presence. If there is a universal concept of nursing it embodies the characteristics of a service that is intimate, constant and comforting.

What are some of the more significant definitions of nursing?

Professional nursing is usually said to date from the Florence Nightingale era. Some historians may question this, citing Mrs Fry’s work, or the skilled ministrations of members of religious orders before the Nightingale era (Abel-Smith 1960). Without going into this question I will cite Miss Nightingale’s concept of nursing as the first clear statement on the subject that I have found. About 1860 she said: ‘It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case is to put the patient in the best condition for nature to act upon him’ (Nightingale 1860). With the current scepticism about technological medicine, the emphasis on biofeedback and on self-help, this statement seems strangely contemporary. Some of you may have read Ronald J. Glasser’s (1976) book *The Body is the Hero*. He says ‘…in the long struggle of evolution there began to develop a system of protection so sophisticated and so powerful that after a billion years of continuous battle…we [humans] have prevailed’. Like Florence Nightingale he is saying that at best we can only aid and abet nature. He discusses the body’s defences and how, with every new threat, it develops new protective mechanisms.

Nursing activity

Throughout the first two decades of this century nursing was defined in nurse practice Acts within the USA and elsewhere. By and large these Acts reflected the concept of the nurse as a follower of the physician rather than a creative independent worker. To this day, most nurse practice Acts fail to protect adequately the nurse in independent practice (Hall 1975b).

During the 1940s and 1950s, there were many studies of the nurse’s function – detailed activity analyses. One extensive study identified about 450 activities in hospital staff nursing alone (California State Nurses Association 1953). With the elaboration of healthcare providers in this century, scheduling and coordinating what was done to and for the patient came to be a major task. Professional nurses were identified in some studies as essentially coordinators. This has been a sore point with registered nurses, who now spend less time with patients as more and more of their former functions are taken over by auxiliary nurses and by others, as, for example, physical therapists, occupational therapists, social workers, health educators, clerical clerks and pharmacists.

Some researchers, in the 1950s, stressed the emotional or psychic support offered to patients by nurses. Being mostly women, nurses have sometimes been called ‘professional mothers’. Even today, many writers say that nurses are more concerned with the psychosocial aspects of human welfare than are physicians.

Psychiatric nursing, which was once a stepchild of the nursing profession, came into its own during the 1950s when there was perhaps more money for studies of psychiatric nursing in the USA than for the study of any other branch of clinical nursing. One such study was that of Ida Jean Orlando (1961) at Yale University School of Nursing during which, I believe, she coined the term ‘nursing process’. She said: ‘The purpose of nursing is to supply the help a patient requires in


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order for his needs to be met. The nurse achieves her purpose by initiating a process which ascertains the patient’s immediate need and helps to meet the need directly or indirectly. She meets it directly when the patient is unable to meet his own need; indirectly when she helps him obtain the services of a person, agency, or resource by which his need can be met.... In order for the nurse to develop and maintain the professional character of her work she must know and be able to validate how her actions and reactions help or do not help the patient or know and be able to validate that the patient does not require her help at a given time.’

The ‘nursing process’ is now a part of the language of nursing in the USA. While Miss Orlando’s concept is close kin to the one I had stated in a nursing text in 1955 (Harmer & Henderson), her insistence that the nurse gets the patient to confirm or validate the impression on which the nurse based an assumption of the patient’s need was, in my judgement, an important contribution to the concept of nursing.

In 1970 Margaret M. Lamb, then Chairman of the General Nursing Council for Scotland, asked ‘Nursing is What?’ and answered the question in the following terms: ‘The nurse exists...to nourish or cherish the patient...The bulk of nursing is physical care...I submit that nursing yesterday, today and tomorrow is caring for and that unless it is built on an ideal of service to others it is built on shifting sand’ (Lamb 1970). I believe Miss Lamb’s statement has been echoed by many.

In this decade (1970s) there is considerable discussion of the difference between the practice of nursing and medicine. Rozella M. Schlotfeldt (1972) made this statement: ‘Simply stated, the goal of nursing as a field of professional endeavor is to help people attain, retain, and regain health. The phenomena with which nurses are concerned are man’s health-seeking and coping behaviors as he strives to attain health. Nurses are independent, professional practitioners whose field of work is health care.’

