THE MEANING OF NURSING

A comparative analysis
of
the conceptual history
of
modern nursing in the United States (1873-1960)

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FOREWORD

This study takes off from the variety of adjectives currently in use to denote the meaning of nursing, notably the adjectives '*individualised*,' '*comprehensive'* and '*patient-centred*,' and is aimed at identifying what each of these adjectives adds to the meaning of nursing in terms of opinions, beliefs and values as to what nursing does stand for and what not. To achieve this objective, the meaning of nursing is investigated within the framework of a theory of meaning rather than a theory of reference.

Following a detailed comparison between Grounded Theory and Practice Theory, it is decided that the former is the chosen method for this study because it is demonstrably best geared to the discovery of meaning in order to transform an indeterminate and meaningless situation into a determinate and meaningful situation.

On coding and analysing the data obtained from the extensive literature on nursing, each of the adjectives under investigation is shown not only to designate rather a different meaning of nursing, as is demonstrated by means of the concepts of nursing, nursing education and professional nursing that go with it, but also to amount to a specific model of nursing which can be differentiated from each other by means of their distinctively different implications.

Apart from that, the meanings of the adjectives under investigation are shown to add up to a conceptual history of modern nursing in the United States. For the sake of comparison, the research subsequently has been extended to the Nightingalian model of nursing.

The major conclusion to be drawn from the findings of this study is that, over the years, the meaning of nursing has changed dramatically. Consequently, the question can be raised as to what we are talking about when discussing the models of nursing identified in this study, or any model of nursing for that matter. It is not nursing as it exists in the real world but nursing as it is conceptualised.

An important corollary of this conclusion is that these models of nursing refer not so much to the supposedly timeless nature of nursing or the bare, value-free facts of nursing, whatever they may be, as to certain opinions, beliefs and values concerning nursing. These conclusions have significant implications for nursing science, nursing research, and, indeed, the nursing profession as a whole.

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INTRODUCTION

1. The subject of the study

This study originates in the variety of adjectives currently in use to designate the meaning of nursing such as, for example, *individualised* nursing, *comprehensive* nursing, *patient-centred* nursing, *total* nursing, *personalised* nursing, and *holistic* nursing. Given this variety, it seems reasonable to assume that each adjective stands for a different meaning of nursing. This raises the question of what each of these adjective should be taken to mean. Semantically there are two ways of dealing with this question depending on the orientation of the researcher, viz. whether he adheres to a theory of reference or a theory of meaning.

1.1. A theory of reference

According to the theory of reference, the earlier mentioned adjectives (when used in a proposition about nursing) are seen as words which have a definite relationship with the reality they refer to, i.e. nursing as it exists in the real world. It is assumed that there is a more or less rectilinear relationship between language and the reality it refers to which is similar to the geometrical projection of surface A (language) on surface B (reality). In this sense, language provides us, as Wittgenstein put it, with '*pictures*' of the real world.

Knowing the meaning of patient-centred nursing, for example, would then be the same as knowing which entities in the real world it extends to. For this we must possess some permanent body of knowledge of the relationship between words and their referents in the real world, i.e. the extension of concepts.

By means of this theory of reference, it is possible to explain what we understand when we hear a proposition about patient-centred nursing but only if we are able to find any entity in the real world it refers to. If not, and this might well be the case, the theory of reference runs into trouble because this word would have no meaning at all.

However, few people will claim that we cannot have a meaningful discussion about patient-centred nursing, even when we are certain that it has not come into existence yet. Thus, this theory of reference can be discounted for, in order to understand the meaning of patient-centred nursing, no empirical knowledge of the real world of nursing is required. Only if someone wants to investigate patient-centred nursing as it exists this knowledge is indispensable. On the other hand, it can be argued, the earlier mentioned adjectives are only meaningful to us because they refer to something which may not exist in the real world but somewhere else. This leads us to the so-called theory of meaning.

1.2. A theory of meaning

According to the theory of meaning, the earlier mentioned adjectives (when used in a proposition about nursing) are seen as linguistic representations of certain thoughts and ideas about nursing. For example, if someone discusses patient-centred nursing, he is bound to have some mental representation (*Vorstellung*) of it, which will be reflected in what he says about it. Within the framework of a theory of meaning the earlier mentioned adjectives (when used in a proposition about nursing) provide us therefore with 'pictures' too, but these are not pictures of the real world but of the speaker's mental representation of nursing. It can be argued, however, that the speaker's utterances are reflecting more than just these picture-like mental representations, for they are not sufficient to explain the interpretative process itself (Seuren, 1979).

First, the speaker provides the listener not only with clues as to his thoughts and ideas about patient-centred nursing but, from what he says about patient-centred nursing, the listener can infer what else must be the case if his utterances are to be meaningful, i.e. his presuppositions. In this sense, the utterances are a sign of the presuppositions underlying the speaker's thinking.

Secondly, from the way the speaker verbalises his thoughts and ideas about patient-centred nursing the listener can also infer the speaker's commitment to his thoughts and ideas about patient-centred nursing. He can, for example, notice that the speaker is uttering his convictions or his doubts concerning patient-centred nursing.

In this sense, the speaker's utterances are not only a sign of the presuppositions but also of the implications of his thoughts and ideas.

While discussing this theory of meaning it is worthwhile to recall the definition of a "sign" given by Augustine (De Dialectica):

> *`Signum est quod se ipsum sensui et preater se aliquid animo ostendit.'*

This means: a sign is a datum which shows itself to the perception and shows something else to the mind as well. This 'something else' consists of information as to what else must be the case (presuppositions) if the speaker's utterances are to be meaningful and also what follows from them (implications). The speaker's utterances thus create a specific mental domain of interpretation (Seuren, 1979) within which each uttered proposition makes sense and can, therefore, be understood and interpreted.

On the other hand, comprehension of what a proposition about patient-centred nursing means requires the reconstruction of the speaker's thoughts and ideas in the mind of the listener, i.e. the reconstruction of his mental representation as well as the accessory presuppositions and implications.

Knowing the meaning of patient-centred nursing, for example, would then be the same as knowing the domain of interpretation in which these words make sense, i.e. the intention of concepts. For this, one needs a body of knowledge which is not permanent but flexible, as one may have to switch from one domain of interpretation to the other at times. According to the different possible meanings of patient-centred nursing, one hypothesises time and again what else must be the case then (presuppositions) and what follows from that (implications). This leads up to one or more domains of interpretation within which patient-centred nursing has a meaning even if it does not refer to something which really exists. To understand the meaning of patient-centred nursing the relationship with the real world of nursing is, therefore, not relevant as this does not come under the interpretative process. Only after the mental domain of interpretation is reconstructed can the researcher decide to investigate whether nursing as it exists answers to the description of patient-centred nursing or not. In that case, he has indeed to turn to the real world as a domain of verification.

2. The purpose of the study

This study deals with the meaning of nursing which comes to the fore in the various adjectives currently in use to denote the meaning of nursing. It does so by investigating the meaning of these adjectives within the framework of a theory of meaning, i.e. by reconstructing the domain(s) of interpretation within which these adjectives when used in connection with nursing make sense.

Apparently, nurses feel very strongly about the meaning of these adjectives. Nursing care that deserves, for example, the label 'patient-centred,' is considered to be good nursing care while nursing care which doesn't is not. This suggests that each of these adjectives reflects a strong body of opinions, beliefs and values as to what nursing does stand for and what not. The purpose of this study is to find out more about the body of opinions, beliefs and values associated with each of the adjectives concerned as this would be relevant for nursing science, nursing research and for the nursing profession.

2.1. Nursing science

The development of nursing science has raised more questions than it has answered, especially as far as the metatheoretical aspects of nursing science are concerned. The discussions about these problems are characterised by a perfect Babel of tongues (Grypdonck, 1980). Although it is not very easy to seize the broad outlines of these discussions, one thing is definitely clear: all painstaking metatheoretical debates cannot conceal the lack of agreement as to the issue of which knowledge constitutes nursing knowledge. This can be illustrated by the following definitions of science in nursing, science of nursing, and nursing science (Andreoli & Thompson, 1977):

- **science in nursing**
  '... the body of verified knowledge found within the discipline of nursing. At the present time, this verified knowledge consists of knowledge from the biological and behavioral sciences.'

- **science of nursing**
  '... that body of verifiable knowledge that will be derived from nursing practice. ... Nursing draws from the behavioral and biological sciences, but the way nursing utilizes this knowledge in the practice field is unique to nursing and is therefore the science of nursing.'

- **nursing science**
  'For all practical purposes, the terms "science of nursing" and "nursing science" are the same. ... Abdellah states, "Nursing science is defined as a body of cumulative scientific knowledge, drawn from the physical, biological, and behavioral sciences, that is uniquely nursing".'

These definitions demonstrate how nursing scientists fail to identify which knowledge constitutes nursing knowledge. Is nursing science doomed then to remain just a clearly defined area of scientific activity in which the knowledge, borrowed from other sciences, is applied, albeit in a unique way? Or does it possess some unique '*body of knowledge*' after all? Some nursing scientists hope to develop such a body of knowledge from nursing practice (Dickoff, James & Wiedenbach, 1968a and 1968b) but even then it remains open to debate what constitutes nursing's unique body of knowledge.

All this is not, however, to say that nursing scientists do not know how this problem could be solved, viz. by identifying a unique perspective which could regulate their scientific activities or constitute some form of nursing science (Crawford et al, 1979):

> *`All knowledge utilised by the profession of nursing is not nursing knowledge; only those theories and knowledge which have been derived from nursing's perspective comprise nursing knowledge. Nursing knowledge will be developed from nursing's unique perspective by asking questions and viewing phenomena unlike other disciplines. The knowledge base of nursing will be developed from basic, applied, and prescriptive research in nursing.'*

Many nursing scientists feel that the development of nursing science is seriously impeded by the lack of such a perspective. On the other hand, there is an increasing body of opinion that nursing's unique perspective must be derived from the nature of man (the word 'man' as it used here refers to both men and women; the reason for not using the more neutral word 'person' is that one of the adjectives to be investigated is the word 'personalised' and this might be confusing):

- **Rogers (1970)**
  'Nursing's central concern is with man in his entirety. ... Nursing's theoretical sytem is built upon basic assumptions about man.'

- **Newman (1972)**
  'We have established a viable conceptual system - one that provides us with clear, relevant guidelines for theory building and research. We are no longer overly concerned with ourselves as nurses. Concerned with the phenomenon of man, we are beginning to understand man. We no longer are completely dependent on other disciplines for the knowledge of our practice, but neither are we completely independent. We are beginning to realize our own potential for discovering a particular kind of knowledge that is relevant to other disciplines and essential to nursing. The problem of the past has been the dearth of nursing knowledge. The problem of the future will be the acceleration of that knowledge.'

- **Colaizzi (1975)**
  'If the proper object of nursing science is the experience of health and illness, then this object is not to be found within the technical dimension of human existence, but in the existential dimension (that is, having to

do with lived experience). Furthermore, there must be a model of man, a way of conceiving man, that will remain faithfull to that object.'

- **Fuller (1978)**
  'I would suggest, therefore, that we cease to define nursing by functions or role, methods or process, and areas or focus of practice, and consider instead that the knowledge and concepts essential to nursing are already defined by the nature of the human being. The biological, psychological, and sociological dimensions of the human being transcend the traditional boundaries of nursing practice and could, if we would let them, give order to the science of nursing, to the education of nurses at all levels, and to the practice of nursing.'

This study intends to contribute to the search for this nursing perspective by analysing the meaning of nursing expressed by means of designating adjectives like 'individualised,' 'comprehensive,' 'patient-centred,' and so on.

Obviously, this study takes issue with the dominant positivist tradition in nursing science which, by definition, excludes itself from a philosophical discussion about the meaning of nursing, and rightly so, because to the degree that the meaning of nursing is based on opinions, beliefs and values, it defies the positivist standards of formalisation, objectivity, falsity, truth, observation, operationalisation and prediction to name just a few. So, to the degree that this study contributes to the search for a perspectice that is uniquely a nursing perspective, it may also contribute to an approach in nursing science which remains faithful to what, at present, is perceived to be its unique perspective: the nature of man.

2.2. Nursing research

The lack of a uniquely nursing perspective is also an obstacle for the development of nursing research for, as yet, it is far from clear which facts are nursing facts and, therefore, relevant for nursing research. This means that the '*present criterion for research questions in nursing is whether or not the scientific method can be faithfully applied to the content to be investigated*' (Colaizzi, 1975). Although this approach has yielded a considerable body of knowledge, it is open to debate whether this is the body of knowledge nurses are looking for, as an uneasy alliance appears to exist between nursing philosophy and the scientific method used in nursing research (Munhall, 1982):

- **nursing philosophy**
  'Nursing is a profession that identifies itself as humanistic, and adheres to a basic philosophy that focuses on individuality and the belief that the actions of men are in some sense free. Nursing philosophy almost universally includes a belief about holistic man. In nursing philosophies the nurse is the advocate of the individual's autonomy and acts to safeguard the patient's rights.'

- **the scientific method**
  'The basic premises of the scientic method are: individuals are alike according to categories, experience is quantifiable, and human and environmental constancy and passivity can be produced. The end result is a situation-producing theory that is deterministic, atomistic, and scientific. The basic world view is mechanistic: the individual reacts to predetermined stimuli to produce a desired outcome as set by the nurse.'

As a result of these differences between nursing philosophy and the scientific method, increasingly many nursing researchers begin to feel the need for research methods other than the predominantly positivist method. The call is for more qualitative research methods as opposed to quantitative methods for they '*may be more consistent with nursing's stated philosophical beliefs in which subjectivity, shared experience, shared language, interrelatedness, human interpretation, and reality as experienced rather than contrived are considered*' (Munhall, 1982). The following definitions explain the main differences between the two approaches to research (Leininger, 1985):

- **qualitative research**
  'The qualitative type of research refers to the methods and techniques of observing, documenting, analyzing, and interpreting attributes, patterns, characteristics, and meanings of specific, contextual or gestaltic features of phenomena under study.'

- **quantitative research**
  '... quantitative research focuses upon the empirical and objective analysis of discrete and preselected variables that have been derived a priori as theoretical statements in order to determine causal and measurable relationships among the variables under study.'

By virtue of its focusing on the body of opinions, beliefs and values associated with the different meanings of nursing, this study draws heavily upon a qualitative method for nursing research as this is more in line with the questions under study. Using this approach it may be possible to identify more precisely which facts bear empirical relevance for nursing, and by which methods they should be researched.

2.3. The nursing profession

At present, there is evidently a lack of interest in the conceptual history of modern nursing, except for the models and theories of nursing which have emerged in recent years. As a result, adjectives like 'individualised' and 'comprehensive' are indiscriminately used to designate the present meaning of nursing, without taking into account the historical circumstances which have given rise to the use of these adjectives in the first place.

In other words, due to the lack of interest in the conceptual history of modern nursing, nurses are insufficiently aware of the different meanings of nursing, past and present. This lack of historical awareness is most unfortunate, for knowledge of the conceptual history of nursing is indispensable for understanding the situation the nursing profession finds itself in at present, as well as for shaping the future of the nursing profession.

This study breaks new ground in that it deals with the conceptual history of modern nursing in the United States. This is done not so much by means of a chronology of historical events as by tracing the changing meaning of nursing and the accessory changes of opinions, beliefs, and values as to what nursing does stand for and what not.

Hopefully, this study will make nurses aware of the fact that, for example, 'individualised nursing' signifies the meaning of nursing as it was conceived in the 1920s and the 1930s, and that it may be wise to limit the use of this designating adjective to denote the meaning of nursing in that particular period. If so, nurses should find new words to express the meaning of nursing as it is conceived today. Given the growing body of opinion that nursing's unique perspective should be derived from the nature of man, it may well be that the present meaning of nursing would be best expressed by the adjective 'man-centred' instead of one of the older and more established adjectives. On the other hand, the meaning of individualised nursing may turn out to be more or less timeless to the effect that it reflects some persistent trend in the conceptual history of nursing. In that case, the use of the adjective 'individualised' to denote the present meaning of nursing would be justifiable after all. Whatever the conclusion, this study, by virtue of its focusing on the meaning of nursing, is expected to cast a new light on the history of the nursing profession in the United States.

3. The method of the study

The purpose of this study is to investigate the meaning of nursing which comes to the fore in designating adjectives like 'individualised,' 'comprehensive,' 'patient-centred,' and so on. This is thought relevant because it may contribute to the search for a uniquely nursing perspective in nursing science, i.e. the nature of man.

Furthermore, it may also demonstrate that the use of qualitative methods of nursing research (or a combination of quantitative and qualitative methods) is more in line with this perspective than purely quantitative methods.

Finally, it is hoped that this conceptual history of modern nursing in the United States will contribute to nurses' awareness of the history of the nursing profession.

This study deals with the meaning of specific adjectives currently in use to designate the meaning of nursing for the reasons explained above. Therefore, the method to be used must meet several requirements.

First, it must be geared to the reconstruction of the various mental representations of words like 'individualised,' 'comprehensive,' 'patient-centred,' and so on, when used in connection with nursing. Therefore, it should enable the researcher to collect the data which are relevant for that purpose.

Secondly, the method must be conducive to the demarcation of the mental domains of interpretation within which these adjectives are meaningful. Therefore, it should direct the researcher's attention to the presuppositions and implications which condition the correct interpretation of each of these adjectives.

Thirdly, the method must be poised to identify both the similarities and the differences between these domains of interpretation. It should, therefore, help the researcher to compare the various domains of interpretation with regard to the question of what nursing means and what it does not.

Last but not least, the method must provide the means to identify the practical bearings of the similarities and differences between 'individualised nursing,' 'comprehensive nursing' and 'patient-centred nursing,' and so on, for nursing science, nursing research and the nursing profession as a whole.

All these requirements point in the direction of a method geared to '*the discovery of meaning*' which, for reasons to be explained in Part I of this study, is just another expression for '*the generation of theory*.' The methodological considerations in Part I are also needed to prepare the ground for the discussion about the research method used in this study (see chapter 4).

PART I
METHODOLOGICAL ASPECTS

The main purpose of this study is to investigate some of the adjectives currently in use to denote the meaning of nursing in order to discover the accessory opinions, beliefs and values as to what nursing is and what it is not. This purpose calls for a method of research which is geared to the reconstruction of the domain(s) of interpretation within which these adjectives (when used in connection with nursing) make sense, or better still, a method conducive to the generation of hypotheses regarding such domain(s) of interpretation. For reasons to be explained in this part, Grounded Theory appears to be the chosen method for this purpose.

Grounded Theory. Grounded Theory is a method for the discovery of theory from data systematically obtained and analysed in social research, mainly by the use of a general method of comparative analysis. The main source of information about this method is Glasers and Strauss's book `The discovery of Grounded Theory' which was published in the United States of America in 1967. References in this study, however, are to the British edition which was published in the next year (Glaser & Strauss, 1968). Other available publications, written by the same authors, have only been used in order to check specific interpretations of this book.

Although Grounded Theory was developed for sociologists it has been used by nursing scientists as well (e.g. Kratz, 1974; Baker, 1978; Melia, 1979; Kappeli, 1982), and rightly so as Glaser and Strauss believe that their book `*can be useful to anyone who is interested in studying social phenomena - political, educational, economic, industrial, or whatever - especially if their studies are based on qualitative data*' (Glaser & Strauss, 1968, p. viii). However, when using Grounded Theory these nursing scientists did not pay much attention to its potential and its limitations. Therefore, the first part of this study is aimed at:

- justifying the use of this particular method to discover the various meanings of nursing,
- demonstrating its potential and its limitations as well.

Practice Theory. In order to achieve both these goals, Grounded Theory is compared with the theory of theories advocated by Dickoff and James (Dickoff & James, 1968a and 1968b; Dickoff, James & Wiedenbach 1968a and 1968b; Dickoff & James 1975; Dickoff, James & Semradek 1975a and 1975b). In contrast to Grounded Theory, this theory has been specially developed for use by nurses to generate nursing theory. For convenience sake, this theory will be denoted here as Practice Theory and its originators will be referred to as Dickoff and James. Whenever reference is made to a particular publication the names of the other co-authors are mentioned too.

The reason for comparing both these theories is that, though emphasising different aspects of theory, they reflect rather similar views with regard to the nature of theory. Whereas Grounded Theory is `*a way of arriving at theory suited to its supposed uses*' (Glaser & Strauss, 1968, p. 3), Practice Theory is `*a conceptual system or framework invented to some purpose*' (Dickoff & James, 1968a, p. 198). These definitions contrast sharply with the widespread view that a theory is the result of an inquiry and describes, explains and predicts facts for they focus on a theory's use or purpose instead.

To account for this, it would be too simple an explanation that Glaser and Strauss as well as Dickoff and James try to meet the need of applicable theory as there are many other similarities which can only be explained by the pragmatist origin of their respective theories. The latter is borne out by the fact that, in both cases, John Dewey is referred to as the main source of inspiration.

Pragmatist philosophy. John Dewey, the pragmatist philosopher, is well known for his strong opposition to the so-called `*spectator theory of knowledge*' which he considers to be at the source of all sorts of dualisms but, most importantly, it creates a gap between theory and practice. The concept of dualism in Dewey's philosophy should not, however, be taken to mean a contradiction of concepts in the Hegelian sense which may lead to the synthesis of thesis and antithesis in the end. Dualism, as Dewey sees it, is a characteristic of `*any doctrine which maintains that two things are mechanically related when as a matter of fact they are organically related*' (White, 1964, p.32).

Within the framework of empiricist philosophies, for example, man's knowledge of the external world is confined to the consciousness of his sensible experiences, so that he can have no knowledge of the external

world itself, let alone of himself as a knowing subject. Therefore, this knowledge-relationship is a mechanical one, or, better still, a matter of impact. More importantly though, it is conducive to the view that man is a passive spectator and that the division between the subject and the object of knowing is inevitable.

According to Dewey, however, the knowledge-relationship is an organic one, thereby doing justice to the interaction between the subject and object of knowing and to the activity of the human mind as well. In order to avoid such dualisms, Dewey developed his instrumentalist version of pragmatism which he himself once defined as `*an attempt to constitute a precise logical theory of concepts, of judgements and inferences in their various forms, by considering primarily how thought functions in the experimental determinations of future consequences*' (Copleston, 1966, p. 123).

To grasp the views advocated by either Glaser and Strauss or Dickoff and James, it is expected to be helpful to consider some of Dewey's views for, in the final analysis, both Grounded Theory and Practice Theory originated in Dewey's views, and, for that matter, those of other pragmatist philosophers as well. More importantly, the analysis of Dewey's views will also cast some light on the implications of using Grounded Theory as a method for generating theories. Stating these implications explicitly at the start of this study seems appropriate to clarify both the scope and the limitations of this study.

Finally, after the introduction of both Grounded Theory, Practice Theory, and pragmatist philosophy (chapter 1), the first part of this study deals with the in-depth analysis of Grounded Theory (chapter 2) and Practice Theory (chapter 3). The final chapter is concerned with the outcome of this analysis, the justification of the use of Grounded Theory as the chosen method for this study, and the outline of the research design used in this study (chapter 4).

1.
GROUNDED THEORY, PRACTICE THEORY, AND PRAGMATIST PHILOSOPHY

Leaving the more detailed analysis until later chapters, this chapter introduces Grounded Theory and Practice Theory by sketching the most characteristic themes and features of each theory and some relevant aspects of pragmatist philosophy as well.

1.1. Two theories of theories

1.1.1 Grounded theory

Glaser and Strauss do not leave the readers of `The discovery of Grounded Theory' in the dark about their intentions very long for they start off with the following remarks (Glaser & Strauss, 1968, p. 1):

> *`Most writing on sociological method has been concerned with how accurate facts can be obtained and how theory can thereby be more rigorously tested. In this book we address ourselves to the equally important enterprise of how the discovery of theory from data - systematically obtained and analyzed in social research - can be furthered. We believe that the discovery of theory from data - which we call grounded theory - is a major task confronting sociology today, for, as we shall try to show, such a theory fits empirical situations, and is understandable to sociologists and layman alike. Most important, it works - provides us with relevant predictions, explanations, interpretations and applications.'*

These remarks indicate the three central themes of the book:

- **generating theory (pp. 2-3)**
  `The basic theme in our book is the discovery of theory from data systematically obtained from social research. Every chapter deals with our beginning formulation of some of the processes of research for generating theory. Our basic position is that generating grounded theory is a way of arriving at theory suited to its supposed uses. We shall contrast this position with theory generated by logical deduction from a priori assumptions.'

- **the nature of theory (p. 9)**
  `We know others' work as published product; we know our own better as work-in-process - and discovering theory as a process is, of course, the central theme of this book.'

- **criteria of adequacy of Grounded Theory (p. 8)**
  `The general comparative method for generating grounded theory ... provides criteria for judging the worth of all theory, as well as grounded theory. This theme pervades the whole book.'

1.1.2. Practice theory

Dickoff and James are equally outspoken about the intentions of their theory of theories. Right from the start of their first article they announce the position which they take on two important issues (Dickoff & James, 1968a, p. 197):

> *`first, on the issue of what a theory is; then, on the issue of what a nursing theory should be. Even more fundamentally, the position is taken that the difficulty in identifying and developing nursing theory stems in important part, on the one hand, from a conceptual muddle as to what theory is in any of its manifestations and, on the other hand, from the tendency in nursing, or in any discipline or individual, to*

grasp any structural security - even one that vitiates the basic purpose of individual or discipline - rather than to rest without security or even to brave fumbling toward a more significant security.'

As for the first issue, they hold the view that a theory is `*a conceptual system or framework invented to some purpose*' (Dickoff & James, 1968a, p. 198). Applying this definition to the second issue - what a nursing theory should be - leads to the position that such a theory `*must provide for more than mere understanding or "describing" or even predicting reality and must provide conceptualization specially intended to guide the shaping of reality to that profession's professional purpose*' (Dickoff & James, 1968a, p. 199). Finally, they claim two points of novelty for their theory (Dickoff & James, 1968a, pp. 202-203):

`The first point of novelty to be urged is the contention that nursing or any so-called applied theory is more, rather than less, conceptually sophisticated than are so-called "pure" theories. To exclude the possibility of specific guidance in the attempts to put to use descriptive theories of reality is to confuse the present state of theory production with the theoretic possibilities for theory production. This brings us to the main point of novelty claimed. We suggest that proposing a theory of theories that sees theory as a conceptual system invented to some purpose - when seen in its full consequences - has revolutionary possibilities. The proposal allows at last for theory to be viewed as a proper tool to man even in his role of providing himself with a purpose.'

1.1.3. Dewey's brand of pragmatist philosophy

From these short descriptions of the main themes of Grounded Theory and Practice Theory similar features emerge, albeit in a different form. For a start, the authors of both theories take issue with a specific view of the nature of theory. Whereas Glaser and Strauss enter into a detailed argument with theory generated by logical deduction from a priori assumptions, Dickoff and James fuel the opposition to the view that theory is merely a matter of understanding, describing or predicting reality. Both theories thus appear to be precipitated by the authors disagreeing with the predominant view as to the nature of theory in sociology and nursing respectively.

Secondly, they set out to counterbalance these predominant views by means of an alternative notion of theory which puts high emphasis on the process of generating theory being determined by the supposed uses or the purpose of the theory.

Thirdly, the originators of both theories claim special merits for their proposals which differ from the commonly used criteria of adequacy of a theory. A grounded theory, for example, is suited for its supposed uses because it fits the situation, because it is understandable to sociologists and laymen alike, and because it works, whilst a practice theory is capable of serving its purpose because it is invented to help the nurse to shape reality according to her professional purpose.

Summing up, both Grounded Theory and Practice Theory intend to liberate its potential users from some commonly held views as to the nature of theory and to redirect their attention to a view that is to be preferred because it does not lead them astray as far as the application of theory is concerned for by virtue of its practical nature it enhances the possibilities of application. The originators of Grounded Theory and Practice Theory do not set out to substitute a better theory for any sociological or nursing theory that already exists. They just point out how to develop theories that can indeed be applied. They don't offer their readers, so to speak, fish but they teach them to fish instead. This approach reflects a zeal for emancipation which is another important feature both theories have in common, and, it is contended here, not without good reason, for it is due to the influence of Dewey's instrumentalism in both theories.

Glaser and Strauss are very explicit about their zeal for the emancipation of the sociologist as a theorist (Glaser & Strauss, 1968, pp. 6-10):

`This book is intended to underscore the basic sociological activity that only sociologists can do: generating theory. Description, ethnography, fact-finding, verification (call them what you will) are all well done by professionals in other fields and by layman in various investigatory agencies. But these people cannot generate sociological theory from their work. Only sociologists are trained to want it, to look for it, and to generate it. ... Our principal aim is to stimulate other theorists to codify and publish their own methods for generating theory.'

The same goes for Dickoff and James (Dickoff, James & Wiedenbach, 1968a, p. 423):

> *`The aim is not to propose a nursing theory but is rather to touch on what can be expected as ingredients or as a structure of ingredients in any proposed nursing theory. And perhaps even more importantly ... our intention here is to liberate the would-be theorist from some all too prevalent "orientation stereotypes." Freed from these sets of mind he may be able to take new viewpoints even on old and recognized dimensions of a difficulty, as well as to invent more novel dimensions from which to treat well-known problems.'*

In trying to further the emancipation of the nurse as a theorist, Dickoff and James moreover point to three sources required for a nursing theory (Dickoff, James & Wiedenbach, 1968b, p. 545):

> *`awareness of status of practice theory; interest in developing practice theory; and openness to relevant empirical reality. If you do not know what you are looking for, you will not recognize it even if you were to find it; if you know what something is but do not see it as worth your trouble, you will spend no energy getting it; and if you are not willing to stimulate and risk your inventions in the fire of reality, your conceptions, however magnificent, have no claims beyond the academic.'*

Considering the influences of Dewey's thinking in both theories, this zeal for emancipation is definitely no coincidence for, in Dewey's view, philosophy and science should be instrumental in solving the problems man is confronted with. Accordingly, philosophy and science should be directed to practical action. This is not to say that, according to Dewey, philosophy and science have succeeded in achieving this goal, for it is exactly their failure to do so which has given rise to his instrumentalist version of pragmatist philosophy. This can be demonstrated by Dewey's views concerning the role of philosophy and science in relation to practical action.

Philosophy and practical action. As far as philosophy is concerned, Dewey's instrumentalism signifies his opposition to virtually all philosophers, great and small, since they search for absolute certainty and are only concerned with the elevated sphere of unchanging, timeless being and truth. But in order to find what they are looking for, it is argued by him, they have to indulge in complex systems of dialectic reasoning with the inevitable result that they lose touch with the experience of everyday life, for these philosophies simply cannot account for the phenomenon of change in the world. In this way philosophy (theory) becomes divorced from reality (practice).

In order to reunite theory and practice Dewey does not start from the world as philosophers think it ought to be but from the world man finds himself in and which is `*precarious and perilous*' (Dewey, 1925, p. 42). This view of the world, he emphasises, should be the point of departure of any philosophy which claims to take human experience and man's search for security and certainty seriously. An important corollary of this point of departure is that the objective of philosophy cannot be absolute security and certainty, for this can never be achieved. Only that security or certainty is feasible which results from practical solutions for the hazards man is exposed to, and both the hazards and the solutions are closely linked with the particular situations man finds himself in.

Transferring Dewey's philosophical views to the philosophy of science which comes to the fore in Grounded Theory, it becomes clear why Glaser and Strauss emphasise that for a theory to be suited to its supposed uses it should not be logically deduced from a priori assumptions but that it must be grounded in the data. Further, Dewey's views can also help to account for Dickoff and James' warning that nurses should not `*grasp any structural security*' on offer as well as their advice to `*rest without security or even to brave fumbling toward a more significant security*,' for this security, as they point out, can only be found in a theory which is `*invented to some purpose*.' The latter remark becomes even more significant if it is applied to the relationship between science and practical action.

Science and practical action. As far as science is concerned, Dewey is equally adamant that practical action is the ultimate goal, and, generally speaking, he thinks rather favourably of the rise of modern science, for science enables man to understand processes of change and, within certain limits, to control them. Moreover, as a result of this change of emphasis man is capable of bringing about the changes he desires and preventing those which

he does not desire. In this respect, science is capable of something which philosophy is not, namely dealing with the phenomenon of change.

On the other hand, Dewey takes issue with the popular belief that science deals with the world just as it is, thereby eliminating all qualities and values from it, and that science is, therefore, free of or indifferent to moral values. The reason for taking this position is that this value-free notion of science creates a gap between the reality of the physical world and the reality of values. This dualism has given rise to other philosophical systems similar to those Dewey has ruled out because of their dualism between theory and practice. Consequently, every philosophical attempt to reconcile the two spheres mentioned is considered to be based on an inadequate view of the problem. For values are not separated from the world but they are incorporated in it. Therefore, the existence of values does not need any philosophical explanation or proof in order to complete the scientific view of the world. Instead, Dewey reformulates the problem in the form of the following question (Dewey, 1925, p. 42):

> *`Why should we not proceed to employ our gains in science to improve our judgments about values, and to regulate our actions so as to make values more secure and more widely shared in existence?'*

Instrumentalism. Dewey sees it as the task of philosophy to give guidance to the use of science, not by taking over the scientist's job but by developing methods for using science in such a way that it helps to bring about a desired situation. In order to do this the philosopher examines the possible consequences of scientific practice with a view to examining the ways in which it should be changed in order to bring about the consequences which are considered to be desirable. However, for lack of any absolute values to go by, the philosopher is forced to use an experimental method which is equally applicable to both the technical experiments of scientific practice and the values which direct the conduct of human life. In other words, not only the means but also the ends of practical action are seen as the result of scientific inquiry. An important corollary of this view is that science or theory is no goal in itself but an instrument or a tool for achieving practical goals.

This experimental attitude is characteristic of Grounded Theory and Practice Theory too, for their respective originators repeatedly stress that they do not claim to have written the final chapter on their subject. On the contrary, they repeatedly invite their readers to join in the discussion about the methods to be used in the respective sciences. This is fully in line with Dewey's own attitude toward his instrumentalist philosophy which he considers, in the final analysis, to be an experiment in itself too. The instrumental attitude of Dewey is reflected by Grounded Theory when, for example, Glaser and Strauss emphasise `*theory as process*' and theory being `*suited to its supposed uses*.' It is also reflected by the two points of novelty claimed for Practice Theory, viz. that it offers `*guidance to put descriptive theories of reality to use*' and allows theory to be viewed as `*a proper tool to man even in his role of providing himself with a purpose*.'

1.1.4. Summary

The comparison of the basic themes and features of Grounded Theory and Practice Theory has revealed some striking similarities between what a sociologist is trained for on the one hand, and the reasons Dickoff and James give for tapping the three sources of nursing theory on the other. The sociologist's ability `*to look for*' theory parallels the nursing theorist's `*awareness of the nature of theory*.' Similarly, `*to want'* theory parallels *`interest in developing theory*,' and `*to generate'* theory parallels *`openness to empirical reality*.'

These parallelisms show what the respective authors, operating within the framework of Dewey's instrumentalism, think is required to be a good theorist. To be able to look for theory, one must be aware of the nature of theory in general and its relation to reality in particular, thereby avoiding the dualism between theory and practice. To want theory, however, presupposes that one thinks it to be valuable for practical purposes, and this requirement prevents the dualism between the world of science and the world of values. Both these conditions being fulfilled, one should set out to generate or invent theory which is suited to its supposed uses or is capable of serving its purpose respectively, not by merely conceptualising reality (as philosophers tend to do) nor by merely mirroring reality (as scientists tend to do), but by developing theory in interaction with the real world and with a view to the theory's practical application.

In order to illustrate this relationship between the core ideas of Grounded Theory and Practice Theory on the one hand, and Dewey's philosophy on the other hand, the remaining part of this chapter deals with some relevant aspects of pragmatist philosophy.

1.2. Pragmatist philosophy

John Dewey (1859-1952) is one of the representatives of pragmatist philosophy, this `*most characteristic expression of the American mind*' (Miller, 1966, p. 76), the other two being Charles Sanders Peirce (1839-1914) and William James (1842-1910). Pragmatism can be best thought of as `*a method or rule for making ideas clear, for determining the meaning of ideas*' (Copleston, 1966, pp. 66-67), and according to William James, it also entails `*the doctrine that the whole meaning of a conception expresses itself in its practical consequences*' (Miller, 1966, p. 375). To understand the pragmatist position it is, therefore, helpful to see the generation of concepts or ideas not as an attempt to merely understand, describe or predict reality or facts but as a process of thinking resulting in ideas which are essentially plans or rules for action.

1.2.1. Ideas

Pragmatist philosophy is, first of all, about ideas. Therefore, it is relevant to first see what Peirce, James and Dewey say about the role of thought in generating ideas. The next step will be to discuss their views concerning the meaning and the truth of ideas.

Charles Sanders Peirce. According to Peirce, the pragmatist philosopher of meaning, one cannot generate ideas or a theory from scratch, as claimed by the rationalist philosopher Ren Descartes, whose point of departure was a universal doubt. For the need to generate ideas or to replace an existing idea with a new one always presupposes some beliefs about the actual state of affairs so that there cannot be such a thing as an absolutely presuppositionless point of departure.

Rejecting this rationalist approach, Peirce does not think much of the empiricist approach either, for he maintains it to be impossible `*that we should have an idea in our minds which relates to anything but conceived sensible effects of things. Our idea of anything is our idea of its sensible effects; and if we fancy that we have any other we deceive ourselves, and mistake a mere sensation accompanying the thought for a part of the thought itself*' (Copleston, 1966, p. 72). The theatre of discussion is thus not the actual world but the world as it is conceived from its `*sensible effects*.' Therefore, this discussion takes place at a conceptual level and is not about facts but about one's intellectual conception or ideas of them. Peirce subsequently discerns three different types of ideas (Copleston, 1966, p. 67):

- the idea of firstness or `*the idea of a percept or sense-datum considered in itself, without relation to anything else*,'
- the idea of secondness or `*the idea of acting which involves two objects, viz. an agent and a patient or that which is acted upon*,'
- the idea of thirdness or `*the idea of a sign relation, of a sign signifying to an interpreter that a certain property belongs to a certain object or to a certain kind of object*.'

These three types of ideas enable Peirce to counterbalance the empiricist and positivist philosophy of science which was so dominant at the time by explaining that there is, so to speak, more to thinking than meets the eye. Acknowledging that the real world provides man with sensible experiences (ideas of firstness), Peirce also stresses man being aware of his own actions, one of which is thinking (ideas of secondness). Both types of ideas taken together culminate in man being conscious of the practical meaning which the world has for him. This consciousness is constituted by man's intellectual concepts or conceptions of the world (ideas of thirdness). This shows why Peirce holds the view that the function of thought is to substitute a determinate or meaningful situation for an indeterminate or meaningless situation.

William James. James, the pragmatist philosopher of experience, gives a deeper insight into this pragmatist theory of knowledge in his famous paragraph about the 'selectiveness of consciousness' (Miller, 1966, p. 378):

> *`Looking back, then, over this review, we see that the mind is at every stage a theatre of simultaneous possibilities. Consciousness consists in the comparison of these with each other, the selection of some, and the suppression of the rest by the reinforcing and inhibiting agency of attention. The highest and most elaborated mental products are filtered from the data chosen by the faculty next beneath, out of the mass*

offered by the faculty below that, which mass in turn was sifted from a still larger amount of yet simpler material, and so on. The mind, in short, works on the data it receives very much as a sculptor works on his block of stone. In a sense the statue stood there from eternity. But there were a thousand different ones beside it, and the sculptor alone is to thank for having extricated this one from the rest. Just so the world of each of us, howsoever different our several views of it may be, all lay embedded in the primordial chaos of sensations, which gave the mere matter to the thought of all of us indifferently. We may, if we like, by our reasonings unwind things back to that black and jointless continuity of space and moving clouds of swarming atoms which science calls the only real world. But all the while the world we feel and live in will be that which our ancestors and we, by slowly cumulating strokes of choice, have extricated out of this, like sculptors, by simply rejecting certain portions of the given stuff. Other sculptors, other statues from the same stone! Other minds, other worlds from the same monotonous and inexpressive chaos! My world is but one in a million alike embedded, alike real to those who may abstract them. How different must be the worlds in the consciousness of ant, cuttle-fish, or crab!'

In contrast to Peirce, James is not so much interested in the meaning of ideas as in their significance for human experience. Therefore, he interprets the developing consciousness of man as the transformation of `*pure experience*' (Peirce's idea of firstness) to `*articulate experience*' (Peirce's idea of thirdness).

John Dewey. Dewey, the pragmatist philosopher of value, expresses similar ideas by stating that the object of knowledge is made or constructed by thought (Dewey, 1925, p. 381):

`... knowledge is not a distortion or perversion which confers upon its subject matter traits which do not belong to it, but it is an act which confers upon non-cognitive material traits which did not belong to it.'

At first sight, it seems to be a tautology to say that the object of knowledge comes into being through the process of knowing or by being known. But, as Copleston rightly points out (Copleston, 1966, p. 116):

`Dewey obviously does not intend the statement to be a tautology: he intends to say something more. And what he intends to depict is the process of knowing as a highly developed form of the active relation between a living organism and its physical and cultural environment, a relation whereby a change is effected in the environment. In other words, he is concerned with giving a naturalistic account of knowledge and with excluding any concept of it as a mysterious phenomenon which is entirely sui generis. He is also concerned with uniting theory and practice. Hence knowledge is represented as being itself a doing or making rather than, as in the so-called spectator theory, a "seeing".'

In this way the relationship between the non-cognitive material of sensible experience and the activity of knowing becomes an organic relationship for there is a third living entity which contains both of them as its parts, viz. nature. Moreover, in this way thought is also placed within the wider context of experience as `*a transaction, a process of doing and undergoing, an active relation between an organism and its environment*' (Copleston, 1966, pp. 114-115).

Under normal circumstances, this transaction is based on habits, but as soon as a problematic situation arises the habitual response will be replaced by reflection in order to resolve the problem. Therefore, Dewey holds the view that thought is always preceded by some antecedent conditions of existence which are considered to be problematic, just as Peirce holds the view that thought always starts from some natural beliefs. In so far as this change of response requires the recognition of a problematic situation as being problematic, the normal relationship between the organism and its environment is somehow disrupted as reflection is substituted for the habitual response. But, to the degree that both habits and thought are directed toward resolving the problem, they are organically related parts of the unified whole of experience.

In his early years, Dewey had resorted to the idealist notion of `*universal consciousness*,' a concept put forward by his teacher George Sylvester Morris (1840-1889) which resembles Hegel's `*Geist*,' in order to account for the organic relationship between the subject and the object of knowing. This universal consciousness was supposed to embrace the `empirical consciousness' of each individual which, in turn, embraced the individual and the object of his knowledge. Using this concept, Dewey managed to overcome the divorce

between the subject and the object of knowledge. Both the subject and object of knowledge were viewed as elements within the larger organic whole of the universal consciousness, thereby avoiding dualisms of an inner-outer variety. This provided him with the basic outline of his later theory of knowledge (White, 1964):

> *`He need only convert the universal consciousness into nature, the individual into organism, and the object of knowledge into environment. The result, translated into naturalistic terms, is that the organism and its environment are both parts of nature. It follows that whatever holds true of nature in general, holds true of human organisms in particular, and that the activity or capacity known as "knowledge" appears in man in accordance with the principle of organic evolution.'*

These views form the basis for Dewey's so-called naturalistic empiricism. According to his theory of knowledge, thought develops out of the evolutionary relationship between man and his environment. On the basis of this naturalistic account of knowledge Dewey, therefore, holds the view that intellectual operations are foreshadowed in the non-selective responses of inanimate things and in the selective responses of living organisms. In so far as such responses are directed at the problematic as problematic, they acquire mental quality. But if such responses are also intended to change man's precarious and problematic relationship with his environment into a secure and a resolved one, they are not only of a mental but also of an intellectual nature. The central theme of Dewey's theory of knowledge is that thought starts from experience and leads back to experience, thereby transforming or reconstructing the relationship between man and his environment time and again. This explains why Dewey's instrumentalist version of pragmatist philosophy focuses on the function and value of thought for the transformation of the unstudied into the studied control of practical matters.

Finally, there are two other features of this naturalistic empiricism worth mentioning. Firstly, the act of knowing, as Dewey sees it, implies a relationship with the environment which is not merely intellectual, for the interactions between man and his environment involve physical actions too (e.g. doing and making). This feature is also reflected in the slogan of his philosophy of education, i.e *`learning by doing*.' Secondly, the environment should be taken to mean not only man's physical but also his cultural environment including all its customs and traditions. These form the breeding ground for the development of individual habits, which in turn enable man to interact with his environment. If this relationship becomes problematic, the situation provides man with the impetus to change his individual habits and this may ultimately lead to a wider cultural change. This is also the reason why Dewey views all psychology as social psychology.