Marjorie Ramphal (1972), addressing an American Nursing Association (ANA) Congress on Nursing Practice in 1972, said that the goal of nursing was to help the patient in his pursuit of ‘behavioral integrity’, which goal she said was ‘likely to...result in biological, psychological and social health’. Shirley Chater (1976) seems to share Miss Schlotfeldt’s concept of nursing as more related to health promotion than cure of disease: ‘Nursing is a process through which care is provided to individuals, families, or community groups primarily around circumstances and situations that arise from health-related problems. Medical practice, on the other hand, is primarily cause- and cure-oriented.’

Perhaps the last word should be the statement of the ICN Council of Nurses Representatives (International Labour Office 1976) defining ‘the professional nurse’ and ‘the auxiliary nurse’: ‘A [professional nurse] is a person who has completed a programme of basic nursing education and is qualified and authorized in her/his country to practice nursing. The first-level nurse [professional nurse] is responsible for planning, providing and evaluating nursing care in all settings for the promotion of health, prevention of illness, care of the sick and rehabilitation; and functions as a member of the health team. In countries with more than one level of nursing personnel, the second-level programme prepares the nurse, through study of nursing theory and clinical practice, to give nursing care co-operation with and under the supervision of a first-level nurse... [professional nurses] assist individuals, families, groups and communities in the promotion and preservation of health as well as contributing to recovery and rehabilitation in illness. They [professional nurses] participate in the development and implementation of the therapeutic and educational plans of the health team... Auxiliary nurses... provide care which does not require the training and theoretical knowledge of a professional nurse. They work in an organized health service which provides guidance and supervision.’

In the definitions of nursing cited I have identified the nurse variously as helping nature cure the patient, helping the physician cure the patient, acting as a professional mother, giving psychological support, meeting a person’s health needs, nourishing and giving physical care, attaining, retaining and regaining health, helping the patient pursue behavioural integrity and caring for and rehabilitating the sick. Other concepts of nursing might be added to those cited. The current goals of nursing programmes (often called ‘missions’) state or imply concepts of nursing that increase the emphasis on health counselling and on independent health practice.

Because the ICN has recognized a concept of nursing that I first published in 1955 and because it has been adopted by some schools of nursing in the USA, but principally because people so often ask me whether I still hold this view of nursing, I will now discuss nursing as I see it—the extent to which I have modified the concept published in the ICN’s booklet Basic Principles of Nursing Care (Henderson 1968).

This concept is not opposed to those just listed, but, in my judgement, is so flexible, or open-ended, that it could incorporate any or all of them. I hope, however, it is sufficiently specific to characterize what effective nurses do and to differentiate their work from the work of other health providers. An English-woman, Jocelyn Evans (1971), who nursed her husband through a terminal illness, happened to read the ICN booklet. She said, citing the definition of the nurse’s unique function, that it ‘reflects my attitude abso-
Nurse’s unique function

The following definition of nursing has appeared in a nursing text (Harmer & Henderson 1955), in a monograph, The Nature of Nursing (Henderson 1966), and in the ICN booklet, Basic Principles of Nursing Care (Henderson 1968): ‘Nursing is primarily helping people (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help people to be independent of such assistance as soon as possible...The nurse is temporarily the consciousness of the unconscious, the love of life of the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the newborn, knowledge and confidence for the young mother, a voice for those too weak to speak, and so on.’

This function, as just outlined, is, I believe, the one most of us hope someone will perform when we need ‘nursing’ and I believe no other health workers want to claim it or take it from nurses. I think this function is infinitely complex for it requires identification with, or understanding of, all kinds of people – male and female – the infant, the child, the adult, the middle-aged and the aged, the learned and the ignorant, the rich and the poor, those of all races, nationalities and creeds, people in relatively good health, the handicapped, and the critically ill and dying. This concept of the nurse’s unique function demands that nurses understand the fundamental needs of man so that they can help their clients or patients provide for all those needs or make their lives as normal and productive as possible, even during illness. Nurses, who practise according to this concept, must know how to assess the client’s or patient’s need for help with the following daily functions or daily activities—breathing, eating, eliminating, resting, sleeping and moving, keeping the body clean, warm and clothed, and making life more than a vegetative process by communicating with others, maintaining human relationships, learning, working and playing, or recreating.

It is my belief that while nurses are, under ideal circumstances, health workers who act interdependently with other health workers, they should be masters of their unique role and the health care system should enable them to design, initiate and be responsible for all practices inherent in this role of the patient’s alter ego. To this extent I believe the nurse is an independent practitioner. Nurses should be rehabilitators par excellence. It is my contention, however, that in situations where other members of the health team are unavailable (e.g. the physician, the nutritionist, the physical therapist, or the social worker) the nurse may be the person best prepared to supply the help such specialists would furnish were they available. Professional nurses should be prepared to screen patients and, if not able to help them with their health problems, they should know how to refer them to other appropriate healthcare providers. It has been suggested that, in the future, nurses, physician’s assistants and physician’s associates may provide all primary care (meaning in this case the person’s introduction to the health care system).

I repeat that the concept of nursing, as implied in the definition just cited, seems to me to be open-ended. The complexity and quality of the service is limited only by the imagination and the competence of the nurse who interprets it. Any interpretation, however, implies an individualized service given with the patient’s understanding or consent and in the case of an infant, the small child, the unconscious patient, or the mentally deficient, it implies the understanding and consent of the parents or guardian.

Planning individual care

The concept of nursing, just set forth, and the idea of individualized plans of care for patients are both stressed in the ICN booklet Principles of Nursing Care (Henderson 1968), which has been translated into 22 languages. Planning individually for patient care is embodied in the Patient’s Bill of Rights, sponsored by nursing and hospital organizations in the USA (American Hospital Association 1973); but those of us who use health services and visit friends and relatives in health institutions too often get impersonal care, or see others getting it. Patients may have a health provider they can call ‘my doctor’ and, if physical therapy is part of their treatment, they may be able to say ‘my therapist’, but, much less often can they say ‘my nurse’ unless they have a private nurse, or unless they are in one of the few hospitals or nursing homes where a nurse is assigned to each patient and is responsible for his or her care. Marie Manthey (1973) calls this ‘primary nursing’ (While I believe the patient assignment system, designed and described by Mrs Manthey, does promote effective individualized care, I question calling it ‘primary care’ since this term is commonly used in a different sense). Community, or public health nursing operates under a patient assignment system, but in many, if not most, hospitals and nursing homes functional nursing predominates. Since student experience is largely in hospitals and since these institutions in the industrialized countries employ over half of the nursing personnel, many nurses have never had the
satisfaction of giving individualized care, or of knowing the extent to which they have helped people get well, adjust to a handicap, or die peacefully. Functional nursing protects nurses from knowing the extent to which they fail clients or patients. The nurse can always blame others for the patient’s pain, discomfort, dissatisfaction, or the family’s distress. Others can be held accountable for a death that should not have occurred, for a cross infection, or for a crippling condition that developed during treatment. Health care, including nursing care, is so often, in Western countries, impersonal and technical rather than individualized and humane. None of us wants it to be less technically effective, but I believe all of us would like to see health care a humane service.

If the concept of nursing, as an individualized and highly-personal service, is to be practised by nurses, they must see and give it as students. As nursing students are our best hope for the future, suggested below are some characteristics of initial, or basic, nursing education programmes that I believe will further the concept of nursing as described above.

**What kind of education will most likely produce effective nurses?**

This is a period of experimentation in nursing education in the USA and I suspect in most countries. The 1975 Conference of the Association of Integrated and Degree Courses in Nursing was reported under the title *Nursing: An Education or Training?* (Smith 1975). The 1976 Conference, *Developing a Theory of Nursing* (Smith 1976), includes discussions giving the impression that Great Britain is also experimenting and searching for a pattern.