1.2.2. Meaning and truth

Having established what Peirce, James and Dewey hold to be the role of thought in generating the ideas necessary to achieve these goals, the next step is to discuss their views concerning the meaning and the truth of such ideas.

Charles Sanders Peirce. The answer to the first question can be found in one of Peirce's formulations of the principle of pragmatism (Copleston, 1966, p. 67):

> *`In order to ascertain the meaning of an intellectual conception one should consider what practical consequences might conceivably result by necessity from the truth of that conception; and the sum of these consequences will constitute the entire meaning of the conception.'*

The question of whether such a conception is true or false is also dealt with at the conceptual level by Peirce (Copleston, 1966, p. 62):

> *`When we speak of truth and falsity, we refer to the possibility of the proposition being refuted.'*

This so-called principle of fallibilism refers to the possibility of a proposition being refuted by experience and not to its actual verification, for it is typical of Peirce's views that if one *`could legitimately deduce from a proposition a conclusion which would conflict with an immediate perceptual judgment, the proposition would be false. If, however, experience would not refute a proposition, the proposition is true, supposing such a testing*

were possible' (Copleston, 1966, p. 62). In so doing, one should adhere to some sort of canons or principles of correct reasoning, i.e. logic. The logic Peirce has in mind, however, is quite different from formal logic and deals primarily with the meaning and truth of signs and symbols. Peirce's logic consists of three parts:

- **speculative grammar**
  The first part, speculative grammar, is concerned with the formal conditions of the meaningfulness of signs or symbols. Therefore, speculative grammar clarifies why signs, e.g. a term, a proposition or a statement, mean what they mean. To start with, a sign does not denote reality or fact as an object of knowledge in its entirety, for it stands for this object only in respect of certain `*characteristics*,' and this is called `*ground*.' Accordingly, a term like `nursing' can have different meanings, dependent on the set of characteristics this term supposedly stands for. Furthermore, the term `nursing' should be thought of as arousing another sign in the mind of the interpreter which Peirce coined `interpretant.' Whenever he writes about the meaning of a term, a proposition or an argument, it is the interpretant it refers to and not reality or facts.
- **critical logic**
  The second part, critical logic, deals with the formal conditions of the truth of symbols. This part resembles traditional logic in so far as it is concerned with induction and deduction, but critical logic also deals with the canons and principles of abduction, i.e. the rules for formulating a hypothesis from observed facts and deducing or predicting what else should be the case if the hypothesis is true.

- **speculative rhetoric**
  The third part, speculative rhetoric, is concerned with the general conditions of the reference of symbols or other signs to the interpretants which they aim to determine and, therefore, deals with the intended interpretant of a symbol or a sign, i.e. their meaning.

It simplifies matters if one thinks of generating and clarifying ideas, as Peirce views it, as an activity by which man, starting from some natural beliefs, tries to make sense of his perceptions and to foresee the practical consequences which follow from that. As long as these consequences stand a good chance of not being refuted by further experience, they are considered to be true. This might suggest that Peirce considers truth to be provisional and relative to the individual as it lacks the certainty provided by actual verification. But he also believes that there is some `*transcendental truth*,' referring to the real character of things which they have independent of us knowing these things. In his view, man is capable of accumulating this sort of knowledge of objective reality and the conformity of this knowledge with reality lies in its concordance with `*the ideal limit towards which endless investigation would tend to bring scientific belief*' (Copleston, 1966, p. 64).

William James. William James takes Peirce's notion of truth one decisive step further by identifying the truth of a theory with the process of its verification, or validation as pragmatists prefer to call it. In so doing, he gives a certain twist to Peirce's brand of pragmatism, which made Peirce change its name into `*pragmaticism*.'

To start with, James rephrases Peirce's method for ascertaining the meaning of intellectual conceptions slightly but significantly, though (Copleston, 1966, p. 91):

> *`To attain perfect clearness in our thought of an object, we need only consider what conceivable effects of a practical kind the object may involve - what sensations we are to expect from it, and what reactions we must prepare. Our conception of these effects, whether immediate or remote, is then for us the whole of our conception of the objects, so far as that conception has positive significance at all.'*

James is thus not so much interested in the meaning of an intellectual conception as in whether it has any positive significance in terms of the sensations to expect from it and the reactions to prepare for it. In other words, an idea is meaningful to the degree that it leads to an experience of some sort of `*satisfaction*.' In addition, James also rephrases Peirce's definition of truth. He agrees with Peirce that matters of truth or falsity have nothing to do with reality or fact as such (Copleston, 1966, p. 92):

> *`Realities are not true, they are; and beliefs are true of them.'*

This does not prevent him, however, from replacing Peirce's principle of fallibilism (the conceivability or possibility of refutation) with the process of actual verification by means of `*experience*.' Therefore, James defines truth as the correspondence of a subjective belief with objective reality or fact in terms of the personal `*satisfaction'* resulting from such a belief. Accordingly, it is experience which shows a belief to be true or false, and a belief is true if it works. This means that a belief (Copleston, 1966, p. 94):

> *`must mediate between all previous truths and certain new experiences. It must derange common sense and previous belief as little as possible, and it must lead to some sensible terminus or other that can be verified exactly. To "work" means both these things.'*

The main objections of Peirce against this notion of truth focused not only on the substitution of verification for the principle of fallibilism but also on the fact that truth, as James defines it, depends upon a subjective, personal and individual experience of satisfaction rather than an objective, neutral and public debate.

John Dewey. As for Dewey, ideas are meaningful to the extent that they provide plans or designs for the reconstruction of antecedent conditions of existence which are considered to be problematic. The intermediate factor between the antecedent and the consequent conditions of existence is human thought which is always practical, both at the level of daily living and at the level of science, for Dewey views thought as an instrument or tool for an inquiry which he defines as (Copleston, 1966, p. 121)

> *`the controlled or directed transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to convert the elements of the original situation into a unified whole.'*

Dewey believes that the canons and principles for this inquiry are different from Aristotelian logic. Although the latter, dealing with a priori truths which are fixed antecedently to all inquiry, may be useful for philosophers and scientists who are concerned with the realm of timeless being and truth, the former are more suitable for practical purposes because they are generated in the process of transformation itself. Dewey's opposition to formal logic dates back from his early years when he accused certain outmoded psychologists of trying, as White (1964, pp. 40-41) puts it, `*to make living concrete facts square with the supposed norms of an abstract, lifeless thought. ... They emasculated experience till their logical conceptions could deal with it; they sheared it down till it would fit their logical boxes; they pruned it till it presented a trim tameness which would shock none of their laws; they preyed upon its vitality till it would go into the coffin of their abstractions*.' Therefore, fully in line with his instrumentalist approach, Dewey thinks of logic as provisional canons and principles of reasoning resulting from the process of inquiry itself.

As far as truth is concerned, Dewey's position implies that the validity of ideas, including the process by which they are generated, is measured by their success in bringing about the desired changes. Therefore, an idea is true to the degree that it leads one either to or away from the desired end. In other words, an idea is true if it works. Although Dewey appears to hold a rather subjective view of truth, similar to that of James, he also subscribes to Peirce's definition of truth, `*namely that the true is that opinion which is fated to be ultimately accepted by all investigators*' (Copleston, 1966, p. 123).

The ultimate test of the validity of an idea is thus practical action in a concrete situation, but inquiry and thought do not always lead to such action. In that case, the inquiry results in a set of predictive ideas which are possible plans for action and which look forward to being verified in practice, but this does not result in any form of warranted knowledge. On the other hand, these ideas' connection with action is with possible actions rather than with the most preferable or suitable action in a particular situation. Therefore, the inquiry must end up with some sort of a decision-making process as to this choice.

1.2.3. Summary

Pragmatist philosophy is a method or rule for determining the meaning of ideas or making ideas clear. This process of inquiry presupposes not only watching in the sense of seeing and perceiving but also doing in the sense of thinking and acting. Both activities are aimed at the conceptualisation of ideas in order to transform an

indeterminate or meaningless situation into a determinate or meaningful situation (Peirce), or pure experience into articulate experience (James), or an insecure or problematic situation into a secure and resolved situation (Dewey).

According to pragmatists philosophers, an idea is meaningful to the extent that it clarifies what practical consequences might conceivably result by necessity from the truth of that idea (Peirce), or leads to an experience of some sort of satisfaction (James), or is instrumental in the reconstruction of antecedent conditions of existence which are considered to be problematic (Dewey).

In addition, an idea is held to be true as long as its conceivable consequences stand a good chance of not being refuted by further experience (Peirce), or corresponds with objective reality or fact in terms of the personal satisfaction resulting from it (James), or helps to bring about the desired changes (Dewey).

According to pragmatist philosophy, ideas are thus meaningful and true insofar as they are inequivocally and irrefutably clear about their practical consequences. Instead, one can also say that ideas are essentially plans or rules for practical action.

2.
GROUNDED THEORY

As stated before, the originators of both Grounded Theory and Practice Theory take issue with those views of the nature of theory which are conducive to a division between theory and reality on the one hand, and theory and practice on the other hand. This chapter and the next chapter enter into this subject in more detail, by outlining each theory's position and its relationship to Dewey's instrumentalist version of pragmatist philosophy. From this analysis it will become clear that both theories fully agree with Dewey's views of the nature of science. This conclusion is borne out by both theories' opposition to theories which are merely based on:

- a priori assumptions, or idle speculation,
- facts, or attempt to provide a picture-image of reality.

The reason for this opposition is that these types of theories lead not only to a division between theory and reality but in the end also, and more importantly, to a division between theory and practice.

The solution for these two types of dualism, as proposed by Grounded Theory and Practice Theory, is in line with Dewey's view of science too. In both cases, it emerges that the generation of a theory is seen as a process that is grounded in the data and nursing practice respectively, for it starts from the data or nursing practice, and leads back to it. This view of the nature of theory is closely linked with Dewey's instrumentalist views concerning the role of human thought in the transformation of insecure or problematic situations into secure and resolved situations.

2.1. Introduction

The sociological climate which gave rise to the development of Grounded Theory is characterised by '*the embarassing gap between theory and empirical research*' (Glaser & Strauss, 1968, p. vii). Glaser and Strauss have tried to bridge this gap by writing a book about the process of generating grounded theory as opposed to '*other processes of arriving at theory, particularly the logico-deductive*' (Glaser & Strauss, 1968, p. 31).

The resulting argument is prompted by the '*overemphasis in current sociology on the verification of theory, and a resultant de-emphasis on the prior step of discovering what concepts and hypotheses are relevant for the area that one wishes to research*' (Glaser & Strauss, 1968, pp. 1-2). This zeal for verification is closely linked with (Glaser & Strauss, 1968, p. 9):

- '*the influential style of logico-deductive theorizing, which encourages the drive toward verification' and is inhibitive for generating theory*,'
- '*the distinction usually drawn between qualitative and quantitative data - a distinction useless for the generation of theory*.'

2.1.1. Logico-deductive theory and verification

The emphasis on verification is explained by the '*assumption by many sociologists that our "great men" forefathers (Weber, Durkheim, Simmel, Marx, Veblen, Cooley, Mead, Park, etc.) have generated a sufficient number of outstanding theories on enough areas of social life to last for a long while*' (Glaser & Strauss, 1968, p. 10). These classics of sociological theory have been so influential and prevalent that for many researchers they are '*synonymous with "theory" - and so they think of "theory" as having little relevance to their research*' (Glaser & Strauss, 1968, p. vii). This being so, there was every reason to continue to focus on empirical studies and on efforts to improve the methodology of verification.

Glaser and Strauss illustrate this state of affairs by pointing to the division of labour in the community of sociologists. On the one hand there are the sociologists who play the part of '*theoretical capitalist*' whose task it is to generate theory, preferably by logical deduction from a priori assumptions, and on the other hand there is '*the mass of "proletariat" testers'* trying *'to test their teachers' work but not to imitate it*' (Glaser & Strauss, 1968, pp. 10-11).

2.1.2. Qualitative and quantitative data

The distinction drawn between qualitative and quantitative data is explained by the improvement of methods for testing theory (Glaser & Strauss, 1968, pp. 15-16):

> *'... advances in quantitative methods initiated the zeal to test unconfirmed theories with the "facts." Qualitative research, because of its poor showing in producing the scientifically reproducible fact, and its sensitivity in picking up everyday facts about social structures and social systems, was relegated ... to preliminary, exploratory, groundbreaking work for getting surveys started. Qualitative research was to provide quantitative research with a few substantive categories and hypotheses. Then, of course, quantitative research would take over, explore further, discover facts and test current theory.'*

As a result of the momentum of this development all generators of sociological theory - whether they advocated the use of qualitative data or whether they were of a logico-deductive persuasion - became subordinated to the methods of quantitative verification. The assumption was that '*sociology was embarked on a straight-line course of progress towards becoming a science, by virtue of quantitative verifications of hypotheses*' (Glaser & Strauss, 1968, p. 16).

2.2. Theory and practice

On reading 'The discovery of grounded theory,' one is initially tempted to think that Glaser and Strauss wrote this book primarily in order to counterbalance the logico-deductive way of generating theory and its obsession with verification and quantitative methods, because this approach does not come near to closing the gap between theory and empirical research. This impression is borne out by their remark that the '*book is directed toward improving social scientists' capacity for generating theory that will be relevant to their research*' (Glaser & Strauss, 1968, pp. vii-viii). However, this is not the only reason for writing this book. The other reason is that theory, as it is conceived by most sociologists, and the type of research that goes with it, lacks any significance for practical matters as theory's only reason for existence is to be tested, verified, and if necessary, modified. Glaser and Strauss, on the other hand, emphasise that theory is essentially practical and that '*grounded theory has been developed in order to facilitate its application in daily situations by sociologists and laymen*' (Glaser & Strauss, 1968, p. 237).

Therefore, Glaser and Strauss's intentions reach further than just a discussion about sociological methods for, although the emphasis in the book is on the generation of theory rather than its verification, the authors '*take special pains not to divorce those two activities, both necessary to the scientific enterprise*' (Glaser & Strauss, 1968, p. viii). Also, they see no '*fundamental clash between the purposes and capacities of qualitative and quantitative methods or data*' (Glaser & Strauss, 1968, p. 17). So the argument is neither between generating and verifying theory nor between qualitative and quantitative methods or data but between two different ways of arriving at theory, and the theory's relationship with reality and its relevance for practice.

Before moving on to this argument it is worthwhile to dwell on the origin of Glaser and Strauss's views in order to gain a better understanding of the message they are trying to convey. The notion that a theory is essentially practical, it is contended here, can be traced back to Dewey's instrumentalism. In 'The discovery of grounded theory' it is, however, not until the third part of the book that Glaser and Strauss become more explicit about this (Glaser & Strauss, 1968, pp. 249-250):

> *'..., as John Dewey has clarified for us, grounded theory is applicable in situations as well as to them. Thus people in situations for which grounded theory has been generated can apply it in the natural course of daily events. ... By attempting to develop theory that can also be applied, we hope to contribute to the accomplishments of both sociological theory and practice. Social theory, as John Dewey remarked thirty years ago, is thereby enriched and linked closely with the pursuit and studied control of practical matters.'*

Whereas the second part of this quotation refers to one of Dewey's remarks in an article with the title 'Social science and social control,' the first part refers to a quotation, taken from his book 'Experience and Nature,' and used earlier by Glaser and Strauss (Glaser & Strauss, 1968, pp. 237-238, footnote):

> *'What is sometimes termed "applied" science ... is directly concerned with ... instrumentalities at work in effecting modifications of existence in behalf of conclusions that are reflectively preferred. ... "Application" is a hard word for many to accept. It suggests some extraneous tool ready-made and complete which is then put to uses that are external to its nature. But ... application of "science" means application in, not application to. Application in something signifies a more extensive interaction of natural events with one another, an elimination of distance and obstacles; provision of opportunities for interactions that reveal potentialities previously hidden and that bring into existence new histories with new initiations and endings. Engineering, medicine, social arts realize relationships that were unrealized in actual existence. Surely in their new context the latter are understood or known as they are not in isolation.'*

A rather obvious explanation for mentioning Dewey's views so late in the book may be that the references to his views are made in the chapters which deal with the credibility of a grounded theory and the criteria of adequacy for application of such a theory.

On the other hand, it is also worth noticing that these chapters had been published before (Glaser & Strauss, 1965a; 1965b; 1966). This could very well suggest that Glaser and Strauss in 1967, writing a book on sociological method, did not feel the need any more to point to their intellectual dependence on Dewey but that they still acknowledged his influence as they did not exclude these references while editing these earlier written chapters.

Whatever the reason, for a good comprehension of Grounded Theory it is important to be constantly aware of Dewey's influence on the positions taken by Glaser and Strauss in the debate between Grounded Theory and logico-deductive theory. This debate is the subject of the other chapters which were newly written for this book.

Incidentally, both Glaser and Strauss were trained at the universities where John Dewey had been working; Glaser at Columbia University where Dewey had been professor of philosophy (1904-1929) and Strauss at the University of Chicago where Dewey had been head of the department of philosophy (1894-1904). Considering the enormous influence of Dewey on the intellectual climate in American universities, it is maybe not so far fetched a thought after all that Glaser and Strauss have been influenced by his views.

Finally, looking at 'The discovery of grounded theory' as a whole, it appears to be inspired by the gap between theory and empirical research in sociology but even more so by the division between sociology and the studied control of practical matters, the latter being caused by the former. And it is in order to improve sociology's relevance for practice that it makes sense for Glaser and Strauss to focus on the relationship between theory and empirical research, and, more specifically, on the best ways to generate a theory that lends itself to practical application.

2.3. Two ways of arriving at theory

Entering the argument between the two different ways of arriving at a theory, Glaser and Strauss go out of their way to stress the differences between the two in as much detail as they can. This should not be interpreted as merely an attempt to discredit the logico-deductive approach, for this detailed approach is also part and parcel of the constant comparative method of analysis which they advocate. Their zeal for detail, however, sometimes tends to obscure the essential differences between the two theories which become most manifest in the two opposing views of the nature of theory (Glaser & Strauss, 1968, passim):

- **Grounded Theory**
  Grounded Theory is presented as '*a way of arriving at theory suited to its supposed uses' by the 'initial, systematic discovery of the theory from the data of social research*' (p. 3).

This means that '*most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of research. Generating a theory involves a process of research*' (p. 6).

Further, the strategy of comparative analysis, a '*strategic method for generating theory*' (p. 21), puts a '*high emphasis on theory as process; that is, theory as an ever-developing entity, not as a perfected product*' (p. 32).

- **Logico-deductive theory**
  Logico-deductive theory, on the other hand, is presented as a way of arriving at a theory '*which is dubiously related to the area of behavior it purports to explain, since it was merely thought up on the basis of a priori assumption and a touch of common sense, peppered with a few old theoretical speculations made by the erudite*' (p. 29).

  This approach ultimately leads to the position that data should fit the theory, which contrasts sharply with Glaser and Strauss's position that '*the theory should fit the data*' (p. 261).

  Consequently, logico-deductive theorists, '*in their zeal for careful verification and for a degree of accuracy they never achieve*' (p. 223), put a high emphasis on the product of their scientific endeavours, the evidence, '*because evidence is still most important to the analyst as the means for testing how he knew his theory was "right"* (pp. 27-28).

These descriptions of Grounded Theory and logico-deductive theory suggest that the argument focuses, more than anything else, on the use of the data.

The logico-deductive theorist is not interested in the data until he has formulated his concepts and hypotheses. Then, in order to verify his preconceived theory, he turns to the data, adhering to the systematic canons and rules of evidence of quantitative analysis which put severe restrictions on the data to be used, even to the extent that he may have to force round data into square theories to get his story straight.

In generating a grounded theory, however, the theorist starts from the data and turns back to the data, and it is exactly this approach that indeed warrants the theory being grounded in the data. This is also one of the reasons why, in contrast with the severely restricted use of data by logico-deductive theorists, Glaser and Strauss seek to further both library and field research and the theoretical elaboration of quantitative data (Glaser & Strauss, 1968, chapters 7 and 8) as they think these are important sources of data too.

2.3.1. The use of the data

Glaser and Strauss's open-minded attitude toward data from whatever source, to the extent that even trivial data are taken into consideration (Glaser & Strauss, 1968, p. 188), as well as their opposition to the logico-deductive way of handling the data can be traced back to Dewey's view that (Dewey, 1925, p. 10):

> *'experience for philosophy is method, not distinctive subject-matter. ... Experience includes dreams, insanity, illness, death, labor, war, confusion, ambiguity, lies and error; it includes transcendental systems as well as empirical ones; magic and superstition as well as science. It includes that bent which keeps one from learning from experience as well as that skill which fastens upon its faint hints. This fact convicts upon sight every philosophy that professes to be empirical and yet assures us that some especial subject-matter is experience and some other not.*
>
> *The value of experience as method in philosophy is that it compels us to note that denotation comes first and last, so that to settle any discussion, to still any doubt, to answer any question, we must go to some thing pointed to, denoted, and find our answer in that thing. As method it has a contrast which it does not possess as subject matter, that with "rationalism" understanding by rationalism method which assumes the primacy and ultimacy of purely logical thought and its findings. There are two kinds of demonstration: that of logical reasoning from premises assumed to possess logical completeness, and that of showing, pointing, coming upon a thing.'*

If, apart from some other minor changes, the word '*data'* were to be substituted for the word '*experience*,' one would get very close to what Glaser and Strauss mean by saying that a theory must be grounded in the data. For

'*data*' stands not for the subject-matter of theory but for the experiences the theorist can point to when asked what he means by his theoretical concepts. Elaborating on the distinction between experience as subject-matter and as method, Dewey adds (Dewey, 1925, p. 13):

> *'Now the notion of experience, however devoid of differential subject-matter - since it includes all subject- matters -, at least tells us that we must not start with arbitrarily selected simples, and from them deduce the complex and varied, assigning what cannot be thus deduced to an inferior realm of being. It warns us that the tangled and complex is what we primarily find; that we work from and within it to discriminate, reduce, analyze; and that we must keep track of these activities, pointing to them, as well as to the things upon which they are exercised, and to their refined conclusions. When we contemplate their fruits we are not to ignore the art by which they are produced. There is a place for polishers of stones and for those who put the stones together to make temples and palaces. But "experience" reminds us that a stone was once a part of some stratum of the earth, and that a quarryman pried it loose and another workman blew the massive rock to smaller pieces, before it could be smooth-hewn and fitted into an ordered and regular structure. Empirical method warns us that systems which set out from things said to be ultimate and simple have always worked with loaded dice; their premises have been framed to yield desired results.'*

- **Grounded Theory**
  Dewey's warnings go a long way towards accounting for Glaser and Strauss's position that '*the adequacy of a theory for sociology today cannot be divorced from the process by which it is generated*' (Glaser & Strauss, 1968, p. 5), for an important feature of Grounded Theory is that it implies a process of constant interaction between the theorist and the data he uses.

  As a matter of fact, it is exactly this process which Glaser and Strauss's book is all about, because the theorist who sets out to generate theory, '*is no longer a passive receiver of impressions but is drawn naturally into actively generating and verifying his hypotheses through comparison groups*' (Glaser & Strauss, 1968, p. 39).

  Further, in order to yield the desired results, the theorist must adhere to specific canons suited to the discovery of theory and to the rules of procedure associated with it. One highly important aspect of this method of generating theory that pervades Glaser and Strauss's whole book is the joint collection, coding, and analysis of data. '*The generation of theory, coupled with the notion of theory as process, requires that all three operations be done together as much as possible. They should blur and intertwine continually, from the beginning of an investigation to its end*' (Glaser & Strauss, 1968, p. 43).

- **Logico-deductive Theory**
  Glaser and Strauss's position is in sharp contrast with the claim of theorists of a logico-deductive persuasion that the canons for assessing a theory are '*completely independent of the process of generation*' for, as Glaser and Strauss argue, this notion '*too often ends up being taken as a licence to generate theory from any source - happenstance, fantasy, dream life, common sense, or conjecture - and then dress it up as a bit of logical deduction*' (Glaser & Strauss, 1968, pp. 5-6). Moreover, as a result of focusing on description and verification, it does not offer any explanation of or methods for generating theory either.

  The logico-deductive position is also different as to the need for joint collection, coding and analysis of data, for '*in many (if not most) studies of description and verification, there is typically a definite focus on one operation at the time that the others are slighted or ignored. This definite separation of each operation hinders generation of theory. For example, if data are being coded and a fresh analytic idea emerges that jolts the operation, the idea may be disregarded because of pre-established rules or plain routine - thus stifling at that moment the generation of theory*' (Glaser & Strauss, 1968, p. 43).

2.3.2. Summary

Both the ways of arriving at theory discussed here assign a different role to the data. In logico-deductive theory the data function as evidence for the preconceived theory and are thus part of the result. In Grounded Theory, on

the other hand, it is by means of the data that the theory is generated so that they are part of the process of inquiry itself, the result being a theory that is grounded in the data. Therefore, the data do not provide the subject-matter of the theory but are at the heart of the method advocated by Glaser and Strauss.

2.4. The meaning of 'grounded'

After the foregoing paragraph it should be sufficiently clear why Glaser and Strauss have taken the position that a theory must be grounded in the data or in social research itself, as opposed to generating theory from logical assumptions and speculations. It remains, however, to be seen why they call such a theory '*grounded'* and do not, for example, use the word '*empirical'* (as opposed to logical) or '*inductive'* (as opposed to deductive).

2.4.1. The position taken by Glaser and Strauss

In 'The discovery of grounded theory,' Glaser and Strauss explain the meaning of the word '*grounded'* only three times. From two of these explanations it appears that it should not be taken to mean anything more than that a grounded theory is generated (Glaser & Strauss, 1968, p. viii) or discovered (Glaser & Strauss, 1968, p. 1) from data systematically obtained from social research.

The theory arrived at in this way can be either a substantive theory, '*developed for a substantive, or empirical, area of sociological inquiry, such as patient care, race relations, professional education, delinquency, or research organizations*,' or a formal theory, '*developed for a formal, or conceptual, area of sociological inquiry, such as stigma, deviant behavior, formal organization, socialization, status congruency, authority and power, reward systems, or social mobility* (Glaser & Strauss, 1968, p. 32). Both types of theory are considered as '*middle-range*,' that is, '*they fall between the "minor working hypotheses" of everyday life and the "all-inclusive" grand theories*' (Glaser & Strauss, 1968, pp. 32-33). In addition, it is said that substantive and formal theories must be grounded in the data (Glaser & Strauss, 1968, pp. 33-34):

> *'Substantive theory faithful to the empirical situation cannot, we believe, be formulated merely by applying a few ideas from an established formal theory to the substantive area. To be sure one goes out and studies an area with a particular sociological perspective, and with a focus, a general question, or a problem in mind. But he can (and we believe should) also study an area without any preconceived theory that dictates, prior to the research, "relevancies" in concepts and hypotheses. Indeed it is presumptuous to assume that one begins to know the relevant categories and hypotheses until the "first days in the field," at least, are over. A substantive theory generated from the data must first be formulated, in order to see which of diverse formal theories are, perhaps, applicable for furthering additional substantive formulations.'*

While discussing formal theory being grounded in the data, Glaser and Strauss for the third time explain what is meant by the word '*grounded*,' emphasising that they use this word to underline the point that the formal theory they are talking about '*must be contrasted with "grand" theory that is generated from logical assumptions and speculations about the "oughts" of social life*' (Glaser & Strauss, 1968, p. 34-35).

So Grounded Theory appears to take its name from the fact that a theory which has been generated by this method is grounded in the data. Although this might reflect a view of the nature of theory that is close or identical to the empiricist view, it should not be taken to indicate this at all. For Glaser and Strauss also emphasise that (Glaser & Strauss, 1968, p. 23):

> *'in generating theory it is not the fact upon which we stand, but the conceptual category (or a conceptual property of the category) that was generated from it. A concept may be generated from one fact, which then becomes merely one of a universe of many possible diverse indicators for, and data on, the concept. These indicators are then sought for the comparative analysis.'*

Therefore, Grounded Theory, not being based on logical deduction from a priori assumptions and speculations, does not stand on facts either, and so, Glaser and Strauss's position is neither logical nor empiricist, '*it is*

phenomenological' (Glaser & Strauss, 1968, p. 6). This is not, however, to say that they deny the need for logical thinking and for facts while generating theory, but both these elements are subordinated to something more important, viz. the theory being grounded in the data.

Besides, although Grounded Theory is admittedly '*an inductive method of theory development*' (Glaser & Strauss, 1968, p. 114), Glaser and Strauss still prefer to call it Grounded Theory because '*the constant comparisons required by both methods differ in breadth of purpose, extent of comparing, and what data and ideas are compared*' (Glaser & Strauss, 1968, p. 104).

2.4.2. Evaluation of Glaser and Strauss's position

On evaluating the position taken by Glaser and Strauss it emerges that what they mean by theory is neither a matter of mere speculation as demonstrated by logico-deductive theory, nor the mere consultation of reality in the form of quantitative verification. On the contrary, it is the purposeful interaction between the theorist and his data in order to conceptualise reality as it shows itself to him by means of the data. These data should not be taken to describe the area under study in its entirety - as would be the case if the study was aimed at verification - for the data in a grounded theory only show those characteristics of the area under study which the researcher can point to when asked what he means by his conceptual categories. Therefore, it is contended here, the word '*grounded*,' as used by Glaser and Strauss, designates the very same relationship as the word '*ground'* in the speculative grammar of Peirce's logic, viz. the relationship between a term, a proposition or an argument, and the interpretant.

On the basis of his data, the researcher is forced to look for abstractions with an increasing level of generality, e.g. categories and concepts, in order to make sense of the data, and thereby of reality. Next, he will turn back to the lower level of abstraction to verify the concept's existence by verifying the data behind it. With regard to the generation of hypotheses, i.e. generalised relationships among concepts, the approach will be similar. This process ends up with the integration of all conceptual levels of the theory.

Next, the resulting substantive theory can be developed even further to the level of formal theory. By doing this, the resulting substantive or formal theory will not be divorced from reality. Also, it will be meaningful to those who want to use the theory. This is, in a nutshell, the answer of Grounded Theory to the threat of theory being divorced from reality, and thereby from practice as well.

Furthermore, Glaser and Strauss take the position that concepts are not capable of denoting facts for, as illustrated by the standard concepts in sociology, they '*usually become very differently defined, dimensioned, specified, or typed. Typical boundaries of the standard concept become broken*' (Glaser & Strauss, 1968, p. 38). By grounding the theory in the data, however, the researcher is bound to discover more about '*structural conditions, consequences, deviances, norms, processes, patterns, and systems*' (Glaser & Strauss, 1968, p. 18) in the area under study. In other words, he will find out more about what his data mean, and thereby about the meaning of reality, or as Glaser and Strauss put it (Glaser & Strauss, 1968, p. 23):

> *'In discovering theory, one generates conceptual categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept. The evidence may not necessarily be accurate beyond a doubt (nor is it even in studies concerned only with accuracy), but the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied. Furthermore, the concept itself will not change, while even the most accurate facts change. Concepts only have their meanings respecified at times because other theoretical and research purposes have evolved.'*

Grounded theory should thus be seen as a method for discovering the meaning of reality more than anything else. One of the few instances Glaser and Strauss are really explicit about this is when they discuss the sociologist's job (Glaser & Strauss, 1968, p. 30):

> *'The sociologist with theoretical generation as his major aim need not know the concrete situation better than the people involved in it (an impossible task anyway). His job and his training are to do what these laymen cannot do - generate general categories and their properties for general and specific situations and problems. These can provide theoretical guides to the layman's action. The sociologist thereby*

brings sociological theory, and so a different perspective, into the situation of the layman. This new perspective can be very helpful to the latter.'

So Grounded Theory is basically a tool or a method for discovering the meaning of reality with a view to practical action, i.e. the transformation from indeterminate into determinate situations or from the unstudied into the studied control of practical matters. Therefore, it poses no problem for Glaser and Strauss if two researchers, working on the same data, come up with two different theories unless their theories are not grounded in the data, for a theory is an ever-developing entity and not a perfected product.

2.5. The nature of grounded theory

Although Glaser and Strauss set out to bridge the gap between theory and empirical research, their main concern appears to be the resulting gap between theory and practice. Therefore, Grounded Theory should be seen as an alternative view of the nature of theory which manages to avoid both.

Glaser and Strauss's opposition to the logico-deductive way of arriving at a theory should be taken to mean that generating theory by logical deduction from a priori assumptions, apart from assuming that theory arises out of a vacuum, inevitably leads to a theory which, confronted with reality by means of empirical research, necessitates all sorts of pretexts to reconcile the theory with reality. In this sense, their objections against logico-deductive theory are similar to those of Dewey and the other pragmatist philosophers. In order to overcome this dualism between theory and reality Glaser and Strauss propose that theory can best be seen as the discovery of the meaning of reality by means of the data.

Closely linked with their opposition to logico-deductive theory are Glaser and Strauss's objections to the drive toward verification which is considered to be inhibitive for generating theory, and to the discrimination of qualitative data from quantitative data. Discussing these issues, however, they go out of their way to emphasise that both verification and quantitative data can be very useful indeed for generating a grounded theory. That is not, however, to say that they think of empirical research as the single and most important source for generating theory for, due to the zeal for quantitative verification, the facts obtained provide a limited and rather distorted view of reality. Moreover, this approach lacks sensitivity in picking up everyday facts about social structures and systems and does not provide a perspective on the qualitative aspects of life, e.g. structural conditions, consequences, deviances, norms, processes, patterns, and systems. Therefore, a more plausible explanation of their position would be that theory based on facts may meet the criteria of pure science but that, given its value-free nature, it lacks any potential for practical application as it does not bring a meaningful perspective into the situation of the layman that can be helpful to him. Therefore, Glaser and Strauss's attitude toward quantitative verification reflects the views of Dewey and the other pragmatist philosophers as well.

In conclusion, Glaser and Strauss take the position that theory must be grounded in the data. This notion of theory amounts to the discovery of the meaning of reality by means of the data. The data provide the theorist with a two-sided link with reality: firstly, at the start of the process of research and, secondly, at the end of it. Moreover, the former link warrants the avoidance of dualism between theory and reality (in contrast with logico-deductive theory), while the latter makes sure that the theory is suitable for its supposed uses (as opposed to theory based on quantitative verification).

Therefore, a grounded theory is different from theory based on logical deductions from a priori assumptions and speculation, for it is generated in continuous interaction with reality (by means of the data obtained from social research). In providing more than just accurate facts, however, it is also different from merely empirical theories, for it is generated with a view to its value for practical matters.

In short, in order to arrive at the stage of the actual application of theory it must grounded in the data, and this entails the notion of theory as a process of research that starts from the data and leads back to it. It is exactly this condition of theory being grounded in the data which is the core idea of Glaser and Strauss's view of the nature of theory.

2.6. Criteria of adequacy

The analysis of Grounded Theory so far has resulted in a pragmatist notion of theory, viz. conceptual ideas which are meaningful to the degree that they spell out their practical bearings. To arrive at such theory the following steps must be taken:

1. Starting from reality by means of the data.

2. A process of continuous interaction between the theorist and his data by means of the method of the constant comparative analysis with a view to the generation and testing of:
   a. conceptual properties of concepts, or categories,
   b. concepts,
   c. hypotheses, and
   d. the integration of the theory.

3. Conveying the credibility of the theory to the people who might use his theory.

4. Applying the theory in that segment of reality it is meant to be used in.

Therefore, with reality as the alpha and the omega of the process of research (step 1 and 4), the generation of a grounded theory involves a process of both generating categories, concepts and hypotheses from evidence, and testing them by means of new evidence (step 2). This process of research results in integration of the theory (Glaser & Strauss, 1968, pp. 40-41):

> *'Integration of the theory - which takes place at the many levels of generality that emerge - does not necessitate a distinction between "working" (or "ordinary") and theoretical hypotheses. Our emphasis on integration takes into account the fullest range of conceptual levels; anyone who uses the integrated theory can start at a more general level and, focussing upon a specific area within the theory, work down to data, still guided by hypotheses for limited, specific situations.'*

In this process of research, the data at the lower levels of theory do not need to ensure absolute certainty and accuracy for there are ample mechanisms during the later phases of the research process to correct this. Generating a grounded theory thus implies a somewhat evolutionary process that finally results in the integration of the theory. To understand Glaser and Strauss's analysis of this process more fully it may be worthwhile to keep James' description of the activities of consciousness in mind.

Before it comes to the application of the theory, however, the theorist has to convey its credibility to the potential users of the theory (step 3). This step is probably prompted by Glaser and Strauss's assumption that the theorist is not the same person as the one who uses the theory, i.e. the layman.

Finally, it remains to be seen what the criteria of adequacy of Grounded Theory are. In other words, what makes a grounded theory a true, a valid, or a good theory?

2.6.1. Three different sets of criteria

Having explained that a theory should be judged by the process by which it was generated, Glaser and Strauss do not mean to say that it does not have to satisfy some other criteria as well. One such set of criteria, for example, entails that the theory (Glaser & Strauss, 1968, p. 1):

> *'fits empirical situations, and is understandable to sociologists and layman alike. Most important, it works - provides us with relevant predictions, explanations, interpretations and applications.'*

Furthermore, in chapter 9, Glaser and Strauss mention criteria of adequacy such as the '*credibility, plausibility and trustworthiness*' of a grounded theory.

Finally, in chapter 10, yet another set of criteria comes up for discussion (Glaser & Strauss, 1968, p. 237):

> *'The practical application of grounded sociological theory ... requires developing a theory with (at least) four highly interrelated properties. The first requisite property is that the theory must closely fit the substantive area in which it will be used. Second, it must be readily understandable by laymen concerned with this area. Third, it must be sufficiently general to be applicable to a multitude of diverse daily situations within the substantive area, not to just a specific type of situation. Fourth, it must allow the user partial control over the structure and process of daily situations as they change through time.'*

Bearing in mind that the chapters dealing with these three sets of criteria of adequacy were written at different times, one might think that, without giving much care and attention to the editing, the authors have put together some articles and some newly written chapters.

A better explanation would be, however, that a grounded theory is adequate to the degree that it is clear about the practical bearings of the conceptual ideas it contains, or, as Glaser and Strauss put it, Grounded Theory is '*a way of arriving at theory suited for its supposed uses*' (Glaser & Strauss, 1968, p. 3). This condition results in one set of criteria for a theory as a theory, another set of criteria for ascertaining its meaning and yet another set of criteria for its application.

As for the first set of criteria of adequacy, a theory is held to be adequate to the degree in which it is a grounded theory and therefore, by definition, not divorced from reality or practice.

As for the second set of criteria of adequacy, it should be noted that Glaser and Strauss are at pains to stress one additional property of a grounded theory (Glaser & Strauss, 1968, p. 249-250):

> *'One property of an applied grounded theory must be clearly understood: The theory can be developed only by professionally trained sociologists, but can be applied by either laymen or sociologists.'*

This property explains why the sociologist has to convey the credibility of his theory to his readers or the potential users of his theory, i.e. laymen or sociologists, for, before they can apply the theory, they have to ascertain its practical bearings. Therefore, it is contended here, this set of criteria of adequacy is related to Peirce's principle of fallibility.

The final test of a grounded theory, however, is its application in daily life, and this necessitates yet other criteria of adequacy of a theory. Contrary to the second set of criteria of adequacy, this third set is related to Dewey's notion of truth (a theory is good, or valid, or true, if it works when put to use).

Summing up, these three sets of criteria of adequacy reflect both Peirce's and Dewey's views as to the truth or validity of a theory, and, therefore, if seen in this light, it comes as no surprise that one and the same theory has to meet different sets of criteria of adequacy at different times.

2.6.2. Fitness, understandability and workability

At first, the adequacy of a grounded theory, or for that matter, all theories is measured by the yardstick of its functions or jobs. The interrelated jobs of theory in sociology are said to be (Glaser & Strauss, 1968, p. 3):

> *1) 'to enable prediction and explanation of behavior;*
> *2) to be useful in theoretical advance in sociology;*
> *3) to be usable in practical applications - prediction and explanation should be able to give the practitioner understanding and some control of situations;*
> *4) to provide a perspective on behavior - a stance to be taken toward data; and*
> *5) to guide and provide a style for research on particular areas of behavior.*
> *Thus theory in sociology is a strategy for handling data in research, providing modes of conceptualization for describing and explaining.'*

This conclusion results in the following remarks about a grounded theory's adequacy (Glaser & Strauss, 1968, p. 3):

> *'The theory should provide clear enough categories and hypotheses so that crucial ones can be verified in present and future research; they must be clear enough to be readily operationalized in quantitative studies when these are appropriate. The theory must also be readily understandable to sociologists of any view-point, to students and to significant laymen. Theory that can meet these requirements must fit the situation being researched, and work when put to use.'*

These criteria of adequacy are characteristic of the notion of theory, advocated by Glaser and Strauss, for they view theory in sociology as a strategy or a tool for handling data in research and for providing modes of conceptualisation, understandable to sociologists, students and significant laymen alike. But to fulfill these functions the theory should not only be understandable, but also it should fit the situation about which the theory is a theory, that is '*the categories must be readily (not forcibly) applicable to and indicated by the data under study*,' and, last but not least, the theory should work when put to use, that is, the categories '*must be meaningfully relevant to and be able to explain the behavior under study*' (Glaser & Strauss, 1968, p. 3).

These criteria of understandability, fitness and workability, should not, therefore, be interpreted within the framework of logico-deductive theory and quantitative verification. On the contrary, as these criteria reflect Glaser and Strauss's opposition to the '*rhetoric of verification*' (Glaser & Strauss, 1968, p. 16), for they take the position that a theory, although resting upon the data, should give a new meaning and explanation to them or, as Dewey puts it (Dewey, 1925, p. 21):

> *'There are two dimensions of experienced things: one that of having them, and the other that of knowing about them so that we can again have them in more meaningful and secure ways.'*

'*Having experiences*' refers to '*immediate or "presentative" knowledge, sensory acquaintance or whatever*,' as well as '*reflective and inferential knowledge*,' for both are considered to belong to the realm of experience. Holding this view, Dewey manages to avoid having to deal with one of the perennial problems of philosophy, viz. the reconciliation between the object of knowledge (concepts, ideas) and the reality of the things perceived, and unless (Dewey, 1925, pp. 21-22):

> *'there is something immediately and non-cognitively present in experience so that it is capable of being pointed to in subsequent reflection and in action which embodies the fruits of reflection, knowledge has neither subject-matter nor objective.'*

In other words, a theory's meaning is dependent upon being explicit as to its practical consequences. It is this theory of knowledge, it is contended here, which is at the source of the first set of criteria of adequacy put forward by Glaser and Strauss.

For in both cases knowledge is not considered to be a matter of merely experiencing (quantitative verification) or merely knowing (logico-deductive theory) things as this would amount to a '*mechanical'* relationship between the subject and object of knowing. Instead, this theory of knowledge assumes an '*organic'* relationship between the organism (the sociologist) and his environment (the social world) to the effect that knowing involves a kind of making or doing which transforms this relationship so that the subject of knowing (the sociologist) can have the object of knowing (his social world) '*in more meaningful and secure ways*.'

2.6.3. Credibility, plausibility and trustworthiness

Only if the notion of theory as an ever-developing transformation of the relationship between the sociologist and the social world is accepted, the next statement of Glaser and Strauss makes sense (Glaser & Strauss, 1968, pp. 223-224):

> *'In each chapter of this book, we have for a proposed phase of research detailed its level of credibility, plausibility, and trustworthiness; what accounts for this level; and the purposes for which its techniques are used.'*

This set of criteria of adequacy - the credibility, plausibility and trustworthiness of a theory - is more or less another way of summing up the first set of criteria of adequacy (the theory's fitness, understandability and workability). The former criteria, however, should be interpreted within the perspective of the reader who has to make up his mind as to the practical value of the theory, while the latter are criteria for judging a theory as a theory. The second set of criteria of adequacy is put forward for discussion in chapter 9 of Glaser and Strauss's book ('The credibility of grounded theory'). In this chapter they describe how the theorist brings the research to a close and decides to write for publication. He then (Glaser & Strauss, 1968, p. 228):

> *'faces the problem of conveying to colleagues and laymen the credibility of his discovered theory so that they can make some sensible judgment about it.'*

The task of conveying the theory's credibility can be divided into two sub-problems (Glaser & Strauss, 1968, p. 228):

- '*getting readers to understand the theoretical framework*,'
- '*how to describe the data of the social world studied so vividly that the reader, like the researchers, can almost literally see and hear its people - but always in relation to the theory*.'