The following effort to suggest a programme that might prepare effective nurses applies to the preparation of registered nurses in the USA and might also apply to the education of the state registered nurses of Great Britain. Admittedly, I know much more about the former than the latter and it may seem presumptuous on my part to suggest that I can speak to the problem of nursing education outside the USA.

Last year, in an effort to cite facts rather than impressions about the confusion in initial, or basic, programmes in the USA, I analysed the catalogues of 17 collegiate nursing schools offering bachelor’s degrees because I believe this is the type of programme that North American nursing leadership hopes will be dominant in the future. I tried first, unsuccessfully, to find a pattern in the statement of the aims of the schools, now more commonly called ‘missions’. Parenthetically, I notice that the *Journal of Advanced Nursing* in July 1977, in the section JAN Forum, reported objectives of 9 baccalaureate programmes in 7 countries. I refer you to this report to illustrate the difficulty of categorizing the aims or missions of nursing schools anywhere.

Analysing the curricula (usually 4-year programmes) of the 17 USA schools, I was able to classify courses into (1) the humanities, (2) the biological and physical sciences, (3) the social sciences, and (4) the medical and nursing arts and sciences. This analysis is the basis on which I make the statement that the USA is experimenting in nursing education, particularly in the clinical aspect of the curriculum. It was relatively easy to see a pattern in the realm of the humanities. All of the 17 programmes were based on the assumption that students would bring with them some background in the humanities – the only courses to be included in the programmes of the nursing schools were English, ethics, philosophy, logic, religion, history and music appreciation.

It was not so clear that students were expected to bring as much knowledge of the physical and biological sciences. These courses were universally required in the nursing school programmes and were listed under 20 different titles. They included anatomy, physiology and pathology (separately or combined), chemistry and microbiology. Some programmes included physics, more than half listed nutrition. Social sciences were universally required within the programmes, rather than as prerequisites and these were listed under 43 different titles. These titles were often ambiguous and hard to classify, but suggested that sociology and anthropology, as they are usually considered, were included. A few courses dealt with management, with computer science and analysis, and with health care systems.

Courses classified as nursing, or medical arts and sciences, were hardest to classify. They were listed under 140 different titles and, while I feel sure that these courses had to do with the care and treatment of human beings of all ages and in various settings, the descriptions were often so vague or ambiguous that it was impossible to be certain that students studied the care of all age groups. It was equally hard to approximate the time students spent in hospitals, clinics, visiting nurse, school, industrial, or other types of health service. The variety of initial programmes of nursing education and even the differences, as just demonstrated, in programmes offering a bachelor’s degree in nursing, lead to endless debate in the USA. An article in the *American Journal of Nursing* for 1976 is entitled ‘Can we Bring Order out of the Chaos in Nursing Education?* (Schlotfeldt 1976). I do not presume to think that I can bring order out of the chaos in nursing education, but if nursing is to perform its unique function, as I see it, and if nurses are to collaborate effectively with other health workers, it seems to me that we must describe the programmes clearly and reduce the variation in beginning programmes.
Proposals for a basic nursing programme

At the risk of sounding iconoclastic and possibly presumptuous, I am going to suggest the following characteristics of basic nursing programmes that I believe most likely to enable graduates to practise effective nursing.

Having students of nursing study with students in other health fields

This means that there should be centres (colleges and universities in the developed countries) where the emphasis is on interdisciplinary education. The World Health Organization has several publications devoted to this subject (Miller & Fülöp 1974, World Health Organization 1973). Edmund Pellegrino (1973), as its Dean, has described the New York State Health Science Centre Medical School at Stony Brook, New York, which is trying to achieve optimum interdisciplinary education. Vernon Lippard (1974), former Dean of the Yale Medical School, in an historical review of medical education, has said that the medical faculty as such may cease to exist. In other words, separate faculties for any of the health schools may give way to more effective organization of those who educate health workers. If doctors, dentists, nurses, social workers and others are to pool their competences in the service to clients, sick and well, it is obvious that encouraging students of medicine, dentistry, nursing and social work to study together will further a collaborative approach to practice. It will also foster mutual understanding of the special strengths, or abilities, of each type of worker.