Conveying the credibility of a theory thus involves the enhancement of its understanding by the reader by showing how the theory fits the data. By doing this '*always in relation to the theory*,' the sociologist also casts a new light on the data. Subsequently, it is up to the reader to make up his mind as to the credibility of the theory presented (Glaser & Strauss, 1968, p. 230):

> *'Several aspects of the presentation enter into how the reader judges the credibility of the theory. First of all, if a reader becomes sufficiently caught up in the description so that he feels vicariously that he was also in the field, then he is more likely to be kindly disposed toward the researcher's theory than if the description seems flat or unconvincing.*
> *Second, the reader's judgment of credibility will also rest upon his assessments of how the researcher came to his conclusions.'*

In doing that, he has to qualify the theory (Glaser & Strauss, 1968, pp. 231-232):

> *'Such reader qualification of the theory we may term "the discounting process." Readers surely discount aspects of many, if not most, published analyses (whether they rest upon qualitative or quantitative data). This discounting takes several forms: the theory is corrected because of one- sided research designs, adjusted to fit the diverse conditions of different social structures, invalidated for other structures through the reader's experience or knowledge, and deemed inapplicable to yet other kinds of structures. It is important to note that when a theory is deemed inapplicable to a social world or social structure, then it cannot be invalid for that situation. It is not correct to say that because a theory "does not fit" a structure, then it is invalid. The invalidation or adjustment of a theory is only legitimate for those social worlds or structures to which it is applicable.'*

The discounting process corresponds with Peirce's principle of fallibility, i.e. the possibility of a theory being refuted by experience. This possibility is judged by considering '*what practical consequences might conceivably result by necessity from the truth of that conception*.' For this, it is necessary that the sociologist or the layman can point to specific experiences being able to refute the theory. Lacking these experiences, however, one is compelled to hold the theory to be true.

2.6.4. The adequacy of a theory for application

The third and final set of criteria of adequacy has to do with the criteria for the application of a grounded theory. These criteria are (Glaser & Strauss, 1968, pp. 237-250):

- **fitness**
  'That the theory must fit the substantive area to which it will be applied is the underlying basis of a grounded theory's four requisite properties. ... Deducing practical applications from formal theory rests on the assumption that the theory supplies concepts and hypotheses that fit. ... Clearly, a grounded theory that is faithful to the everyday realities of a substantive area is one that has been carefully induced from diverse data, as we have described the process. Only in this way will the theory be closely related to the daily realities (what is actually going on) of substantive areas, and so be highly applicable to dealing with them.'

- **understanding**
  'A grounded substantive theory that corresponds closely to the realities of an area will make sense and be understandable to the people working in the substantive area. This understanding can be crucial since it is these people who will wish either to apply the theory themselves or to employ a sociologist to apply it. Their understanding the theory tends to engender a readiness to use it, for it sharpens their sensitivity to the problems that they face and gives them an image of how they can potentially make matters better, through their own efforts or those of a sociologist.'

  Therefore, as Glaser and Strauss pointed out earlier, the type of concepts that should be generated have two, joint, essential features (Glaser & Strauss, 1968, pp. 38-39):
  - the concepts should be analytic, i.e. 'sufficiently generalized to designate characteristics of concrete entities, not the entities themselves,'
  - the concepts should also be sensitising, i.e. they should 'yield a "meaningful" picture, abetted by apt illustrations that enable one to grasp the reference in terms of one's own
  - experience.'

- **generality**
  'In deciding upon the conceptual level of his categories, the sociologist generating theory should be guided by the criteria that the categories should not be so abstract as to lose their sensitizing aspects, but yet must be abstract enough to make his theory a general guide to multi-conditional, ever-changing daily situations. Through the level of generality of his concepts he tries to make the theory flexible enough to make a wide variety of changing situations understandable, and also flexible enough to be readily reformulated, virtually on the spot, when it does not work in application.

  The sociologist should also be concerned with the theory's being general enough to be applicable to the whole picture. Because of the changing conditions of everyday situations, it is not necessary to use rigorous research to discover precise, quantitatively validated, factual knowledge upon which to base the theory. ... to achieve a theory general enough to be applicable to the total picture, it is more important to accumulate a vast number of diverse qualitative "facts" on many different situations in the area.'

- **control**
  'The person who applies the theory must be enabled to understand and analyze ongoing situational realities, to produce and predict change in them, and to predict and control consequences both for the object of change and for other parts of the situation that will be affected. As changes occur, his theory must allow him to be flexible in revising his tactics of application and in revising the theory itself if necessary. To give this kind of control, the theory must provide a sufficient number of general concepts and their plausible interrelations; and these concepts must provide the practitioner with understanding, with situational controls, and with access to the situation in order to exert the controls. The crux of controllability is the production and control of change through "controllable" variables and "access" variables.'

From these criteria it becomes clear that for a theory to be adequate for application, it should in fact meet the criteria discussed earlier, but this time within the perspective of its actual application. As for the latter, Glaser and Strauss share Dewey's view that '*application of "science" means application in, not application to,*' and it therefore signifies a more extensive interaction of natural events with one another, an elimination of distance and obstacles, and provision of opportunities for interactions that reveal potentialities previously hidden and that bring into existence new histories with new initiations and endings (Dewey, 1925, pp. 237-238).

A theory should thus be able to bring about a new and more meaningful relationship between the living organism, i.e. the layman who uses the theory, and his environment. This requirement is similar to the one mentioned before, viz. that generating a grounded theory entails the transformation of the relationship between the sociologist and the social world studied. This similarity is typical of the pragmatist philosophy of science and can be best illustrated by Glaser and Strauss's description of the merits of field work (Glaser & Strauss, 1968, pp. 226-227):

> *'The evolving systematic analysis permits a field worker quite literally to write prescriptions so that other outsiders could get along in the observed sphere of life and action. That is one benefit of a substantive theory. If he has "made out" within the particular social world by following these prescriptions, then presumably they accurately represent the world's prominent features; they are workable guides to action and therefore their credibility can, on this account too, be accorded our confidence.*
>
> *In effect, this is how shrewd or thoughtful visitors to any social world feel about their knowledge of these worlds. ... What the field worker does is to make this normal strategy of reflective persons into a successful research strategy.'*

So, the differences between the activities of the sociologist and the reflective layman are more or less a matter of degree. This claim of the similarity between scientific and practical knowledge can also be found in the earlier works of Dewey (White, 1964, p. 109):

> *'Current antithesis between science and art not tenable ... Science does not teach us to know; it is the knowing; art does not teach us to do, it is the doing.'*

Finally, it is this similarity which at the source of Glaser and Strauss holding the view that '*the person who applies theory becomes, in effect, a generator of theory, and in this instance the theory is clearly seen as process: an ever-developing entity*' (Glaser & Strauss, 1968, p. 242).

3.
PRACTICE THEORY

3.1. Introduction

As stated before, the impetus for developing Practice Theory stems, amongst other things, from the 'conceptual muddle as to what theory is in any of its manifestations.' Therefore, Dickoff and James must have had some idea about the notions of theory commonly held by nurses, and so they had indeed (Dickoff & James, 1968a, p. 198):

> *'Theory whose purpose is prediction is the most familiar kind of theory, and the most developed methodology is that for testing the "goodness" of such a theory (or at least of the component elements of such a theory).'*

It is this view of the nature of theory, and also of the accessory type of research, which prompted the development of Practice Theory and provided Dickoff and James with the starting point for scrutinising the '*ordinary doctrine*' of predictive theory, for '*a severe limitation in many current notions of theory stems from the oversimple view that takes as theory only sets of causal laws, so that the only conceptual systems regarded as theories are those that allow prediction on their bases*' (Dickoff & James, 1968a, p. 200). As far as predictive theory itself is concerned, Dickoff and James are really at pains to demonstrate the narrow-mindedness of such a view in order to arrive at a broadened notion of theory (Dickoff & James, 1968a, p. 200):

> *'It seems to us that careful attention to the structure of predictive theory suggests three things:*
> *1) predictive theory presupposes the prior existence of more elementary types of theory;*
> *2) predictive theory is not the only kind of theory dealing essentially with relations conceived as between states of affairs; and*
> *3) there is a type of theory which presupposes and builds on theories at the level of relations between states of affairs.'*

As to the testing of predictive theory, Dickoff and James are admittedly less explicit (Dickoff, James & Wiedenbach, 1968b, p. 552):

> *'The technique used in arriving at the broadened notion of theory was to scrutinize carefully the ordinary doctrine of predictive theory to lay bare the implicit presuppositions of such doctrine and to draw attention to the not-often- explored extensions of such doctrine. (Brief indication is given also to this same generalizing move with respect to research methodology which must parallel the more sophisticated view of theory.)'*

In both cases, however, the analysis is aimed at arriving at a broader notion of theory and research, i.e. practice theory and practice research.

3.1.1. Predictive theory

The analysis of predictive theory directs the attention to three different levels of theory (Dickoff, James & Wiedenbach, 1968a, pp. 419-420):

- **pre-predictive levels of theory**
  '*To announce a prediction or causal law requires characterizing both the initial and the subsequent state of affairs. And such characterization requires conceptualizing the salient or significant factors within the state of affairs, as well as characterizing the relations as among those factors. Both this conceptualization of factors and the conceptualization of relations among factors are modes of theorizing - i.e., conceptualizing -*

necessarily prior to predictive or causal theory. These presupposed kinds of theory might be called respectively factor-isolating theories and factor-relating (or depicting) theories.'

- **other theories at the predictive level**
  '*Prediction is a statement of causal or consequential relatedness as between two states of affairs. But it is quite possible to conceive relations other than merely consequential or causal as between two states of affairs and possible also to conceive relations as among more than just two states of affairs. Hence, as there are kinds of theories presupposed by predictive theory, so also there could be theories which deal with relations among states of affairs but which are not merely predictive theories. These further theories might be called theories of promotion or inhibition of occurrence of causal connections. ... Such theories would conceptualize both the qualitative and quantitative subtleties of consequential relatedness*.'

- **the post-predictive level of theory**
  '*Once given factoring theories, depicting theories, predictive or causal theories (and promoting or inhibiting theories), yet another kind of theory, which presupposes all of these, is prescriptive theory. Prescriptive theories are situation-producing or goal-incorporating theories. They are not satisfied to conceptualize factors, factor relations, or situation relations, but go on to attempt conceptualization of desired situations as well as conceptualizing the prescription under which an agent or practitioner must act in order to bring about situations of the kind conceived as desirable in the conception of the goal*.'

As a result of this analysis Dickoff and James arrive at the broader notion of practice theory which links theory with practical purposes and entails four different levels of theory:

1) factor-isolating theory (theories of classification, systems or conventions for naming or marking off significant elements, or factoring theory),

2) factor-relating theory (depicting theory, or situation-depicting theory),

3) situation-relating theory (including both predictive or causal theory, as well as promoting and inhibiting theories),

4) situation-producing theory (prescriptive theory, or goal-incorporating theory). This level of theory includes goal content, prescriptions, and a survey list (including agency, patiency or recipiency, framework, terminus, procedure, and dynamics).

According to Practice Theory, predictive theory does not stand on its own, for it presupposes other levels of theory which allow a bit less than prediction and it implies still another level of theory which goes beyond mere prediction, viz. situation-producing theory. This demonstrates that predictive theory is indeed the decisive turning-point for this broader notion of theory, as practice theory is aimed at the reconciliation of two different notions of theory:

- theory without practical purpose,
- theory invented to some practical purpose.

That predictive theory is the decisive turning-point also comes to the fore when Dickoff and James distinguish academic theories from non-academic theories (Dickoff, James & Wiedenbach, 1968a, p. 419):

> *'Many theories are proposed for the sole purpose of quieting the mind's demand for a conceptual grasp on reality. Terminologies and classifications, theories of causal and other relations are venerable even as merely academic knowledge. But that theory can serve the end of doing away with intellectual chaos and uncertainty - and further that historically theories have been proposed first of all only for such academic interest - does not preclude that theories shall have no further purpose. We call nonacademic any theory proposed for a purpose beyond mere understanding. Customarily such "nonacademic theories" might be termed "applied" as opposed to "pure" theory or "pure" science, or might be called not theory at all but simply application of theory. Such nomenclature incorporates a serious misconception of the boundaries*

of theory. But the misconception is understandable. For as we shall see, these pure and purely descriptive theories are essential precursors and building blocks for any nonacademic theory.'

To explain what is meant by an academic or pure theory, Dickoff and James point to the theories of Hempel, Carnap, Toulmin, Nagel, and so on, which '*are special cases of the broader theory proposed here; these earlier views are not wrong so much as they are overly restrictive, concentrating only on one kind of theory without backing up to inquire as to theoretic activity itself and without seeing that one kind of theory - predictive - in relation to other kinds*' (Dickoff & James, 1968a, p. 203). The distinction between academic and nonacademic theory also foreshadows Dickoff and James' notion of theory being an invention to some practical purpose, i.e. situation-producing theory presupposing the other levels of theory. Therefore, although indicating four levels of theory, practice theory itself results from a two-tier notion of theory:

- theory without practical purpose (factor-isolating theory, factor-relating theory, and situation-relating theory).
- theory invented to some practical purpose (situation-producing theory).

This two-tier notion of theory, it is contended here, is related to Dewey distinguishing between:

- ideas which are just plans for possible action but do not lead to practical action in the end, and thereby cannot result in warranted knowledge,
- ideas which are verified by being put into practice.

3.1.2. Testing of predictive theory

Although Dickoff and James' analysis of the testing of predictive theory, as stated before, is suggestive rather than explicit, it can be shown to parallel that of predictive theory. For, as they point out (Dickoff & James, 1968b, pp. 204-205):

'Our contention is that research can function in the assaying or testing of a theory - or even in stimulating thought toward the production of theory. ... And as protocols or procedures may change depending on whether the research is for testing or for heuristic purposes, so too we ought to expect research procedures to differ according to the level of theory being tested or sought. It seems to us that methodological considerations have confined themselves almost entirely to questions concerning testing and for the most part the testing of predictive - that is, third level - theory.'

On this basis, Dickoff and James arrive at the broader notion of practice research indicating four levels of research, viz. as to factor-isolating theory, factor-relating theory, situation-relating theory, and situation-producing theory.

Apart from distinguishing these four levels of research, Dickoff and James take the position that research has both a heuristic or divining function and an assaying or testing function. Therefore, they suggest, there is '*a need for setting forth the appropriate protocols or conventions for the eight kinds of research just distinguished - namely, testing or stimulating for each of the four levels of theory*' (Dickoff & James, 1968b, p. 205). This notion of research was later coined '*8-4 research*,' as opposed to '*pseudo-technical research*' (Dickoff, James & Semradek, 1975b and 1975b).

So once the notion of practice theory is accepted as plausible, it leads to a broader notion of research as well, and it is the level of prediction which once again proves to be the decisive turning-point. For according to the notion of practice research, the testing of predictive theory does not stand on its own, for it presupposes other levels of research which are aimed at something less than the confirmation of predictive theory. Also, it implies yet another level of research which goes beyond the level of mere prediction, viz. testing situation-producing theory. These different levels of research also apply when practice research is aimed at '*stimulating thought toward the production of theory*' (Dickoff & James, 1968b, p. 204).

This goes a long way to show that the level of prediction is the decisive turning-point for a broader notion of research too, for practice research is aimed at the reconciliation of two different notions of research:

- research without practical purpose,
- research with a view to some practical purpose.

The correspondence with the analysis of practice theory is borne out by some of Dickoff and James' remarks about the testing of theories (Dickoff, James & Wiedenbach, 1968b, p. 548):

> *'That factor-relating theories and especially predictive theories can be tested is fairly well accepted and hence not particularly discussed here, except to remark that to test such theories is exactly to ask if they fulfill their own claims. In fact, methods of testing factor-relating or situation-relating theories are almost the only kinds of methodology that routinely have their due - or at least have characteristic procedures specified, however much lack of clarity exists as to what following such procedures amounts to or has significant terminus. We are more familiar with the procedure by which we make these tests than we are with seeing at what these tests aim. One advantage of looking at the extreme levels of theory is to make necessary the articulation of the larger context of theory-testing.'*

Therefore, although indicating four different levels of research or 8-4 research, practice research itself results from a two-tier notion of research:

- research without practical purpose (by means of stimulating or testing factor-isolating theory, factor-relating theory, and situation-relating theory),
- research with a view to some practical purpose (by means of stimulating or testing situation-producing theory).

3.2. Theory and practice

From the analysis of Practice Theory so far, it appears that Dickoff and James are mainly concerned with broadening the limited views of nurses as to the nature of theory and research by showing that both only make sense if directed at some practical purpose. However, Dickoff and James' intentions reach further than that, for their theory of theories is a proposal for developing a '*theory in a practice discipline*' (Dickoff, James & Wiedenbach, 1968a and 1968b, p. 204):

> *'... we as philosophers have proposed a theory of theories. And a philosopher - in the tradition of Socrates and more recently of Dewey - is a practitioner, not a mere academic. That is, as philosophers we have an aim beyond merely describing what theory is and what its levels are. Our aim is to produce a theory of theories that constitutes a practice theory for theorizers.'*

This intention reflects Dickoff and James' intellectual dependence on pragmatist philosophy in general and Dewey's version of it in particular. This is borne out by the point of departure of Practice Theory, i.e. the confusion within the nursing profession as to the nature of theory. But it is also demonstrated by the solution they propose, for it is typical of a pragmatist philosopher to consider it as his task to develop methods for using science in such a way that it can help to bring about the transformation of problematic situations.

3.2.1. The analysis of the problem as a guide for its solution

Apart from the frequent references to the philosophy of John Dewey and, to a lesser degree, of Charles Sanders Peirce, the influence of Dewey shows itself by the fact that Dickoff and James take off from a problematic situation, i.e. the nursing profession being dominated by unfruitful habits and by an unstudied awareness that leads to a concern with either mere theory, or mere research, or mere practice (Dickoff, James & Wiedenbach, 1968a, p. 415):

> *'a nurse can get lost in the business of theory and then never become reoccupied with practice or research except as contributor to theory. Or she can engage in research as a self-perpetuating activity done with no thought of an output beyond research itself - though perhaps making use of practice and theory as guides or aides to research. But a third equally unfortunate response for a would-be theorist in a practice discipline is to conceive the necessary dependence of research and theory on practice as an*

excuse for resting always with the mere particulars of the immediate problem situation and thereby restricting "analysis" of these situations to recording of anecdotes.'

It is to prevent each one of these responses that Dickoff and James have developed their theory of theories. However, considering their drive for a complete and systematic exposition of Practice Theory, they were bound to be misunderstood, for the early expositions of this theory of theories are admittedly overwhelming and confusing. In a later attempt to restate their position in a less formal way by means of '*a few reminders to some purpose*,' they are more explicit as to their intentions (Dickoff & James, 1975, p. 42):

'To break a fixation is our aim; to destroy a stance. Which one? The fixation that deifies the scientific while seeing the scientific as strongly opposed to the practical, the philosophical, and the "theoretical" - in the inventive sense of that word. The obsession that opposes the scientific to the value realm and to the realm of even professionally intersubjective preferences. Our reminders are aimed at creating a new posture, one that preserves for theoreticians the natural grace of common sense and professional practical sense. A stance that takes theory and research as an additive to, a strengthener of, rather than a substitute for a more unstudied awareness. A posture that sees theory as a tool for, not as a diversion from, nursing.'

This was, in a nutshell, the problematic situation which provided Dickoff and James with the impetus to reconsider nurses' fixations with a view to the transformation of the unstudied to the studied control of nursing practice. And, as Dickoff and James point out, '*sometimes the very manner in which we characterize the problem makes a big difference in the possibility of resolving the problem*' (Dickoff, James & Wiedenbach, 1968a, p. 418).

Therefore, considering the analysis of the problematic situation precipitating the development of Practice Theory, the proposal of the solution must be seen as a constructive, or rather reconstructive, and purposeful invitation to produce a guide to activity. There is, however, one condition which is that (Dickoff & James, 1975, p. 49):

'... the invitation is to produce the guide not by a reliance on unarticulated or unsystematic or uninventive or untested "application" of predictive theory. Quite the contrary. The invitation is to produce a guide for activity by using extensions of already developed scientific techniques of invention, testing, and readjusting ... To remain at the level of thoughtless application or single- purpose engineering application of predictive theory is becoming patently unacceptable, even in the natural sciences, including the purest of physics)' (Dickoff & James, 1975, p. 49).

The proposal of Practice Theory is thus fully in line with Dewey's instrumental views as to the role of human thought, for this theory of theories should be seen as a tool for reconstructing antecedent conditions of existence within the nursing profession which are considered to be problematic. Thus, Practice Theory, purports to start from a problematic situation and to lead back to it.

This process is also reflected by the sequence of publications about Practice Theory which were published in Nursing Research. Whereas the first two articles sketch the problematic situation (Dickoff & James, 1968a and 1968b), the next two articles present the proposed solution (Dickoff, James & Wiedenbach, 1968a and 1968b). The later articles are concerned with the the role of beliefs and values (Dickoff & James, 1970) and nursing research (Dickoff, James & Semradek, 1975a and 1975b).

3.2.2. The solution guided by the analysis of the problem

It is one thing to identify the problematic situation that gave rise to Practice Theory, but it is equally important to analyse the solution proposed by it, for this analysis will show that Dickoff and James see theory, as Glaser and Strauss would put it, as a process being grounded in practice. Apart from that, it once again demonstrates Practice Theory's intellectual dependence on Dewey's instrumentalism.

In an attempt to formulate a solution for the earlier mentioned problematic situation, Dickoff and James first take the position that '*not only is theory relevant to practice but also practice relevant to theory and both*

relevant to research' (Dickoff, James & Wiedenbach, 1968a, p. 415). Therefore, neither theory, nor research, nor practice can stand on its own as they are interrelated and interdependent.

What Dickoff and James set out to do in the articles, written in collaboration with Wiedenbach, is to indicate '*how the three are interdependent'* and to suggest *'the appropriate hierarchy as among the nurse's competing roles as practitioner, researcher and theorist*' (Dickoff, James & Wiedenbach, 1968b, p. 415):

> *'The contention here is that theory is born in practice, is refined in research, and must and can return to practice if research is to be other than a draining-off of energy from the main business of nursing and theory more than idle speculation.'*

In other words, just like Practice Theory itself, theory starts from practical problems and conceptualises possible solutions. Next, these solutions are tested by research and applied in professional practice. This shows that thought or theory, as Dickoff and James see it, is an instrument or a tool in the process that starts with the analysis of a problematic situation and ends up with bringing about the desired changes in this situation, or, as Dewey himself would put it, in the process of reconstructing antecedent conditions of existence which are considered to be problematic. This process entails three steps (Dickoff, James & Wiedenbach, 1968a and 1968b).

First, theory, being a conceptual invention, is a product of human thought, but, lacking the link with reality, it is deemed to remain mere theory. Therefore, it must have some point of departure in reality, and, as far as a theory is intended as a practice theory for nursing, it is obvious that this should be nursing practice, or more specifically, problematic situations in nursing practice. Further, stating that such a theory should start from problematic situations in nursing is just another way of saying that it is invented to some purpose, or to resolve the problematic situation. Therefore, nursing theory, as Dickoff and James see it, is '*thought for action,*' starting from nursing practice and leading back to it again, as opposed to mere theory or '*thought without action.*'

Secondly, research, being just another form of interaction with reality, is intended to arrive at initial conceptions and to test these conceptions in relation to reality. To the degree that research is practice research for nursing, it starts from nursing practice but it remains subordinated to the purpose the practice theory was invented for in the first place. Otherwise, practice research would amount to mere research or '*action without thought*.' However, nursing research, as Dickoff and James see it, amounts to '*action for thought.*'

Ultimately, this process leads back to nursing practice again, resulting in '*action guided by thought*' and incorporating both theory as '*thought for action*' and research as '*action for thought*.' By virtue of being guided by thought, nursing practice reflects a studied awareness of the profession's goals and its means to achieve these goals in order to transform the situation from a problematic into a resolved one.

Therefore, the solution proposed in Practice Theory casts a new light on the relationship between nursing theory, nursing research and nursing practice which can be summarised as follows:

- nursing theory: thought for action,
- nursing research: action for thought,
- nursing practice: action guided by thought.

This shows how all levels of practice theory originate in nursing practice and lead back to it again. The return to nursing practice can take two different forms which both reflect a certain '*openness to relevant empirical reality*.' First, indirectly via nursing research by the researcher, and, secondly, via professional practice by the practitioner. The differences between the researcher and the practitioner are more or less a matter of degree, for in both cases, it is theory which proves to be the intermediating factor between nursing practice as the antecedent or problematic situation and nursing practice as the consequent or resolved situation.

Therefore, it is concluded here that Dickoff and James' notion of theory amounts to a process being grounded in practice for it is it is by means of theory that the transformation of nursing practice is achieved, and also, that this instrumentalist notion of theory is inspired by Dewey's version of pragmatism.

3.3. Theory as a process being grounded in practice

One of the reasons why the articles by Dickoff and James make such difficult reading is that the outline chosen for the exposition of Practice Theory, although corresponding with their views concerning the generation of theory, is rather complex. Nevertheless, it is an illuminating exposition once its structure becomes evident (Table 1). The remaining part of this chapter is aimed at illustrating Dickoff and James' notion of theory as a process being grounded in practice. The exposition of Practice Theory is organised around the following question: '*To have a nursing theory what sources must be tapped?*' (Dickoff, James & Wiedenbach, 1968b, p. 545). These sources are:

A. awareness of status of practice theory,

B. interest in developing practice theory,

C. openness to relevant empirical reality.

These are the three elements which make essential contributions to the generation of a practice theory, and, as Dickoff and James point out, '*the same things are required - mutatis mutandis, for other levels of theory*' (Dickoff & James, 1968b, p. 204).

The relationships between awareness, interest, and openness should be taken to mean this (Dickoff, James & Wiedenbach, 1968b, p. 545):

A. '*If you do not know what you are looking for, you will not recognize it even if you were to find it*;'

B. '*if you know what something is but do not see it as worth your trouble, you will spend no energy getting it*;'

C. '*and if you are not willing to stimulate and risk your inventions in the fire of reality, your conceptions, however magnificent, have no claims beyond the academic*.'

In other words, knowing what a nursing theory is all about (A) is insufficient to warrant its generation, for there must be an antecedent problematic situation which raised the interest in developing nursing theory (B). Next, the reason for generating a nursing theory in the first place is that it is going to be used in nursing practice, thereby indicating the need for openness to relevant empirical reality (C). The actual sequence of theorising in nursing practice, therefore, adds up to a process in which the interest raised by a given situation (B) is transformed by means of a theory (A) into some sort of practical action (C).

These relationships between awareness, interest and openness are reflected in the structure of the line of reasoning that recurs time and again in the exposition of Practice Theory, and on three different levels of analysis at the same time (Table 1). In the following analysis of the structure of Practice Theory, the element of '*awareness*' is represented by (A), (1), or (a), the element '*interest'* by (B), (2), or (b), and the element '*openness'* by (C), (3), or (c). All in all, it adds up to a rather complex outline of nursing theory as a spiralling process being grounded in nursing practice, or, as Dewey would call it, an analysis of (Copleston, 1966, p. 121):

> *'the controlled or directed transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to convert the elements of the original situation into a unified whole.'*

This process shows the evolution in the theorist's relationship with the situations about which the theory is a theory, or the change from an unstudied towards a studied control of practical matters in nursing practice.

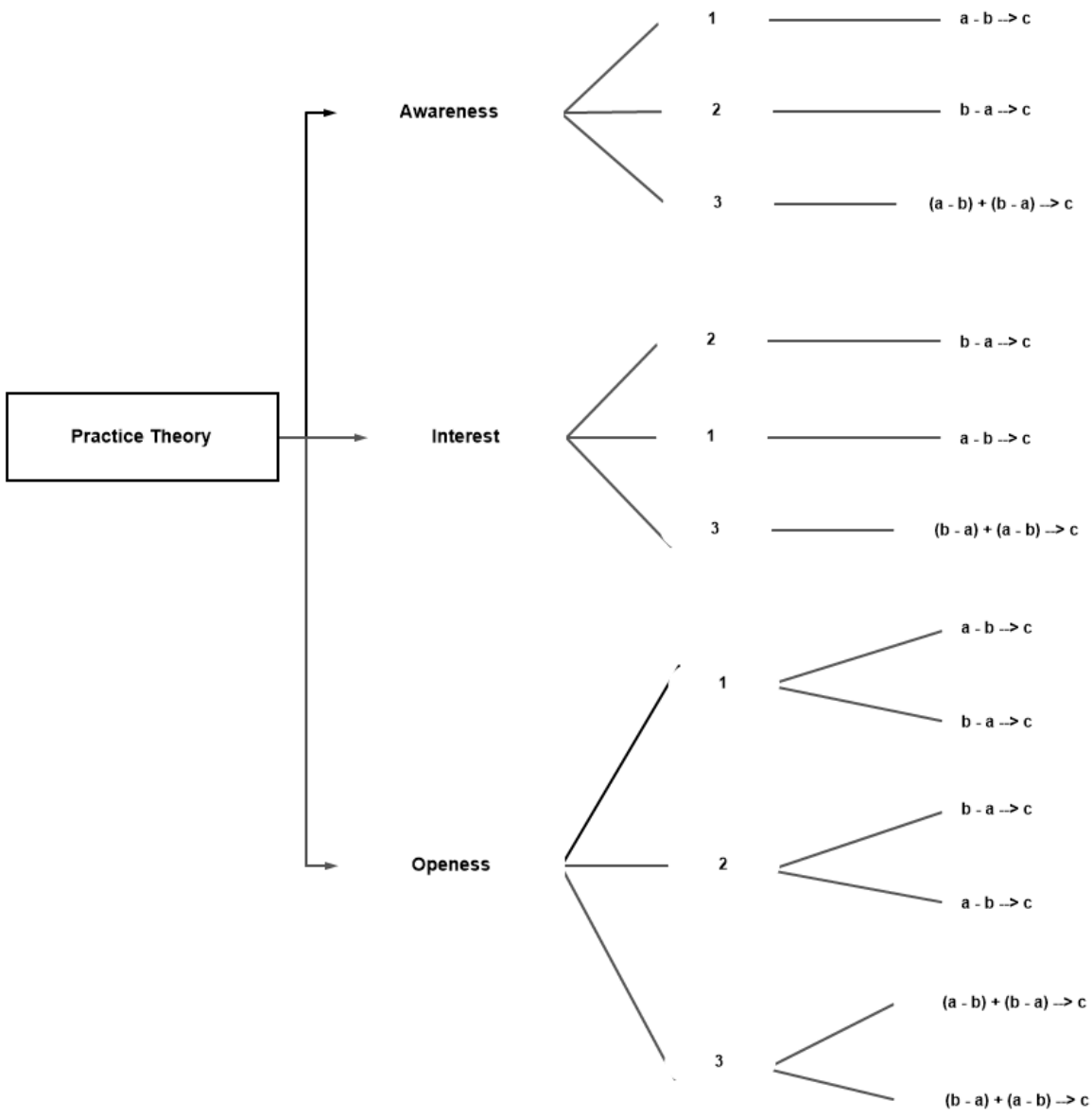

Table 1. The structure of Practice Theory.

3.3.1. Awareness of status of practice theory

The need to tap this source of nursing theory arises from the fact that '*if you do not know what you are looking for, you will not recognize it even if you were to find it*.' This part of the process gives rise to three questions which, between them, reflect the relationships between awareness, interest, and openness:

1. what is theory?

2. what is practice theory?

3. what is nursing theory?

What these questions, between them, add up to is that, for a theory to be a nursing theory, it must be a practice theory. This line of reasoning is characterised by the structure: 1 - 2 → 3, meaning that the notion of theory presupposes (-) the notion of practice theory to arrive at (→) the notion of nursing theory.

To complicate the analysis further, the answer given to each of the questions raised by Dickoff and James reflects the relationships between awareness, interest, and openness, albeit at a lower level, too. To illustrate these relationships, the following analysis focuses upon Dickoff and James' views concerning theory, practice theory and nursing theory.

Theory. In an attempt to answer the question '*what is theory?*' Dickoff and James describe two divergent but popular notions of theory (Dickoff, James & Wiedenbach, 1968a, pp. 418-419):

- the depreciatory notion of theory that expects nothing from theory because it is '*an idle speculation invented without reference to pertinent reality and made usually to amuse, to busy, or to promote the theorizer,*'
- the commendatory notion of theory that demands that which theory can never give: '*The theory, if true, reveals the facts about reality. The theory gives us a description of reality as it really is, rather than somebody's speculations made about reality.*'

These two notions of theory help to highlight the relation of a theory to that about which the theory is a theory, and give rise to the following remarks (Dickoff, James & Wiedenbach, 1968, p. 419):

a. '*Theory is neither a useless fairy tale nor a picture of the real. More properly, theory is an invention of concepts in interrelation.*'

b. '*If such a conceptual invention be made to some purpose, and not as an idle speculation, then the invention should hardly be called "mere" theory.*'

c. '*And if the invention be further subject to an interplay with reality in an attempt to determine the adequacy of the invention for the purpose the theory is designed to fulfill, we may be willing to consider a theory a good one - even after we realize that we have no way of ascertaining whether the theory gives an exact picture of reality (and when we see that some theories have as purpose something beyond describing reality).*'

Between them, these remarks show that the generation of a theory (a) presupposes some purpose (b) in order to arrive at a theory that works when put to the test (c). These relationships between awareness, interest, and openness (a - b → c) result in the following notion of theory (Dickoff & James, 1968a, p. 198):

> *'A theory, then, is a conceptual system - but a conceptual system invented to some purpose. To emphasize that theory is invented rather than found in, or discovered in, or abstracted from, reality calls not only to the conceptual status of theory but also to the necessity for imagination and risk-taking in the proposing of a theory. Reality is not prefactored; and even more obviously, no relation among factors comes automatically noted or automatically labelled.*
> *Though theory is no mere picture of reality, neither is a theory an invention that is mere fancy. Rather theory is a conceptual system invented to some purpose. And a good theory - or in perhaps more familiar terms a true or valid theory - is a theory that in fact fulfills the purpose for which the theory was proposed or invented.'*

Practice theory. Although the notion of theory articulated above is good for a start, it does not meet the needs of a theory for a practice discipline, for it is not specific enough about the exact purpose of a theory. Therefore, without further specification, this notion of theory amounts to no more than mere theory, at least within a practice discipline, for a practice theory requires the articulation of a professional purpose (Dickoff & James, 1968a, p. 199):

b. '*A true professional as opposed to a mere academic is action-oriented rather than being a professional spectator or commentator.*'

a. '*But a professional as opposed to a mere technician is a doer who shapes reality rather than merely a doer who merely tends the cogs of reality according to prescribed patterns.*'

c. '*A true professional - as opposed to a mere visionary - shapes reality according to an articulated purpose and in the light of means conceptualised in relation not only to purpose but also in relation to existent reality. In short, a professional cannot just watch, cannot just do, and cannot just hope and dream*.'

These remarks deal with the earlier mentioned division between pure and applied science, or the academic and nonacademic aspects of theory. For theory which fails to acknowledge the professional's action-orientation amounts to nothing more than mere '*understanding or "describing" or even predicting reality,*' or, as Dewey would put it, to possible plans for action which look forward to being verified in practice, let alone that such a theory could guide the professional to shape reality according to an articulated purpose.

Practice theory in the true sense of the word, acknowledging that a professional is action-orientated, requires a commitment beyond that, resulting in a '*conceptualisation specially intended to guide the shaping of reality to that profession's professional purpose*' (Dickoff & James, 1968a, p. 199) which actually can be verified in practice. In short, a theory becomes a practice theory to the degree that it has been invented not to some purpose but to a practical purpose.

Within the framework of practice theory, the professional's action-orientation (b) thus presupposes theory (a) to arrive at a theory suited to shape reality according to the profession's professional purpose (c). These relationships between interest, awareness, and openness (b - a → c) result in the notion of practice theory being a situation-producing theory (Dickoff & James, 1968a, p. 199):

> *'Situation-producing theory is called highest level theory because each of the other levels of theory exists in part at least to allow or provide basis for the next level of theory. But situation-producing theory is not as such developed for the sake of producing a theory of more elaborate structural level but rather for the production of or shaping of reality according to the situation-producing theory's conception. In plainer terms, situation-producing theory is produced to guide action to the production of reality.'*

Instead, one can also say that the generation of situation-producing theory is instrumental in the transformation of the professional's interest into a new openness to reality. This notion of practice theory as a situation-producing theory is a self-contained and unified whole in so far as it bridges the gap between theory without practical purpose and theory invented to some practical purpose. But this broadened notion of theory falls still short of achieving its ultimate goal, i.e the generation of a situation-producing theory for nursing or a nursing theory. This indicates that the analysis must be taken one step further.

Nursing theory. As explained before, theory should not only start from practice but also lead back to it. Therefore, the whole process ends up with the notion of nursing theory consisting of the following elements (Dickoff, James & Wiedenbach, 1968a, p. 422):

a. goal content: '*The first essential ingredient for a situation-producing theory is the conceptualization of a goal content - that is both the conceptualization of a content and the conceptualization of that content as desirable to attainment. The insistence on conception both of content and of the valuableness of that content is to emphasize that no mere feeling or reverence to some shadowy high ideal can substitute in theory for the conception of goal as goal. Nor can any less than articulate (that is, less than verbalized or - what amounts to the same - less than conceptualized in communicable form) notion of that idea's content serve as a conception of goal content*.'
b. prescriptions: '*The conceptualization of prescriptions to the effect that actions should be taken to realize the goal-content is conceived is the second essential ingredient of a situation-producing theory. At the conceptual and hence communicable level there must be articulated the awareness that the goal-content will not be realized without activity and that activity itself is something that takes place in particular. Three points about any prescription are noteworthy especially for our subsequent discussion of nursing theory: 1) the prescription is a command and so gives a directive; 2) the given directive commands acting toward a specified end; and 3) the command is directed to some specified agent or agents*.'
c. survey list: '*A survey list for activity constitutes the third ingredient of a situation-producing theory. Such a survey list is the articulate conceptual awareness that, however particular the goal-content and however particular the prescriptions, still activity under the prescription toward the realization of the goal is not*

totally determined by goal and prescription taken together. An agent's judgement, in the good-sense connotation of that term, is required to produce particular activity in a given-space situation such that the activity is a response to the prescription as an attempt to realize the goal.' An important feature of this judgement is the capacity 'to consult all salient features in the particular situation and make the adjustments of a more routine activity in the light of any idiosyncratic (that is, nonroutine) characteristics presented by these salient features in this particular situation.'

A nursing theory thus requires the theorist to be equally articulate about the theory's purpose and the means for achieving it (Dickoff, James & Wiedenbach, 1968a, p. 422):

> *'Depending on which of the first two ingredients is being emphasized, a situation-producing theory is variously known as a goal-incorporating theory or as a prescriptive theory.'*

Such a goal-incorporating or prescriptive theory is possible to the degree that the theorist starts from a given situation in nursing practice that provides the nursing theory with its goal content and prescriptions.

Subsequently, the goal content and the prescriptions must be linked to the particular situation(s) in which the theory is supposed to be used. The nursing theorist does so by means of the survey list (Dickoff, James & Wiedenbach, 1968a, pp. 421-422):

> *'the survey list calls to attention two sorts of things: First, to all those factors, facets, and aspects of activity judged relevant to achieve situations of the given kind but which for reasons of complexity or primitive state of development are not yet conceptually translated into directives of action, and, secondly, to those theories, at whatever level, knowledge of which or taking account of which is deemed to enhance the possibility of realizing the goal of the situation-producing theory.'*

A nursing theory thus requires both goal-content (a) and prescriptions (b) to arrive at a survey list (c). As far as the relationships between awareness, interest, and openness are concerned, the goal content presupposes the prescriptions (a - b), and vice versa (b - a), in order to arrive at the survey list (c), thereby reflecting a line of reasoning characterised by the following structure: (a - b) + (b - a) → c.

Theory, practice theory and nursing theory. Nursing theory (3), if considered in relation to the notions of theory and practice theory, unifies:

- theory as a conceptual invention to some purpose (1), with
- practice theory intended to shape reality according to a professional's purpose (2).

On this level of Practice Theory (1, 2, 3), the relationships between awareness, interest, and openness reflect a line of reasoning which is characterised by the following structure: 1 - 2 → 3.

On the next higher level of Practice Theory (A, B, C), this notion of nursing theory results in the 'awareness of status of practice theory' and helps to avoid the threat of a dualism between nursing theory and the reality about which the theory is a theory, i.e. nursing practice. More importantly, it shows nursing theory to be instrumental in the transformation of the unstudied into the studied control of practical matters in nursing practice.

However, lacking the interest in developing practice theory (B) and the openness to relevant reality (C) as sources of nursing theory, this awareness in itself is insufficient to warrant the generation of nursing theory in the end.

3.3.2. Interest in developing practice theory

The need to tap this source of nursing theory arises from the fact that 'if you know what something is but do not see it as worth your trouble, you will spend no energy getting it.' Therefore, this source of nursing theory deals with the element of interest in developing practice theory implicitly present in the first source of nursing theory (Dickoff & James, 1970, p. 421):

> *'Awareness without energy is not productive of action; on the other hand, energy or motive without proper awareness may not produce satisfactory activity. So the question for nursing or any practice discipline is how to exploit, prepare, and sustain beliefs and values in support of nursing practice.'*

In other words, '*Awareness is not enough. We need to consider energy sources to ensure action*' (Dickoff & James, 1970, p. 426). The question of what sort of energy, motive or interest is needed for nursing theory gives rise to the following remarks (Dickoff, James & Wiedenbach, 1968b, p. 546):

> *'What is needed is persons who both care about the problems of nursing and see vividly practice theory's potential as a help towards the resolution of these problems. No sane person, however much his interest in nursing, would invest the extensive energies requisite to move further in the development of nursing theory were he not convinced of the potential worth of that theory. But what too often exists is either persons really disturbed about the problems of practice and characterized by researchers as mere "problem solvers" or else researchers who fear their commitments to practice as biases against a true research orientation. Given the sophistication and complexity involved in helping any development, it is somewhat dubious whether motives of achieving academic status or desire for freedom from less fastidious areas of nursing would ever be sufficient to provide persistently untiring and nondespairing energy for what is admittedly a difficult, exacerbating, and not-soon- to-be-finished enterprise.'*

These are, in a nutshell, Dickoff and James' views as to interest in developing practice theory. Moreover, it also foreshadows the accessory relationships between interest, awareness, and openness, for the nursing theorist should '*exploit'* his care about the problems in nursing (2) by '*preparing'* the resolution of these problems (1) in order to '*sustain'* the development of nursing theory (3). It is along these lines that Dickoff and James give an outline of interest as a source of nursing theory. Just like the awareness of practice theory, the interest in developing nursing theory starts from practice and leads back to it (Dickoff, James & Wiedenbach, 1968a, pp. 415-416):

> *'Though we sometimes regard theorizing as an elevated, distant, and inaccessible activity, to see the roots of theorizing in activities commonly carried on and well within our ordinary powers is both useful and salutary. Spoken criticism - a most ordinary endeavor - can be viewed as a potential starting place for theory though, of course, no criticism itself constitutes theory. A skill essential to theory building in a practice discipline is the art of moving from criticism to more constructive reactions to the situations giving rise to the criticism.'*

Next, using descriptions of different situations in nursing which can give rise to criticism, Dickoff and James answer the question '*How can critical comment come to have theoretical worth?*' (Dickoff, James & Wiedenbach, 1968a, pp. 416-417):

- interest: '*First, the comment itself must be respected as potentially valuable. Then the interest or energy required to make the critcism in the first place - we do not bother to criticize what is indifferent to us - must be tapped in further exploration.*'

- awareness: '*Criticism evinces not only our interest and concern but suggests that we have in mind, at least implicitly, some standard violated by the criticized activity*.'

- openness: '*Being able to react critically to the situation described indicates both some interest in and some awareness of the nursing realities involved. But an immediate and merely critical reaction as an end in itself is no more than an emotional outlet. Still such critical reactions - especially if made by a seasoned practitioner or by other sensitive individuals - can be highly valuable when exploited intelligently and purposively*.'

These remarks show that, for a critical comment to have theoretical worth, requires the invention of a common thread in the situations criticised in order '*to move beyond that initial, merely negative feeling toward the particular situation*.' In other words, interest in developing nursing theory, although originating in nursing practice, requires some sort of thought beyond the initial critical reaction, otherwise the criticism amounts to nothing more than just an '*emotional outlet*.' James and Dickoff's discussion about interest in developing nursing theory is, therefore, directed at nurses who '*conceive the necessary dependence of research and theory on practice as an excuse for resting always with the mere particulars of the immediate problem situation and thereby restricting "analysis" of these situations to recording of anecdotes*.' To prevent this unfortunate response is exactly what the discussion about interest in developing practice theory is aimed at. This discussion deals with three valuable commodities which reflect the relationships between interest, awareness, and openness (Dickoff, James & Wiedenbach, 1968b, p. 545):

2. 'criticism at the verbal level demands conceptualization,'

1. 'a beginning awareness of goal or at least of a better state is implicit in any criticism,'

3. 'But particularly relevant at the moment is the further ingredient of criticism - the interest betokened in the subject matter criticized.'

To complicate the analysis, each of these commodities reflects the relationships between interest, awareness, and openness, albeit at a lower level, too. To illustrate these relationships, the following analysis focuses upon Dickoff and James' views concerning interest as a source of nursing theory.

Criticism at the verbal level demands conceptualisation. For a start, there are two things to be '*exploited'* from a criticism in order to conceptualise it (Dickoff, James & Wiedenbach, 1968a, p. 417):

b. '*First of all, the interest - however masked - that gives rise to the critical reaction. We are oftentimes so aware of the unpleasant and negative connotation of criticism that we overlook that a criticism, even a hostile one, is often far more useful than a reaction of mere indifference. The difficult but desirable stance to take is to maintain a critical attitude while investing the energy and interest which provoked the criticism in something beyond a venting of feelings or a mere publicizing of the faults of others*.'

a. '*The second thing to exploit from a criticism is the happy fact that we rarely keep our criticisms to ourselves but rather tend to voice them to appreciative audiences. But of what significance is this tendency? To voice a criticism is to verbalize it; and whereas critical reaction probably starts with a vague, perhaps not fully conscious felt discontent, articulating the criticism tends to bring to conceptual awareness at least some striking feature of the "situation" provoking the critical response*.'

c. '*But now how should the interest evidenced by the criticism and the initial characterization that voices the criticism be exploited toward activity that might terminate at least indirectly in doing away with the faults of the criticized situation? How can we exploit this interest and articulation to begin getting answers to the questions of: Exactly what needs changing? What direction should the change take? and How can this change actually be brought* about? Consider our initial characterisations of the particular situations presented here in hopes of arousing your feelings of discomfort or discontent. Observe that the presentations were in fact not situations but were already a reporting of what somebody took to be the salient features of some situation.'

Between them, these remarks show that interest in developing a theory, as reflected in the initial criticism (b), requires some sort of theorising activity (a) in order to result in the conceptualisation of that criticism (c). These relationships between interest, awareness, and openness (b - a → c) show that interest is indeed a source of theory, for it precipitates the characterisation or articulation needed for the transformation of the initial criticism into a conceptualisation of that criticism.

A beginning awareness of goal or at least of a better state is implicit in any criticism. To arrive at a nursing theory, however, requires more than just the conceptualisation of a problematic situation (Dickoff, James & Wiedenbach, 1968a, p. 418):

> *'If criticism is to be productive of positive action, we must be directed not only to pointing out problems but also at suggesting ways of resolving them; and sometimes the very manner in which we characterize the problem makes a big difference in the possibility of resolving the problem. In other words, it is often well to try to see the problem in a wider perspective - to see further elements within the problem situation, to see a broader aspect of the problem, or even to see the problem in relation to other pressing problems or as an instance of some more general problem.'*

What is needed, therefore, is the transformation of a conceptualised criticism into a problem. This activity involves some sort of a theoretical activity (Dickoff, James & Wiedenbach, 1968a, p. 418):

> *'Whereas criticism can give the initial impetus and direction to problem identification, the fuller articulation and pregnant characterization of a problem requires thought beyond initial reaction. For any presenting situation is ambiguous with respect to what are its salient features and what is the significant interrelation among these features. A more simple-minded way of putting this point is to say that a situation does not dictate its own description. Or even more pointedly, it is a bit hard to say what a "situation" is apart from some description of that situation.'*

So, whereas a criticism is at best saying something is wrong, it is argued by Dickoff and James, a problem is a sophistication of a criticism to the point of (Dickoff, James & Wiedenbach, 1968a, p. 418):

a. '*being articulate about what is at fault,*

b. *along with a desire to remove the fault*.

c. *Thus we say a problem is a director of inquiry. For genuinely having a problem - rather than a mere worry, criticism, or vague discontent - is having both impetus (interest and energy) and direction (initial conceptualization). This move from discomfort felt in practice to articulation of the difficulty, and thence to first speculative and then eventual practical resolution of the difficulty epitomizes that theory is born in practice and must return to practice*.'

To be articulate about what is at fault (a), the theorist first must have the desire to remove that fault (b). Otherwise, he will not able to arrive the formulation of a problem (c). This beginning awareness of goal or at least of a better state, which is implicit in any criticism, demonstrates the relationships between awareness, interest, and openness (a - b → c) on this level of Practice Theory.

The interest betokened in the subject matter criticised. As far as the structure of Practice Theory is concerned, the interest betokened in the subject matter criticised stands on the same level as nursing theory. But, whereas the latter is about the nature of theory, the former deals with the role of interest in the generation of nursing theory (Dickoff & James, 1970, p. 422):

> *'The ingredients of a practice theory - goal, prescription, and survey list - mirror and suggest the function of beliefs and values in support and guide of practice.'*

This similarity is borne out by the way Dickoff and James analyse the inquiry moving from the conceptalisation of a criticism via the formulation of a problem toward its outcome, i.e. the interest betokened in the subject matter criticised. The inquiry should therefore result in (Dickoff, James & Wiedenbach, 1968a, p. 418):
a. '*a speculation or invention related to but not entirely dictated by the problem-giving situation*.

b. *This speculation must be articulated and understandable in such a fashion that if the speculation is entertained by a practitioner ... who acts in good faith and with requisite skill with respect to the content of that speculation,*

c. *then the practitioner ... will not be subject in her nursing activity to the criticisms which gave rise to the problem.*'

To make sure that the practitioner will not be subject in her nursing activity to the criticisms which gave rise to the problem (c), it is simply not enough to have a speculation or invention which is prompted by the criticisms (b - a), for there must also be a desire or interest on the part of the practitioner to put this speculation or invention to use (a - b). The interest betokened in the subject matter criticised thus once again demonstrates the relationships between awareness, interest, and openness. In this case, these relationships reflect a line of reasoning characterised by the following structure: (b - a) + (a - b) → c. In other words, to the degree that interest is complemented by theory (b - a), and theory by interest (a - b), the resulting nursing theory (c) will be instrumental in the transformation of an unstudied into a studied control of practical matters in nursing practice.

Conceptualisation, awareness, and interest. On the next higher level of Practice Theory (1, 2, 3), the interest betokened in the subject matter criticised (3) unifies:

- the interest implicit in the conceptualisation of the initial criticism (2), with
- the interest implicit in the awareness of a goal or a better state (1).

All this goes a long way to show interest to be the driving force behind the generation of nursing theory. Instead, one can also say that it requires some sort of theoretical activity:

- to exploit one's care about problems in nursing practice (2),
- to prepare solutions of these problems (1), and
- to sustain the development of nursing theory (3).

The line of reasoning indicated above is characterised by the following structure: 2 - 1 → 3.

On the next higher level of Practice Theory (A, B, C), the interest betokened in the subject matter criticised guarantees that the generation of nursing theory is a purposeful activity because it is based on the theorist's interest in developing such theory. However, this interest combined with the theorist's awareness of status of practice theory, is insufficient to warrant the generation of nursing theory. For this, openness to relevant empirical reality is required as well.

3.3.3. Openness to relevant empirical reality

The need to tap this source of nursing theory arises from the fact that '*if you are not willing to stimulate and risk your inventions in the fire of reality, your conceptions, however magnificent, have no claims beyond the academic*,' indicating that this part of Practice Theory is directed at nurses who '*engage in research as a self-perpetuating activity done with no thought of an output beyond research itself - though perhaps making use of practice and theory as guides or aides to rereserch*.'

This is not to say, however, that this openness is a prerogative of research alone, for Dickoff and James are really at pains to make clear that practice and research, apart from some important differences, are alike in being types of openness to relevant reality, (Dickoff & James, 1968b; Dickoff, James & Wiedenbach, 1968b, pp. 546-547). Therefore, both nursing practice and nursing research are examples of '*openness to relevant empirical reality*.' The analysis of openness to relevant empirical reality focuses upon the notions of (Dickoff, James & Wiedenbach, 1968b, pp. 547-550:

1. research,

2. practice research,

3. reality research.

Between them, these three notions of research once again reflect the relationships between awareness, interest, and openness, and so does each of these notions in itself, albeit at a lower level. Also, it is worth recalling that, within the framework of Practice Theory, openness to relevant empirical reality is conceived as a two-way process (Dickoff, James & Wiedenbach, 1968b, p. 547:

> *'We can say that research has two objectives or that research has theory as its immediate objective but in two different ways. Research may be aimed at helping towards a statement of theory where none exists or where the existent one is thought to be inadequate; or research may be aimed at testing the adequacy of some already stated theory or of some part of that theory. For simplicity's sake let us say that research can function as a tester of theory or as a stimulator of theory.'*

Research. According to Dickoff and James, there are three avenues available to man '*both for arriving at initial conceptions and for assaying the conception in its relation to reality*.' These avenues are (Dickoff, James & Wiedenbach, 1968b, p. 547):

a. '*man's conceptualizing power,*

b. *his senses, and*

c. *his capacity to interact with reality - whether in plain daily living, in professional practice, or in research*.'

Given that openness to relevant empirical reality is a two-way process with, on this level of Practice Theory, theory as its aim, man's interaction with reality should be looked at from two different perspectives. As for research in its role of stimulator of theory, man's conceptualising power in itself is insufficient to result in interaction with reality, and it, therefore, presupposes the use of his senses (a - b → c) to avoid the theory being separated from reality. As for research in its role as tester of theory, on the other hand, man's senses in themselves are insufficient to result in interaction with reality either, and, therefore, presuppose the use of man's conceptualising power (b - a → c) to avoid the theory lacking any purpose.

On the level of research (C.1), man's openess to relevant empirical reality thus adds up to a two-way process in which, to use Dewey's words, man and reality are not mechanically but organically related. Dependent upon the role attributed to research, the relationships between awareness, interest, and openness indicated here, reflect a line of reasoning characterised by the following structure: either a - b → c, or b - a → c. Whereas the former structure mirrors that of the notion of theory (A.1), the latter parallels the structure of the conceptualisation of an initial criticism (B.2).

Practice research. The notion of research as outlined above amounts to mere openness without any other purpose than man's interaction with reality, and, therefore, it stands on the same level as the respective notions of theory and the conceptualisation of an initial criticism. These three notions, between them, indicate how Practice Theory closes the gap between theory and reality.

However, if viewed in relation to the notions of practice theory and the beginning awareness of goal or at least of a better state, opennes to relevant empirical reality also entails a practical or professional purpose, or, practice research, i.e man's systematic way of exploiting in conjunction all three avenues towards (Dickoff, James & Wiedenbach, 1968b, p. 547):

a. '*inventing,*

b. *testing, or*

c. *readjusting a conceptual framework*.'

Given that openness to relevant empirical reality is a two-way process with, on this level of Practice Theory, practice theory as its aim, the readjustment of a conceptual framework should be looked at from two different points of view. As for practice research in its stimulating role, the interest to apply a practice theory, or to test its

capability to shape reality according to the profession's professional purpose, presupposes the invention of such theory in the first place (b - a → c). As for practice research in its testing role, on the other hand, the invention of a practice theory (i.e. the articulation of its practical purpose) presupposes the interest to put it to the test (a - b → c).

The relationships between awareness, interest, and openness on the level of practice research (C.2) thus reflect a line of reasoning characterised by the following structure: either b - a → c, or a - b → c. Whereas the former structure resembles that of the notion of practice theory (A.2), the latter corresponds with the structure of a beginning awareness of goal or at least of a better state (B.1).

Reality research. The openness to relevant empirical reality on the level corresponding with that of nursing theory forms the apotheosis of the theorising process altogether, and results in '*eight-to-four research, or more simply 8-4 research, or implementation research, or reality research*' (Dickoff, James & Semradek, 1975a, p. 84). This kind of research entails the integration of three kinds of judgements (Dickoff, James & Semradek, 1975a, p. 84):

a. practical judgement or 'nursing-care judgement,'

b. technical judgement or '*methodological considerations*,'

c. political judgements, which is '*a convenient name to signal awareness of all the factors not delineated from a technical or practical point of view.*'

As for the reason for distinguishing these judgements, the following explanation is given (Dickoff, James & Semradek, 1975a, p. 84):

> *'The practical, the technical, and the political are three aspects of judgements. No claim as to their distinctness is made. Still the three emphases can be and should be discriminated to mark out where lie problems - and so solutions - for making research have adequate payoff for nursing practice. The practical-technical-political dimensions must be reflected in every aspect of research methodology. To leave the practical dimension to problem solvers, to limit the political dimension to permissions for studying and for applying findings, and to reserve only technical judgement for creating, assessing, and using research methods will leave nursing research forever in the state of having only promise of nursing payoff.'*

This notion of reality research (C.3) stands on the same level as the notions of nursing theory (A.3) and interest betokened in the subject matter criticised (B.3). Consequently, the three judgements mentioned above mirror the elements contained in the notions concerned. As for nursing theory, these elements are:

- the goal content,
- the prescriptions, and
- the survey list.

As for the interest betokened in the subject matter criticised, these elements are:

- the speculation or invention related to the criticisms,
- the desire or interest to put this speculation or invention to use,
- the practitioner not being subject in her nursing activity to the criticsms which gave rise to the problem.

These parallelisms should be taken to imply that, to arrive at political judgements, both a practical and a technical judgement is required. The relationships between awareness, interest, and openness on the level of reality research (C.3) are reflected in the line of reasoning characterised by the following structure: (a - b) + (b - a) → c. However, against the background of the distinction between the two functions of research, reality research adds up to two different lines of reasoning characterised by the following structures: either (a - b) + (b - a) → c, or (b - a) + (a - b)→ c.

Research, practice research, and reality research. On the next higher level of Practice Theory (1, 2, 3), reality research, itself a kind of openness to relevant empirical reality (3), unifies:

- research as man's capacity to interact with reality (1),
- practice research as a systematic way of readjusting a conceptual framework (2).

On this level, the relationships between awareness, interest, and openness are reflected in the line of reasoning characterised by the following structure: 1 - 2 → 3. However, dependent upon the function of reality research, i.e. generating or testing nursing theory, these relationships amount to a line of reasoning characterised by the following structures: either 1 - 2 → 3, or 2 - 1 → 3.

3.4. The structure of practice theory

The structure of Practice Theory shows the interrelatedness and interdependence of three sources of nursing theory:

A. awareness of status of practice theory,

B. interest in developing practice theory,

C. openness to relevant empirical reality.

One of the outstanding features of Practice Theory is the analogy between the different levels of its structure (Table 1). The almost symphonic elegance of this structure should be taken to mean that, depending upon the kind of openness to relevant reality that is needed (i.e. either for generating or for testing nursing theory), awareness presupposes interest and vice versa: either A - B → C, or B - A → C.

Because of this structure, Dickoff and James hold the view that, in order to arrive at a practice theory for nursing, all three sources of nursing theory are required at the same time. This is demonstrated by the analoguous relationships between the elements awareness, interest, and openness. However, if asked for the actual sequence of the generation of nursing theory, Dickoff and James take the position that (Dickoff, James & Wiedenbach, 1968a, p. 415):

> *'theory is born in practice, is refined in research, and must and can return to practice'* .

This sequence (B → A → C) corresponds with the structure of Practice Theory which gives rise to a notion of nursing theory which is a process being grounded in nursing practice, as well as an instrument in the transformation of a problematic situation into resolved situation. Consequently, nursing theory is not only a situation-producing theory but also a normative theory (Dickoff, James & Wiedenbach, 1968a, p. 422):

> *'a situation-producing theory is also called a "normative theory" or even a "value theory" in contrast to theory whose purpose is merely to describe - whether by giving factors, depicting of situations, or relations of situations - rather than to specify how situations of a desired kind can be brought about. The goal-content of a situation-producing theory serves as a norm or standard by which to evaluate activity; activity that furthers the goal is, in terms of the theory, valuable or good activity. And so, the specification of goal-contents entails taking them as values - thus it signifies conceiving these contents as situations worthy to be brought about. When a situation-producing theory is regarded as a source not merely of evaluation but of the actual bringing into existence activity evaluated as good by the theory then the situation-producing theory tends to be called a practice theory.'*

As a result, Practice Theory doesn't lead to a fixed image of nursing, let alone to one single general theory of nursing. In other words, nursing theory has nursing practice not as its subject matter but as its method. This notion of nursing theory amounts to theory as a tool in the continuous and ever-developing process of redefining the nurse's relationship with the nursing environment she finds herself in. So, theory leads to an evolution from an unstudied to a studied awareness of the image of nursing (Dickoff, James & Wiedenbach, 1968b, p. 554):

'Intellectually we humans tend to think of a realm somehow outside and above work-a-day reality, a realm wherein all knowledge is present; and we see our task as that of laying bare or discovering what was put there somehow by an agency beyond our own. But just as Nietzsche would emphasise the importance of learning to live with self-imposed standards, so Dewey translates this emphasis into a method of inquiry that urges capacity to live with the tentative. The function of intelligence is, as Dewey urges, one of rising invention rather than of making pre-patterned discoveries. So what is required to supply nursing research with the wanted criterion is an invention as to what the most fruitful and yet feasible image of nursing should be. ...

In short, to supply a nursing image is to venture a nursing theory. Theory at any level requires invention. Theory for a practice discipline requires theory at the highest level - situation-producing theory. Theorizing at such a level involves in a double sense the risk of novelty. Such theories are creative not merely because knowledge must be invented rather than simply discovered but because they have as purpose not merely an awareness of the world as it is but rather the bringing into being segments of reality according to the pattern of the theory's conception.'

Finally, what Dickoff and James' notion of nursing theory adds up to is the transformation of discovering knowledge and having a purpose into bringing about the desired changes. To the degree that a nursing theory is instrumental in this transformation, it is considered a good theory.

4. CONCLUSION

The purpose of this chapter is to show the transformation of the methodological aspects discussed in the previous chapters into the research design used in this study. This will be done by means of:

- a summary of the outcome of the comparison between Grounded Theory and Practice Theory,
- the justification of the use of Grounded Theory as the chosen method for this study,
- a description of the research design used in this study.

In the process, the discussion will also enter into the potential and limitations of Grounded Theory.

4.1. Grounded theory and practice theory revisited

The comparison between Grounded Theory and Practice Theory has shown these theories of theories to have common ground in their intellectual dependence upon Dewey's pragmatist philosophy, resulting in rather similar views with regard to the nature of theory, the generation of theory, as well as the criteria of adequacy of theory.

4.1.1. The nature of theory

For a start, the respective theories take issue with sociologists and nurses who view theory either as generated by logical deduction from a priori assumptions (Grounded Theory), or as a matter of understanding, describing or predicting reality (Practice Theory), because these narrow views of theory give rise to a division between the theory and the reality about which the theory is a theory, on the one hand, and the theory and its application, on the other. Both objections can be traced back to Dewey's views concerning the role of theory, i.e. theory as a plan or a design for the reconstruction of antecedent conditions of existence which are considered problematic.

Furthermore, theory is regarded as a process that is determined by the supposed uses (Grounded Theory) or the purpose of the theory (Practice Theory). For this, it is necessary that the theory starts from the data (Grounded Theory) or situations in nursing practice (Practice Theory), and returns to it.

Theory and reality. It is important to note that the data and situations concerned do not represent reality in its entirety but only those of its characteristics which the theorist considers relevant to his theory. In other words, the data and the situations on which the theory is to be based already are conceptualisations of reality, and, more importantly, it is these data and situations to which the theory refers.

This is precisely what is meant by the word '*grounded*,' a technical term first used by Peirce to signify the relationship between a theoretical proposition and its interpretant. This is the pragmatist philosopher's solution for closing the gap between a theory and the reality about which the theory is a theory.

Theory and its application. As for theory leading back to the data or the nursing situations concerned, both theories of theories put great emphasis upon the theory's use or purpose. In other words, theory narrowly conceived amounts to possible plans for action which look forward to being verified in practice. However, for theory to be useful or purposeful, it needs to be generated with a view to its practical application. Because the data and the situations incorporated in the theory are conceptualisations of reality and not reality itself, the theory at this end of the process must supply concepts of control (Grounded Theory) or a survey list (Practice Theory) in order to warrant the link with its application in the real world. This is the pragmatist philosopher's solution for closing the gap between theory and its application.

Theory. What '*theory as a process*' adds up to is the notion of theory as an instrument or tool in which the data or the nursing situations concerned are not the subject matter of the theory but the means used by the theorist to transform antecedent conditions of existence which are considered indeterminate or problematic into consequent conditions of existence which are determinate or resolved.

4.1.2. The generation of theory

In Grounded Theory, the discovery of theory from data is the result of the joint collection, coding, and analysis of data, i.e. the constant comparative analysis. In Practice Theory, on the other hand, theory as a process is dependent upon tapping three sources of theory, viz. awareness of the status of practice theory, interest in developing practice theory, and openness to relevant empirical reality. The relationships between these sources of theory are reflected in this theory's structure in which awareness (A) mediates between the antecedent situation which prompted the interest (B) in developing theory in the first place, and the consequent situation in which the theory will be applied, thereby giving rise to a new openness for reality (C). The similarity of the theories generated by either method is borne out by the parallelism between the two (Table 2).

Grounded Theory	Practice Theory
properties of concepts, or categories	factor-isolating theory
concepts	factor-relating theory
hypotheses	situation-relating theory
integrated theory	situation-producing theory

Table 2. Grounded Theory versus Practice Theory.

4.1.3. Criteria of adequacy

As for the criteria of adequacy of theory, Grounded Theory and Practice Theory have common ground in the view that, in the final analysis, a theory is good to the extent that it works. In Practice Theory, this should be taken to mean that a theory must indeed lead to some sort of practical action. In Grounded Theory, on the other hand, it means that a good theory provides a new perspective from which to look at the area under investigation, or better still, that it helps to have the situation set out in a more meaningful and secure way. In other words, Practice Theory (James & Dickoff, 1982, p. 49, footnote):

> *'has some of the features of a "grounded" theory; but note that for us "grounded" relates to origin and use of empirical stimulus for concept development; grounding does not for us replace [the] need for test.'*

In both cases, however, theory gives rise to a new or transformed relationship between the theorist and his environment.

4.1.4. Conclusion

Summing up, whereas Practice Theory primarily reflects Dewey's instrumentalism, Grounded Theory should be seen as a method for discovering the meaning of social behaviour along the lines of Peirce's brand of pragmatist philosophy which had been handed down by Dewey. This goes a long way to indicate that, as far as this study is concerned, Grounded Theory is the chosen method, for this study is concerned with the discovery of the meaning of adjectives like '*patient-centred*,' '*comprehensive*,' '*total*,' '*individualised*,' '*personalised*,' '*holistic*,' and so on (when used to denote the meaning of nursing).

4.2. The justification of grounded theory

This study sets out from an indeterminate or meaningless situation, i.e. the lack of clarity as to the meaning of the designating adjectives mentioned above, in order to end up with a more determinate or meaningful situation, in order to clarify what these adjectives add to the meaning of nursing, especially in terms of opinions, beliefs and values concerning what nursing stands for and what it does not.

In the introduction, mention was made of the requirements which have to be met by a method to deserve consideration for a study like this. On the basis of the comparison between Grounded Theory and Practice

Theory, it can be concluded that Grounded Theory is the preferable method to be used in this study because these requirements are matched by this method's capacity to generate theory (Table 3).

Requirements	Grounded Theory
the reconstruction of: • mental representations • presuppositions and implications • domains of interpretation	the discovery of: • conceptual properties, or categories • concepts • hypotheses
in order to arrive at a the meaning of nursing	in order to arrive at the integration of theory

Table 3. Requirements of this study met by Grounded Theory.

4.2.1. Mental representations

> *'First, it [the method] must be geared to the reconstruction of the various mental representations of words like 'individualised,' 'comprehensive,' 'patient-centred,' and so on, when used in connection with nursing. Therefore, it should enable the researcher to collect the data which are relevant for that purpose.'*

The analysis of Grounded Theory has shown that it enables the researcher to identify the meaning of nursing which comes to the fore in the adjectives under investigation, for it does not reveal bare facts but conceptual properties or categories discovered from data systematically obtained from social research. The use of this method is, therefore, likely to result in the description of mental representations of, for example, '*patient-centred nursing*.' For, according to Grounded Theory, such words are meaningful insofar as they bring to awareness the characteristics which are indicated by the data.

To discover these characteristics, this study focuses not on the real world of nursing but on more or less explicit accounts of nurses which reflect what they have in mind when they speak about '*patient-centred nursing*.' This method is, therefore, expected to yield answers to questions such as 'What are the conceptual properties of the concept of patient-centred nursing?'

The data to be used for this purpose, therefore, have to be extracted from utterances about nursing in the literature. The selection of the literature will be determined by the criteria of theoretical purpose and relevance (Glaser & Strauss, 1968, p. 48). In other words, the process of collecting, coding and analysing the data will be controlled by the emerging theory. The initial decisions as to the collection of the data, however, will be determined by the search for books and articles with one of the earlier mentioned adjectives in the title.

4.2.2. Presuppositions and implications

> *'Secondly, the method must be conducive to the demarcation of the mental domains of interpretation within which these adjectives are meaningful. Therefore, it should direct the researcher's attention to the presuppositions and implications which condition the correct interpretation of each of these adjectives.'*

The analysis of Grounded Theory has shown that its use is not aimed at arriving at nominal definitions referring to specific entities in the real world, i.e. facts, but intends to discover structural conditions, consequences, deviances, norms, processes, patterns, and systems indicated by the data, and to make them understandable and relevant for practical application. In other words, it primarily purports to help make sense of the data extracted from the real world.

As for this study, the use of Grounded Theory entails the constant comparative analysis of the data in order to clarify the structural conditions and the consequent processes which determine the correct interpretation of the data extracted from the literature. In other words, this study is aimed at discovering the presuppositions and implications which condition the correct interpretation of, for example, '*comprehensive nursing*.'

For this, it is necessary to analyse the historical situation which gave rise to the use of the adjective '*comprehensive'* in the first place. The next step will be the comparative analysis of the data in order to discover the presuppositions and implications which condition the meaning of, in this case, '*comprehensive nursing*.'

4.2.3. Domains of interpretation

> *'Thirdly, the method must be poised to clarify both the similarities and differences between these domains of interpretation. It should, therefore, help the researcher to compare the various domains of interpretation with regard to the question of what nursing means and what it does not.'*

By virtue of the constant comparative analysis, Grounded Theory enables the researcher to decide upon the similarities and the differences between, for example, '*individualised nursing*' and '*comprehensive nursing*.' As a matter of fact, it is precisely this capacity which is reflected in its name.

At this point it is important to recall the words of Peirce to the effect that '*In order to ascertain the meaning of an intellectual conception one has to consider what practical consequences might conceivably result by necessity from the truth of that conception*.' In other words, if two apparently different ideas or beliefs give rise to practical consequences which are in fact identical, these ideas or beliefs can be said to have the same meaning.

Therefore, this study is also aimed at comparing the practical consequences of '*comprehensive nursing*,' '*patient-centred nursing*,' and so on, in order to see whether they are identical, i.e. whether they lead to identical behaviour or not. If so, the meaning of these adjectives can be said to be identical. If not, these adjectives have a different meaning altogether. To achieve this requires a comparative analysis of the practical application of, for example, '*comprehensive nursing*' and '*patient-centred nursing*' in terms of the nurse's behaviour.

4.2.4. The meaning of nursing

> *'Last but not least, the method must provide the means to identify the practical bearings of the similarities and differences between 'individualised nursing,' 'comprehensive nursing' and 'patient-centered nursing,' and so on, for nursing science, nursing research and the nursing profession as a whole.'*

Using the constant comparative analysis to its fullest potential, it should be possible to achieve some sort of integration of the meanings of nursing identified as a result of the comparative analysis of the adjectives under investigation. This would imply the identification of certain similarities to the effect that the adjectives concerned can be said to be different ways of expressing one and the same meaning of nursing. Moreover, it should be possible to state clearly the practical bearings of these ideas for nursing science, nursing research, and the nursing profession as a whole.

4.3. The research design

Apart from the fact that Grounded Theory meets the requirements for a study like this, it has been established that this method of generating theory is aimed at helping the researcher to discover the meaning of his data. Because the data reflect the researcher's conception of the real world, a grounded theory does not picture the area under investigation in its entirety, but only those of its characteristics which the researcher can point at when asked what his theory means. Consequently, a grounded theory can be best thought of as a semantic expression which reflects the researcher's cognitive representation of the real world, rather than the world itself. This gives rise to the following relationships between language, thought, and reality in this study (Table 4).

grounded theory	cognitive representation	real world
categories	mental representations	accounts of nurses
concepts	presuppositions and implications	
hypotheses	domains of interpretation	
integrated theory	the meaning of nursing	

Table 4. The relationships between language, thought, and reality in this study.

As for this study, generating a grounded theory thus amounts to reconstructing semantic representations (i.e. categories, concepts and propositions) of the meaning(s) of nursing, which are grounded in the researcher's cognitive representation (i.e. the data) of nurses' utterances about nursing (i.e. the literature).

4.3.1. The collection of the data from the literature

The obvious place to start looking for the data was the literature. Initially, it was expected that most of the literature to be studied dated from the years since the end of the Second World War and that, thereafter, the research would move on to more recent publications. It says a lot about the flexibility of the constant comparative analysis that what actually happened was precisely the opposite. As a result, what had started as a comparative analysis of contemporary meanings of nursing turned into a comparative analysis of the conceptual history of modern nursing in the United States.

Contemporary meanings of nursing. The first step was to consult the indexes of nursing literature:

- International Nursing Index (1966-),
- Cumulative Index to Nursing Literature (1956-),
- Thompson, A. (1968) A bibliography of nursing literature (1859- 1960). Royal College of Nursing, London.

Despite the wealth of information available, it proved extremely difficult to structure the literature search by means of these indexes, as they did not carry special entries re the adjectives under investigation, except for comprehensive nursing and patient-centred nursing.

Although this discovery aroused a great deal of concern, I continued anxiously with the literature search by turning to 'Patient-centered approaches to nursing' (Abdellah et al, 1960). In this book, most of the adjectives under investigation were very much in evidence, thereby providing me with the first data from which to extract their meaning. More importantly, this book made it abundantly clear that the publication from which to obtain data about comprehensive nursing was the Brown Report (Brown, 1948). In the meantime, I had started a systematic screening of the major nursing journals:

- American Journal of Nursing (1948-1960),
- Nursing Research (1952-1960),
- Nursing Outlook (1953-1960).

From then on, the literature search began to snowball. The Brown Report and the literature related to it suggested the need for the detailed analysis of two other reports, published in the same year (Ginzberg, 1948; Murdock et al, 1948b). Also, it began to dawn on me that comprehensive nursing and patient-centred nursing had common ground in the use of the team approach, albeit in markedly different ways.

A conceptual history of modern nursing. At this stage of the literature research, it was clear that comprehensive nursing was connected with the Brown Report and patient-centred nursing with the ensuing evolution of nursing in the 1950s, and both were connected with the team approach in nursing. Given that '*comprehensive nursing*' put such great emphasis on the social and health aspects of nursing, it was rather startling to find that these aspects were introduced at a much earlier stage (Brooks, 1949, p. 277):

> *'We recommend to any nurse in search of stimulation a trip back through the sections of the Curriculum Guide for schools of nursing, which deal with a definition of nursing. Be sure to see all of the editions - but the words of the 1927 edition, which are quoted in part on pages 20-22 of the 1937 Curriculum Guide*

offer a special challenge. The same adventure can be pushed back further to the writings of Florence Nightingale. Yet we talk of the new emphasis on the social and health aspects of nursing!'

This discovery proved a turning-point, since the data pointed in the direction of a historical study rather than a study of the contemporary meanings of nursing. To grasp the full meaning of comprehensive nursing, it was necessary to follow the trail backward rather than forward into the conceptual history of modern nursing. This change added a considerable body of literature to be studied. My guides for the period concerned (1873-1937) were 'American nursing, history and interpretation' (Roberts, 1954) and 'The education of nurses, historical foundations and modern trends' (Stewart, 1944).

The main sources from which to extract data were the three consecutive editions of the Curriculum (NLNE, 1917, 1927, 1937), and the many publications related to it. In addition, I systematically screened the Journal of Nursing (1900-1948) in conjunction with the Public Health Nurse (from 1931: Public Health Nursing).

What all the data extracted from the literature added up to was the discovery of the origin and evolution of '*individualised nursing*' and the use of the case method that went with it. This came as a big surprise as I originally expected the adjective '*individualised*' to have been introduced more recently. In fact, it proved to be the oldest adjective used to denote the meaning of nursing.

The Nightingalian model of nursing. In the course of the literature search, I came across many references to the influence of Florence Nightingale on American nursing. To round off the study, it therefore seemed appropriate to investigate the Nightingalian model of nursing in relation to the conceptual development of modern nursing in the United States. This decision proved most fortunate as Nightingale's writings demonstrated an appoach to nursing which is different from the approach emerging in the United States.

4.3.2. The discovery of the meaning of nursing from the data

So far, it may seem that the collection of the data extracted from the vast amount of literature took place in a rather orderly and systematic manner. In reality, it was more a matter of going to and fro between the data. That is probably what Glaser and Strauss meant when stressing that the collection of the data has to take place in conjunction with the coding and analysis of the data. In my experience, the research process was orderly and systematic as long as there were two or more meanings of nursing to be compared. As soon as the research focused too exclusively on just one of the meanings of nursing, it yielded far less fruitful results.

The continuous interaction with the data by means of the constant comparative analysis proved not only a laborious but also a very effective method of isolating conceptual properties of concepts or categories which, between them, added up to meaningful concepts. In due course, the data indicated that the presuppositions and implications of the adjectives under investigation could best be compared by reconstructing the concepts of nursing, nursing education, and professional nursing which were indicated by the categories.

This should not, however, be taken to imply that the categories did not suggest any other concepts, but these were not used for the reason that they were not conducive to the creation of different domains of interpretation which were susceptible to further comparison.

The presuppositions and implications which were selected, though, added up to such '*unified wholes*' (i.e. the total of the concepts of nursing, nursing education and professional nursing identified was more than the sum of its parts), that I decided to designate the combined concepts by the word '*model*.' Consequently, this study challenges the conventional wisdom of limiting the use of the word '*model*' for what is considered here to be just a part of it, i.e. a concept of nursing encompassing four key elements: person, environment, health and nursing (e.g. Fawcett, 1984, pp. 5-6). On the basis of the data extracted from the literature studied, it would seem viable to differentiate the following models of nursing:

- the Nightingalian model of nursing,
- the model of individualised nursing,
- the model of comprehensive nursing,
- the model of patient-centred nursing.

As for the other adjectives under investigation, the data did not justify the use of the word '*model*.' This is reflected in the outline of this study. As for the practical application of these models of nursing, the comparative

analysis of the data pointed in the direction of the different methods of assignment that went with them (except for the Nightingalian model of nursing), viz. the case method and the team method.

4.3.3. The presentation of the results

This study presents the results of the comparative analysis of the different meanings of nursing which come to the fore in the adjectives under investigation. Between them, these adjectives add up to a conceptual history of modern nursing in the United States. The outline of this study is prompted by the method used, i.e. the constant comparative analysis (Table 5):

- part II deals with the Nightingalian model of nursing, which is compared with the American models of nursing,
- part III deals with the model of individualised nursing, as opposed to the model of functional nursing which can be regarded as its antithesis,
- part IV deals with the models of comprehensive nursing and patient-centred nursing.

	Part II the Nightingalian model of nursing	**Part III** the model of individualised nursing	**Part IV** the model of comprehensive and patient-centred nursing
the historical situation	chapter 5	chapter 11	chapter 17
the concepts of: • nursing • nursing education • professional nursing	 chapter 6 chapter 7 chapter 8	 chapter 12 chapter 13 chapter 14	 chapter 18 chapter 19 chapter 20
the model's application	chapter 9	chapter 15	chapter 21
the meaning of nursing	chapter 10	chapter 16	chapter 22

Table 5. The content of this study.

As for each of these parts of the study, the first chapter is devoted to the historical situation that gave rise to the model of nursing concerned. The second, third and fourth chapters deal with the model's concepts of nursing, nursing education, and professional nursing (i.e. presuppositions and implications), and the fifth chapter with its practical application in terms of the nurse's behaviour (i.e. the chosen method for implementing the particular model of nursing). The sixth and last chapter of each part sums up the outcome of the comparative analysis by outlining the resulting meaning of nursing and by comparing this meaning with the ones emerging from the other models of nursing.

As a result of this similarity, this study can be read in two different ways. One way is to read the parts of the study consecutively. The other is to make a cross-section by only reading the chapters on, for example, each model's application. Whereas the former method is conducive to grasping the conceptual history of modern nursing, the latter helps the reader to compare the different models with regard to particular aspects of it.

Finally, at the end of this study, I will return to the question of its practical bearings for nursing science, nursing research and the nursing profession as a whole.

PART II
THE NIGHTINGALIAN MODEL OF NURSING

By common consent the publication of 'Notes on nursing' in 1859, and the founding of the Nightingale training school for nurses in 1861, heralded the beginning of modern nursing. However, these historical events reveal little or nothing about the Nightingalian model of nursing which is said to have marked '*the beginning of the development of theoretical models of nursing'* (Riehl & Roy, 1974, p. 16). For, to grasp the meaning of this model (encompassing Nightingale's concepts of nursing, nursing education and professional nursing) requires an analysis of its presuppositions (a remarkable mixture of statistical inquiry, religious speculation, and a zeal for social reform) as well as its implications (a sanitary approach to nursing) which have been at the source of these historical events (chapter 5).

Granted these presuppositions and implications, the question arises whether the Nightingalian model of nursing justifies Nightingale being regarded as the founder of modern nursing, and, also, to what extent this model has influenced the conceptual development of nursing in the United States. The answer to these questions is to emerge from the detailed analysis of Nightingale's concepts of nursing, nursing education, and professional nursing (chapters 6, 7, and 8) as well as the practical application of her concept of nursing (chapter 9).

The analysis put forward here breaks new ground insofar as it is aimed at clarifying Nightingale's impact on later models of nursing, particularly in the United States, by means of a conceptual interpretation rather than by a reconstruction of the chronology of the historical events which made up her life. It, therefore, will focus primarily on the publications through which Nightingale's views have been handed down to American nurses:

- 'Notes on nursing (1859b),
- 'Nurses, training of' (1882a), and 'Nursing the sick' (1882b),
- 'Sick nursing and health nursing' (1893).

As far as the conceptualisation of nursing is concerned, it will become clear that, because of the religious presuppositions and the sanitary implications of the Nightingalian model of nursing, Nightingale should not be regarded as the founder of modern nursing (chapter 10). Moreover, between them, these presuppositions and implications, have given the Nightingalian model of nursing a flavour so idiosyncratic as to be prohibitive of exercising any influence at all. This is however not to say that Nightingale should not be awarded the title of '*founder of modern nursing*,' only that it should be attributed to her for reasons other than the model of nursing which bears her name.

5.
FLORENCE NIGHTINGALE

Florence Nightingale (1820-1910) is generally conceded to be the founder of nursing, but to assess more precisely the influence she has exerted on the conceptual development of nursing is sooner said than done, mainly because of the way nursing historians have gone about both her life and her writings on nursing. As to the Nightingalian model of nursing, it should be added that nursing historians are evidently inclined to consider it, if at all, in isolation from Nightingale's endeavours in other areas, notably religion and statistics. This approach may result in more or less comprehensive chronologies of historical events but this, it is contended in this chapter, is not conducive to a good understanding of the Nightingalian model of nursing, let alone an accurate appraisal of its significance for the conceptual development of nursing.

5.1. The biographies

Florence Nightingale's life has given rise to virtually as many different interpretations as the number of her biographers. The first biography of lasting importance to be published was 'The life of Florence Nightingale' by Cook (1913a and 1913b). It is no secret that Cook had to work within the constraints imposed upon him by the relatives of Nightingale who had commissioned this biography and wanted to see certain events, for example her love affair with Richard Monckton Milnes, kept out of the book. On the other hand, he must have had access to virtually all the sources available at the time because his study is still second to none as far as the documentation is concerned. Whereas Cook, in contrast with the sentimentalised image of the lady with the lamp still dominant at his time, painted a more or less detached picture of Nightingale, Strachey, in his book 'Eminent Victorians,' reached quite a different verdict (Strachey, 1918, p. 115):

> *'Everyone knows the popular conception of Florence Nightingale. The saintly, self-sacrificing woman, the delicate maiden of high degree who threw aside the pleasures of a life of ease to succour the afflicted, the Lady with the Lamp, gliding through the horrors of the hospital at Scutari, and consecrating with the radiance of her goodness the dying soldier's couch - the vision is familiar to all. But the truth was different. The Miss Nightingale of fact was not as facile fancy painted her. She worked in another fashion, and towards another end; she moved under the stress of an impetus which finds no place in the popular imagination. A Demon possessed her. Now demons, whatever else they may be, are full of interest. And so it happens that in the real Miss Nightingale there was more that was interesting than in the legendary one; there was also less that was agreeable.'*

Apparently, it was Strachey's iconoclastic interpretation that has given a new lease of life to the traditional semi-mythical image which antedated Cook's biography, resulting in a new wave of biographies in which Nightingale was depicted alternatively as, for example, the lost commander, the soldiers' heroine, the fiery angel, the angel of the Crimea or, almost inevitably, the lady with the lamp (Hebert, 1981). The third most influential biography has been written by Woodham-Smith (1951) who followed Cook's chronology of events as well as Strachey's interpretation of Nightingale's personality.

More recently published studies on Nightingale's life, on the other hand, tend to be less comprehensive than these biographies. In turn, they provide a greater in-depth view of particular aspects of her life like her ailments since the return from the Crimea (Pickering, 1974), her use of her reputation and power (Smith, 1982), or her influence on nursing and nursing education (Prince, 1982; Baly, 1984). Moreover, whereas the comprehensive biographies mentioned earlier were based upon the groundwork done by Cook and portrayed Nightingale as the intelligent, masterful, soft-spoken lady with the lamp, these studies are based upon original research of the historical sources and tend to present a far less idealised image of Nightingale. Finally, special mention should be made of the study by Kalisch and Kalisch (1983a and 1983b) concerning the sentimentalised images of Nightingale presented by popular biographies, stage productions, film, radio and television dramatisations.

Summing up, it appears that, more than half a century after Nightingale's death, nursing historians have finally reached the stage at which it is possible to publish well documented and relatively unbiased studies of certain aspects of her life.

5.2. The original works

As far as Nightingale's original works are concerned, the situation is strikingly similar. Except for Cook's study, which deals with her writings in more detail than any other biography, the interest shown by most nursing historians has been limited to 'Notes on nursing' (Nightingale, 1859b), her first book on nursing which has always been readily available. A notable exception is Newton's dissertation 'Florence Nightingale's philosophy of life and education' (1949) but, regrettably, this study is buried in the library of Stanford University and has never been published. Fortunately, the content has been reported extensively by Barritt (1973).

Newton's study reflected the growing interest in Nightingale's writings at the time. In 1949, the National League of Nursing Education, for reasons to be explained later, thought it fit to publish 'Nursing of the sick,' the report of the International Congress of Charities, Correction and Philanthropy which met in Chicago during the World's Fair in 1893. This report included Nightingale's 'Sick nursing and health nursing' (Nightingale, 1893), which was her last comprehensive and authoritative statement on the nature of nursing.

In 1954, Seymer's 'Selected writings of Florence Nightingale' was published. This compilation contained, amongst others, 'Nurses, training of' (Nightingale, 1882a) and 'Nursing the sick' (Nightingale, 1882b), two articles which Nightingale contributed to Quain's 'A dictionary of medicine'.

Consequently, Nightingale's most important writings on nursing have been readily available ever since. The same cannot be said about her other writings, or as her bio-biographer Bishop reportedly put it (Bishop & Goldie, 1962, p. 5):

> *'The popular legend of Florence Nightingale is being perpetuated, while her own writings are neglected, and her most important achievements forgotten. There is little understanding of her real message for today. ... It was her friend Benjamin Jowett who wrote of Miss Nightingale that she had become a legend in her own lifetime. She remains a "legend" - but for all the wrong reasons.'*

That situation, however, was about to change as a result of a research project that started in 1955 and was initiated and sponsored by the International Council of Nurses (ICN) and the Florence Nightingale International Foundation (FNIF). This project has resulted in 'A bio-bibliography of Florence Nightingale,' (Bishop & Goldie, 1962), and 'A calendar of the letters of Florence Nightingale' (Goldie, 1980).