Fostering a humanistic concept of health care

It would be desirable for students of all health professions to bring with them a broad knowledge of the world and the nature of man, an ability to appreciate and identify with peoples of many cultures. Nurses need the ability to use the language effectively and, to understand the present in the light of history, they need some knowledge of dominant philosophies and living religions. If students do not have an adequate background in the humanities the nursing programmes should offer the opportunity to acquire it.

Providing courses in the social sciences underlying nursing practice

If nurses are to help shape national health and welfare programmes, they need an understanding of government and economics. Other supporting social sciences are psychology and human development from birth to death, sociology and anthropology.

Providing courses in the biological and physical sciences

A background in them cannot be too strong. Nurses need knowledge of anatomy, physiology, nutrition, microbiology, chemistry and physics. The more that nurses know about these sciences, and the more they can apply to practice, the more help they can be to those they serve. All of the subjects that have been mentioned can be prerequisites or they can be offered as part of the nursing programme, but it is desirable that they be studied with people in other fields – especially other health fields.

Helping students to develop the habit of inquiry

It is generally conceded that health workers must be lifetime students. It is impossible to teach nursing students all they must know to practise safely in a 2, 3, or even 4 year programme, because science is never static and there are always new knowledge and new skills to be acquired and new therapeutic approaches to learn. It is therefore important in the initial programme to help students develop the habits of inquiry and of seeing all health care as a problem-solving process. Students are most likely to acquire these habits if they work with preceptors who have them.

Giving students an opportunity to see and give effective care

While the apprenticeship system of learning is now considered wasteful, there is no substitute for teaching by example. It is possible, of course, for gifted students to conceive of better ways of nursing than they have seen practised, but, by and large, they will give the kind of care as graduates that they see given as students, whatever the setting. Therefore, any successful attempt to teach a concept of nursing, including the one I have commended, depends upon the presence of nurse practitioners who understand and can apply the concept. I would assign students to practitioners as preceptors, or tutors, the students being observers at first and increasingly participants until they can safely function independently. The helping relationship of nurse to client or patient would be seen throughout as the essence of nursing. This would include the ability to identify with the person, to recognize his or her needs, to assess health deficits, to judge when to give help and when to encourage patients to help themselves.

Making no attempt to use fashionable pedagogy, I will suggest a way of organizing the clinical nursing curriculum
that I think emphasizes the concept of the nurse as the patient’s most intimate, comforting and available helper. I suggest that there may be three natural stages of learning this art, science and the related skills. The first stage is devoted to studying basic human needs or functions and helping patients with the activities of daily living regardless of, or with minimal involvement in, therapy. The second stage focuses on symptomatic nursing, or helping patients with common dysfunctions – physical or emotional problems that occur in any setting. The third stage is devoted to studying and giving the specific help needed during the maternal cycle, during infancy, childhood and adulthood, including old age and the specific help needed because particular diseases are present.

With reference to teaching medical students the treatment of specific diseases, Vernon Lippard (1974) says that ‘all thought of total coverage has been abandoned’. This is equally true of nursing education.

In each stage of learning it is important for students to spend enough time with patients to know them, which includes knowing their families and the conditions under which they live. It is most important that nursing students develop clinical judgement and the ability to recognize patients’ needs. This comes with protracted rather than brief encounters with people. It is also important that nursing students acquire enough nursing competence to get satisfaction from their work. They should be given the opportunity to help clients and patients attain a high state of wellness, prevent disease, achieve independence after an illness, cope with a handicap, or accept death. Students may rarely have such experiences if they see only a fragmented, technical, disease-oriented service. From the patient’s point of view, it is essential that they (the patients) have the feeling ‘This is my nurse’. For nurses, it is essential that they think ‘This is my patient – whether or not his or her experience with this health service is constructive depends at least in part on what I do’.

Giving students an opportunity to see and give effective care in a variety of settings

It is desirable for students to see and participate in health care in all settings, including private homes, nursing homes, clinics, hospitals, schools, industries and penal institutions otherwise they have a distorted idea of the health problems within society and there will continue to be neglected elements of society, since it is unusual for graduates to accept employment in areas of practice they do not see as students. If every student cannot practise in every setting, he or she might at least see what it is like and be offered some electives in practice.