Summing up, mainly as a result of Bishop's and Goldie's efforts, Nightingale's original works have become more readily accessible which is not the same as readily available, as most of her writings, published and unpublished, are widely dispersed among libraries all over the world.

5.3. Towards a reappraisal of Florence Nightingale

The foregoing bibliographic review goes a long way to show that, whereas, at present, nursing historians have at their disposal the historical sources needed to study Florence Nightingale's life and writings, the sheer volume of these sources - amounting to some 200 books, pamphlets and articles, and more than 15,000 letters - has made it virtually impossible to cover them all. It seems likely, therefore, that nursing historians will refrain from writing comprehensive biographies and confine themselves to the study of particular aspects instead.

So far, however, this change of emphasis has contributed hardly anything to resolve the controversy between the semi-mythical and the iconoclastic images of Nightingale. On the contrary, it rather seems to have prompted a debate more intense than ever before. Whereas, for example, Cook is accused of playing down the frictions between Nightingale and her mother and sister, Woodham-Smith is said to magnify them (Kalisch & Kalisch, 1983a). Other issues are whether Nightingale happened to be a lesbian (Gordon, 1978) or not (Palmer, 1983a), whether she suffered from physical and mental disease (Palmer, 1983a) and whether she used her illness to her own advantage (Pickering, 1974). Apart from these more or less anecdotal issues, the controversy is concerned with issues which are relevant for the present time too, like the acclaimed independence of the Nightingale

training school for nurses. This controversy, incidentally, also exposes a line of division between researchers of American and English origin.

American researchers (e.g. Stewart, 1944; Newton, 1949) tend to portray the Nightingale school's educational independence as the hallmark of professional education. After the introduction of this system in the United States, its independence, so the interpretation goes, was lost because, at an early stage, hospitals and doctors gained control over the training of nurses, resulting in an apprenticeship type of training.

On the other hand, Prince (1982) and Baly (1984), both English researchers, have convincingly demonstrated that the original Nightingale school never achieved any educational independence whatsoever. Their research shows that, in fact, it was only a matter of years after the school's foundation in 1860 before the hospital governors and the medical profession were effectively in control of the training of the Nightingale nurses. Whereas these researchers blame Nightingale for this failure, the American researcher Palmer (1983b), although admitting Nightingale's failure, attempts to explain it away by pointing to a whole range of mitigating circumstances.

The Nightingale school's educational independence therefore appears to based upon myth rather than reality. But, whereas the English researchers, because of the present problems in nursing education which can be traced back to the failure of the Nightingale system, would prefer to tackle these problems by facing the reality of Nightingale's failure rather than upholding the myth of her educational reform, American researchers make no secret of the nursing profession's 'vested interest in preserving Florence Nightingale's reputation and in promoting the positive association evoked by her name. ... *her value and fame ought to be used for the advancement of the profession and not shelved as out-of-date*' (Kalisch & Kalisch, 1983b, p. 278).

As for Nightingale's original works, American researchers have demonstrated a similar attitude by taking her writings at face value and using them as it suited their own purposes (e.g. Roberts, 1937; Stewart, 1931; Thompson, 1980). By publishing 'Nursing the sick' in 1949, for example, American nursing leaders deliberately used Nightingale's contribution politically to support their struggle for the professional education of nurses. Hopefully, the change of emphasis in the Nightingale research noted earlier will give rise to a renewed and less politicised study of the Nightingalian model of nursing.

A promising approach would be to investigate this model of nursing in relation to two other subjects in which Nightingale showed so much interest, viz. religion and statistics. Cook (1913a, p. 428) has characterised her as a '*passionate statistician*,' and there is hardly a better way of putting her interest in religion and statistics into perspective. From these interests, in combination with her activities in the field of nursing, an essentially different Nightingale emerges, viz. the religiously inspired woman, advocating the need of statistical inquiry which was to result in practical applications like nursing.

This characterisation, if probed a bit further, indicates the need for a new interpretation of the Nightingalian model of nursing as well as a reappraisal of its significance for the conceptual development of nursing.

5.3.1. Religion

Nightingale's passion for statistics must be attributed to her religious beliefs as she has expressed them in 'Suggestions for thought' (Nightingale, 1860a, 1860b, and 1860c). She had started writing on religion as early as in 1852 but did not finish the three volumes until 1860. Who better can sum up the content of the 800+ octavo pages of this work than she herself has done in a letter to her father (in: Cook, 1913a, p. 482):

> *'I think the subject is this: Granted that we see signs of universal law all over this world, i.e. law or plan or constant sequences in the moral and intellectual as well as physical phenomena of the world - granted this, we must, in this universal law, find the traces of a Being who made it, and what is more of the character of the Being who made it. If we stop at the superficial signs, the Being is something so bad as no human character can be found to equal in badness, and certainly all the beings He has made are better than Himself. But go deeper and see wider, and it appears as if this plan of universal law were the only one by which a good Being could teach His creatures to teach themselves and one another what the road is to universal perfection. And this we shall acknowledge is the only way for any educator, whether human or divine, to act - viz. to teach men to teach themselves and each other. If we could not depend upon God, i.e. if this sequence were not always to be calculated upon in moral as well as in physical things - if He were to have caprices (by some called grace, by others answers to prayers, etc.) there*

would be no order in creation to depend upon. There would be chaos. And the only way by which man can have Free Will, i.e. can learn to govern his own will, to have what will he thinks right (which is having his will free), is to have universal Order or Law (by some miscalled Necessity). I put this thus brusquely because philosophers have generally said that Necessity and Free Will are incompatible. It seems to have appeared to God that Law is the only way, on the contrary, to give man his free will. And this I have attempted to prove. And further that this is the only plan a perfectly good omnipotent Being could pursue.'

In Nightingale's writings, there are few words which figure so prominently as the word 'law,' or for that matter, 'universal law,' and understandably so, for it was the most basic assumption of her whole argument, viz. that 'observation and experience afford evidence that law is manifested in the beginning, the constitution, the history, and the tendency of all modes of being that have a beginning' (Nightingale, 1860a, p. 3).

Law manifesting necessity. By the manifestations of law, Nightingale meant specific '*uniformities in nature,' so-called 'laws of nature,' which expressed 'uniform relations of simultaneity and succession, in which one mode of being is observed to exist to another*' (Nightingale, 1860a, p. 10). As for every mode of being which had a beginning, so she reasoned, it was possible to pinpoint its constituent elements (Nightingale, 1860a, pp. 10-14):

- **its beginning**
  which '*is uniformly preceded by and simultaneous with certain conditions, without which it is true to say of each existing mode of being which has had a beginning that it would not have begun; while, if ever or whenever these conditions recur, the same mode of being will again begin to be*.'

- **its constitution or nature**
  '... something in which indiviuals uniformly resemble each other, so as to admit of being classed together; or ... definite states uniformly simultaneous with or successive to definite antecedent or co-existing circumstances in beings of the same class or in an individual.'

- **its history**
  which '*is in accordance with law - i.e., from that time present in which a mode of being begins to be, in each successive time present some change takes place; all such change being relative to a definite nature or constitution in the being in which it takes place, as well as to its circumstances of simultaneity and succession to other modes of being*.'

- **its tendency or future**
  meaning that all modes of being which have a beginning '*are throughout existence tending to some definite state or mode of being - i.e., the present is a definite preparation for a definite future*.'

What these uniform relations add up to is that, given a mode of being which, for example, is called 'being ill,' and assuming that no treatment is given, it is possible to pinpoint the circumstances which have caused the illness, its symptoms, its progress as well as its result. If, on the other hand, treatment is started by manipulating the circumstances affecting this mode of being, it should likewise be possible to point out the resulting mode of being's constituent elements.

These elements, therefore, indicated the existence of a universal law which not only presupposed a law-giver, i.e. God, but implied a deterministic view of man too. An important corollary of this conclusion is that the way Nightingale described the constituent elements of these modes of being made them susceptible to statistical inquiry. Or, as Cook summed it up (Cook, 1913a, p. 480):

'The laws of God were, she held, discoverable by experience, research, and analysis; or, as she sometimes put it, the character of God was ascertainable, though his essence might remain a mystery. The laws of God were the laws of life, and these were ascertainable by careful, and especially by statistical, inquiry.'

This was also the point where the free will of man, to be analysed shortly, entered into the discussion.

5.3.2. Statistics

Whereas remarkably little is written about Nightingale's religious views, except for Cook (1913a and 1913b), Tarrant (1914) and Mantrip (1932), her endeavours in the field of statistics have generated wider interest (Kopf, 1916; Nutting, 1929; Agnew, 1958; Grier & Grier, 1978; Diamond & Stone, 1981). It is beyond doubt that Florence Nightingale has contributed as much to statistics as to nursing, if not more so, also taking into account that she was elected to fellowship in the Royal Statistical Society in 1858 and made an honorary member of the American Statistical Society in 1874. The major part of her statistical research was concerned with sanitation (e.g. Nightingale, 1859a).

As to the origin of Nightingale's interest in statistics there are two conflicting theories. According to Cook (1913a) and Kopf (1916) her interest was inspired by the book 'Sur l'homme et le de'velopment de ses faculte's, ou essay de physique sociale,' published in 1835 and written by Adolphe Quetelet, the Belgian statistician whom she once described as the 'the founder of the most important science in the whole world' (Agnew, 1958, p. 665). The other theory, put forward by Diamond and Stone (1981), holds that it was her association with Dr. Farr and other leading statisticians in England which was at the source of her interest in statistics. Moreover, she knew only the second edition of Quetelet's book, entitled 'Physique sociale' which he had given to her in 1869. Otherwise, Diamond and Stone (1981, p. 71) argue, she would not have requested him in 1872 to publish a second edition on the grounds that the first edition was unobtainable in England.

Quetelet's work evidently influenced Nightingale deeply. One of the things that must have appealed to her in Quetelet's work was his belief that the causal explanation of human behaviour, for example crime, had to be looked for in the antecedent and coexistent conditions of behaviour observed and that, insofar as statistics could be used to display the regularities of this behaviour, such a social phenomenon became material for scientific inquiry (Grier & Grier, 1978, p. 104).

In these so-called '*moral statistics*' Nightingale must have seen the confirmation of '*her deep conviction, variously expressed in her several papers, that the social and moral sciences are in method and substance statistical sciences. ... Statistics, she mused, discovered and codified law in the social sphere and thereby revealed certain aspects of the "character of God"* (Kopf, 1916, p. 98). In other words, by means of statistics Nightingale could deal not only with physical but moral modes of being, too, thereby adding a new dimension to her statistical research, viz. the laws of moral behaviour manifesting God's law which, so she once wrote to her father, was '*the only way - to give man his free-will*' (Diamond & Stone, 1981, p. 75).

Law giving man his free will. The germ from which Nightingale's religious philosophy is said to have been developed was, as she herself once put it: '*God's scheme for us was not that He should give us what we ask for, but that mankind should obtain it for mankind*' (Cook, 1913a, p. 479). In her opinion, the laws of nature reflected God's '*will, that a definite mode of being should invariably be simultaneous with certain definite (and invariably the same) circumstances*' (Nightingale, 1860a, pp. 5-6), and, more importantly, it was also God's will that *'... man is capable of finding out what state and what circumstances will be SIMULTANEOUS. And thus, within certain limits, he may determine his state*' (Nightingale, 1860a, pp. 7-8).

Between them, these statements on God's dealings with man were tantamount to the antithetic relationship between necessity manifested in God's law, on the one hand, and man's free will exemplified by his reason, feeling, conscience, and all his other faculties, on the other. The synthesis Nightingale attempted to arrive at was that '*human will accords with law*' which was her somewhat idiosyncratic interpretation of the atonement or, as she used to spell it, the '*at-one-ment*' (Nightingale, 1860a, p. 40), resulting in the '*union of God and man in one common thought, feeling, purpose*' (Nightingale, 1860a, p. 9).

Necessity. Because man was part of nature, Nightingale considered him to be subject to God's laws or the '*laws of nature*.' Given a certain constitution affected by certain circumstances, man therefore always acted according to God's 'laws of nature' (Nightingale, 1860b, pp. 303-304):

> *'His moral and His physical law stand on exactly the same basis: neither is ever broken: bodies do not fall upwards; and his moral law which says "if you kill, certain consequences will follow, and if certain circumstances take place, you will kill," is always kept.'*

To discover the character of God, man had to '*study the nature of God in other natures, in which He has manifested and revealed His own*' (Nightingale, 1860b, p. 271), stressing that '*not phenomena, but laws, are the only evidence of character. We cannot estimate a man's character from any action which he performs, but only from the principles which govern his whole conduct. So with God'* (Nightingale, 1860b, p. 79).

On the other hand, Nightingale was painfully aware that, in order to find out God's law, '*People do not ... investigate physiological laws, consult statistics, or make out what they can from the experiences of those who have experience*' (Nightingale, 1860b, p. 217). This was one of the greatest frustrations she experienced during her campaigns for sanitary reforms.

Free will. The study of physical and moral phenomena, advocated by Nightingale, was based upon the assumption that '*The whole of the laws of God is such that they are self-rectifying, with regard to their effect upon man's well-being'* (Nightingale, 1860a, p. 6). If, for example, a person became ill, it was not God who was to blame for inflicting disease upon him, but the person's ignorance or indifference with regard to His laws. Given that God's law was always being kept and man was afforded both the inducement (being ill) and the means (sanitary science) to discover the uniform relations manifesting His law, God had enabled him to '*advance in [the] knowledge, will, [and] power'* (Nightingale, 1860a, p. 17) needed to improve his health. Incidentally, these human capabilities were to return in Henderson's definition of nursing.

The study of uniform relations in the state of the body to decide whether man's mode of being was healthy or unhealthy was more or less subordinated to the study of similar relations in the state of the mind determining whether man was morally right or morally wrong (Nightingale, 1860b, p.44):

> *'We cannot be good in all circumstances. God does not intend it; and this, instead of making us do nothing, is the greatest spur we can have to exertion. If God does not intend us to be right under such and such circumstances, we must alter them.'*

It is from remarks like these that the deeper significance of Nightingale's writings can be inferred. Although she admittedly emphasised the need for scientific inquiry into the laws of nature to justify sanitary reform, such reform also required a moral decision for or against such reform. Given, however, that she held man's moral mode of being to be subject to the laws of nature which determined the uniform relations between his moral condition and the circumstances affecting it, he could not possibly be free to decide one way or another. Her position therefore appeared to be based upon a circular reasoning. In order to break the resulting deadlock, she would emphasise that (Nightingale, 1860c, pp. 78-79):

> *'Mankind has to learn by experience, 1st, what are his capabilities? 2nd, what are all the various laws of God concerning them? 3rd, that it is desirable to cultivate these capabilities aright; 4th, which of these laws enable him to do so? 5th, how to keep them? 6th, how to incline himself to keep them? All this man has to learn and to practice before he can be one with God.'*

Finally, sanitation was just one of the many areas in which this process of learning by experience had to take place (Nightingale, 1860a, p. 50):

> *'Sanitary science is showing how we may affect the constitution of the living and of future lives. In one direction, sanitary science is understood to apply to the physical nature; but each part of man's nature affects every other. Moreover, there is a sanitary science essential to each of man's faculties and functions. For each there is an appropriate state and operation - in other words, a healthy state; and there is a science discoverable as to how, by what means to bring about that appropriate state.'*

Man's union with God. It was thus by virtue of God's laws always being kept, that man was afforded his free will (albeit a freedom of choice rather than absolute free will) to choose for or against approximating his union

with God's thought, feeling, and purpose. The major lesson to be learnt from this was that man, instead of being at the mercy of the circumstances, was 'in the hands of God' (Nightingale, 1860b, p. 46). For all the necessity manifested in God's laws, man's free will enabled him to approximate the union with God, if only he was willing to use the inducement and the means afforded to him, and this in itself amounted to a moral decision in favour of social reform (Nightingale, 1860b, p. 267):

> *'A true understanding of the nature of God and man, of our relations to God and to our fellow-creatures, depends upon, requires the right exercise of, the whole nature of all mankind. We can only have such right exercise by a right organization of society, by mankind arranging circumstances so that they will have employment, work, suited to their natures, suited to call forth their natures into right exercise.'*

Summing up, just like the laws of God revealed His government of the world, mankind had to learn how to govern its own behaviour according to these laws in order to become one with God. This process of learning involved observation by means of statistics, reflection as to the lesson to be learnt from it, and, most important of all, social reform. The relatively new science of statistics therefore provided Nightingale with the scientific vindication of her religious beliefs (Nightingale, 1860b, p. 346):

> *'Our religious creed consists in this - belief in an omnipotent eternal spirit of love, wisdom, righteousness, manifesting itself by calling into existence, by definite laws, beings capable of the happiness of love, wisdom, and righteousness, - capable of advancing themselves and each other in divine nature - living in an universe in which, by definite law, the means and inducement are afforded which insure their advance through their own activity to humanity's blessedness. Observation, reflection, experience are that which furnishes the evidence.'*

5.3.3. Towards a positive theology

Nightingale's interests in religion and statistics influenced each other to the degree that, between them, they enabled her (Nightingale, 1873a) to defend her conception of God as a God of law, whose character may be learnt from social and moral science 'against some current ideas of Christian churches on the one side, and against the too cold and impersonal creed, as she thought, of Positivism on the other' (Cook, 1913b, p. 218). The article in Fraser's Magazine, cited here by Cook, was a condensed version of the far more extensive inquiry of these issues in 'Suggestions for thought' which prompted Nightingale to develop a new 'positive theology' (Nightingale, 1860c, pp. 178-202), already foreshadowed by her remarks in this work (Nightingale, 1860a, p. 35):

> *'Wiser than former generations in abstaining from futile speculation, some powerful minds show a determination to seek no truth except what is supposed to admit of proof. We conceive that the limit to our inquiry should be those subjects on which we can hope progressively to receive evidence.'*

The defence against the Christian churches. Nightingale's positive theology was based upon '*the revelation of moral evidence*' (Nightingale, 1860a, p. 115) rather than the revelation through the Bible, or through the church, or through both of them: '*Now we say that there is a revelation to every one, through the exercise of his own nature - that God is always revealing Himself*' (Nightingale, 1860b, pp. 95). In her view, this openness to empirical reality signalled a new phase in theology which was antedated by the miraculous theology and the supernatural theology in which God was associated with miracles and special providences respectively. According to Nightingale's '*positive' theology, however '... we see Him in law. But law is still a theology, and the finest*' (Nightingale, 1860b, pp. 155-156).

The defence against positivism. Nightingale's positive theology was also directed against '*the conscientious unbelievers of the present day*,' especially the positivist philosopher Comte, who '*say, that, when all is said and done, and the whole of the faculties exercised, &c., all that we can discern with these faculties is the law of nature*,' an attitude which elicited the following rhetorical questions '*Is there not an absurdity in saying that all*

we can discern is whatever is, is according to law? For is it not our experience of law that it always springs from a will, from a purpose?' (Nightingale, 1860c, p. 26).

Thirteen years later, she attacked Huxley for having said that '*Objects of sense are more worthy of your attention than your inferences and imaginations*' by emphasising that '*the finest powers man is gifted with are those which enable him to infer from what he sees what he can't see. They lift him into truth of far higher import than that which he learns from the senses alone*' (Nightingale, 1873a, p. 568).

Nightingale's theology. Most importantly though, Nightingale's positive theology provided her with the foundation of a moral science which she described as *'... the science of the social and political improvement of man, the science of educating and administering the world by discovering the laws which govern man's motives, his moral nature*,' or the study of the character of God, '*because the laws of the moral world are the expressions and solely the expressions of the character of God'* (Nightingale, 1873a, p. 577).

Whereas Bacon and Newton had laid the foundation for physical science by discovering the method by which all enquiry into physical science had to be conducted to be successful, she believed she had found an equally successful method for moral science, viz. careful observation by means of statistics. Between them, these sciences were inevitably to lead to social reform (Nightingale, 1873a, p. 575):

> *'In the very measure of the progress we make in finding out the real facts of moral science, e.g. educational science, or the real facts of physical science, e.g. sanitary science, in that very measure those facts show the perfect God leading man on to perfection. ... Exactly as we find out the real facts, we find that every one of those facts has attached to it just the lesson which will lead us on to social improvement.'*

This parallelism between physical and moral science was a recurring theme in Nightingale's writings, exemplified, amongst others, by her admiration for social improvements as a result of advances in physical science which she sought to copy in the field of morality (Nightingale, 1860b, p. 39):

> *'Suppose that we had done with steam as we have done with morals, that is, asserted that "everything has been discovered, nothing more is to be done, you have only to believe;" should we have had any railroads, any steamboats, any manufactures? yet within the last thirty years how astounding has been the advance?'*

Another example is provided by her repeated comparisons between the 'uniform' differences in the state of the body (healthy versus unhealthy), on the one hand, and those of the mind (morally right versus morally wrong). These comparisons, however, did not stop her from using the word 'healthy' also to identify '*the healthy state of mind*,' or '*moral feeling*,' i.e. '*the consciousness, existing with a feeling of satisfaction in the right, of dissatisfaction in the wrong*' (Nightingale, 1860a, p. 14). In both cases, however, the '*uniform' differences to be discovered manifested law for they existed relatively to the 'uniform*' conditions of man's bodily and mental state. As for the former, these differences existed '*relatively to physical organization and to circumstances which affect it*,' while as for the latter, they existed '*relatively to physical organization and to circumstances which otherwise definitely and uniformly affect the state of mind*' (Nightingale, 1860a, pp. 12-13). The wording used by Nightingale herself reflected her own assessment of the state of the art at the time of both physical and moral science.

5.3.4. Nightingale's religious pragmatism

It is worth noting that Nightingale's positive theology, most poignantly advocated in her first article in Fraser's Magazine (Nightingale, 1873a), amounts to the position that both religion and science are meaningful to the degree that they result in social reform. In this sense, so it is contended here, she can be seen as a 'pragmatist avant la lettre,' a fact first perceived by Cook (1913a, p. 488):

> *'Miss Nightingale was broad-minded in her attitude towards creeds and churches. For her own part she believed that religious truth was positive, and could be discovered; but in her outlook upon the beliefs of*

others, she judged them by their fruits. ... There is a school of philosophy, much current in our day, which carries this point of view further. The meaning of a conception, it tells us, expresses itself in practical consequences, if the conception be true; religious truth is relative to the individual; the way to test a religion is to live it.'

It is this religious pragmatism, it is contended here, which calls for a renewed interpretation of the Nightingalian concept of nursing as well as a reappraisal of its historical significance for the conceptual development of nursing.

5.4. Florence Nightingale: founder of modern nursing?

Granted Nightingale's religious pragmatism, it remains to be seen to what extent it has influenced her concepts of nursing, nursing education and professional nursing (Nightingale, 1859b, 1882a and 1882b, 1893). Her religious pragmatism does not immediately become apparent when reading her original writings on nursing. The first impression gained from these writings is that they demonstrate a good deal of common sense, soundly based upon her detailed observation and her rich experience, and, even when turning a blind eye on the many references to God, Nature and the laws of nature, her line of reasoning does make sense. However, if these references are taken into account, a rather different image of Nightingale emerges from her texts, viz. that of the religious pragmatist who attempts to become one with God by discovering His laws and adapting her own will, and that of others as well, to His will.

Personally, I have always been much struck by the many references to God and His dealings with man in her writings, and there were simply too many to be ignored. After reading Nightingale's main works on religion (Nightingale, 1860a, 1860b, 1860c, 1873a, and 1873b) I realised that her religious beliefs played a most important role in her writings on nursing to the effect that, without the former, the latter would not have been written in the first place.

For reasons explained earlier, and because only 150 copies of 'Suggestions of thought' have been printed, these original works on religion have become far less widely known than her writings on nursing. Apart from that, these writings make difficult reading as Nightingale omitted to edit 'Suggestions for thought' as carefully as her writings on nursing with the effect that she repeated herself time and again. Moreover, in discussing her personal beliefs, she compared them with those of others who may have been well known in her day but not anymore. All this goes a long way to explain why so few biographers have attempted an interpretation of her writings on nursing in the light of her original works on religion such as will be undertaken in this study.

As for this study, clarifying the interrelationships between Nightingale's views on religion and nursing is relevant to assess her real influence on the conceptual development of nursing. As a result, it will become clear whether Nightingale, especially with regard to the United States, should be seen as the founder of modern nursing or not. The following chapters are therefore aimed at a detailed analysis of Nightingale's model of nursing against the background of her religious pragmatism.

6.
NIGHTINGALE'S CONCEPT OF NURSING

'Notes on nursing' is said to contain Nightingale's principles or philosophy of nursing (Seymer, 1954) and rightly so, because it deals primarily with sanitary nursing, the concept of nursing which she has never abandoned. At the time of writing 'Notes on nursing' she was highly optimistic about the growing importance of sanitary science (Nightingale, 1859b, p. 3):

> *'Every day sanitary knowledge, or the knowledge of nursing, or in other words, of how to put the constitution in such a state as that it will have no disease, or that it can recover from disease, takes a higher place. It is recognized as the knowledge which every one ought to have - distinct from medical knowledge, which only a profession can have.'*

By distinguishing two different kinds of knowledge to combat disease, she also suggested two different notions of disease, viz. in the medical and in the sanitary meaning of the word, and it was the latter rather than the former which she considered relevant for nursing. A book like 'Notes on nursing,' so she felt, was needed because she thought it was extraordinary that (Nightingale, 1859b, p. 7, see also 1893, pp. 29-30):

> *'whereas what we might call the coxcombries of education - e.g. the elements of astronomy - are now taught to every school-girl, neither mothers of families of any class, nor school-mistresses of any class, nor nurses of children, nor nurses of hospitals, are taught anything about those laws which God has assigned to the relations of our bodies with the world in which He has put them. In other words, the laws which make these bodies, into which He has put our minds, healthy or unhealthy organs of those minds, are all but unlearnt. Not but that these laws - the laws of life - are in a certain measure understood, but not even mothers think it worth their while to study them - to study how to give their children healthy existences. They call it medical or physiological knowledge, fit only for doctors.'*

By comparing the laws of astronomy and the laws of life she added a moral dimension to her concept of nursing. This interpretation is vindicated by her use of the example of astronomy in 'Suggestions for thought' too (Nightingale, 1860b, p. 202):

> *'In astronomy, Copernicus, Galileo, Kepler, Newton, Laplace, Herschel, and a long line of saviours, we may call them, if we will - discoverers they are more generally called, - have saved the race from intellectual error, by finding out several of the laws of God. ... In the same way, there may be, there must be saviours from social, from moral error.'*

It is this comparison between the physical and moral dimension of man's existence, reflected in the manifold comparisons between medicine and nursing, which casts a new light on Nightingale's view of the nature of nursing. This interpretation is further vindicated by her definition of nursing (Nightingale, 1859b, p. 75):

> *'And what nursing has to do ... is to put the patient in the best condition for nature to act upon him.'*

This definition which links nursing with nature, and thereby with the laws of nature and consequently with God's will, rather than with medicine, she has never abandoned (Nightingale, 1893, p. 26). Underlying her concept of nursing was her view of man's relationship to God being mediated by his experience and observation of natural phenomena manifesting God's universal law, the foundation of her religious pragmatism. This assumption which was at the source of so many of her endeavours can be illustrated by her explanation as to the cause and the nature of disease.

6.1. Miasmatism versus contagionism

One of the major issues in health care during the last century was the scientific explanation of epidemic diseases (Ten Have, 1983). According to the contagionist theory, diseases originated from infectious matter which was transmitted from one person to another. This causal explanation of disease was based upon the so-called germ theory which emerged during the 1860s. For reasons to be explained below, Nightingale never accepted this theory.

On the other hand, according to the miasmatic theory, diseases were the result of harmful influences in the environment which were called miasmas or miasmatas, although it proved to be rather difficult to pinpoint the '*mechanics of the miasmatic theory, whether the inhalation of putrescent substances oxidised and corrupted the bloodstream, or whether the exhalations of such substances or affected persons introduced poisons into neighbouring bodies*' (Smith, 1982, p. 98). Notwithstanding its lack of explanatory power, this theory gained much support during the first half of the nineteenth century. Nightingale is said to have held this belief since at least her Harley Street days (early 1850s), when she had probably acquired it from Chadwick and other sanitarians' writings in the 1840s (Smith, 1982, p. 98), while in 'Notes on hospitals' she pointed to medical evidence in a translation of Paulus Aegineta corroborating her sanitary observation and experience (Nightingale, 1859a, p. 6, footnote).

6.1.1. Nightingale's position

Contrary to what Smith (1982, p. 98) and Strachey (1918, p. 168-169) would like us to believe, speculations about the mechanics of the miasmatic theory were not completely foreign to Nightingale's nature (Nightingale, 1858, pp. 128-133):

> *'It is a vulgar error to suppose that epidemics are occasioned by the spread of disease, from person to person, by infection or contagion; for it is an ascertained fact that, before any people is attacked epidemically, the disease attacks individuals in a milder form, one at the time, at distant intervals, for weeks or months before the epidemic appears. Before an epidemic of cholera, these cases consist generally of diarrhoea of more or less intensity, followed by a rapidly fatal case or two, very much resembling cholera. ... Experience appears to show that without this antecedent preparatory stage, affecting more or less the entire population of a town or district, the occurrence of an epidemic is impossible - the epidemic being, in fact the last or, so to speak, the retributive stage of a succession of antecedent phenomena extending over months or years, and all traceable to the culpable neglect of natural laws. It is simply worse than folly, after the penalty has been incurred, to cry out "contagion," and call for the establishment of sanitary cordons and quarantine, instead of relying on measures of hygie`ne. Epidemics are lessons to be profited by: they teach, not that "current contagions" are "inevitable" but that, unless nature's laws be studied and obeyed, she will infallibly step in and vindicate them, sooner or later.'*

In sharp contrast with other sanitarians, however, Nightingale based her speculations not only upon observation and experience but upon her religious beliefs too, for when it came to the reason for holding these views, she asked herself what lesson either contagion or infection contained as to the image of God (Nightingale, 1873a, p. 575-576):

- **contagion**
  'Were "contagion" a fact, what would be its lesson? To isolate and to fly from the fever and cholera patient, and leave him to die; to kill the cattle; instead of improving the conditions of either. This is the strictly logical "lesson" of "contagion." If it is not strictly followed, it is only because men are so much better than their God. If "contagion" were a fact - this being the lesson which it teaches - can we escape the conclusion that God is a Spirit of Evil, and not of Love?'

- **infection**
  'Now take the real facts of "infection." What is their lesson? Exactly the lesson we should teach, if we wanted to stir man up to social improvement. The lesson of "infection" is, to remove the conditions of dirt, of over-crowding, of foulness of every kind under which men live. And even were not socalled "infectious" disease attached to these conditions by the unchanging will of God, it would still be inseparable from social improvement that these conditions should be removed. Disease is Elijah's earthquake, which forces us to attend, to listen to the "still small voice." May we not therefore say that "infection" (facts and doctrine) shows God to be a God of love? And this is but one instance.'

Such speculations, based upon observation and experience, were typical of Nightingale's religious pragmatism to the effect that, whereas miasmatism entailed practical lessons as to which circumstances God wanted man to change, contagionism didn't. Apart from that, contagionism presupposed for every infectious disease a first case, directly infected by God. Given her belief in God's wisdom and benevolence, she therefore could not but accept the miasmatic explanation of disease. Not surprisingly, Strachey (1918, p. 167) has therefore characterised Nightingale's image of God as being that of a '*glorified sanitary engineer*' in which it is hard to distinguish '*the Deity and the Drains*.'

6.1.2. The implications for nursing

Nightingale's speculations on the causal explanation of disease adds a moral or religious significance to some of her seemingly purely scientific statements on nursing like '*That there is no such thing as "inevitable" infection, is the first axiom of nursing*' (Nightingale, 1882b, p. 337), or '*The fear of dirt is the beginning of good nursing*' (Nightingale, 1882b, p. 344). She was convinced that her sanitary approach, if taken to its logical conclusion, would result in a situation in which '*Scarlet fever and measles would be no more ascribed to "current contagion," or to "something being much about this year," but to its right cause; nor would "plague and pestilence" be said to be "in God's hands," when, so far as we know, He has put them into our own*' (Nightingale, 1893, p. 30).

On the other hand, she was well aware of the growing body of opinion, also based on observational evidence, which supported the contagionist view, but, even if confronted with empirical data contradicting her miasmatic point of view, Nightingale could not bring herself to change her mind.

This shows that her religious belief, more than anything else, was the yardstick by which she evaluated the results of observation and experience, thereby raising the level of the discussion from a physical to a moral level, and this, as has been shown earlier, was the core of her religious pragmatism. Similar observations can be made when it comes to her views on the nature of disease.

6.2. Health and disease

'Notes on nursing' starts with some very significant assumptions as to the nature of disease which not only reflect Nightingale's religious pragmatism but are essential to grasp the meaning of her concept of nursing too (Nightingale, 1859b, p. 5):

> *'Shall we begin by taking it as a general principle - that all disease, at some period or other of its course, is more or less a reparative process, not necessarily accompanied with suffering: an effort of nature to remedy a process of poisoning or of decay, which has taken place weeks, months, sometimes years beforehand, unnoticed, the termination of the disease being then, while the antecedent process was going on, determined?'*

Obviously, this notion of disease was inspired by Nightingale's stance on the controversy between miasmatism and contagionism, affected as it was by her religious pragmatism. To prove her point, as might be expected from her, she first appealed to observation (Nightingale, 1859b, p. 5):

> *'In watching disease, ... the thing which strikes the experienced observer most forcibly is this, that the symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different - of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, of each or of all of these. ...*

In 'Notes on hospitals' she put it even more poignantly when she related that, on the basis of her observation of hospital wards, it was impossible for her '*to resist the conviction that the sick are suffering from something quite other than the disease inscribed on their bedticket*' (Nightingale, 1859a, p. 3).

In Nightingale's opinion, suffering as a result of disease had thus to be distinguished from suffering due to the lack of the right circumstances affecting man's healthy mode of being. However, if asked '*Is such or such a disease a reparative process? Can such an illness be unaccompanied with suffering? Will any care prevent such a patient from suffering this or that?'* she humbly answered: *'I do not know*' (Nightingale, 1859b, p. 6). But what she did know was what kind of practical action was needed to answer these questions decisively (Nightingale, 1859b, p. 6):

> *'... when you have done away with all that pain and suffering, which in patients are the symptoms not of their disease, but of the absence of one or all of the above- mentioned essentials to the success of Nature's reparative process, we shall then know what are the symptoms of and the sufferings inseparable from the disease.'*

From these remarks it can be inferred that, in Nightingale's opinion, the suffering accompanying disease was a moral or religious rather than a sanitary issue, for it is worth noting here that Nightingale wrote '*Nature'* and not '*nature*.' This was the way she used to refer to '*the Absolute and Perfect Moral Nature, from whom, through the law which reveals His existence and all that we can comprehend of His nature, we may attain enlightment possible to us concerning the right*' (Nightingale, 1860a, p. 31). She therefore appears to have favoured a theological rather than a medical notion of health and disease.

Moreover, her opinion as to how deal with the suffering of the sick also exposes another characteristic of her religious thinking, viz. her optimism, based upon God's plans for man, that, ultimately, at one time or another in the future, the battle against disease could be won, for (Nightingale, 1892, p. 33):

> *'... after all it is health and not sickness that is our natural state - the state that God intends for us. There are more people to pick us up when we fall than to enable us to stand upon our feet. God did not intend all mothers to be accompanied by doctors, but He meant all children to be cared for by mothers.'*

It was this line of reasoning in a text entitled 'Health visiting in rural districts' (Nightingale, 1892) which also came to the fore in her writings on nursing analysed here (Nightingale, 1859b, pp. 6-7; 1893, p. 24). Granted this theological interpretation of Nightingale's notions of health and disease, it goes without saying that the analysis has to start with her notion of disease.

6.2.1. Disease

To return to the suffering accompanying disease, in 'Suggestions for thought' this phenomenon did not seem to pose a problem to Nightingale at all. On the contrary, for somehow she even seemed to welcome it (Nightingale, 1860b, p. 237):

> *'In certain diseases there is no remedy known for acute and constant suffering, and it is right that it should be so, in order to bring about circumstances in which the causes of such suffering shall be removed, in which man shall attain a right physical state.'*

The practical implications of the suffering of the sick, indicated here, were matched by those of disease (Nightingale, 1882b, pp. 334-335):

'Sickness or disease is Nature's way of getting rid of the effects of conditions which have interfered with health. It is Nature's attempt to cure - we have to help her.'

In 'Sick nursing and health nursing' Nightingale repeated this definition of disease, only adding that '*Diseases are, practically speaking, adjectives, not noun substantives*' (Nightingale, 1893, p. 26). The meaning of this somewhat cryptic statement had been explained by her as early as in 1859: '*Is it not living in a continual mistake to look upon diseases, as we do now, as separate entities, which must exist, like cats and dogs? instead of looking upon them as conditions, like a dirty and a clean condition, and just as much under our own control; or rather as the reactions of kindly nature, against the conditions in which we have placed ourselves*' (Nightingale, 1859b, p. 19, footnote).

This explanation of the nature of disease suggests that Nightingale considered the mode of being which was called 'disease' to be subject to the laws of God which '*visit us with consequences till we do something. We may try the experiment; we may sit still if we like; but, while we do so, God's laws will never cease molesting us. His laws have provided that it shall be impossible to us - that our nature is such, our desires, energies, inclinations such, that we can't do nothing*' (Nightingale, 1860b, p. 168).

In other words, disease and the suffering accompanying it, however physically real to the person concerned, were the phenomena from which he was to discern the laws of God so that he could let his will accord with God's law. These phenomena therefore pointed to some moral or religious reality behind or underlying the reality observed and experienced by the sick, viz. the will or the character of God. As for the practical lessons to be learnt from disease, Nightingale was very adamant (Nightingale, 1859b, pp. 17-18):

'And now, you think these things [pure air, pure water, efficient drainage, cleanliness, and light] trifles, or at least exaggerated. But what you "think" or what I "think" matters little. Let us see what God thinks of them. God always justifies His ways. While we are thinking, He has been teaching. I have known cases of hospital pyaemia quite as severe in handsome private houses as in any of the worst hospitals, and from the same cause, viz., foul air. Yet nobody learnt the lesson. Nobody learnt anything at all from it. They went on thinking - thinking that the sufferer had scratched his thumb, or that it was singular that "all the servants" had "whitlows," or that something was "much about this year; there is always sickness in our house." This is a favourite mode of thought - leading not to inquire what is the uniform cause of these general "whitlows," but to stifle all inquiry. In what sense is "sickness" being "always there," a justification of its being "there" at all? ... Yet nobody learns the lesson. Yes, God always justifies His ways. He is teaching while you are not learning. This poor body loses his finger, that one loses his life. And all from the most easily preventible causes.'

This text illustrates Nightingale's writings on nursing being susceptible to two different interpretations. Taken at face value, it seems to stress the need for sanitary reform, but also it suggests a more important lesson to be learnt, viz. the character of God and His way of dealing with man.

This theological interpretation of Nightingale's writings on nursing is vindicated by her religious works. In 'Suggestions for thought,' for example, she contrasted the physical and moral laws of God to the effect that people do not mind being saved by the former, while, as to the latter, '*Most people have not learnt any lesson from life at all - suffer as they may, they learn nothing, they would alter nothing - if they began life over again they would live exactly the same life as before*' (Nightingale, 1860b, pp. 202-203).

6.2.2. Health

The theological interpretation of Nightingale's definition of disease is further vindicated by her definition of health (Nightingale, 1882b, pp. 334-335; see also 1893, p. 26):

'Health is not only to be well, but to be able to use well every power we have to use.'

This definition should be taken to mean that being healthy was not limited to the absence of disease in the medical meaning of the word but also assumed man's '*capability to find out how to bring about right physical being - right circumstances in which to live*' (Nightingale, 1860c, p. 55). From the way Nightingale has defined

the word 'power' in 'Suggestions for thought' it can be inferred that her definition of health indeed had a theological meaning for her (Nightingale, 1860b, pp. 53-54):

> *'Man has capability to learn how circumstances regulate and modify human nature, to learn what circumstances develop and exercise human nature aright. By the united efforts of mankind, in accordance with God's ever-present, ever- efficient law, to bring about such circumstances is man's work. The capability for this is man's power.'*

6.2.3. The implications for nursing

Nightingale's view of the nature of health and disease adds a moral or religious dimension to some of her statements on nursing like, for example, '*The art of nursing, as now practised, seems to be expressly constituted to unmake what God had made disease to be, viz. a reparative process'* (Nightingale, 1859b, p. 6), or '*To get rid of the conditions which have interfered with health is of course the first nursing step in helping Nature to get rid of the effects of those conditions*' (Nightingale, 1882b, p. 337), or, '*Everything has come before health. We are not to look after health, but after sickness. Well, we are to be convinced of error before we are convinced of right; the discovery of sin comes before the discovery of righteousness, we are told on the highest authority*' (Nightingale, 1893, p. 25).

Nursing, as Nightingale viewed it, amounted thus to the gradual discovery and application of God's laws upon which depended whether man's mode of being was to be healthy or not, although, at least in 1859, she was well aware of the fact that (Nightingale, 1859b, p. 6):

> *'The very elements of what constitutes good nursing are as little understood for the well as for the sick. The same laws of health or of nursing, for they are in reality the same, obtain among the well as among the sick. The breaking of them produces only a less violent consequence among the former than among the latter, - and this sometimes, not always.'*

Nightingale used the word 'elements' here not inadvertently as she probably referred to Dalton's discovery of the system of chemical elements which she admired very much because it demonstrated the wisdom of God so well (Nightingale, 1860b, pp. 50-51). In the same way, she envisaged the discovery of the elements of man's health or of nursing, or as she is said to have put it once, '*I look forward to the day when there will be no nurses of the sick, only nurses to the well*' (in: Baly, 1969, p. 2) which is consistent with her religiously inspired optimism: '*People think that the world is in the mud, and that it must stay there. We think it is in the mud too, but we are sure it is not to remain there*' (Nightingale, 1860b, p. 203).

In most of her discussions on the nature of nursing, it was this religiously inspired optimism which set the tone of the argument, viz. that man, using his intelligence to discover God's laws and his free will to adopt God's will as manifested by His laws, could work out his own health by putting an end to all conditions and circumstances giving rise to disease.

6.3. Nursing: what it is, and what it is not

Over the years, Nightingale's concept of nursing has remained remarkably consistent. This is not to say that her three main publications on nursing are so identical that they are completely interchangeable. On the contrary, each one of them is directed at different readers and deals with different aspects of her concept of nursing.

'Notes on nursing' (Nightingale, 1859b), for example, was '*meant simply to give hints for thought to women who have personal charge of the health of others*' (p. 3), and dealt with '*sanitary nursing*' as opposed to the '*handicraft of nursing*' or '*surgical nursing*' or '*practical manual nursing*' as it was practised at the time (p. 71). In this book, Nightingale used the word 'nurse' indiscriminately for both '*amateur and professional nurses,*' and, whereas the latter referred to nurses of the sick and nurses of children, the former were to include friends, relations and mothers of families '*who take temporary charge of a sick person*' (p. 79).

'Nurses, training of' (Nightingale, 1882a) and 'Nursing the sick' (Nightingale, 1882b), on the other hand, have been written for the probably well-educated readers of Quain's medical dictionary. Both articles were

concerned with the subject of nursing in the sense of an 'art, requiring an organised practical and scientific training' (1882b, p. 335) as it had been provided by the Nightingale training schools for nurses since 1861.

Finally, 'Sick nursing and health nursing' (Nightingale, 1893) stands out somewhat from the other publications on nursing because it was to be read for an audience of mostly professional nurses. Whereas the articles for Quain's medical dictionary had dealt with '*nursing proper, that is, nursing the sick and injured*' as opposed to '*Preventive or Sanitary Nursing*' and '*nursing healthy children*' (p. 334), this publication signalled the extension of Nightingale's concept of nursing with '*health nursing*' or '*general nursing*' as opposed to '*nursing the sick*' or '*nursing proper*' (p. 24) and pleaded for the attention of the public to be directed to the need for the training of health missioners as already had been done with regard to the training of sick nurses (p. 31).

However, in the final analysis and despite the differences noted above, all Nightingale's writings on nursing were based on one single concept of nursing, viz. sanitary nursing. Underlying this concept, as will emerge from the analysis of her various definitions of nursing, was her ever-present religious pragmatism rather than the opposition between medicine and nursing. Admittedly, Nightingale's works on nursing can be interpreted as an attempt to identify the differences between medicine and nursing, but her religious beliefs call for a different interpretation. For within the context of her religious pragmatism Nightingale considered medicine to be less relevant than sanitary nursing as the latter did teach man about the character of God and the former did not.

6.3.1. 'Notes on nursing'

Nightingale's sanitary approach as opposed to the medical approach, apparently already dominant at the time, comes to the fore in her first definition of nursing (Nightingale, 1859b, p. 75):

> *'... what nursing has to do ... is to put the patient in the best condition for nature to act upon him. Generally, just the contrary is done. You think fresh air, and quiet and cleanliness extravagant, perhaps dangerous, luxuries, which should be given to the patient only when quite convenient, and medicine the sine qua non, the panacea. If I have succeeded in any measure in dispelling this illusion, and in showing what true nursing is, and what it is not, my object will have been answered.'*

So essential thought Nightingale these differences between nursing and medicine to be that she even considered the idea of giving her sanitary approach a new name. But, as she herself noted, she used '*the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet - all at the least expence of vital power to the patient*' (p. 6).

By explaining her concept of nursing and the nursing actions involved (Table 6), Nightingale thus once again pointed to the difference between nursing as a derivative of medicine, on the one hand, and sanitary nursing, on the other. This raises the question of how she was to adapt her concept of nursing once the Nightingale nurses had moved into the hospital, which leads us to the definition of nursing in 'Nursing the sick' (Nightingale, 1882b).

6.3.2. 'Nursing the sick'

In this article Nightingale understandably qualified her definition of nursing to accommodate for the notion of nursing proper which included hospital nursing, private nursing, district nursing and midwifery (Nightingale, 1882b, p. 334):

> *'Nursing is putting us in the best possible conditions for Nature to restore or to preserve health - to prevent or to cure disease or injury. The physician or surgeon prescribes these conditions - the nurse carries them out.'*

This definition of nursing suggests a change of heart on the part of Nightingale which is not, however, borne out by the general outline of the article. On the one hand, she was admittedly very careful in awarding the physician the position he probably occupied anyway, for example, by conceding that nursing was '*the skilled servant of medicine, surgery, and hygiene*' (Nightingale, 1882b, p. 335). On the other hand, she qualified this statement by

emphasising that '*real nursing*' existed '*in obeying the physician's and surgeon's orders intelligently and perfectly*' (Nightingale, 1882a, p. 326), that is, in the nurse relying also on her own observation, reflection and training (Nightingale, 1882a, p. 323).

This diplomatic approach was probably indicated by the fact that she wrote the article for a medical dictionary and is further exemplified by her outline of the nursing actions involved (Table 62). Apart from two references to the role of medicine, this outline of nursing actions was basically the same as the one she had given in 'Notes on nursing' (see also Table 6). Moreover, in the text of the article itself it was only at the end that the relationship between medicine and nursing was mentioned. Nightingale did this by using a standard phrase to the effect that the physician, the surgeon or the medical attendant '*requires the nurse to ...*,' followed by those nursing actions which were the prerogative of the physician to prescribe.

Finally, she also mentioned the 'management of convalescents - a whole department of nursing in itself,' and '*housekeeping'* as other duties of the nurse (Nightingale, 1882b, p. 349).

Notes on nursing	Nursing the sick
What nursing has to do, is to put the patient in the best condition for nature to act upon him	Nursing proper means besides giving the medicines and stimulants prescribed, or, applying the surgical dressings and other remedies ordered
Ventilation and warming	The providing, and the proper use of, fresh air, especially at night - that is, ventilation, and of warmth or coolness
Light Cleanliness of rooms and walls Bed and bedding	The securing the health of the sick-room or ward, which includes light, cleanliness of floors and walls, of bed, bedding, and utensils.
Petty management	
Taking food What food?	The administering and sometimes preparation of diet (food and drink).
Personal cleanliness Noise Variety Chattering hopes and advices	Personal cleanliness of patient and of nurse, quiet, variety, sympathy, and cheerfulness.
Observation of the sick	Observation of the patient.
Health of houses: pure air, pure water, efficient drainage, cleanliness, light	The application of remedies. In other words, all that is wanted to enable Nature to set up her restorative processes, to expel the intruder disturbing her rules of health and life. For it is Nature that cures: not the physician or nurse.

Table 6. Sanitary nursing and nursing proper (Nightingale, 1859b and 1882b; for the sake of the comparison, the sequence of the table of contents of 'Notes on nursing' has been adapted to the sequence of nursing actions in 'Nursing the sick').

6.3.3. 'Sick nursing and health nursing'

This paper is best known for the introduction of the concept of health nursing or general nursing which was not so new after all as it covered virtually the same principles of sanitary nursing as those in 'Notes on nursing' (Nightingale, 1893, p. 31):

> *'The work we are speaking of has nothing to do with nursing disease, but with maintaining health by removing the things which disturb it, which have been summed up in the population in general as "dirt, drink, diet, damp, draughts, drains."*

This was Florence Nightingale, the sanitary reformer, as we have come to know her from 'Notes on nursing'. Not surprisingly, she therefore saw no need to change her definition of nursing (p. 26):

> *'Both kinds of nursing are to put us in the best possible conditions for nature to restore or to preserve health - to prevent or to cure disease or injury.'*

Her sanitary approach to nursing also came to the fore in the nursing actions involved in both types of nursing (p. 29):

> *'Nursing proper means, besides giving the medicines and stimulants prescribed, or the surgical appliances, the proper use of fresh air (ventilation), light, warmth, cleanliness, quiet, and the proper choosing and giving of diet, all at the least expense of vital power to the sick. And so, health-at-home nursing [another name used for health nursing] means exactly the same proper use of the same natural elements, with as much life-giving power as possible to the healthy.'*

Even the persons practising both types of nursing remained the same. Whereas in nursing proper, it was the professional nurse who had to apply the principles of sanitation, in health nursing it was the mother of the family (p. 37). The only real innovation put forward in this paper was the introduction of a professional or trained nurse, the so-called health-missioner, who was expected to teach and instruct the mother of the family how to practise the principles of sanitation (p. 31; see also Nightingale, 1892). This conclusion is further vindicated by her comparison between sick nursing and health nursing (Table 7).

Summing up, whereas the idea of the professional nurse in the role of the health-missioner was new, the concept of health nursing in itself amounted to nothing else than a repetition of the principles of sanitary nursing. Even Nightingale's complaints about the lack of public confidence in sanitation were repeated (p. 31):

> *'But, in fact, the people do not believe in sanitation as affecting health, as preventing disease. They think it is a "fad" of the doctors and rich people. They believe in catching cold and in infection, catching complaints from each other, but not from foul earth, bad air, or impure water.'*

The same goes for the reason why she advocated this concept of nursing which, incidentally, also illustrates her persistent religious pragmatism (pp. 29-30):

> *'The laws of God - the laws of life - are always conditional, always inexorable. But neither mothers, nor school-mistresses, nor nurses of children are practically taught how to work within these laws, which God has assigned to the relations of our bodies with the world in which He has put them. In other words, we do not study, we do not practise the laws which make these bodies, into which He has put our minds, healthy or unhealthy organs of those minds; we do not practise how to give our children healthy existences.'*

6.4. Conclusion

The first conclusion to be drawn is that, over the years, Nightingale's concept of nursing did indeed remain essentially the same. Her concept of sanitary nursing exemplified her optimism as to man's ability to extinguish disease and to attain a permanent state of health. Therefore, this concept (and the nursing actions involved) was more closely related to what we, at present, would call a health science rather than medical science. More importantly, this concept of nursing was firmly based upon her religious outlook on life which gave it its typical Nightingalian flavour of a morally inspired zeal for sanitary and social reform.

This conclusion is clearly at variance with Seymer's observation (1954, p. xi) that 'By 1893, a change seems to have come over Florence Nightingale's spirit. Unlike many other older women, whose ideas are incapable of expansion in later life, she saw clearly the paramount value of what one might call "preventive nursing" ... and outlines the basic principles of much that would now be classed under "public health." It was a great achievement for a woman of seventy-three, who had been out of active nursing for so many years, to have the

Nursing proper	Health nursing
This type of nursing was based upon a want '*nearly as old as the world, nearly as large as the world, as pressing as life or death. ... that of sickness*.'	This type of nursing was based upon the assumption that '*God did not mean mothers to be always accompanied by doctors*.' Therefore there must be '*a want older still and larger still*,' and this was the want of being healthy although she omitted to name it that way.
The new art created for this want was '*that of **nursing the sick**. Please mark - nursing the, sick; **not nursing sickness***.' This, as Nightingale pointedout, was '*one of the distinctions between nursing and medicine*.' In addition, she wrote: '*We will call the art nursing proper. This is generally practised by women under scientific heads - physicians and surgeons.*'	At the time, the art, as far as households, families, schools and workshops were concerned had not yet been created, though it was an art which concerned '*every family in the world*.' The art Nightingale was hinting at was '*the art of health, which every mother, girl, mistress, teacher, child's nurse, every woman ought practically to learn. But she is supposed to know it all by instinct, like a bird. Call it **health nursing** or **general nursing** - what you please. ... It is the want of the art of health, then, of the cultivation of health, which has only lately been discovered; and great organizations have been made to meet it, and a whole literature created. We have medical officers of health; immense sanitary works. We have not "missioners" of health-at- home.*'
'*Nursing proper means, besides giving the medicines and stimulants prescribed, or the surgical appliances, the proper use of fresh air (ventilation), light, warmth, cleanliness, quiet, and the proper choosing and giving of diet, all at the least expense of vital power to the sick.*'	'*And so, health-at-home nursing means exactly the same proper use of the same natural elements, with as much life-giving power as possible to the healthy*.'
As to the new science that went with it, she omitted to mention it by its name but, on the basis of her distinguishing between nursing proper and medicine, can be inferred that it was certainly not medical science - encompassing medicine, surgery, and hygiene - but probably sanitary science.	In contrast with the art, the science to meet the want of being healthy had been created but once again Nightingale did it not mention it by its name. However, circumstantial evidence indicates that she meant sanitary science.
The nurse proper had to be able to 'recognize the laws of sickness, the causes of sickness, the symptoms of disease, or the symptoms, it may be, not of the disease, but of the nursing, bad or good.'	Furthermore, it was uponwomankind and not the nursethat the national health, asfar as the household was concerned, depended. Therefore it was she, and not the nurse, who 'must recognize the laws of life, the laws of health.'
Since nursing proper was the art of nursing the sick, it could'only be properly taught and properly learnt in the sick-room and by the patient's side.'	Sanitation could 'only be properly taught and properlylearned in the home and the house.'
Summing up, nursing proper was 'to help the patient suffering from disease to live.'	Summing up, health nursing was'to keep or put the constitution of the healthy child or human being in such a state as to have no disease.'

Table 7. Nursing proper and health nursing (Nightingale, 1893).

foresight to rate prevention higher than cure.' As a matter of fact, there was no change of heart at all as the concept of health nursing exemplified the same sanitary approach as 'Notes on nursing' which had been written some thirty-four years earlier, except for the introduction of the professional or trained nurse as a health-missioner. A more plausible interpretation of the course of events may be something like this. Nightingale's initial optimism as to the importance of sanitary science for the well-being of mankind had prompted her to write on the principles of sanitation and to create the Nightingale training school for nurses in order to bring about sanitary reform. During the 1860s and thereafter, however, the contagionist point of view gained more and more

support, helped by the discoveries of Pasteur and many others confirming the truth of the germ theory. During that period Nightingale's activity in the field of sanitation decreased significantly, according to Pickering (1974) as a result of her bad health, but in the light of her position on the controversy between miasmatism and contagionism there may well have been a second reason, viz. the decreasing support for sanitary reform. After that, during the 1880s, the practice of nursing became increasingly influenced by the advances in medicine, most notably of surgery. However, at that time, too, the value of district nursing for the prevention of disease was realised, and this prompted Nightingale to seize the opportunity to reinforce her sanitary approach to nursing by introducing the concept of health nursing and the accessory health-missioner.

Secondly, Nightingale was not so much interested in the practice of nursing as in the moral lessons to be learnt from it. Her writings on nursing, it is true, contain many anecdotes and examples of the practice of nursing, both in the hospital and in the home, but she never bothered to write a comprehensive textbook of nursing. Instead, she emphasised the principles of sanitation, which she considered to be one of the major instruments by which to teach mankind about the character of God. Nursing, as she viewed it, was therefore subordinated to a higher goal, viz. man's union with God. In the final analysis, using the lessons taught by sanitary observation and experience, her endeavours in the area of nursing were therefore directed at the moral improvement of mankind.

Thirdly, and most importantly, the analysis has shown Nightingale's concept of nursing to be based upon her miasmatic views as to the cause and the nature of disease. Starting with the observation of epidemic diseases, and assuming that God whom she held to be wise and benevolent could not possibly be the cause of such diseases, she arrived at the conclusion that the miasmatic explanation was the right one. As to the latter, she started with the assumption that disease was a reparative process or an effort of nature to remedy the process of poisoning or of decay, an assumption for which she found proof, time and again, in the observation of disease. Both these elements of statistical observation and religious reflection were to reappear in her concept of sanitary nursing, thereby vindicating that her religious pragmatism was at the source of her concept of nursing. A similar observation can be made as to Nightingale's concept of nursing education.

7.
NIGHTINGALE'S CONCEPT OF NURSING EDUCATION

The persistent theme of Nightingale's concept of nursing was its sanitary approach to matters of health and disease (Nightingale, 1859b, 1882b and 1893), as well as being inspired by her religious pragmatism, for to nurse as it ought to be done required '*knowledge, practice, self-abnegation, and ... direct obedience to, and activity under, the highest of all Masters, and from the highest of all motives*' (Nightingale, 1865, pp. 10-11).

Furthermore, Nightingale strongly believed that '*Man has the power to realize all that is right and good, not by prayers to another Being to do his work, not by a mysterious "self determining" power through which he shall "will" to do it, but by taking God's appointed means*' (Nightingale, 1860a, p. 172), or as she once put it in a letter to Jowett summarised by Smith (Smith, 1982, p. 184):

> *"It is a religious act to clean out a gutter and to prevent cholera, and ... it is not a religious act to pray (in the sense of asking)." Moreover, she was divinely appointed to know. ... She reminded Jowett that ... she was uniquely 'part of God's plan. God had created her like Himself, "a Trainer", in a world which was "a training school." Her task was to declare God's laws of sanitation and virtue, and to aid and measure each person's adherence to those laws and thereby guide the world's slow march towards perfection.'*

It is on the basis of such remarks that her religious pragmatism can be expected to have influenced her concept of nursing education.

7.1. Education

As shown earlier, Nightingale's concept of nursing was based upon her belief that the methods of sanitary science, i.e. statistics, were given to man by God in order to enable him to discover His laws, His will. Next, it was up to man's free choice to bring his will in accordance with God's will (Nightingale, 1860b, pp. 53-54):

> *'Man has capability to learn how circumstances regulate and modify human nature, to learn what circumstances develop and exercise human nature aright. By the united efforts of mankind, in accordance with God's ever-present, ever- efficient law, to bring about such circumstances is man's work. The capability for this is man's power.'*

Nursing, as Nightingale viewed it, was thus one of the areas, and a very important one, for man to employ his power to learn the 'how' and the 'what' of human nature in order to develop and exercise it aright. However, to achieve this, he needed some sort of education (Nightingale, 1873a, pp. 576):

> *'The facts of what is more strictly called education, though sanitary facts are one of the most powerful means of educating mankind, show, if possible, still more strongly what here has been imperfectly expressed. ... viz. that education is to teach men not to know, but to do; that the true end of education is production, that the object of education is not ornamentation, but production - (after man has learnt to produce, then let him ornament himself) - but "production" in the widest sense of the term. And, to teach man to produce, the educating him to perfect accuracy of thought - and, it might have been added, to accurate habits of observation - and to perfectly accurate habits of expression, is the main, the constant way - what a grand "lesson" this is.'*

This line of reasoning in one of Nightingale's writings on religion, if compared with her remarks on the training of nurses, is yet another proof of her consistency. To grasp its significance, however, one first has to note the parallelism with the requisites for Nightingale's religious concept of education:

- '*to learn how circumstances regulate and modify human nature*' is on a par with '*accurate habits of observation*,'
- '*to learn what circumstances develop and exercise human nature aright*' is on a par with '*perfect accuracy of thought*,'
- '*to bring about such circumstances*' is on a par with '*accurate habits of expression*.'

This was also the line of reasoning used by her in 'Nurses, training of' (Nightingale, 1882a, p. 321):

> *'Observation tells how the patient is; reflection tells what is to be done; training tells how it is to be done. Training and experience are, of course, necessary to teach us, too, how to observe, what to observe; how to think, what to think. Observation tells us the fact; reflection the meaning of the fact. Reflection needs training as much as observation.'*

To grasp Nightingale's concept of nursing education, it seems therefore appropriate to dwell upon Nightingale's views on observation, reflection and training. From the analysis of these views, it will moreover become clear that Nightingale's writings on nursing education can be interpreted narrowly as well as broadly, and that it is the latter interpretation which provides a richer insight in her concept of nursing education.

7.1.1. Observation

'Notes on nursing' contains one chapter, entitled 'Observation of the sick', which is full of anecdotal examples of observation by nurses. These examples, however, are used to teach the following lesson (Nightingale, 1859b, p. 59):

> *'The most important practical lesson that can be given to nurses is to teach them what to observe - how to observe - what symptoms indicate improvement - what the reverse - which are of importance - which are of none - which are the evidence of neglect - and of what kind of neglect.'*

On the next page, this skill of observation is contrasted with (1859b, p. 60, footnote), '*observation simple*' in which, despite the exposure to sensory phenomena, nothing is observed, as well as '*observation compound, compounded, that is, with the imaginative faculty*.' Whereas the information of the former was simply '*defective*,' that of the latter was '*much more dangerous*' as it was based upon mere imagination. So crucial thought Nightingale the skill of observation to be that she advised mothers of families that '*if you cannot get the habit of observation one way or another, you had better give up the being a nurse, for it is not your calling, however kind and anxious you may be*' (1859b, p. 63).

Two important aspects of observation, she further pointed to, were that the nurse must '*distinguish between the idiosyncracies of patients*' (1859b, p. 66) and that observation also implied '*an inquiry into all the conditions in which the patient lives*' (1859b, p. 68). Both aspects were of equal importance. Although Nightingale held the view that man's behaviour was determined by the uniform relations between his condition and the circumstances affecting it, she did not fail to acknowledge certain idiosyncracies in human behaviour as well. These idiosyncracies she attributed to the fact that, up to a certain degree, some of the circumstances affecting the human condition were in each case unique and were never to be repeated again. As for the physical nature of man, this should be taken to mean (Nightingale, 1860a, p. 12):

> *'... certain conditions are essential to human life, others to the healthy existence of a human being; while, in other particulars, individuals vary as to those which are essential or conducive to health. But uniform relation is observable in all states in which human nature exists.'*

In 'Nurses, training of,' Nightingale, partly repeating herself, elaborated on the subject of observation (Nightingale, 1882a, pp. 320-321):

'The trained power of attending to one's own impressions made by one's own senses, so that these should tell the nurse how the patient is, is the sine qua^ non of being a nurse at all. ... To look is not always to see. ... Without a trained power of observation, no nurse can be of any use in reporting to the medical attendant ... neither can the nurse obey intelligently his directions. It is most important to observe the symptoms of illness; it is, if possible, more important still to observe the symptoms of nursing; of what is at fault not of the illness, but of the nursing.'

These remarks on what to observe, once again, highlighted nursing proper being different from medicine, as the nurse's observation had to focus not only on the symptoms of illness but also on the uniform relations between the patient and the circumstances affecting him. The nurse had thus to look for sanitary phenomena manifesting God's laws, and to that extent, nursing was an art to be performed independently from the physician or the surgeon, thereby placing it under the authority of God.

7.1.2. Reflection

Observation in itself was not enough as it had to be complemented by reflection, and this skill required training too (Nightingale, 1882a, p. 321):

'Reflection needs training as much as observation. Otherwise the untrained nurse, like other people called quacks, easily falls into the confusion of "on account of," because "after" - the blunder of the "three crows".'

More than twenty years before, Nightingale had expressed the same concern in 'Notes on nursing' (Nightingale, 1859b, p. 65):

'Almost all superstitions are owing to bad observation, to the post hoc, ergo propter hoc; and bad observers are almost all superstitious. Farmers used to attribute disease among cattle to witchcraft; weddings have been attributed to seeing one magpie, deaths to seeing three; and I have heard the most highly educated now-a-days draw consequences for the sick closely resembling these.'

Nightingale's remarks on the need for reflection, and for observation for that matter too, it is contended here, should be interpreted against the background of her positive theology in which she repeatedly pointed to the dangers of:

- thinking without observation, which was on a par with superstitions as a result of the miraculous and the supernatural theology,
- observation without thinking, which was on a par with positivism.

Whereas positivists, notably Huxley, used to attack all sorts of theology for being '*extra-belief (Aberglaube), meaning, not superstition, but belief in things not verified by the senses,*' Nightingale herself accused Huxley of advocating or succumbing to '*a sort of infra-belief; covering, indeed, but small part of the ground man stands upon, less still of the horizon he looks on*' (Nightingale, 1873a, p. 568). This broadened interpretation of Nightingale's remarks on the nurse's observation and reflection is borne out by the way she discussed the third requisite of the nursing: training.

7.1.3. Training

Both in 'Nurses, training of' and in 'Sick nursing and health nursing,' Nightingale addressed the subject of training in two different ways. On the one hand, she discussed training in a rather simple and straightforward manner (Nightingale, 1882a, p. 320):

'Training is to teach not only what is to be done, but how to do it. The physician or surgeon orders what is to be done. Training has to teach the nurse how to do it to his order; and to teach, not only how to do

it, but why such and such a thing is done, and not such and such another; as also to teach symptoms, and what symptoms indicate what of disease or change, and the "reason why" of such symptoms.'

On the other hand, Nightingale also discussed training in a wider sense (Nightingale, 1882a, p. 322):

'To obey is to understand orders, and to understand orders really is to obey. A nurse does not know how to do what she is told without such "training" as enables her to understand what she is told; or without such moral and disciplinary "training" as enables her to give her whole self to obey.'

This broadened meaning of training fitted in with her description of man's relationship to God, viz. '*the relation between a perfect Creator, creating and training His creatures to perfection*' (Nightingale, 1860a, p. 22). As for this relationship, man was not expected to obey blindly. On the contrary, he was expected to develop and exercise his God-given capabilities so as to enable him to bring his will in accordance with God's will.

Not surprisingly, Nightingale advocated '*the substitution for authority ... of sense of truth and right, of accordance with right*,' adding that '*No longer can it be duty submitted to, but right accorded with, which must be the spirit of mankind. ... Truth, in our relations both with God and with man, must come in this substitution of accordance of the whole nature with right for authority, vaguely acknowledged from fear or duty*' (Nightingale, 1860b, p. 246). Furthermore, this training in the wide sense also reflected on training in the narrow sense insofar Nightingale held the opinion that '*Training has to make her [the nurse], not servile, but loyal to medical orders and authorities*' (Nightingale, 1882a, p. 333). The opposite of this '*accordance with right*' expected from the nurse was '*might is right*' (Nightingale, 1860b, p. 247).

The widened and above all moral interpretation of Nightingale's concept of training is borne out by her twofold definition of the nurse's training (Nightingale, 1893, p. 26; see also Nightingale, 1882a, pp. 333-334)

- **training in the narrow sense**
  'Training is to teach the nurse to help the patient to live. Nursing the sick is an art, and an art requiring an organized, practical and scientific training; for nursing is the skilled servant of medicine, surgery and hygiene. A good nurse of twenty years ago had not to do the twentieth part of what she is required by her physician or surgeon to do now; and so, after the year's training, she must be still training under instruction in her first and even second year's hospital service. The physician prescribes for supplying the vital force, but the nurse supplies it.'

- **training in the wide sense**
  'Training is to teach the nurse how God makes health, and how He makes disease. Training is to teach the nurse to know her business, that is, to observe exactly in such stupendous issues as life and death, health and disease. Training has to make her, not servile, but loyal to medical orders and authorities. True loyalty to orders cannot be without the independent sense or energy of responsibility, which alone secures real trustworthiness. Training is to teach the nurse to handle the agencies within our control which restore health and life, in strict, intelligent obedience to the physician's or surgeon's power and knowledge; how to keep the health mechanism prescribed to her in gear. Training must show her how the effects on life of nursing may be calculated with nice precision, such care or carelessness, such a sick rate, such duration of case, such a death-rate.'

Finally, whereas the narrowly interpreted concept of training is related to the concept of nursing being ancillary to medicine, training in the wide sense corresponds most closely to Nightingale's concept of sanitary nursing and, by implication, to the service to God through the service to mankind.

7.2. Discipline: the essence of training

Nightingale's concept of training in the wide sense was a corollary of her concept of nursing. Underlying both these concepts was her religious pragmatism putting great emphasis upon statistical observation of sanitary phenomena, followed up by religious reflection and resulting in training and experience with regard to social

reform. The essence of Nightingale's concept of training was therefore of a moral and religious rather than an educational nature. This conclusion is corroborated by the concept of discipline emerging from it (Nightingale, 1882a, p. 334; see also Nightingale, 1893, p. 27):

> *'And discipline is the essence of training. People connect discipline with the idea of drill, standing at attention - some with flagellating themselves, some with flagellating boys. A lady who has, perhaps, more experience in training than anyone else, says: "It is education, instruction, training - all that in fact goes to the full development of our faculties, moral, physical, and spiritual, not only for this life, but looking on this life as the training-ground for the future and higher life. Then discipline embraces order, method, and, as we gain some knowledge of the laws of nature ("God's laws"), we not only see order, method, a place for everything, each its own work, but we find no waste of material or force or space; we find, too, no hurry; and we learn to have patience with our circumstances and ourselves; and so, as we go on learning, we become more disciplined, more content to work where we are placed, more anxious to fill our appointed work than to see the result thereof; And so God, no doubt, gives us the required patience and steadfastness to continue in our 'blessed drudgery,' which is the discipline He sees best for most of us.'*

Nightingale's concept of education therefore amounted to a permanent and cyclic process of learning by means of observation, reflection and training, which, except for its religious connotations, was similar to Dewey's philosophy of education.

7.3. Conclusion

All this should not, however, be taken to mean that Nightingale succeeded in putting these concepts of nursing education into practice in the first Nightingale training schools for nurses. On the contrary, for this project went astray for two reasons mainly.

One has to do with the reluctance on the part of the governors of St. Thomas's Hospital in London to accept a training school for nurses, but '*If they were going to accept a cuckoo in the nest, a cuckoo other hospitals had refused, they were going to make sure that the nurses were under their control*' (Baly, 1986, p. 17). As a result the first two decades of the school were dominated by the battle between, on the one hand, the faction led by Mrs. Wardroper, the matron, who used the probationers as cheap pairs of hands, and, on the other, the Nightingale faction which defended the educational purposes of the school.

The other reason for the project's decline was the lack of a clearly articulated purpose for the school. Although, in 1872, a five-point plan was made to salvage the school, Nightingale omitted to outline the educational objectives as well as the theoretical content and the practical experiences needed to achieve these objectives. As a result (Prince, 1984, p. 160):

> *'Nursing as a separate enterprise did not emerge. The failure to define the nursing job led not only to sisters and nurses not knowing what they should do, but not knowing what they should not do. The intellectual contribution to the curriculum was autonomously and capriciously decided by medical men; the practical experience, such as it was, by Matron and ward sisters.'*

At the end of the day, the Nightingale faction lost the battle, but, in spite of that, Nightingale kept in touch with the schools by means of the addresses to her nurses in which '*through the simple and popular style of the addresses something of a philosophical framework can be seen. When Miss Nightingale hopes that her nurses are a step further on the way to becoming "perfect as our Father in Heaven is perfect," she has in mind the conception she had formed of a moral government of the world in which science, activity, and religion were one*' (Nash, 1914, p. vii).

Finally, the analysis of Nightingale's original works on nursing has shown her concepts of nursing and nursing education undoubtedly to have been influenced, not to say determined, by her religious pragmatism. A similar observation can be made as to her answer to the question whether nursing should be regarded as a calling or a profession.

8.
NIGHTINGALE'S CONCEPT OF PROFESSIONAL NURSING

One of the issues to be addressed in every analysis of Nightingale's influence on the development of nursing is her stance on the question of whether nursing is a profession or not. Given the results of the analysis so far, it will come as no surprise that she thought nursing to be a calling rather than a profession, and this, too, was one of the persistent themes in her writings on nursing.

In Nightingale's writings on nursing, analysed in these chapters, the theme of nursing being a calling emerged for the first time in 'Notes on nursing' when she wrote that it was better for mothers of families unable to master the skill of observation to give up being nurses, for it was not their calling. This was long before the issue of whether nursing was a profession in its own right could even have been raised, as the nursing profession was nonexistent at the time. Nightingale's remarks on this issue in 'Notes on nursing' should, therefore, be interpreted not so much within the context of the question of whether nursing is either a calling or a profession as within the perspective of Nightingale's religious pragmatism.

However, in 1893, when Nightingale wrote 'Sick nursing and health nursing,' the situation had changed dramatically. Nursing was emerging as one of the new professions. Since 1886, the so-called 'Nurses Battle' over the State Registration for nurses was raging in Great Britain. As for the United States, the meeting at which Nightingale's paper was presented was also the first time the nursing profession came into the open in that part of the world. This paper, unlike 'Notes of nursing,' therefore calls for an interpretation within the context of the debate of whether nursing was calling or a profession. Although Nightingale still viewed nursing as a calling, her unchanged position contrasted sharply with the signs of the time.

8.1. Nursing: a calling from God

The best way of accounting for the position taken by Nightingale in 1859 is provided by her summary of 'Notes on nursing' which she started with the following remarks (Nightingale, 1859b, p. 73):

> *'... the answer to two of the commonest objections urged, one by women themselves, the other by men, against the desirableness of sanitary knowledge for women, plus a caution, comprises the whole argument for the art of nursing.'*

The way in which Nightingale elaborated on both these objections and the caution are most illuminating as to what she meant by nursing being a calling, because it shows that her position on this issue was determined by her religious pragmatism too.

8.1.1. Health observation and experience

The first objection, put forward by men, drew attention to the danger of amateur 'physicking' by women as a result of teaching them the laws of health. To this objection Nightingale answered (Nightingale, 1859b, pp. 73-74):

> *'But this is just what the really experienced and observing nurse does not do; she neither physics herself nor others. And to cultivate in things pertaining to health observation and experience in women who are mothers, governesses or nurses, is just the way to do away with amateur physicking, and if the doctors did but know it, to make nurses obedient to them, - helps to them instead of hindrances. Such education in women would indeed diminish the doctor's work - but no one really believes that doctors wish that there should be more illness, in order to have more work.'*

Both this objection and Nightingale's reaction to it were concerned with the need to teach women the skills of health observation and experience, not in terms of amateur '*physicking'* which had to do with disease but as the

conditio sine qua non for promoting health. However, this was, as shown earlier, only the first step of nursing which had to give rise to some sort of reflection on the laws of health.

8.2.2. The laws of health

The second objection, put forward by women themselves, was that they could not know anything of the laws of health because they could know nothing of pathology and could not dissect. To this '*confusion of ideas which it is hard to attempt to dissentangle*' Nightingale answered by comparing the lessons to be learnt from pathology, on the one hand, and observation and experience, on the other (1859b, p. 74):

> *'Pathology teaches the harm that disease has done. But it teaches nothing more. We know nothing of the principle of health, the positive of which pathology is the negative, except from observation and experience. And nothing but observation and experience will teach us the ways to maintain or to bring back the state of health. 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. ... And what nursing has to do in either case, is to put the patient in the best condition for nature to act upon him.'*

This objection and Nightingale's reaction to it, were concerned with observation and experience as the subject matter for reflection, or with the question of what lesson was to be learnt. In Nightingale's opinion, the positive lesson taught by observation and experience, i.e. the principle of health, was far more valuable than the negative lesson taught by pathology, i.e. the harm the disease had done.

She furthermore emphasised that it was not medicine but nature that cured, and that it was nursing rather than medicine or surgery which had to help nature by putting the patient in the best condition for nature to act upon him. By adding this information, and not for the first time, Nightingale changed the tone of the argument from a pure scientific into a religious argument: health observation and experience were to teach man not only the principle of health but also the laws of nature which constituted the laws of God, resulting in a process of learning by experience and careful inquiry.

8.1.3. Learning by experience and careful inquiry

The caution which ended Nightingale's summary of 'Notes on nursing' was directed against '*the commonly received idea among men and even among women themselves that it requires nothing but a disappointment in love, the want of an object, a general disgust, or incapacity for other things, to turn a woman into a good nurse*' (Nightingale, 1859b, p. 75). This remark should not be taken to mean that Nightingale favoured the idea of nursing being a profession as opposed to the romanticised idea of nursing. On the contrary, so she argued (Nightingale, 1859b, p. 75):

> *'... the knowing what are the laws of life and death for men, and what the laws of health for wards ... are not these matters of sufficient importance and difficulty to require learning by experience and careful inquiry, just as much as any other art? They do not come by inspiration to the lady disappointed in love, nor to the poor workhouse drudge hard up for a livelihood.'*

In other words, sanitary nursing, as Nightingale wanted mothers of families to practise it, required a positive commitment to learning the laws of life and death, i.e. the laws of God, and acting accordingly.

This religious interpretation is prompted by Nightingale's comparison of the commitment demanded from Roman Catholic nurses and that of the English mothers of families: '*It is true we make no "vows." But is a "vow" necessary to convince us that the true spirit for learning any art, most specially an art of charity, aright, is not a disgust to everything or something else? Do we really place the love of our kind (and of nursing, as one branch of it) so low as this?*' (Nightingale, 1859b, pp. 75-76).

8.1.4. Related issues

Nightingale's summarisation of 'Notes on nursing' portrayed the art of nursing as an instance of man's relationship with God, involving both a calling from God and efforts of the nurse to make her election sure (see also Nightingale, 1893, p. 32). However, outlining her position, she also mentioned the value of nursing and medicine and the role of men and women in society. Both these elements may give rise to an interpretation of Nightingale's position different from the one put forward here.

The value of nursing and medicine. Nightingale viewed nursing as a calling rather than a profession which followed the footsteps of the medical profession. Incidentally, in 'Suggestions for thought' Nightingale has articulated her view of a profession, viz. (Nightingale, 1860b, p. 5, footnote):

> *'a set of men paid to profess some kind of opinions; the clergy are paid to profess one kind of religion, the Wesleyans another. In the medical profession, the allopath is paid to profess one system of medicine, the homoeopath another. And all have their small families to support.'*

This description not only is consistent with Nightingale's judging an opinion by the good it created for mankind rather than by the income it generated, but it also explains the manifold references to the differences between nursing and medicine in her writings, aimed at emphasising the moral implications of nursing which were conspicuously absent in medicine. Nightingale's description of a profession also suggests that, whereas medicine was men's work, nursing was women's work. This interpretation is vindicated by Nightingale's statement that nursing was an activity for which women were gifted with a special aptitude (Nightingale, 1859a, p. 54):

> *'... the woman is superior in skill to the man in all points of sanitary domestic economy, and more particularly in cleanliness and tidiness. Great sanitary civil reformers will always tell us that they look to the woman to carry out practically their hygienic reforms. She has a superior aptitude in nursing the well quite as much as in nursing the sick.'*

In the book from which this quotation is taken, 'Notes on hospitals,' Nightingale also compared '*personal hygiene*' with '*public hygiene*' (Nightingale, 1859a, pp. 46-47). Similar to the physician or the surgeon who was in charge of the hygiene of his patients, she argued, the army had to have at its disposal an officer of health in charge of the hygiene of buildings, to which it can be added that, whereas the former dealt with disease, the latter was concerned with health. It remains to be seen, however, whether these two roles were sex-linked or not.

The role of women in society. Nightingale's summary of 'Notes on nursing' contains too many references to the opinion of men and women to be simply ignored. The main question is whether the texts analysed here should be interpreted within a feminist perspective (Smith, 1981) or not.

Admittedly, the second volume of 'Suggestions for thought' contains, apart from the text of 'Cassandra' (Nightingale, 1860b, pp. 374-411) which some consider to be one of the classics in feminist literature, many autobiographical references to the position of girls and women in Victorian society reflecting Nightingale's own conflicts, especially with her mother and her sister. These references leave us in doubt as to the degree in which Nightingale's life had been affected by her family disagreeing with what she did. On the other hand, her Unitarian beliefs which favoured a more active role for women in occupations may have played a role as well.

However, in contrast with many of Nightingale's remarks on the position of women in Victorian society, it definitely was not her intention to present nursing as being a calling within the context of the feminist cause for women's rights, for at the end of her summary of 'Notes on nursing', she added a footnote (Nightingale, 1859b, p. 75) in which she asked her '*sisters to keep clear ... of the jargon ... about the "rights" of women, which urges women to do all that men do, including the medical and other professions, merely because men do it, and without regard to whether this is the best that women can do.*' This was not to say that they should not keep clear of yet another jargon, namely '*the jargon which urges women to do nothing that men do, merely because they are women, and should be "recalled to a sense of duty as women." and because "this is women's work," and "that is men's," and "these are things which women should not do," which is all assertion and nothing more*.' It was typical of Nightingale that her religious belief transcended both these positions (Nightingale, 1859b, p. 75):

'Surely woman should bring the best she has, whatever that is, to the work of God's world, without attending to either of these cries. ... Oh, leave these jargons, and go your way straight to God's work, in simplicity and singleness of heart.'

Nightingale's religiously inspired position on the issue of nursing being a calling probably was prompted by her conviction that, on at least four occasions (1837, 1853, 1854, and 1861), she was 'called' by God to do the work she did. In addition, the position taken by her also reflected her religious pragmatism leading to its logical conclusion, for, granted that man was afforded the inducements as well as the means to advance in knowledge, will and power needed to approximate the union with God, it would be a folly to exclude women from both the inducements and the means to participate in mankind's serving God through serving mankind. This was a position, probably few modern feminists would be willing to subscribe to.

8.1.5. Nursing: a progressive calling

In 'Nursing the sick,' written some two decades after the publication of 'Notes on nursing,' Nightingale did not mention that she saw nursing as a calling explicitly, except at the end of the article. There she characterised nursing as a progressive calling, pointing to the fact that (Nightingale, 1882b, p. 349):

'Year by year nurses have to learn new and improved methods, as medicine and surgery and hygiene improve. Year by year nurses are called upon to do more and better than they have done. It is felt to be impossible to have a public register of nurses that is not a delusion. ... Further, year by year, nursing needs to be more and more of a moral calling.'

Writing for a medical dictionary, Nightingale probably had to abstain from mentioning her religious beliefs underlying her concept of nursing and nursing education too explicitly. Nevertheless, as has been shown from her remarks on the training of nurses (Nightingale, 1882a, pp. 333-334), she managed to put in enough religious content as not to be seen to have changed her mind at all. This explains why, at first sight, Nightingale's rejection of a public register appeared to be founded upon the continuous innovation and improvement of the methods of nursing as a result of advances in medicine, surgery and hygiene. Having made her point in this generally acceptable way, she superimposed the actual reason, viz. that the moral dimension of nursing was incompatible with such a public register. This interpretation of Nightingale's position is vindicated by her descriptions of what she considered to be a good nurse (Table 8).

Granted that this interpretation is correct, it once again confirms Nightingale's consistency, this time on the issue of nursing being a calling rather than a profession. Her opposition to a public register of nurses was not so much based upon scientific developments as upon her belief that nursing was a progressive process of learning about the laws of God. In the light of Nightingale's religious pragmatism, her remarks therefore should be taken to mean that nursing was a calling for two reasons. First, as a result of medicine, surgery and hygiene improving year by year, nurses were increasingly able to learn the laws of nature with regard to man's physical mode of being. Secondly, as a result of applying these laws of nature nurses became part of God's plan, viz. that man would bring his own will in accordance with God's will. This religious outlook on the nature of nursing she has never abandoned.

8.2. Nursing: calling versus profession

It is beyond doubt that Nightingale viewed nursing as a calling from as early as the 1850s, probably even earlier than that. Nothing, not even the emergence of the profession of nursing, could bring her to change her position on this issue. This assessment of her position is vindicated by the way in which she expressed her hopes for the future of nursing as late as in 1893 (Nightingale, 1893, pp. 36-37):

'May we hope that the nurse may understand more and more of the moral and material government of the world by the Supreme Moral Governor - higher, better, holier, than her "own acts," that government which enwraps her round, and by which her own acts must be led, with which her own acts must agree in

their due proportion, in order that this, the highest hope of all, may be hers; raising her above, i.e., putting beneath her, dangers, fashions, mere money-getting, solitary money-getting, but availing herself of the high helps that may be given her by the sympathy and support of good "homes"; raising her above intrusive personal mortifications, pride in her own proficiency (she may have a just pride in her own doctors and training-school), sham, and clap-trap; raising her to the highest "grade" of all - to be a fellow-worker with the Supreme Good, with God! That she may be a "graduate" in this, how high! that she may be a "graduate" in words, not realities, how low! We are only on the threshold of nursing.'

This was the very same position taken by Nightingale in 1859 and 1882, except for its changed context, viz. the debate between nursing as a calling and nursing as a profession. These hopes for the future of nursing, and especially her remark on the threshold of nursing, were somehow paralleled by the future God envisaged for man, viz. entering the kingdom of heaven (Nightingale, 1860b, p. 205):

'The "kingdom of heaven is within," indeed, but it must also create one without, because we are intended to act upon our circumstances. We must beware, both of thinking that we can maintain that "kingdom of heaven within" under all circumstances, - because there are circumstances under which the human being cannot be good, and also of thinking that the kingdom of heaven without will produce that within.'

'A really good nurse must needs be of the highest class of character. It need hardly be said that she must be -
(1) Chaste, in the sense of the Sermon on the Mount; a good nurse should be the Sermon on the Mount in herself. ...
(2) Sober, in spirit as well as in drink, and temperate in all things.
(3) Honest, not accepting the most trifling fee or bribe from patients or friends.
(4) Truthful - and to be able to tell the truth includes attention and observation, to observe truly - memory, to remember truly - power of expression, to tell truly what one has observed truly - as well as intention to speak the truth, the whole truth, and nothing but the truth.
(5) Trustworthy, to carry out directions intelligently and perfectly, unseen as well as seen, "to the Lord" as well as unto men - no mere eye-service.
(6) Punctual to a second, and orderly to a hair ...
(7) Quiet, yet quick; quick without a hurry; gentle without slowness; discreet without self-importance; no gossip.
(8) Cheerful, hopeful; not allowing herself to be discouraged by unfavourable symptoms; not given to depress the patient by anticipations of an unfavourable result.
(9) Cleanly to the point of exquisiteness, both for the patient's sake and her own; neat and ready.
(10) Thinking of her patient and not of herself; "tender over his occasions" or wants, cheerful and kindly, patient, ingenious and feat. The best definition can be found, as always, in Shakespeare, where he says that to be "nurse-like" is to be So kind, so duteous, diligent, So tender over his occasions, true, So feat.

Table 8. Nightingale's image of the nurse (Nightingale, 1882b, p. 351).

Moreover, Nightingale's view of nursing being a calling from God rather than a profession adds a religious significance to the dangers she summed up in this last authoritative statement on nursing matters (Nightingale, 1893, pp. 34):

'To sum up the dangers:

1) *On one side, fashion, and want of earnestness, not making it a life but a mere interest consequent on this;*
2) *On the other side, mere money-getting; yet man does not live by bread alone, still less women.*

3) *Making it a profession, and no calling. Not making your 'calling and election sure,' wanting especially with private nurses, the community of feeling of a common nursing home, pressing towards the 'mark of your high calling,' keeping up the moral tone.*
4) *Above all, danger of making it book-learning and lectures - not an apprenticeship, a workshop practice.*
5) *Thinking that any hospital with a certain number of beds may be a box to train nurses in, regardless of the conditions essential to a sound hospital organization, especially the responsibility of the female head for the conduct and discipline of the nurses.*
6) *Imminent danger of stereotyping instead of progressing. 'No system can endure that does not march.' Objects of registration not capable of being gained by a public register. Who is to guarantee our guarantors? Who is to make the inqueries? You might as well register mothers as nurses. A good nurse must be a good woman.'*

One of these so-called dangers, namely the state registration by means of a public register, was at the source of the long lasting conflict between Nightingale and the British Nurses Association led by Mrs. Bedford Fenwick. In a historical study of this conflict (Mills & Dale, 1964, p. 35), Nightingale is said to have been strongly opposed to the use of the word '*profession'* in relation to nursing. Instead, she preferred the word '*calling*,' because she '*did not appear to have a very high opinion of her own sex, and was not disposed to help the progress of the emancipation of women*.' Both the reasons put forward by Mills and Dale are at variance with Nightingale's real position, which was based upon her religious pragmatism. In a letter of 1892, for example, she asked Miss March, one of her correspondents, '*to "pray for the nurses and nursing," for nursing had become "the fashion" with emphasis on registering and wages rather than on duty in the sense of "work for God"* (summarised by Monteiro, 1972, p. 528).