Studying the care of some patients in depth, integrating the supporting physical, social, biological and health sciences

A variety of elaborate schemes exists in the USA designed to integrate the underlying sciences with practice. If, during all phases of the clinical curriculum, students make a study of each client or patient to whom they are assigned, and if clinical teachers, preceptors or tutors, physicians and other therapists, as well as nurses, help them apply the underlying sciences to the problems presented by patients and their families, integration is inevitable. At the same time students learn to use the sciences as they will, or should, later use them in practice, not as exercises to please an instructor. Also, medical science, that is focused on a particular patient, is, in the best health services, more up-to-date than descriptions of care and therapy found in texts.

Medical education, since William Osler (1925), has, in many schools in the USA, been clinically-oriented and ‘case’ focused. Medical students have tended to concentrate on diagnosis and disease, but with the problem-oriented system of medical education advocated by Lawrence L. Weed (1971, 1975), and his associates, making the diagnosis is no longer even the medical student’s single goal. In any event, interdisciplinary conferences around patient care, patient problems or patient management (whatever term is used) cannot fail to promote better results for patients and promote mutual understanding of the roles played by the different professions in helping patients with health management.

Are nursing students overprotected?

Because nursing students have been exploited in the past, they may now be overprotected. For instance, some students graduate and practise as registered nurses without seeing what happens to patients at night, on weekends or public holidays. They are exposed to the most advanced ideas, but given little opportunity to apply them or to act as ‘change agents’. They see patient management only in large health centres and the visiting nurse (home nurse) associations in big cities. Employed elsewhere as graduates they suffer ‘reality shock’, as Marlene Kramer (1974) calls it. If students see expert nurses giving patient-centred care, if they participate in this care, and if, finally, they learn to give the major portion of this care in a variety of settings, reality shock can be avoided. However, what is more important, students will experience the great satisfaction that comes with seeing the results of their efforts expressed in the patient’s recovery, the relief of stress, successful adaptation to a handicap, or a peaceful death. Nursing courses built around the care of
individual patients and their families involve students in realistic health services.

Unless clinical nurse educators identify with patients, alter the system that fails to serve the best interests of patients, unless they demonstrate the ability to assess clients’ health deficits and unless they help patients and families plan and carry out individualized regimens that promote health, recovery from illness, successful adaptation to a handicap, or acceptance of death, it is useless to expect students to adopt the concept of nursing set forth in this paper.

In Great Britain, where the health resources in relatively small geopolitical areas are coordinated and where health providers operate under similar systems of economic reward, it must be easier to effect change than in those countries where health institutions and agencies are relatively autonomous and where some health providers operate under a fee-for-service system and others are salaried. Andrew Malleson (1973), a Canadian psychiatrist who was once in general practice in England, maintains that in a fee-for-service system it pays providers of service to have patients dependent on them (that is ‘sick’). Under a salaried system it pays providers to have patients independent (or to get well). This suggests that a concept of nursing, that has as one of its major goals the development by the client or patient of self-reliance or a healthy independence, is most likely to flourish in a country where there is universal health insurance. I hope, therefore, that my concept of nursing is relevant to British health care, which many of us in the USA greatly admire.