All this goes a long way to show that, as far as Nightingale was concerned, nursing was not a profession in need of some religious justification. On the contrary, for her nursing was a religious activity based upon a calling from God which should not be compromised by such mundane interests as fashion, money-making, registration, emancipation of women and so on.

9.
THE APPLICATION OF NIGHTINGALE'S CONCEPT OF NURSING

Whereas the previous chapters have been concerned primarily with the religious pragmatism which was at the source of the Nightingalian concept of nursing, i.e. Nightingale's concepts of nursing, nursing education and the nursing profession, this chapter deals with the application of her concept of nursing.

The major problem to be faced in the search for applications of Nightingale's concept of nursing is the lack of an identifiable group of followers of Nightingale's sanitary approach to nursing, similar to, for example, the psychoanalysts following Freud's approach. This is not to say that the sanitary measures advocated by her have failed to influence the practice of nursing, on the contrary, for these measures have been very much in evidence in the textbooks of nursing written ever since. But it is quite another thing to say that these textbooks, therefore, were based on the principles of sanitary science, for they definitely were not. This observation is in sharp contrast with Levine's appraisal of the lasting significance of Nightingale's principles of nursing (Levine, 1963, p. 28):

> *'So solid and basic were these principles that they never changed. For fifty years she espoused them, and not even the development of the germ theory could shake her conviction or, more remarkably, the esssential validity of her principles.'*

Bishop, in a discussion about Nightingale's message for today, took this even further (1960, p. 249) when he wrote that:

> *'... in regard to the fundamentals of nursing, I think it is true that Florence Nightingale's prevision was such that no first principle laid down by her has needed alteration, or is likely to.'*

Both Levine's and Bishop's evaluation of the long-term significance of Nightingale's concept of nursing are somewhat misleading for, while many sanitary measures advocated by Nightingale were undoubtedly very effective and still make sense, the theory of miasmatism underlying such measures has become obsolete ever since the discoveries of bacteriology confirmed the contagionist point of view. Other appraisals of Nightingale's concept of nursing which take into account the substitution of bacteriology for sanitary science come from Palmer (1977) and Baly (1969). Whereas the former (Palmer, 1977, p. 87) emphasised Nightingale's rejection of the germ theory as an example of her reactionary character, the latter (Baly, 1969, p. 2) reached a more positive conclusion:

> *'Notes on nursing preceded the germ theory of infection, yet with an almost incredible perspicacity they foreshadow it. "Lack of health teaching" is the theme.'*

At least, this appraisal does some justice to one of Nightingale's lasting contributions to the development of nursing, viz. the nurse in the role of the health missioner, which was to result in the increasing acceptance of the public health nurse. On the other hand, it glosses over the wider implications of the differences between miasmatism and contagionism which, in the final analysis, give rise to two contrasting approaches to nursing. It is this contrast, as will be shown in this chapter, which may explain why Nightingale's concept of nursing has failed to result in what could be rightly called a Nightingalian school of nursing.

9.1. Miasmatism and contagionism revisited

The main reason why Nightingale's concept of nursing has not attracted a group of avowed followers, it is contended here, was her taking sides with the advocates of the theory of miasmatism as well as her subsequent rejection of the germ theory. The latter was not, however, the only implication of the position taken by her, for both miasmatism and contagionism have much wider implications, as both represent a more general orientation or conceptual framework. In his doctoral study on the relationships between medicine and philosophy, Ten Have

(1983, pp. 229-316) has undertaken a detailed comparison of these explanatory theories of epidemic diseases from which most of the material in this chapter is drawn.

9.1.1. Miasmatism

According to the theory of miasmatism, epidemic diseases are caused by impurities in the environment of man. The exact nature of these impurities has given rise to much speculation. Whereas Hippocrates, the acclaimed originator of miasmatism, held air, water, soil, climate and the seasons to be responsible for most epidemic diseases, the miasmatists of the last century pointed to more specific circumstances of living like putrified water, lack of proper ventilation, garbage, excrements, rotten food, and so on, as the source of so-called miasmata (whatever these miasmata may have been, for their existence has never been demonstrated beyond any doubt). Because of these miasmata, man was held to become increasingly susceptible to epidemic diseases which, according to the miasmatists, could not be transmitted from one individual to the other.

Ten Have (1983, pp. 233-235) summarises the miasmatic position by pointing to the following characteristics. According to the miasmatic explanation of the genesis of epidemic diseases, the environment was the active agent and the individual the passive recipient of miasmata.

Further, medical treatment of epidemic disease was directed at manipulating the environmental causes rather than treating the individual affected by the disease, and, although the prevention of epidemic disease was held to be feasible by means of improving sanitation, separating healthy from diseased persons (quarantine) was not considered to be a useful measure. Not surprisingly, most miasmatists of the last century were also fervent supporters of social and political reform.

A third characteristic of the miasmatic position was that everything was seen as interrelated and interdependent. As a result of this so-called universalistic attitude, intervention in one part was considered to be utterly useless unless other relevant factors were dealt with as well.

Finally, at the source of these characteristics of the miasmatic approach was the multicausal and interdependent explanation of disease.

9.1.2. Contagionism

According to the theory of contagionism, originating from the Judaeo-Christian tradition, epidemic diseases are caused by small living entities called contagia. These contagia were believed to be able to enter the living body, to multiply themselves, to be eliminated and to be transmitted to another living body by means of bodily contact, by air and by clothes and other objects. To appreciate the discussion during the first half of the nineteenth century, it is worthwhile to realise that, until the discovery of the germ theory during the 1860s, this contagionist explanation of epidemic diseases was not less fanciful than that of miasmatism.

Summarising the contagionist position, Ten Have (1983, pp. 233-235) points out that, whereas the individual in which the contagia multiplied themselves played the active role in the genesis of the disease, the environment being the medium of transmission was attributed the passive role.

In contrast with the miasmatic approach, medical treatment of epidemic disease initially focused on the stringent separation of all individuals affected by the disease from healthy individuals, thereby foreshadowing the later emphasis upon the individual's biological structure and functions as well as his psychological make-up.

Also in contrary with the miasmatic approach, medical treatment was directed at the adjustment of the individual to his environment, which was held to be unchangeable and static.

The conceptual framework of contagionism was characterised by an atomistic orientation, as it focused upon the individual or parts of the individual which were seen as separate elements to be analysed in isolation of each other and to be treated by means of mechanical manipulation.

Finally, at the source of these characteristics of the contagionist approach was the relatively monocausal explanation of disease, relatively because some held the contagia to be disease-specific while others did not.

9.1.3. Two different orientations or conceptual frameworks

Ten Have's analysis of miasmatism and contagionism has effectively exposed two different orientations or conceptual frameworks in medicine (Ten Have, 1983, pp. 235-236):

> *'Whereas the theory of contagionism represents medicine in its orientation towards man himself, the individual, or the processes within the organism: his structure, his functions and his identifiable diseases, miasmatism stands for the orientation towards the environmental variables, or the environment in the widest meaning of the word: society, the pattern of living, the circumstances of living, the culture as well as the water, the air and the soil.'*

As for the former orientation, Ten Have suggests to name it the '*biological approach*,' a name which reflects the meaning of the Greek word 'bios' in both its somatic and psychological connotations. However, to exclude any environmental orientation and to put even more emphasis upon the orientation towards the individual, he also suggests the use of adjectives like 'personal' and 'individual.' Ten Have himself, however, prefers the term 'biological' because this name also implies a specific method of studying and practising medicine, viz. of natural science.

As for the latter orientation, he suggests to name it the '*sociological approach*,' or alternatively, the '*ecological approach*.' Yet another alternative, one which he himself prefers but rejects because it is an English word (the study was written in the Dutch language), is the term 'environmentalism.' On the other hand, one of the advantages of naming it the 'sociological approach' is that it implies the use of specific methods of study too, viz. the methods of social science.

Modern medicine. Having established these two different orientations for the controversy between miasmatism and contagionism, Ten Have sets out to demonstrate the existence of both the sociological and the biological approach in modern medicine as well. For this, he uses conflicting views as to the cause and the treatment of psychiatric diseases, alcoholism, heroine-addiction, cardiovascular diseases and cancer. Whereas, for example, traditional psychiatry is characterised by a somatic and individual orientation, the anti-psychiatry emphasises societal and social factors in the genesis and the treatment of psychiatric diseases.

Following a similar line of argument for the other examples, Ten Have concludes that the controversy between miasmatism and contagionism should be interpreted as a specimen of the ongoing debate between the sociological and biological approach which is taking place in modern medicine as well (Ten Have, 1983, p. 252):

> *'On the one hand, there is the biological approach focusing on the individual organism, looking for the causes of disease in somatic and psychic disorders of the functions and structures of the individual and directing medical treatment at the physical and mental condition of the individual or his personal patterns of behavior. On the other hand, there is the sociological approach focused primarily on the environment of man, identifying the causes of disease in the physical or social environment, in the circumstances of living, nutrition, the political system, in short in factors external to the individual, while interventions are directed at influencing these supra- individual factors.'*

Philosophy and science. Next, Ten Have widens the debate between the sociological and the biological approach in modern medicine to philosophy and science as well. Whereas, for example in philosophy, the sociological approach is associated with empirism, the theory of the tabula rasa, sensualism, and critical rationalism, the biological approach is related to rationalism, the theory of innate ideas, intellectualism, and inductivism. A similar situation can be found in linguistics where Bloomfield's structuralism is in contrast with Chomsky's transformational-generative grammar. In psychology the sociological approach is represented by associational psychology, functionalism and behaviourism, while neofreudianism, Gestalt-psychology and humanistic psychology advocate the biological approach. In biology the opposing approaches come to the fore in the controversy between nurture (environment) and nature (heredity).

Granted the existence of these contrasting approaches in philosophy and science, Ten Have then arrives at the conclusion that the controversy between miasmatism and contagionism does not stand on its own but should be viewed as a specimen of the debate between the sociological and the biological approach which exists not only in medicine but in philosophy and science as well. To this it should be added that Ten Have does not think of this debate as a dichotomy between two points of view in which one excludes the other. On the contrary, the development of medicine, philosophy and science shows the contrasting approaches to be complementary to each other to the effect that they alternatively dominate the developments in these fields.

Finally, Ten Have's conclusion that the differences between miasmatism and contagionism stand for the wider debate between the sociological and biological approach in medicine, philosophy and science, justifies the use of his results for assessing the practical bearings of Nightingale's concept of nursing.

9.2. Nightingale's approach to nursing

As far as the practical bearings of Nightingale's concept of nursing are concerned, these correspond with the sociological rather than the biological approach.

First, Nightingale considered man's physical and moral condition to be subject to the laws of nature exemplified by the uniform ways in which the circumstances of living affected man's physical and moral mode of being. In her opinion, it was, therefore, the environment which played the active role, while man was the passive recipient of environmental influences.

Secondly, to change the condition of man for better or worse required the manipulation of the circumstances affecting it, thereby effectively changing the uniform relations between the individual and his environment. Nursing, as Nightingale viewed it, amounted therefore to some sort of 'environmental engineering.' Indirectly, this interpretation is vindicated by her fierce opposition to quarantine which she liked to ridicule for its many untenable regulations, and, directly, by her political efforts to bring about sanitary reform.

Thirdly, the individual came into play only insofar as he was the one who had to take the moral decision for or against improving the circumstances in which he lived. To guard against any dichotomy between the moral and physical condition of man, it is necessary to point out once again that Nightingale held both conditions to be subject to the laws of nature. They were, however, different insofar as man's bodily condition needed to be healthy in order to develop and exercise his moral condition aright. This interrelatedness and interdependence between the individual and his environment was paralleled by an interrelatedness and interdependence on a greater scale, viz. God's wise and beneficial government of the world, which showed man to be in the hands of God. This parallelism, it is contended here, not only is similar to the classic idea of the microcosmos of man corresponding to the macrocosmos of the universe, but also exemplifies Nightingale's universalistic attitude.

Finally, at the source of Nightingale's position was her conviction that man's well-being depended not only upon the manipulation of circumstances affecting his physical mode of being (sanitation) but also upon his moral decision to adapt his own free will to the will of God. As a result of this position, Nightingale saw it as the nurse's task to help man to live by teaching him about both the inducement and the means for the manipulation of environmental factors affecting his physical condition. Thereby, she also helped him to live in a morally right way for, to the degree that man adapted his free will to the will of God, he became increasingly one with God too. This implication of her concept of nursing reflects her attitude to the multicausality and the interdependence involved in the practice of nursing.

Summing up, despite her religiously inspired references to some individualising aspects of nursing, Nightingale's concept of nursing exemplifies the self-same characteristics of the sociological approach as have been identified by Ten Have. Given that, during the second half of the nineteenth century, nursing became ancillary to medicine in which the biological approach was becoming increasingly dominant, Nightingale's concept of nursing stood little chance of general acceptance within the nursing community. What nurses did follow, however, were the sanitary measures, advocated by Nightingale, which were evidently not incompatible with the emerging bacteriological explanation and treatment of disease. In other words, Nightingale's concept of nursing, unlike many of the sanitary measures proposed by her, can be said to have died with her, and probably at an even earlier date.

10.
THE MEANING OF THE NIGHTINGALIAN MODEL OF NURSING

This chapter is concerned with the meaning of nursing which comes to the fore in the Nightingalian model of nursing to see whether this model of nursing, especially with regard to United States, marks the beginning of the conceptual development of nursing, and whether Nightingale should be seen as the founder of modern nursing.

The analysis of the Nightingalian model of nursing, put forward in the previous chapters, took off from Nightingale being characterised as a '*passionate statistician*.' Underlying her model of nursing was, namely, the religious belief that the laws of nature manifested God's laws which man had to find out by the use of statistics. The major area in which she used this approach was sanitation.

Nightingale's religious beliefs originated from her dissatisfaction with the teachings of the Christian churches which, in her opinion, amounted to mere reflection without observation, and the philosophy of positivism which she considered to result in mere observation without reflection. By combining observation (statistics) and reflection (religion), she developed her so-called positive theology which, at the end of the day, had to result in some sort of social (i.e. sanitary) reform.

Religion, as Nightingale saw it, was therefore something neither to be affirmed, for example by praying to God or by confirming the articles of faith, nor to be denied by excluding the possibility of man having any knowledge of God. On the contrary, religion required a moral commitment: it had to be lived and to be practised, for, using his intelligence to discover God's laws and his free will to adapt his behaviour to these laws, man was capable to work out his own happiness and advance towards perfection. That, she strongly believed, was the way in which God had envisaged man would learn about His character.

Further, it was Cook's (1913a) pointing to the similarities between Nightingale's positive theology and the pragmatist philosophy of his time that gave rise to the subsequent analysis of Nightingale's writings on nursing against the background of her religious pragmatism. This analysis has resulted in a reappraisal of the Nightingalian model of nursing which, in many respects, is at variance with other interpretations.

Nightingale's religious pragmatism, this highly idiosyncratic mixture of science and theology and its accessory empirical and speculative methods, which was to result in social reform, provided her with an approach which also showed up time and again in her writings on nursing and was characterised by the combination of observation, reflection, and training and experience (chapter 6, 7, and 8). Another feature which emerged from Nightingale's writings on nursing was her approach to nursing which was characterised by what Ten Have called the sociological or environmentalist approach, as opposed to the biological approach (chapter 9).

Obviously, to grasp the full meaning of the Nightingalian model of nursing one has to take into account her religious presuppositions as well as her sociological approach to nursing. Yet another way of interpreting this model of nursing is by taking Nightingale's writings at face value and using them as to suit one's purposes. Both approaches will be discussed in more detail in the following summarisation of Nightingale's concepts of nursing, nursing education and the nursing profession.

10.1. Nursing

A modern model of nursing is required to deal with at least four key elements - person, environment, health, and nursing - to be acceptable as a conceptual model for the study and practice of nursing (Fawcett, 1984, pp. 5-6). Undoubtedly, Nightingale's concept of nursing meets this requirement fully, as will be shown in the review of its key elements.

10.1.1. Person

Generally speaking, the person emerging from Nightingale's writings on nursing is a rather passive one, susceptible as he is held to be to the range of circumstances affecting his different modes of being. This interpretation seems to be vindicated by Nightingale's admonition that '*Half the battle of nursing is to relieve your sick from having to think for themselves at all - least of all for their own nursing*' (Nightingale, 1882b, p.

352), thereby implying that it was the nurse rather than the patient who was in charge of manipulating the circumstances affecting his health.

The passivity implied by man's condition being subject to factors external to him, however, is in contrast with the person's allegedly free will which enabled him to decide for or against changing these circumstances. It is on the basis of this free will that Welch (1986) has set out to reconstruct Nightingale's views on the person and arrived at the conclusion that (Welch, 1986, p. 9):

> *'Her concept of the person is multidimensional and includes the following characteristics: (1) goal of life is oneness with God and nature, (2) knowledge of God's laws gives one power over the environment, (3) happiness is dependent upon one's knowledge and capabilities, (4) freedom and free will are gained through knowledge of God's laws, (5) one utilizes one's senses, direct observation, and experience to gain knowledge, and (6) one's knowledge of truth releases one from blind acceptance of authority. This person is much more active, dynamic, and creative than the one described in the role of the patient in Notes on Nursing.'*

Welch's conclusion therefore raises the question of whether Nightingale's views on the person implied either passivity or activity, or both, on the part of the individual.

The discussion about the relationship between necessity and free will, as Nightingale viewed it, has shown that, in the final analysis, her line of reasoning was bound to end up in deadlock because of the circular reasoning it was based upon. This deadlock she tried to avoid by resorting to the fact that man has to learn by experience. The feasibility of this solution rested upon the assumption that man's different modes of being were related to each other by means of uniform relations of succession. This element of succession created an interval between one mode of being and the other, thereby giving man enough time for observation and reflection to change his behaviour accordingly. Because of this element of succession the rules of formal logic did not come into it any more. To illustrate this effect, one only has to look at the following propositions:

- she married and became pregnant,
- she became pregnant and married.

As far as formal logic is concerned, both these propositions have exactly the same meaning which can be expressed as follows: $p + q = q + p$. However, in most people's experience these propositions have quite different meanings. The explanation for this discrepancy between formal logic and human experience is the element of time which logic is incapable of dealing with, on the one hand, but which enables man to draw practical lessons from his experience, on the other hand. This was Nightingale's solution for the incompatibility of necessity and free will. Not that this should be taken to mean that every individual had to go through this process of learning by experience himself. On the contrary, it was mankind as a whole rather than each individual person who had to do this. Furthermore, this process of learning by mankind was dependent upon the emergence of so-called '*saviours'* from either physical or moral errors. What Newton, for example, had been with regard to the former, Nightingale thought herself to be as to the latter. These saviours were supposed to actively discover the laws of God, while others had to do nothing but absorb and apply the lessons contained in these laws.

Summing up, Welch's attempt to reconstruct Nightingale's views on the person was bound to fail, as Nightingale envisaged the well-being of mankind rather than the individual. Another reason may be the origin of Welch's interest in Nightingale, viz. her '*involvement in the study and organization of the baccalaureate curriculum at St. Joseph's College, which is based upon Florence Nightingale's concepts*' (Welch, p. 3). Given that, at present, curriculums which are based on modern models of nursing emphasise the concept of the person so much, Welch could not but start to look for a concept of the active person in Nightingale's concept of nursing. Therefore, her point of departure was conducive to an interpretation of this concept of nursing being determined by the interpreter's needs rather than Nightingale's original works.

10.1.2. Environment

A further argument against the alleged emphasis on the person in Nightingale's concept of nursing lies in the major role attributed to the environment, resulting in a concept of nursing that implied some sort of

'environmental engineering' rather than the idea of 'nursing the person.' This conclusion is vindicated by the typically Nightingalian combination of theology and science which was at the source of the position taken by her with regard to the controversy between miasmatism and contagionism. As pointed out earlier, the miasmatic position can be summarised as follows:

- whereas the environment is the active agent, the individual is attributed a passive role,
- medical treatment of epidemic disease is directed at manipulating the environmental causes rather than treating the individual affected by the disease,
- a universalistic attitude, implying that all relevant factors are interrelated and interdependent,
- the multicausal and interdependent explanation of disease.

As a result of Nightingale's taking sides with the miasmatists, her concept of nursing meets the criteria of what Ten Have (1983) called the sociological approach as opposed to the biological approach, for miasmatism stands for (Ten Have, 1983, p. 236):

> *'the orientation towards the environmental variables, or the environment in the widest meaning of the word: society, the pattern of living, the circumstances of living, the culture as well as the water, the air and the soil.'*

As for Nightingale's concept of nursing, this sociological or environmentalist orientation should be taken to mean that:

- man's condition was subject to the circumstances affecting it,
- to change man's condition required the manipulation of the relevant circumstances, thereby changing the uniform relations between the individual and his environment,
- the uniform relations between man and his environment enabled man to govern his existence in accordance with the laws of nature which exemplified God's government of the world (universalistic attitude),
- man's condition was subject not only to the physical but also to the moral laws of nature (multicausal and interdependent explanation).

Another way of interpreting the environment in Nightingale's concept of nursing is the appropriation of her views by modern nursing theorists. Roy, for example, interprets it in terms of her own model of nursing (Roy, 1970, p. 44):

> *'Florence Nightingale emphasized that contextual stimuli deal with environment.'*

Apart from the fact that Nightingale never used the notion of contextual stimuli, Roy clearly overlooks the fact that the Nightingale's concept of nursing has nothing to do with her own notions of stress and adaptation whatsoever. Apart from that, it would appear that the notion of adaptation fits in better with the biological approach in so far as it emphasises the adaptational resources of the individual in relation to given environmental stimuli, and not vice versa.

10.1.3. Health

The third element to be evaluated is concerned with Nightingale's views as to the nature of health and disease, the two modes of being she held to be equally subject to the laws of nature. However, because of the actual bifurcation of the field of nursing into hospital nursing, on the one hand, and district nursing, on the other, she nevertheless distinguished two branches of nursing, viz. nursing proper, or sick nursing, and health nursing, and by implication two sorts of nurses, viz. the sick nurse and the health-missioner. More importantly, though, both types of nurses had common ground in applying the self-same principles of sanitary science which constituted the laws of God with regard to the health of man's physical mode of being.

This interpretation is evidently at variance with that of others who refer to Nightingale's distinguishing sick nursing from health nursing as the basis for the distinction between hospital nursing and public health nursing (e.g. NLNE, 1927, Seymer, 1954). The latter distinction, however, resulted not so much from Nightingale's concept of nursing as from the course of events in nursing practice.

Because, long before the turn of the century, institutional nursing became ancillary to both medicine and the hospital, nurse practitioners were drawn into the biological approach which became the increasingly dominant force in medicine, thereby giving rise to the image of the nurse who works under medical direction and provides physical care for the sick in the hospital. The health-missioner, on the other hand, was to become the '*visiting nurse*,' the forerunner of the public health nurse, and this branch of nursing has always maintained close links with social work. So much so, that public health nursing, at times, came to be identified with '*social service*' as opposed to '*institutional service*.' As a result, and in contrast with the nurse practitioners in hospitals, public health nurses were also more aware of the importance of social factors in nursing practice.

However, the bifurcation of institutional and social service, as it emerged in the United States, was not implied by Nightingale's concept of nursing. To arrive at this bifurcation on the basis of her writings on nursing is only possible by taking them at face value and by refraining from an in-depth analysis of Nightingale's concept of nursing which indicates that, in the final analysis, both sick nursing and health nursing amounted to a religiously inspired, sanitary approach to nursing.

10.1.4. Nursing

Nightingale admittedly acknowledged that she used the word '*nursing'* for want of a better one, and rightly so, for nursing in the sense of mothering or nurturing a child, or, for that matter, hospital nursing as it was known at the time, was not quite what she had in mind when using this word. For her, nursing was the art and science of applying the sanitary principles, discovered by means of statistics and manifesting God's law. Because of this ambiguity, the nursing actions which were outlined in her writings on nursing are open to two rather different interpretations, and, in my opinion, they were meant to be that way.

One interpretation is based on the sanitary implications, the other on the religious presuppositions of her concept of nursing, and, with the notable exception of Welch (1986), most historians tend to the former rather than the latter interpretation. This is not to say that historians have failed to acknowledge Nightingale's interest in religious matters. On the contrary, but only Welch goes so far as to contend that (Welch, 1986, p. 6):

> *'If Suggestions for Thought contains the foundations of her philosophy, then Notes on Nursing reflects the application of her philosophy.'*

However, to grasp the full meaning of Nightingale's concept of nursing, the interpretation must be based upon both its presuppositions and implications. For, in Nightingale's opinion, it was by helping the patient to live physically that the nurse helped him to develop and exercise his moral mode of being according to God's will as well. These moral aspects were essential to her concept of nursing.

10.2. Nursing education

The analysis of Nightingale's writings on nursing has shown her concept of nursing education to be a corollary of her concept of nursing. As for nursing education, Nightingale held the opinion that observation and reflection were to lead up to the training and experience needed to learn more and more about the character of God. On the other hand, Nightingale is known to have also been involved with the more down-to-earth matters involved in running a training school of nursing. Consequently, it is possible to interpret her writings on nursing education in two ways as well, either as a corollary of her concept of nursing or as reflecting her administrative involvement in running a training school.

But here it is the religious interpretation which most truly reflects Nightingale's thinking. When she, for example, stressed the need for special homes for nurses to enhance each nurse's 'esprit de corps' (Nightingale, 1882a and 1893), it was not so much an administrative measure to safeguard a place of living for nurses as a way of enhancing the religious inspiration needed for the daily practice of nursing she hinted at.
Furthermore, Nightingale's writings on nursing education, too, have given rise to interpretations which tell more about the interpreter's frame of reference than Nightingale's. Barritt (1973, p. 10), for example, following the outcome of Newton's thesis (1949), uses Nightingale's religious beliefs to infer a human right to health and education:

> *'These deep religious convictions made service to God her basic goal in life, according to Newton. To Miss Nightingale, serving God meant serving mankind. Since she believed that every human being had the right to health and to education, she made better health and better education her two objectives. The Nightingale Training School for Nurses embodied these two underlying aims that guided Miss Nightingale throughout her life.'*

This interpretation, however, is suggestive as to the struggle for professional education of nurses in the United States during this century rather than the religious pragmatism underlying Nightingale's concept of education.

10.3. Professional nursing

Finally, Nightingale's religious pragmatism was also at the source of her opposition to the notion of a profession of nursing for, in her view, the nurse was called by God to acquire skills of observation and reflection in order to gain experience in applying the laws of health, and this implied a life-long process of learning by experience and careful inquiry.

Notwithstanding the ample historical evidence corroborating this position of hers, not even Cook (1913a, p. 445) managed to escape from the conclusion that Nightingale not only '*recognized that nursing was an art and a science*,' but also that '*she raised it to the status of a profession*.' Worse still, Roberts (1937), although aware of Nightingale's position on this controversy, could not resist presenting her as being in favour of professionalisation by simply resorting to a definition of a profession that was not incompatible with Nightingale's notion of a calling, viz. '*a vocation, by implication gainful, involving the individual and thoughtful application of a considerable body of organized knowledge in self-identifying service to others for the good of society*' (1937, p. 775).

On the other hand, one of Nightingale's real contributions to nursing undoubtedly was (Smith, 1982, p. 155):

> *'to identify it in the public mind with sanctified duty. Contrary to nursing folklore, she neither invented modern nursing behaviour nor even the idea of nursing as a calling. But by bestowing her imprimatur upon secular vocational nursing she gave it standing in Victorian Britain and throughout the world.'*

This contribution, however, appears to have had an inhibiting rather than a stimulating effect on the development of professional nursing, as nursing's image of '*sanctified duty*' effectively pre-empted any efforts on the part of doctors, hospital administrators, and the general public, to meet the profession's demands for improvements in both nursing education and nursing practice.

One advantage of this ambivalent attitude towards nursing was that it has forced nurses to continuously identify and articulate their concept of professional nursing in order to achieve the profession's objectives.

10.4. Florence Nightingale: myth versus reality

As far as the conceptual development of nursing is concerned, there are two major reasons why Nightingale should not be seen as the founder of modern nursing. One of the reasons has to do with the religious presuppositions of the Nightingalian model of nursing, i.e. her religious pragmatism which has been shown to result in nothing less than a theological model of nursing; the other has to do with this model's sanitary implications. Between them, these presuppositions and implications resulted in a so-called sociological approach to nursing, as opposed to the biological approach (Ten Have, 1983).

As for the further development of modern nursing, the typically Nightingalian combination of religious presuppositions and sanitary implications, as well as the sociological approach that went with it, have evidently failed to gain much support in the nursing community in the United States. In fact, history, as will be demonstrated in the following chapters, shows that American nurses have gone their own way to the effect that the models of nursing to emerge in the United States can not possibly have originated in the Nightingalian model of nursing.

These conclusions raise the question of whether Nightingale's life and work have had any real significance in the development of modern nursing at all. This, it seems to me, is beyond doubt, albeit in the role of the living

legend of nursing, which was reinforced by the image of the lady with the lamp rather than the founder of modern nursing. And, as for her image of the lady with the lamp, a legend cherished by so many of her biographers, it remains to be seen whether this image has not been detrimental rather than beneficial to the development of nursing for (Baly, 1969, p. 4):

> *'... living in the shadow of a legend is not an unmitigated blessing. Exhorted to the "Nightingale spirit", praised as "ministering angels," sicklied o'er with pale cast of sentimentality, nurses have tended to cling blindly to the tradition that raised them to such a pinnacle. To question the system was le`se-majeste', and this bred orthodoxy; conformity operates against reform. In spite of some enlightened questioning, the profession has tended to look back to its days of glory and has chosen not reform, but a crown of thorns.'*

This conclusion was arrived at after analysing the development of nursing in Great Britain. This study, however, focuses on the conceptual history of modern nursing in the United States and, as yet, it is open to debate whether the legend of Florence Nightingale has exerted a beneficial influence on American nursing or not.

PART III
INDIVIDUALISED NURSING

After the introduction of the Nightingale training school for nurses in the United States in 1873, American nurses were quick to abandon the Nightingalian model of nursing. It took, however, more than half a century to develop an alternative, viz. the model of individualised nursing, which is the subject of this part of the study.

The point of departure is the historical situation which gave rise to the model of individualised nursing as opposed to the model of functional nursing. Right from the start, both these models encompassed their own concepts of nursing, nursing education, and professional nursing, which are analysed as to the categories which make up these concepts.

In the ensuing conceptual development, it was undoubtedly nursing education which played a pivotal role. For this reason, the analysis focuses on the concepts of nursing, nursing education, and professional nursing underlying the three consecutive editions of the Curriculum, published by the National League of Nursing Education in 1917, 1927, and 1937. Apart from revealing the presuppositions and implications of the model of individualised nursing as they developed in the evolutionary stages of the model, the analysis also shows that, in order to understand this model of nursing, it is necessary to analyse the opposing model of functional nursing as well.

Next, the use of the case method in nursing will be shown to demonstrate the various applications of the model of individualised nursing in both nursing education and nursing practice. Incidentally, this part of the analysis also pointedly reveals that the individualising trend in nursing care was strongly influenced by the development of the profession of social work.

All in all, the model of individualised nursing was clearly the outcome of the early conceptual development of American nursing from 1873 until 1937. This development was characterised by a dramatic shift of emphasis from the environment to the individual as the main unit of consideration in nursing. As a result, the early conceptual development of nursing in the United States, although stimulated by Nightingale's writings, took quite a different direction. Moreover, it was a development which was dominated by the differences between the models of functional nursing and individualised nursing. This, too, was a departure from the Nightingalian model of nursing which thrived upon the differences between miasmatism and contagionism. Finally, the genesis and evolution of the model of individualised, as well as its application, added up to a change from the sociological to the biological approach in nursing (Ten Have, 1983).

11.
THE EARLY CONCEPTUAL DEVELOPMENT OF MODERN NURSING IN THE UNITED STATES

Many modern nursing theorists, in spite of the somewhat dutiful references to the Nightingalian model of nursing, tend to think of the start of the conceptual development of nursing as coinciding with the publication of `Nursing for the future' (Brown, 1948). As a result, the preceding period is regarded as an interval between the `*classic'* Nightingalian model of nursing, on the one hand, and the `*renaissance'* of conceptual thinking in nursing in 1948, leading up to the `*modern'* models and theories of nursing of the 1970s, on the other hand. This interval should then be viewed as the '*dark period*' in the conceptual development of nursing, a view which can be shown to be in sharp contrast with the facts for this period gave rise to the model of individualised nursing to be analysed here. To grasp the meaning of this model it is necessary to first elaborate on some of the landmarks in the early history of modern nursing in the United States insofar as they helped to create the climate for the model of individualised nursing to emerge.

11.1. The introduction of the Nightingale training school for nurses

By common consent, the beginning of modern nursing in the United States dates from 1873 when the Nightingale training school for nurses was introduced. The three bearers of the Nightingale tradition were the Bellevue School in New York, the Connecticut Training School in New Haven, and the Boston Training School which later became the Massachusetts General Hospital Training School in Boston. Initially, the American schools of nursing tried to copy the principles laid down for the original Nightingale training school for nurses which were to safeguard the school's educational, administrative, and financial independence. Within less than two decades, however, most American training schools were firmly in the grip of the hospitals.

11.1.1. The aims of the training school for nurses

Originally, the Nightingale training school for nurses was aimed at training nurses for hospital services, district nurses for the sick poor, and nurses to train others. In addition to these educational objectives, the early American schools of nursing were also characterised by more service-oriented objectives. The Bellevue School, despite its close contact with Nightingale herself, presents the most striking example of this ambiguity between education and service (in: Roberts, p. 12):

> *`The object ... is the training of nurses for the sick in order that women shall find a school for their education and the public shall reap the advantage of skillful and educated labor.'*

The major problem was which of these objectives came first, the social and economic or the educational function of the nursing school. Gradually the idea began to take shape that safeguarding the former function would automatically guarantee a good training as well, a situation summed up so well by the slogan `*service for education*'. From the idea of training as a by-product of service it was only a small step to regard the nursing school's one and only raison d'être to be the supply of nursing service. Apart from the school's educational objectives being increasingly watered down, there were other factors at work which were threatening the independence of the early nursing schools. These threats came from the medical profession, the hospitals, and the fact that, after graduation, nurses left the hospital for private duty nursing.

11.1.2. The medical profession

In 1869, prompted by the experience with women volunteers during the civil war - this was not the last time the development of nursing was to be contingent upon a war situation - the American Medical Association's Committee on the Training of Nurses pressed for the training of nurses. Contrary to the advocates of the

Nightingale system, however, this committee, following the practice of nursing schools in Germany at the time, recommended that the training of nurses should be placed under the control of the medical profession. In her letter of advice to the Bellevue School Nightingale rejected this approach, which jeopardised the educational independence of the training school, in the strongest possible terms (Nightingale, 1872). Ironically, however, the first American nurse to graduate, Linda Richards, was trained in such a medically controlled school at the New England Hospital for Women and Children in Boston but, after her graduation in 1872, she became one of the most outspoken advocates of the Nightingale system.

What the medical profession was unable to achieve by means of the committee's recommendations was brought about as a result of the dramatic changes in the practice of medicine during the 1880s. New surgical methods as well as antiseptic and aseptic techniques and new treatments were introduced at such a speed that doctors, overwhelmed by the new technical procedures, were forced to delegate parts of their work, e.g. temperature taking, to others, i.e. the nurses.

As a result of these advances in medicine, the hospital became the workshop of the physician and the surgeon, and the practice of nursing was transformed with the effect that, at the turn of the century, the American textbooks of nursing bore little resemblance to Nightingale's `Notes on nursing' anymore. Moreover, nursing came to be interpreted as the art (Lockwood, 1909, p. 940):

> *`to establish and maintain such condition of person and surroundings that the discomfiture incident to illness be borne with a minimum of distress, and to administer such remedies and treatment for the alleviation of suffering, and the removal of the cause of illness, as are ordered by the medical profession ... and to do this in a professional manner.'*

In addition, the same author continued, the time had not yet come when (Lockwood, 1909, p. 941):

> *`that part of medicine which is absolutely settled and worked out may be given to the profession of nursing as its rightful field literally.'*

What all this adds up to is that, at a very early stage, nursing became ancillary to medicine and loyalty to the doctor came to be seen as the highest ethical principle of conduct for nurses.

11.1.3. The hospitals

Given the initial emphasis on the nursing school's independence, hospital boards were not queuing up to accept a training school on their premises. The reason some did was probably a combination of the increasing need for nurses and the lack of financial resources, a situation worsened by the economic depression which lasted from 1873 till 1878. Schools of nursing were therefore accepted on the condition that the school would supply the increasing number of nurses needed by the hospital. In return, the money which used to be spent on paid nursing staff was transferred to the training school. After the training schools had proved to be a financial asset rather than a liability to the hospitals, they were absorbed in the hospital's administrative structure, thereby effectively putting an end to the school's independence.

The transfer of control from the school to the hospital was not only a major diversion from the original Nightingale system, it also added an administrative and financial dimension to the slogan `service for education'. As a result, the training school for nurses changed into a hospital school, thereby blurring the distinction between nursing service and nursing education for many years to come.

How attractive the hospital school was, can be measured by the number of schools increasing from 3 in 1873, to 15 in 1880, 225 in 1896, 432 in 1900, 1,129 in 1910, 1,775 in 1920, and 2,155 in 1928. After the 1890s, the increase virtually paralleled the number of newly founded hospitals. Whereas, during the first thirty years of this century, the population of the United States increased by 62 per cent, the number of trained nurses increased by 2,374 per cent. This decrepancy shows the increase of the number of nursing schools to be related to the expansion of hospital care rather than the growth of the population at large, or, as McIsaac put it when she reported the findings of her fact-finding visits to schools of nursing all over the country (1912, pp. 876-877):

`the establishment of nursing schools solely because they afford a cheap way of getting the hospital nursing done. ... At the same time it must be admitted that in order to get the hospital work done nearly every if not all hospitals in the country are compelled to admit undesirable candidates.'

After 1928, for reasons to be explained later, the number of schools decreased to 1,843 schools in 1930, 1,311 in 1940 and 1,190 in 1950.

11.1.4. Private duty nursing

The decreasing independence of the training schools was also furthered by the fact that, after graduation, most nurses left the hospital for private duty nursing. This, too, was in sharp contrast with the Nightingalian emphasis on the `esprit de corps' which required graduate nurses to stay and live in a nursing home (Nightingale, 1893, pp. 32-33):

`The want of these [nursing homes] is more especially felt among private nurses. ... The danger is that the private nurse may become an irresponsible nomad. She has no home. There can be no esprit de corps if the `corps' is an undistinguishable mass of hundreds, perhaps thousands, of women unknown to her, except, perhaps, by a name in a register. All community of feeling and higher tone absents itself. And too often the only aim left is to force up wages.'

The religious connotations of Nightingale's concern apart, she has proved to be right in forecasting the individualistic attitude of the private duty nurse who cherished her economic independence and the one-to-one relationship with her patients rather than opting for providing nursing care to the community at large by means of central registries.

The effect of graduate nurses leaving the hospital was that the nursing service was depleted of graduates with their growing experience and expertise. Since some sort of leadership was required on the wards, the nurse's training was gradually extended from a one-year to a two-year course so that student nurses could act as head nurses during the second year of their training. This practice, too, was a deviation from the original Nightingale system in which the head nurse had to play a major role in teaching the probationers.

On the other hand, the phenomenon of private duty nursing helped to highlight the limitations of the institutional preparation for private duty nursing. Whereas most nurses were well-trained in acute hospital work, in the management of a ward and in surgical nursing, many were ill-equiped for the intricacies of nursing patients in their own homes.

Finally, private duty nurses have contributed remarkably little to the professional development of nursing. Nevertheless, this branch of nursing has remained `the model against which nurses, physicians, and patients - consciously or unconsciously - still continue to measure their expectations of what nursing is or should be' (Brown, 1966, p. 181).

11.1.5. The central theme: service versus education

What all the more or less important differences between the American and the Nightingale system of training nurses added up to was that the training of nurses came to be confined to the two year course of training, the content of which was determined by advances in medicine and the needs of the hospital in which the nurse was trained.

The issue of primacy between the two objectives of training schools for nurses had evidently been decided upon in favour of its economic and social functions (Hampton, 1893, p. 4):

`The object of schools for nurses is primarily to secure to the hospital a fairly reliable corps of nurses; and it is in order to ensure a continuous source of supply that such schools are established and certain inducements are offered to women to become pupils in them.'

As for the relationship between medicine and nursing, doctors frequently expressed their concern about the danger of overeducating the nurse (in: AJN, 1904, pp. 488 and 492):

> *`... thanks to the great advance made in nursing in our day, we physicians can usually have our directions and treatment of patients intelligently and faithfully carried out if we constantly have the courage to insist upon what is best for the well-being of our patients and our moral self-respect. I am not quite so sure that the nurse's realization of the doctrine of self-sacrifice and devotion has continuously improved. I am also convinced that more than one subject nurses are taught about at some length in the schools had better be let alone. This acquired smattering of anatomy, physiology, and therapeutics is often of practical detriment in the role of the nurse. They are tempted, with imperfect knowledge, to give counsel or direct at times when they should seek only to comfort and serve.'*

In addition, few nursing leaders held the opinion that training schools should prepare nurses for a wider service than the hospital in which they were trained, despite the growing diversification of nursing practice (private duty nursing, public health nursing). Some nurses, however, held the opinion that nurses were in need of a more sound educational system to be substituted for the training provided by the hospitals, or, as Goodrich put it in 1912 (in: Roberts, 1954, p. 77):

> *`Our place ... has been found in institutions of the sick, but we shall never render our full service to the community until our place is also found in the university.'*

On the face of it, Goodrich drew attention to the contrast between hospital training and university education but in her statement another contrast was implied as well, viz. between service to the hospital and service to the community. Between them, the two lines of Goodrich's argument assumed nursing to be identified not so much with the physical care of the sick in the hospital as with `*the pursuits by which human life, human development, and human health are conserved*'. The latter view of the nature of nursing was first articulated in 1909, at the introduction of the University of Minnesota School of Nursing which claimed to be the first university school of nursing, and foreshadowed the emergence of the issue of `*training versus education*' in American nursing. To grasp the full significance of this issue, however, one also has to take into account its corollary, viz. the controversy between service to the hospital and service to the community which will be dealt with shortly.

11.2. `Nursing of the sick'

The second landmark in the history of modern nursing in the United States was the International Congress of Charities, Correction, and Philanthropy, held in 1893, at the World's Fair in Chicago. In the report on this congress, it is the third section, entitled `Hospitals, dispensaries and nursing', in which nurses figured most prominently (Hampton et al, 1893). The third part of this section bears the title `Nursing of the sick' and includes 29 papers presented at the congress.

Given that, in 1893, nurses were too few in number to make themselves felt nationwide, it is somewhat surprising to find nurses taking part in an international congress. On the other hand, the number of nursing schools had increased dramatically from 15 in 1880 to approximately 200 in 1890, and the Chicago meeting provided an excellent forum for discussing the standards for the education of nurses, an opportunity readily seized upon by Mrs. Bedford Fenwick and Ms. Isabel Adams Hampton (Robb). This probably explains why this meeting is remembered primarily for its papers on nursing education, although the collection of papers as a whole also foreshadowed the growing ramification of nursing practice into hospital nursing, private duty nursing, and public health nursing.

Another significant feature of this congress was that it was the international equivalent of the National Conference of Charities and Corrections, which had been taking place in the United States since 1874. History doesn't tell us why nurses and social workers were gathering at one and the same congress but its name, the International Congress of Charities, Correction, and Philanthropy, suggests that, in 1893, both nursing and social work, and hospitals and dispensaries for that matter too, were thought of as a charity rather than a public service. Also, this feature exposes nursing as a response to social needs rather than medical needs, or, to the needs of society rather than those of the hospital, resulting in the division of nursing practice into `*institutional service*' and `*social service*'.

11.2.1. Public health nursing

In the development which gave rise to the division between institutional and social service, public health nursing played a pivotal role. The history of public health nursing started with the introduction of district nursing, aimed at the care of the sick in their homes by trained nurses, in the United States. Like the hospital training of nurses, the idea of district nursing originated from England.