Conclusion

With the acceptance of health care as a universal human right has come a variety of national, provincial, state and local systems for providing health care. An international network of rapid communications makes peoples everywhere aware of the variety of systems and the fact that some systems, other than their own, show better results, as measured by, for example, the infant mortality rate or the incidence of venereal disease. Traditional roles for doctors, nurses, health educators, social workers and others are in question. Eastern medicine, which emphasizes the well-being of the whole man, is influencing Western medicine, which has emphasized the technological cure or control of disease. Self-help, as typified by the worldwide organization of alcoholics, is thought by many to set a direction for future health care. A family and community sense of responsibility for the health of its members is seen as the most potent factor in any scheme. This involves evaluation of the resources within the family, the community and the larger geopolitical unit of which it is a part. Since the health problems and resources, including health personnel, differ in quality and quantity from one area to another, each geopolitical unit must make the best possible use of its resources, including health personnel. To meet the needs of the people, health educators, physicians, social workers, nurses and all other categories of health personnel must constantly evaluate their roles, be ready to modify them for the common good and modify the programmes that prepare them for their work. The most successful planning, regulatory and educational bodies are almost certainly interdisciplinary, as are those that include provider and consumer participation. While the roles of doctors, nurses and others are necessarily, in these rapidly changing times, in a fluid state, some health worker must provide a 24-hour service that helps human beings with their essential daily activities when they lack the strength, knowledge, or will to carry them out unaided, and to work towards the development of a healthy independence. This intimate and essential service is, in my opinion, the universal element in the concept of nursing. It is a service, which at its best is emotionally and intellectually rewarding to those who give it, and highly-prized by those who receive it. Functioning as the client’s alter ego, nurses may have to supply other types of service when the physician, the physical therapist, the social worker, or other health provider is unavailable, just as each of us functions in these capacities in solving the health problems of everyday living. The most successful preparation of nurses will always include whatever gives them the broadest possible understanding of humanity and the world in which they live. It will also provide an opportunity to see expert nursing care given and to have the satisfaction of seeing the care they themselves give hasten a person’s recovery, help a person cope with a handicap, or die in peace when death is inevitable.

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Our mission now is huge and vital
It is a challenge to comment on the writing of the world’s most beloved and respected nurse, as I have long thought of Virginia Henderson. My personal contacts with Virginia Henderson were as a student at Yale University and, much later, as President of the American Nurses Association. In the latter position, I was privileged and humbled to present Virginia Henderson with a prestigious award at a public ceremony. She seemed embarrassed and somewhat unaccepting of being so honoured. She was a brilliant but modest person.

Virginia Henderson is probably best identified by nurses all around the world in relation to her definition of nursing, published in 1960 in an ICN booklet entitled ‘Basic Principles of Nursing Care’ (Henderson 1960), with many subsequent reprints, and also widely circulated throughout the international literature. There could have been no better scholar and humanist to have addressed the fundamental issue of ‘The Concept of Nursing’ in a paper for Journal of Advanced Nursing in 1978. Henderson’s contributions were in great demand at the time – even although she had been in ‘the business’ of nursing for nearly 60 years by that time! The journal is to be congratulated for having attracted her writing on such a seminal topic.

The use of the word ‘concept’ signified a scope far beyond Henderson’s original definition. Before trying to answer the question ‘Is there a universal concept of nursing?’ she queried whether she was searching for the public’s concept of nursing, or that understood by other healthcare providers, or the concept of nurses themselves. ‘The answer’, she said, ‘is that I am not trying to answer any of these questions definitely, but rather to identify the common elements, if they exist, in representative ideas about nursing’ (p. 114). Accordingly, in her paper, Henderson presented and analysed a range of definitions, historic and contemporary, and proposed characteristics for basic nursing programmes intent on preparing graduates to practice ‘effective nursing’. As a summative document, it was highly significant at the time of its publication, when the profession – worldwide – was testing new directions, both in practice and in education.

Since the late 1970s, a number of developments in nursing and health care have been introduced or have accelerated. For example, were it possible, it would be illuminating to read the late Miss Henderson’s reflections today on Benner’s analysis ‘from novice to expert’ (Benner 1984) and its influence on the concept of nursing; on the ‘advanced practice’ movement and its legal ramifications and effects on the scope of nursing practice; on modern health and information technology; on the accumulation of research on best practices and nursing outcomes; on the ICN Classification of Nursing Practice; on the apparent erosion today of the conviction that health care is a human right; on the requirement of university education for entry into nursing in many more countries; and on all the other happenings in and surrounding the nursing profession that have occurred over these past three decades. Would Henderson see that her earlier conceptions, projections and recommendations have come to fulfilment (or not)?

As to the current relevance of Virginia Henderson’s 1978 JAN paper, I can add personal beliefs about the ‘concept’ of nursing from my own policy and political perspective in today’s world. The influence of Virginia Henderson’s definition of nursing, with its emphasis on the individual and on the nurse’s role in providing intimate and personal care, will continue to be at the heart of nursing, I believe – and I sincerely hope. However, over time, I have come to view nursing as more than the personal care of individuals and communities. I have come to conceptualize nursing within combined micro- and macro-contexts, somewhat parallel to the field of economics, in which the former relates to individual economic problems and the latter to aggregate, systemic, philosophical, and policy issues. Thus, I would expect that future definitions of nursing rightfully also will lay claim to our existing and potential functions within the spheres of management, education, research and social and healthcare policy and systems. We may view this as a distinction between the practice and the profession of
nursing, defined separately. From my perspective, nurses are at the core and throughout the infra-systems of health care, and all are engaged in ‘nursing’. When we define ourselves, if we fail to acknowledge these wider aspects of nursing, we are denying our collective responsibility and impact – that is, nursing writ large. Our mission is huge and vital: modesty must not be, nowadays, our overriding virtue.

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Knowledge is the distinguishing attribute of professional nursing

It is one of the paradoxes of nursing that, although millions of people do it, and millions more experience it every day, nursing is still poorly understood. One reason for this, I believe, is that nurses themselves find it difficult to put into words the concept of nursing that they hold inside their heads. I remember soon after I had given the Inaugural Virginia Henderson Lecture at the ICN Congress in Vancouver in 1997 (Clark 1997), being thanked by a young Chinese nurse for what I had said. I expressed surprise, for I believed that I had said nothing new, and that what I had said was no more than the daily stock-in-trade ideas about nursing of every nurse in every country of the world. In broken English, she replied that this was exactly the point! My efforts on that day were a pale shadow of Virginia Henderson’s work – the significance of which is shown by the fact that, almost half a century after its initial publication (Henderson 1960), her definition of the unique function of the nurse is still the universally recognised and most widely-used definition of nursing (Royal College of Nursing 2003).

In her 1978 JAN paper, Virginia Henderson expresses scepticism about whether a universal concept of nursing is tenable. But she argues that, if it is, that concept lies in the intimacy and constancy of a service that helps human beings with their essential daily activities when they lack the strength, knowledge or will to carry them out unaided, and in working towards the development of a healthy independence. This view has been criticized as being too focussed on the individual and on nursing the sick, and as underestimating the contribution of other carers, including the family who, in many cultures, provide most of this kind of care. Many of these criticisms derive from a failure to take account of the rest of Virginia Henderson’s definition which is much less frequently quoted – helping the patient ‘to carry out the therapeutic plan’, and acting as a member of the multidisciplinary healthcare team (ICN 1968). When taken as a whole, the concept becomes, as Henderson argues, ‘limited only by the imagination and the competence of the nurse who interprets it’. It is as relevant now as the day it was written.

However, Henderson herself is reported as saying, ‘I do wish people would stop talking about that book as though my concept of nursing stopped developing over 20 years ago!’ (Henderson 1991 – Foreword). The world has changed, and other people provide much of the ‘intimate and constant’ service that she describes as the nurse’s ‘unique function’. But, as Hildegard Peplau noted, in accepting the Christine Reimann prize at the same ICN Congress as the Inaugural Virginia Henderson Lecture, if the question of the 20th century was ‘What do nurses do?’, the question for the 21st century is ‘What do nurses know?’ In Henderson’s definition, the knowledge base of the nurse’s ‘unique function’ is not made explicit, yet it is this knowledge, I believe, that makes the work of the professional nurse unique, and distinguishes it from the nursing undertaken by other people.

Virginia Henderson also wrote: ‘I would like to emphasise that I am not presenting my point of view as one with which I expect you to agree. Rather I would urge every nurse to
develop her own concept, otherwise she is merely imitating others or acting under authority’ (Henderson 1991). If Henderson was alive today, I think she would like the definition of nursing developed by the Royal College of Nursing (Royal College of Nursing 2003) which builds on her own by adding the dimension of ‘clinical judgement’: ‘Nursing is: the use of clinical judgement in the provision of care, to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death’.

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