In 1893, Lilian Wald founded the Henry Street Visiting Nursing Service to combine district nursing with the idea of the social settlement which was aimed at improving social conditions affecting health. Whereas the period between 1893 and 1912 is chiefly known for the rapidly increasing number of training schools for nurses, it was also a period in which the number of visiting nurses increased from 200 in 1900 to 3,000 in 1912.

Initially, visiting nurses were expected to adapt the art of hospital nursing to home situations, but, in the end, they did much more than that by developing the educational function of nursing which was first emphasised by the name `*instructive visiting nursing*' and later by Miss Wald prefacing Nightingale's `*health nursing*' with the word `*public'*. As a result, public health nursing entailed not only skilled nursing for the sick but also participation in immunisation and case-finding programmes, and persuasive teaching of health principles in homes, schools, hospitals, industries, clinics, and health centres.

The major impetus for this development was given by preventive medicine and the subsequent emphasis on health preservation, while hospital nursing followed more or less the footsteps of curative medicine and surgery. Whereas nursing in the hospital was a spin-off of the increasing number of hospitals, visiting nursing thrived on what came to be called the new public health movement in which the visiting nurse became the most important figure (Roberts, 1954, p. 83):

> *`How had the visiting nurse attained such stature? By making herself a welcome visitor in the homes of the sick. Her demonstrable nursing skills gave her an entree to households confused by the sudden onset of illness. Her insight into the social and economic problems that caused or were contributory to the illness and her skill in helping families to care for the illness and to solve some of the underlying problems made her a dependable family friend. Broadly speaking, the visiting nursing services at the turn of the century were giving what was later to become known as a generalized service.'*

The transition from visiting nursing to public health nursing brings our attention to yet another significant aspect: the relationship between the visiting nurse and the social worker, who was known as the `*friendly visitor*' at the time. At the turn of the century, both types of workers were concerned with social and economic problems, although the visiting nurse dealt with matters of health and disease in relation to social and economic problems, while the friendly visitor focused on these problems more directly. This proved to be the start of a relationship that will be analysed later. At this point, it is sufficient to establish the growing concern with the social, preventive and teaching elements in public health nursing.

11.2.2. The public health movement

As mentioned earlier, the emergence of public health nursing was prompted by the public health movement. The major assumption of this social movement was that (Winslow, 1923, pp. 1-2):

> *`life and death are not merely dispensations of divine providence but lie within the control of the human mind and the human will.'*

Its origins go back as far as the first half of the nineteenth century when `*... the development of the scientific spirit ... made it possible for the first time to grasp clearly and confidently the possibility of a practical amelioration of the conditions of existence*', and `*the growth of a new motive of humanitarianism ... compelled vigorous efforts to accomplish such an amelioration in the interest of that portion of the human race which had hitherto labored under an accepted curse of misery and suffering*' (Winslow, 1923, p. 12). The scientific spirit and the motive of humanitarianism, the self-same combination of science and morality which dominated the Nightingalian model of nursing, gave birth to the three main periods of the public health movement:

- the period of empirical environmental sanitation (1850-1890),

- the period of scientific control of communicable disease by the application of bacteriology (1890-1910),
- the period of the new public health movement (1910-1920).

Empirical environmental sanitation. The most famous advocate of sanitary reform in Britain was Edwin Chadwick (1800-1890). He was the author of `Sanitary condition of the labouring population of Great Britain' (1842). In the United States, it was the `Report of the Massachusetts Sanitary Commission', better known as the `Shattuck Report' after its author Lemuel Shattuck (1850), which, in a similar vein, called for sanitary reform. Most significantly, both Chadwick and Shattuck were not medical men but statisticians and students of social problems. As for the latter report, it recommended, among other things, that (in: Roberts, 1954, p. 8):

> *`... institutions be formed to educate and qualify females to be nurses of the sick ... bad nursing often defeats the intention of the best medical advice, and good nursing often supplants the defects of bad advice. Nursing often does more to cure disease than the physician himself, and in the prevention of disease and in the promotion of health, it is of equal and even of greater importance.'*

Chadwick and Shattuck were far ahead of their time so that it was not until 1870 that the sanitary movement began to bear fruit on both sides of the Atlantic. What a public health programme at that time involved, can be illustrated by the fundamental health essentials listed in the report of the Royal Sanitary Commission in Britain, published in 1871: the supply of wholesome and sufficient water for drinking and washing, the prevention of the pollution of water, the provision of sewerage and utilisation of sewage, the regulation of streets, highways, and new buildings, the healthiness of dwellings, the removal of nuisances and refuse and consumption of smoke, the inspection of food, the suppression of causes of disease and regulations in case of epidemics, the provision for the burial of the dead without injury to the living, the regulation of markets, etc., public lighting of towns, and the registration of death and sickness (Winslow, 1923, p. 28). In short, all the sorts of things which were also very much in evidence in the writings of Nightingale. Finally, it goes without saying that sanitary reform in those days was based upon the miasmatic explanation of disease.

Scientific control of communicable disease by bacteriology. The second period of the public health movement was the result of the work of the Frenchman Louis Pasteur (1822-1895) who established the science of bacteriology and immunology. Whereas the former made it possible to check the spread of germs, the latter opened the way for building up specific resistance against them. At the end of this so-called `*golden age of bacteriology*' Winslow (1911, p. 909) characterised the public health movement as follows:

> *`It would be somewhat more than a play with words to say that the campaign for public health is passing at present through a humanistic stage. In other words attention is directed to the human body as the source and centre of disease rather than the more remote environment which filled so large a place in the thoughts of an earlier generation. Sanitarians of thirty years ago were mainly concerned with the dangers from swamps and refuse heaps and plumbing pipes and fomites. We are not greatly exercised about these things but focus our attention chiefly upon the original source of the disease germ, the infected human body, whether of the frankly sick or of the carrier class. The emphasis is upon persons where it was once chiefly upon things.'*

Twelve years later, while looking back upon this period, Winslow (1923, pp. 36-37) observed:

> *`The two decades between 1890 and 1910 formed in a sense the golden age of public health. The germ theory was now thoroughly established and its applications went forward by leaps and bounds. No previous period of twenty years had ever seen equal progress in the application of sanitary science and it is doubtful if any similar period in the future will ever witness quite such phenomenal achievements.'*

Apparently, and in spite of the change of emphasis he himself had noted earlier, Winslow considered the germ theory and its applications to be part of sanitary science, as he mentioned sanitation, isolation, and vaccine and serum therapy as equally important elements of the public health machinery during this period. On the other

hand, he also welcomed the improvement of the `*shotgun methods of empirical sanitation and the empirical isolation of earlier days*' which indicated his agreement with the growing awareness that `*filth, if not the mother, is at least the nurse of disease*' (Winslow, 1923, p. 37). The ambiguity of Winslow's description of the second period of the public health movement shows to what degree he evaluated this period within the framework of what Ten Have (1983) has coined the sociological approach.

The new public health movement. The third period of the public health movement entailed the change from an environmentalist to an individual approach (Goldmark, 1923, p. 39):

> *`The distinguishing mark of the new public health work is its emphasis on the individual - man, woman, and child; and their education in habits of hygienic living. So marked has been this new concentration on the individual, that, in the words of a leader in the field [Winslow] "what was `the new public health' of fifteen years ago includes only the more conventional interests of the present day." These more conventional interests center, broadly speaking, on factors of environment. Sanitation and the control of infections, the achievements of the engineer, the bacteriologist, and the epidemiologist, - these have been and continue to be, fundamental to progress in public health.*
> *Yet the sole emphasis on factors of environment ignores the eternal interplay and interrelation of the twin forces which have moulded human destiny: the objective and the subjective, external and internal. Without the intelligent co-operation of the individual, science fails to achieve its maximum benefits. Without the education of man, the conquest of environment is barren of value. Hence a fundamental shift in the accent of modern public health work. The personal conduct of life! This is the new, yet age-old point of attack.'*

The emphasis upon the individual was prompted by experiences during the campaign against tuberculosis which had started as early as the 1890s and indicated the need for new approaches in dealing with the problems of disease, e.g. the open-air method of sanitorium treatment, dispensaries for the early detection and supervision of ambulant cases, visitation of home cases plus instruction in sanitary and hygienic principles, systematic examination and hygienic care of contacts, follow-up and after care for the arrested cases, and by spreading the message of cure: fresh air, food, exercise and rest.

The common denominator of all these activities was `education' which became the keyword of the new public health campaign. The campaign as a whole was based on the idea of bringing hygienic knowledge to each individual and was aimed at both the prevention of disease and the preservation of health. It was at this point that the public health nurse came in (Winslow, 1923, pp. 55-56):

> *`Personal hygiene is after all a very personal matter. The kingdom of health, like the Kingdom of God, is within you. It was essential to utilize some more direct and more individual agency to carry the gospel of health to the individual in the form adapted to that particular individual's needs; and in the person of the public health nurse has been found the ideal agent for carrying the message to Garcia.'*

The recognition of the visiting nurses' role in the new public health movement was reflected in the increase of their numbers from 3,000 in 1912 to 6,000 in 1916 and 11,000 in 1923, although 50,000 were thought to be needed at that time. In the process, visiting nursing was gradually replaced by public health nursing and its special branches in which the education of the individual proved to be essential, viz. tuberculosis nursing, child welfare nursing, school nursing, mental hygiene nursing, industrial nursing, and medical social nursing (Gardner, 1916).

Apart from `*the education of the individual in the principles of healthy living*', the new public health movement also needed a medical service for the detection and the early treatment of incipient disease as `*Education in personal hygiene, if it is to be intensively adapted to the individual, must be based on medical diagnosis*' (Winslow, 1923, p. 57). Finally, nurses and doctors made use of new methods to run their educational campaign, like health bulletins, health news service, health lecture bureaux and institutes, health cinemas, and so-called health radiograms.

11.2.3. The central theme: institutional service versus social service

By responding to the opportunities offered by the public health movement, visiting nurses added a new dimension to nursing as a whole (Nutting, 1912, p. 11):

> *`Nowhere, ... has the growth of opportunity for nurses been so great as in the field which may be broadly termed that of social wellfare. Under the form and title of district and visiting nursing, a system of activities has been developed which makes of the nurse not only a skilled agency for the suffering, but a teacher of sanitary and healthful living, and a power for the prevention of disease. This is looked upon as one of the most promising movements of modern times for social betterment.'*

As a result of their increasing involvement in the social betterment of the population, visiting nurses brought about a bifurcation of nursing practice into institutional service and social service (Dock, 1912a, pp. 213-214):

> *`The most prominent variation of the old to the new type of nursing is that called `social service' (the word `service' being a current technical term in use in hospitals), as distinguished from institutional service. The term arose naturally, yet we may ask whether Miss Nightingale's expression `health nursing' is not truer and more selfexplanatory.'*

Subsequently, it became more questionable still to what degree hospital schools prepared nurses for this social service, as many nurses turned to Teachers College at Columbia University for a postgraduate course on the administration and teaching of visiting nursing. In 1912, the term `*public health nursing*' was adopted for this course. In addition, this distinction between institutional and social service was instrumental in creating the controversy between hospital training and university education in nursing.

During the transition from the second to the third period of the public health movement, public health nurses turned their attention from social and economic problems to the individual patient. This change of emphasis was matched by a similar development in the work of friendly visitors who switched from a `*social action*' approach to a case-by-case approach, resulting in what came to be known as `social casework' (Richmond, 1923). Although both professions arrived at this individual approach along different routes, to be discussed later, it was this focusing upon the individual which put the final touch to the model of individualised nursing in the 1930s.

What all this adds up to is that the early development of modern nursing in the United States, although prompted by advances in curative medicine and stimulated by the increasing number of hospitals, received a major impetus from altogether different quarters as well, viz. preventive medicine, the new public health movement and social work. As a result, nurses became increasingly concerned with social welfare as opposed to health care. How significant this development was, can be inferred from Goodrich's famous dictum that, in the final analysis, `*all nursing is public health nursing*', and that `*every nurse is, or should be rendering social service*' (Goodrich, 1932, p. 62).

11.3. `Educational status of nursing' (1912)

The third landmark in the history of modern nursing in the United States was Nutting's `Educational status of nursing' (1912). This study of the problems of the training schools for nurses was inspired by Flexner's `Medical education in the United States and Canada' (1910), a report which had not only resulted in the grading of medical schools but proved to be instrumental in weeding out the poorer schools too. Nutting's study was presented to the Carnegie Foundation requesting that the Foundation make a study of the relationship of training schools to hospitals, and in fact of the whole question of nursing education. Although the president was much interested in the matter, it was impossible to undertake the work at the time, owing to the fact that all energies were concentrated in other directions.

Apart from the problematic relationship between the training school and the hospital, the institutional training of nurses proved increasingly inadequate for the fast expanding social service provided by public health nurses and, to a certain extent, by private duty nurses as well.

Given this state of affairs, some regulative measures were needed to ensure intelligent and safe nursing care. In other words, the problems which confronted the nursing profession in 1912 called for the nationwide organisation of nurses aimed at `*better schools, better nurses, better service*' (McIsaac, 1912). It was, therefore, no coincidence that in 1911 and 1912 the three national nursing organisations were founded.

The emergence of the national nursing organisation rekindled the issue of whether nursing was a profession or not. Until then, most American nurses had assumed that, without further qualification, nursing was indeed a profession, in spite of Nightingale's (1893) stressing that nursing was a calling. The American position on the issue of `profession versus calling' was clearly expressed by Robb (1901, p. 33):

> *`In speaking of nursing as a profession for women, I have used the term advisedly. Some prefer the term vocation, or the Anglo-Saxon word, calling. The last, if made to bear the significance of a direct call from God to a consecrated service, would rather suggest, on first thought, a sisterhood with its religious restrictions; and surely profession means all that vocation does and more. The work of the clergy, the lawyer and the physician is spoken of as a profession; the term implies more responsibility, more serious duty, a higher skill and an employment needing an education more thorough than that required in some other vocations of life.'*

More then ten years later, all religious connotations except for the requirement of altruism seemed to have dissappeared (Goodrich, 1912, p. 777):

> *`... the word (profession) implies attainment in special knowledge as distinguished from mere skill; a practical dealing with forces as distinguished from studies and investigation; and an application of such knowledge to use for others as a vocation as distinguished from its pursuit for one's own purpose.'*

As a result, the Nightingalian issue of `*profession versus calling*' gradually changed into the issue of the `*trained nurse*' versus the `*professional nurse*'.

11.3.1. The national nursing organisations

The years 1911 and 1912 saw the foundation of three national nursing organisations:

- American Nurses' Association (1911),
- National League of Nursing Education (1912), and
- National Organisation of Public Health Nursing (1912).

In 1896, the Nurses' Associated Alumnae of the United States and Canada was founded to create a smoothly functioning national association of professional nurses and to secure legal registration of nursing in all states by means of so-called `Nursing practice acts'. In 1911, the name was changed into American Nurses' Association. As a result of the subsequent affiliation with the American Red Cross, the ANA gradually moved to the position that nursing was a national service.

In the wake of the Chicago meeting in 1893, the American Society of Superintendents of Training Schools for Nurses of the United States and Canada (1894) was founded to (Roberts, 1954, p. 25):

> *`advance the best interests of the nursing profession by establishing and maintaining a universal standard of training, and by promoting fellowship among its members by meetings, papers, and discussions on nursing subjects and by interchange of opinions.'*

One of the first decisions made was to set up a curriculum committee. In 1912, the name was changed into the National League for Nursing Education. The work of the curriculum committee resulted in three consecutive editions of the Curriculum (NLNE, 1917, 1927 and 1937). Right from the start, the NLNE strove for the kind of education for nurses upon which it was possible to build a professional career in whatever branch of nursing a nurse preferred to work. Such a career did not, however, include administrative and teaching positions in nursing, for which it was necessary to take a postgraduate course.

Also in 1912, the National Organization for Public Health Nursing was brought into existence, because, as the American Journal of Nursing reported at the time (AJN, 1912a, p. 769):

> *`The social workers, including visiting nurses, school nurses, tuberculosis nurses and every other kind of a nurse in the social field, turned out in such forces that they made practically a good sized convention of their own.'*

In contrast to the older organisations whose members felt a great affinity with the hospitals and the schools in which they had been trained, the NOPHN was open to lay members, and demonstrated great interest in cooperative relationships with other health and social agencies. As a result, the NOPHN became some sort of a pressure group in relation to the other organisations, always reminding them of community needs as opposed to the needs of individual hospitals.

Moreover, the NOPHN leaders were quick to see the new opportunities in the field of public health nursing for the nursing profession as a whole, and were responsive to social needs exposed by the public health movement which required well-trained nurses with both initiative and a social point of view. This was in sharp contrast with the other two organisations which appeared to be more concerned about nurses and nursing education than about the care of the patients. In spite of these differences in approach, the newly created organisation immediately applied for affiliation to the ANA. The Joint Conventions with the NLNE and the ANA, taking place every other year, were conducive not only to developing bonds of professional interest between nurses but also to broadening the profession's concept of its function in society. Apart from that, the increasing tempo of the public health movement - from prevention to the preservation of health - was exerting a powerful influence on the development of the nursing profession as a whole.

11.3.2. The central theme: the trained nurse versus the professional nurse

As far as the issue of the trained nurse versus the professional nurse is concerned, it was not until 1915 that the discussion got under way. In that year, Flexner, in a paper read before the Conference of Charities and Corrections, addressed the question `Is social work a profession?' In this paper, he articulated his famous criteria of a profession (Flexner, 1915, p. 10):

> *`Professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from science and learning; this material they work up to practical and definite end; they possess an educationally communicable technique; they tend to self-organization; they are becoming increasingly altruistic in motivation.'*

As for social work, Flexner's lecture was as timely as could be. In 1898, the New York School for Philanthropy, later called the New York School of Social work, had started short courses, and the first full year's course started in 1904. Since the 1890s, social work had developed from `*friendly uplifting, requiring nothing more than warm hearts, cheery spirits and wise thoughts, combined with an ability to deliver homilies on the cheapest kinds of food and the mending of clothes*', into the `*trained skill to use the individual, the group and the community to help men and women to lead happier lives*' (Woodroofe, 1962, p. 97), while the charitable individual of earlier days changed into the paid social worker. It was, therefore, rather disappointing that Flexner arrived at the conclusion that social work was in a twilight zone as social workers were mere `middle men' and social work did not yet meet all the criteria of a profession. On the other hand, the Flexner criteria were to give a major impetus to the rise of social work during the 1920s and 1930s.

As for nursing, the Flexner criteria proved to be a stimulating challenge as well, although the `*nation was to go through two wars before the nursing profession was to feel the full impact of the criteria that had promptly provided potent yeast for the rise of social work*' (Roberts, 1954, p. 102). With regard to nursing, Flexner said in his paper (in: Covert, 1917, p. 107):

> *`The trained nurse is making a praiseworthy and important effort to improve the status of her vocation. ... It is to be observed, however, that the responsibility of the trained nurse is neither original nor final. She, too [just like the social worker], may be described as another arm to the physician or surgeon. Her*

function is instrumental, although not indeed just mechanically instrumental. Yet when all is said, it is the physician who observes, reflects and decides. The trained nurse playes into his hands, carries out his orders, summons him like a sentinel in fresh emergencies, subordinates loyally her intelligence to his theory and policy, and is effective in precise proportion to her ability thus to second his efforts.'

This was not, however, to say that all nurses were incapable of achieving professional status in the future because, as Flexner also suggested, public health nurses were in a better position to show initiative and to take independent action than nurses working `*in the sickroom under orders*'. These remarks did not fail to stir the emotions among nurses as reflected by the following reaction (Covert (1917, p. 109):

`I do not agree with Mr. Flexner that nursing is essentially secondary in nature ... nursing is a science, in that it is based on knowledge and principles which are classified and verified. Applied science is a science put into concrete practice. Practice without theory is "quackery." Science, or a body of theory, is necessary to get safe practice. Nursing is the application of many sciences: dietetics, hygiene, pedagogy, psychology, sociology, bacteriology, etc. Nursing is a profession, for it is based on a body of organized and tested knowledge, it requires social service, it is not on a commercial basis, it does not permit trade and personal advertising, it is capable of constant growth and development, it does not depend on another profession, and it is willing to contribute its discoveries to the public. It would seem that nurses have not as yet measured up to their professional possibilities, but they are making rapid strides in that direction and perhaps, in the not distant future even Mr. Flexner will admit them to the realms of the learned professions.'

The reasons, put forward by Covert, for holding this opinion are even more telling, as they show the contrast between the trained nurse and the professional nurse to correspond closely with the central themes discussed earlier. To support her case that the work of the nurse was of an `*original'* nature rather than `*secondary'*, Covert pointed not only to the nurse's legal responsibility for her actions, but she also contrasted the training and the education of the nurse (Covert, 1917, p. 108):

`It is true that the nurse of the past obtained her knowledge first-hand from doctors, by the apprenticeship method, but at the present time she studies in schools for nurses, which are in some instances connected with colleges or universities, and from books written by nurses of recognized standing, on the subject of nursing rather than medicine.'

It was this relationship between professional and educational issues which was at the source of the central theme of the first edition of the National League of Nursing Education's Curriculum, i.e. the need for `*the theoretical foundation on which really good practical work must always be built*' (NLNE, 1917, p. 6).

11.4. Towards a model of individualised nursing

The three landmarks in the history of modern nursing in the United States discussed so far covered the period between 1873 and 1912 and ended up with three major issues related to nursing education, nursing, and the nursing profession respectively:

- service versus education,
- institutional service and social service, and
- the trained nurse versus the professional nurse.

These issues are interesting for more than one reason. First of all, these issues demonstrate that the discussion on nursing education, nursing, and the nursing profession had changed to the effect that Nightingale can be shown to have exerted relatively little influence on the early development of modern nursing in the United States. Secondly, once these issues had emerged, nursing education proved to be the most central theme to the effect that virtually all historical interpretations are based on the development of nursing education during the period concerned. Last but not least, these issues have been instrumental in the conceptual development of nursing.

11.4. 1. The influence of the Nightingalian model of nursing on American nursing

In spite of personal contacts with Nightingale, the early leaders of American nursing made relatively little use of the Nightingalian model of nursing. In fact, the problems which confronted them were so different that they were compelled to find their own solutions on matters related to nursing, nursing education and the nursing profession. Apart from that, discussions on these matters took place outside the religious framework which was so dominant in the writings of Nightingale.

Nursing. Nightingale's concept of nursing must be interpreted against the background of the controversy between miasmatism and contagionism which can be broadened to the dichotomy between a sociological and a biological approach (Ten Have, 1983). As a result of her taking sides with the miasmatist position, Nightingale could not but advocate a basically sanitary approach to nursing which corresponded with the sociological rather than the biological approach.

In the United States, however, nurses were forced to adopt a more or less biological approach; at first, as a result of advances in surgery, and later, because of the trend toward prevention and health preservation in the public health movement. Once nurses started to substitute the individual approach for the earlier emphasis upon environmental aspects, nursing became dichotomised according to the lines of division between the institutional service and the social service of the nurse (Dock, 1912a).

Nursing education. American views with regard to nursing education, too, reflected a radical change of emphasis. Whereas the Nightingale system rested upon the educational, administrative and financial independence of the training school, the American system was based upon the principle of `service for education'. As a result, educational independence, and administrative and financial independence too, for that matter, became subordinate to the services provided by the pupil nurses, resulting in the dichotomy between service and education.

Furthermore, whereas Nightingale viewed the nurse's education as a cyclic process of observation, reflection, and experience, American nurses increasingly emphasised the need for scientific knowledge to underpin the practice of nursing. Although they admittedly valued the practical training of the nurse, they did not eschew the use of books nor the university. This attitude was in sharp contrast with Nightingale's warning against the danger of substituting `*book-learning and lectures*' for `*an apprenticeship, a workshop practice*' (Nightingale, 1893, p. 35).

Yet another element in the discussion, to be added over the years, was the place where the nurse's education should preferably take place: the hospital or the university. Whereas Nightingale and the early nursing leaders in the United States could not envisage a nurse being trained except in the hospital, American nurses at the beginning of this century began their struggle for university education, at first, for post-graduate courses only, and later, for the basic training as well.

Nursing profession. At the turn of the century, the Nightingalian issue of `profession versus calling' was decided upon in favour of the former, or as Nutting put it in a paper read to the American Society of Superintendents of Training Schools for Nurses (AJN, 1905, pp. 654-655):

> *`We claim, and I think justly, the status of a profession; we have schools and teachers, tuition fees and scholarships, systems of instruction from preparatory to postgraduate; we are allied with technical schools on one hand and here and there a university on the other; we have libraries, a literature, and fast-growing numbers of periodicals owned, edited, and published by nurses; we have societies and laws. If therefore we claim to receive the appurtenances, privileges and, standing of a profession, we must recognize professional responsibilities and obligations which we are in honor bound to respect and uphold.'*

Gradually, the notion of `*profession'* lost all its religious connotations to be replaced with purely educational ones, resulting in yet another issue, viz. the `*trained nurse versus the professional nurse*'.

11.4.2. The pivotal role of nursing education

As noted above, the order of priorities between nursing, nursing education and the nursing profession had changed as well. Whereas, in the Nightingalian model of nursing, it was nursing which came first, in the early development of modern nursing in the United States, it was nursing education which set the tone of all further discussions. This is reflected by the fact that the preoccupation with nursing education during the period from 1873 and 1937 is matched by the emphasis upon nursing education in the historical interpretations of the period concerned, of which three examples will be given.

An educational interpretation. In `The education of nurses' by Stewart (1944), the period between 1873 and 1937 was divided into three periods of twenty years:

- 1873-1893: the Nightingale system is established in the United States,
- 1893-1913: nurses organise to control and improve educational standards,
- 1913-1933: nursing schools are tested and appraised.

These periods were preceded by the founding of the first Nightingale training school for nurses in 1860, and followed by the first movements toward fundamental readjustments which were to result in advances to new frontiers and the development of educational leadership.

In this historical interpretation, the central theme is the struggle for professional education for nurses as opposed to the apprenticeship type of training. Both the selection and the interpretation of the material presented in her book, suggest that Stewart viewed the Nightingale system of training nurses as the ideal programme for nursing education in the United States, a view she had expressed once before (Stewart, 1931). To acquire the professional characteristics of the Nightingale system, it was further suggested by Stewart, the American schools of nursing had to follow a circuitous route to overcome aberrations from the original, the description of which takes up the major part of the book.

A nursing interpretation. A historical interpretation related to the development of nursing was given by Goodrich's distinction between the emotional, technical and creative period of nursing which she characterised in the somewhat stilted language so typical of her (1932, p. 314):

> *`the first period so imaginatively attractive with its crudities mellowed by age and its suffering transmuted into beauty through the pageantry of a colorful past; the second period with its long arid stretches of unremitting toil that boldly and persistently attacked at their base the sores of humanity and laid the foundation for the present dynamic program; a vivid conception of both being imperative to grasp in any measure the significance or implication of the development of the third, which I have ventured to call the creative period ...'*

Whereas nursing, during the first period, was based upon charity and religious compassion, and technical nursing was characterised by following physician's orders for treatment and giving of comfort to bedridden patients, creative nursing had come into existence when nurses began tapping the sources of higher education.

The emergence of creative nursing thus coincided with nurses starting to take basic courses in university schools of nursing during the 1920s. One of these schools was the Yale University School of Nursing of which Goodrich herself was the first dean. An outstanding feature of nursing education at Yale University was the use of the case method for both the theory and practice experiences of its students.

The latter element, once again, calls attention to some striking similarities in the development of nursing and social work. Both professions originated in charitable and philanthropic work. Up till 1917 and thereafter, nurses were taught that nursing was essentially `a form of social work' (NLNE, 1917, p. 124). In the meantime, as a result of the growing emphasis on preventive and constructive measures, new organisations had been formed through which both professions could provide their services, viz. the agencies for public health nursing and the social services. After both professions had discovered the importance of the individual's contributions to their endeavours, the pendulum swung back from a predominantly organisational to an individualised approach by means of the case method which was used by both public health nurses and social workers. The driving force behind the use of the case method in the practice of nursing was indeed the introduction of university schools of

nursing. It was this development to which Goodrich was pointing when she spoke of the creative period of nursing.

A professional interpretation. Another issue was the professional development of nurses, which was very much in evidence in Roberts' `History and interpretation of American nursing' (1954). This book was based upon the premise that, as Miss Follet put it, `*All professions have been developed by the work of their own members. ... There is no one else in the world ... to create the science, the art, the profession*' (in: Roberts, 1954, p. 394). This was indeed the central theme of her book, and as for the period between 1873 and 1937 Roberts observed (Roberts, 1954, p. 61):

> *`No other profession has been developed on the assumption that an education can be secured in exchange for service. ... Regardless of the extraordinary nature of its educational origins, American nursing began at an early date to demonstrate two characteristics of a profession: (1) Continuous effort toward the improvement of nursing education, as a basis for nursing service, has consistently been based on what were believed to be the needs of those to be served, namely, patients, actual or potential, as individuals in relation to their families and communities. These efforts have not been restricted to the area of technical care in which nursing is ancillary to medicine nor to the immediate needs of hospitals and other institutions. (2) Acceptance of responsibility for handing on an ever-increasing body of knowledge.'*

11.4.3. The conceptual development of modern nursing

Whatever the angle from which nurses looked into the period between 1873 and 1937, time and again they tended to come up with nursing education as the central theme. Although Stewart and Roberts dealt with the history of nursing education and the professional development of nursing in depth, they failed to mention the model of individualised nursing at all. Only Goodrich's notion of `*creative nursing*' has given me a lead to follow up concerning the emergence of this particular model of nursing. Otherwise, it has proved to be impossible to find an in-depth study of the conceptual development of nursing during the period concerned. This lacuna, it seems to me, is the result of the preoccupation with education at the time, and the present underestimation of the importance of this period in the conceptual development of nursing.

Given the indications that the model of individualised nursing was the outcome of the conceptual development of nursing between 1873 and 1937, on the one hand, and the central role of nursing education during that period, on the other, the most appropriate way to proceed was to study the model of nursing underlying the three editions of the Curriculum (NLNE, 1917, 1927, and 1937), as well as the Goldmark Report (Goldmark, 1923) and the work of the Grading Committee (1926-1934), which both dealt with the problems of nursing education. Other valuable sources of information were the `American Journal of Nursing' and the `Public Health Nurse' (from 1931: `Public Health Nursing') in which the hot topics of the day were discussed, often at great length.

Without giving away too much of the conclusions of the following analysis, the study of these sources has shown that the dichotomy, as reflected in the issues which had clearly emerged in 1912, foreshadowed two opposing models of nursing:

functional nursing	**individualised nursing**
service	education
institutional service	social service
the trained nurse	the professional nurse

Whereas the former model was brought about by the gradual institutionalisation of nursing, exemplified by the slogan `service for education', the latter model emerged as a result of the rise of the public health movement which called for the professional education of nurses in university schools of nursing.

Also, the model of functional nursing reflected nursing's traditionally close relationship with medicine, while the model of individualised nursing pointed to the increasing similarities between nursing and social work.

Finally, the differences between functional and individualised nursing call attention to two opposing views of the nature of professional nursing. Either it is a set of functions, ancillary to medicine and requiring a trained nurse, or it is a profession in its own right in which case a professionally educated nurse is needed. The analysis of the models of nursing underlying the three editions of the Curriculum is aimed at showing how these differences were intensified, clarified and dissolved in the model of individualised nursing.

12.
`A STANDARD CURRICULUM FOR SCHOOLS OF NURSING'

In 1917, the National League of Nursing Education published `A standard curriculum for training schools of nursing' which will be referred to here as the standard curriculum. The nursing profession had come a long way to this historic moment. At the Chicago meeting in 1893, Isabel Hampton (Robb) had said that (Hampton, 1893, p. 5):

> *`A "trained nurse" may mean then anything, everything, or next to nothing.'*

Some two decades later, little had improved. Apart from the increased number of schools, many of inferior quality, there were short courses and correspondence courses of nursing which fell far short of the standards spelled out in the standard curriculum.

This is not to say that the nursing organisations had been idly standing by. On the contrary, for the Associated Alumnae actively campaigned to secure registration laws in each of the states. As a result of these so-called `Nursing practice acts', the nurse's training had to comply with the minimum educational qualifications required for state registration so that at least some of the conditions in nursing schools improved. In the long run, this campaign also helped to strengthen the case for the standardisation of the nurse's training in order to ensure intelligent and safe practice as required by these acts.

It was, however, the National League of Nursing Education which took the lead in the process leading up to the publication of the standard curriculum. As early as in 1894, the Society of Superintendents of Training Schools for Nurses demonstrated its interest in an improved and standardised curriculum by setting up a special committee, the Committee on Education, to study this matter, and by striving for:

- a three year curriculum,
- an eight hour day for pupil nurses,
- the preclinical course, and
- one year high school as an entrance requirement.

In 1899, the Committee on Education, acting on a suggestion at the Chicago meeting in 1893, and in the belief that the better education of those in charge of nursing schools would improve the quality of nursing education, recommended the establishment of a postgraduate course for nurses at Teachers College at Columbia University whose purpose it was, in the words of its Dean, James Earl Russell, to open the doors of higher education to `the newer fields of life and experience created by the economic and social demands of the Twentieth Century' (in: Bacon, 1987).

That the college lived up to its stated purpose was exemplified by the gradual addition of courses reflecting the rise of public health nursing in the first decade of this century. The one-year course in hospital economics, started in 1899 and was extended to two years in 1905. This course prepared nurses for administrative and teaching positions. One year later, hospital economics became a division of the newly created Department of Household Administration under the leadership of Adelaide Nutting. In the same year, Lavinia Dock and Lilian Wald started lecturing on the history of nursing and the social aspects of nursing. By 1910, the department's name was changed into Department of Nursing and Health, heralding not only the growing influence of public health nursing but also the distinction made between the special preparation for administration and teaching in nursing schools, on the one hand, and courses on visiting nursing and health protection, on the other. In 1912, to designate the latter courses, the term `public health nursing' was adopted.

The postgraduate courses at Teachers College had been operating for fifteen years when the Committee on Education started the actual preparation of the standard curriculum which is the subject of analysis here. This analysis is aimed at identifying and clarifying the concepts of nursing, nursing education and professional nursing underlying this curriculum in order to assess its contribution to the genesis and evolution of the model of individualised nursing.

The best way to become familiar with the standard curriculum's model of nursing is to start with the Introduction in which the Committee on Education explained the standard curriculum's purpose and rationale. By analysing the text of the introduction and by elaborating on its content, it will become clear that the central

theme of this curriculum was the educational nature of the training schools for nurses. However, in outlining this theme the Committee on Education could not but elaborate on changing views as to nursing and professional nursing as well. As a result, the introduction of the standard curriculum reveals some of categories which were at the source of the concepts of nursing, nursing education, and professional nursing underlying the model of individualised nursing.

12.1. Purpose

The standard curriculum was meant to serve different purposes simultaneously. These purposes were (NLNE, 1917, p. 5):

- to `*serve as a guide to training schools struggling to establish good standards of nursing education*',
- to `*represent to the public and those who wish to study our work, a fair idea of what, under our present system, we conceive to be an acceptable training for the profession of nursing*',
- to '*arrive at some general agreement as to a desirable and workable standard whose main features could be accepted by training schools of good standing throughout the country*',
- to '*gradually overcome the wide diversity of standards at present existing in schools of nursing*',
- to `*supply a basis for appraising the value of widely different systems of nursing training*'.

Given these purposes, the title of the curriculum understandably contained the word `*standard'*. In this respect, the standard curriculum reflected a more general trend in education at the time, or, as Beard had put it five years earlier when he predicted the advent of the curriculum (Beard, 1912, p. 787):

> *`Through the influence of the organized nursing profession and through the mutual cooperation of the schools of nurses in each and every state, the education of the nurse is to be standardized, in the near future. ... Education, everywhere and in every vocational field, is being standardized; an education in the nursing field will prove no exception to the rule.'*

On the other hand, the Committee on Education made it clear that the standard curriculum was not offered as a model curriculum, to be adopted irrespective of the conditions existing in the hospitals and training schools. This also was the position taken with regard to the two revisions of the standard curriculum in whose titles the word `standard' was subsequently dropped.

12.1.1. Standardisation

Notwithstanding the later change of the Curriculum's title, it remains to be seen what the word `standard' should be taken to mean. As to this question, two different interpretations have been put forward.

**The `scientific' approach**. Bacon (1987) connects the standardisation aim in the standard curriculum with the scientific approach to industrial management recommended by Frederick Taylor in his book `Scientific Management' (1911). According to her interpretation, the ideal of `*efficiency of operation by analysis of all activities of the worker with special emphasis on the assembly line*' found its way into `*the conservation of time, energy, and material*' in educational administration as well as in the curriculum itself.

In support of the position taken by her, Bacon points to the work of Franklin Bobbitt who is quoted as having said that `*Education is a shaping process as much as the manufacture of steel rails*', and to the fact that the outline of subjects in the standard curriculum was divided into seven areas. Each of these contained two or more courses, all completely outlined and including references to time, objects of course, outlines of lectures and classes, methods of teaching, equipment and illustrative material, and text and reference books. The total programme of study was outlined in great detail, and there was strong emphasis upon student activity as well as very complete records of the practical experience of the students in the care for patients.

The Teachers College approach. Although the `*scientific'* approach to curriculum development was to influence the subsequent editions of the Curriculum significantly (NLNE, 1927, pp. 8-9; NLNE, 1937, pp. 22-26), Murdock (1986) holds the opinion that the first edition was based upon the educational thinking at Teachers

College. Before the turn of the century, Teachers College was known for its training of teachers for domestic and industrial art classes in secondary and elementary schools, so that it was bound have some educational expertise at its disposal, and even more so after its association with Columbia University, in 1899.

By taking postgraduate courses at Teachers College, nurses got in touch with the ideas of John Dewey, Edward L. Thorndike, and Frank McMurry who, between them, represented the mainstream of progressive educational thought at the time. Dewey, for example, taught that the development of thinking was central to education as acquiring knowledge was always secondary to the act of inquiry. Thorndike and McMurry, too, focused upon the process of learning. McMurry, for example, was known for advocating a curriculum in which both the content and the structure were geared primarily to the assimilation of knowledge and the correlation of the subject matter of the curriculum. This approach therefore required a detailed outline of the curriculum too, but for a different reason, viz. to enhance the process of learning rather than for the purpose of efficiency.

12.1.2. The position of the Committee on Education

That the Committee on Education used the approach developed at Teachers College, can be inferred from the reference lists in the standard curriculum mentioning the publications of the educational thinkers of this college, but not any of Bobbitt's work. In the other editions of the Curriculum, on the other hand, although partly based upon the `scientific' approach, the latter's work was not mentioned either. That the Committee on Education opted for the Teachers College approach was made clear during the preparation of the standard curriculum (Stewart et al, 1916, p. 420):

> *`Just at present there is much discussion among educators regarding the use of the ready-made or prescribed curriculum. It is desirable of course in any system of education that there should be a certain acknowledged standard, a certain uniformity in the subjects studied and in the relative time given to each. This is particularly important where, as in nursing, the demands on the graduates are practically the same in all parts of the country, and where the educational standards are on the whole so chaotic. On the other hand it would be extremely unwise to attempt to advise or compel all schools, say in a state, to use exactly the same curriculum regardless of their special needs or opportunities. Such a plan would discourage initiative on the part of teachers and superintendents and would result in a mechanized system of education, which would in the end work against progress. Working from a good model or standard, each school should consider its own special problems, improving on the standard wherever possible, experimenting along new lines, adapting and pruning and changing from time to time to meet the changing conditions and demands in the field of nursing. This is the way all progress comes.'*

Given Teachers College's openness to the `*economic and social demands of the Twentieth Century*', it becomes even more likely that the standardisation, intended by the Committee on Education, had to do with the relationship between the demands of society, on the one hand, and the process of learning, on the other, and was not prompted by an efficiency drive; a conclusion which is, moreover, corroborated by the stated purposes of the standard curriculum.

Finally, Teachers College was bound to influence the educational thinking of the nurses involved in the preparation of the standard curriculum as many of these nurses were conversant with its educational philosophy. Three members of the Committee on Education, Adelaide Nutting (chairman), Isabel Stewart (secretary), and Annie W. Goodrich, were working at Teachers College, while two other members were closely associated with it. Apart from that, many of the nurses taking part in the preparation of the curriculum were graduates from Teachers College.

12.2. Rationale

The standard curriculum's purpose of standardisation came also to the fore in its rationale which, incidentally, reflected Teachers College's influence as well. One year before the publication of the standard curriculum, Isabel Stewart and two other nurses accepted the direction of a new department in the American Journal of Nursing, the `Department of Nursing Education', in which the process of curriculum development was discussed at great

length (Stewart et al, 1916). In the first contribution, dealing with the aims of the training school for nurses, it was made abundantly clear that the curriculum in the making was to reflect the needs of society, more than anything else (Stewart et al, 1916, p. 319):

> *`Before we can discuss the work of any kind of school or judge of its results, we should have clearly in mind the things which it wishes to accomplish. The older types of schools and colleges usually stated this by enumerating the things they wanted to give to, or develop in, the pupil: it might be culture or appreciation, or the development of character, or the ability to earn a living through a certain kind of skill. The tendency nowadays is to think more in terms of what society needs and how each person in the community, according to his special aptitudes and powers, can be fitted to serve those needs most efficiently.'*

The questions to be answered were therefore related to (Stewart et al, 1916, pp. 319-320):

> **the needs of society**
> *`What fundamental needs of society should this school serve?*' which was tantamount to asking, *`What are the vital practical problems of everyday life which these pupils must be ready to solve if they would give their best service to their community, state, or country?'*
>
> **the education needed to serve society's needs**
> *`How can we utilize all the agencies and experiences at our command, how can we organize and administer the material of instruction so that our pupils will be prepared to fill that place, whatever it may be, in the social fabric?'*

As for the standard curriculum, these questions were rephrased to indicate its rationale (NLNE, 1917, pp. 5-6), i.e. the changing role of nursing indicating the need for educational reform.

12.2.1. The changing role of nursing

The major impetus for preparing a curriculum for schools of nursing, it was pointed out in the introduction, was the changing role of nursing in society (NLNE, 1917, p. 5):

> *`The work of the professional nurse is practically the same in all the states of the union, and it would seem to be perfectly evident that the training which is to guarantee a certain acceptable measure of competence, would need to follow somewhat similar lines, whether the nurse is trained in California or New York, and whether the training is given in a small or a large hospital. The main difficulty is the lack of a clear understanding of what the function of a modern nurse is, or what the purpose and scope of her training should be. The war is making us realize, what the public generally and the training schools have been slow to recognize, that nursing is in a very special sense a national service, and that the training of the nurse is a matter of vital concern not only to her hospital and to herself, but to the country at large. It is not enough that she should serve the needs of a single institution or a limited group of people. She must be ready to serve the whole community and to meet conditions as she finds them in many different kinds of communities.'*

12.2.2. The need for educational reform

The remarks on the changing role of nursing were followed by its implications with regard to the training of the nurse (NLNE, 1917, pp. 5-6):

> *`It is becoming clearly evident, that if she is to do this effectively, we must revise many of our old ideas about the nurse's training. The value of her service is being recognized in so many new fields of work, and the character of that service is changing so rapidly, that the preparation which was considered quite adequate a few years ago is no longer sufficient. The steady expansion into new and exacting fields of*

effort, is continually revealing to us both the strength and the weakness of our methods of training. The strength lies in the character of the actual practical work, which in most training schools is sincere and thorough and performed in a spirit of devotion, zeal, and self-forgetfulness which is remarkable. Teachers and students alike are imbued with this spirit. It has become a part of the history and tradition of nursing and forms an almost invaluable contribution to the world's service. The weakness lies in the over-emphasis placed upon the practical aspects of the training and the consequent neglect of the theoretical foundation on which really good practical work must always be built.'

12.2.3. The interpretation

To a certain degree, the rationale of the standard curriculum was self-explanatory: given the changing role of nursing, the training of the nurse was in need of drastic reform. To grasp its full significance, however, the standard curriculum must be analysed within its historical context which will reveal the issues which, in 1917, were the hot topics of the day, as these issues pinpoint some of the categories which foreshadowed the many differences between functional nursing and individualised nursing. What is needed, therefore, is an analysis of the standard curriculum's concepts of nursing, nursing education, and professional nursing. Generally speaking, the standard curriculum reflected the attempts of nursing educators to come to terms with the major issues mentioned earlier, viz.:

- institutional service versus social service,
- service and training versus education, and
- the trained nurse versus the professional nurse.

The solutions put forward, both in the standard curriculum itself and in the literature related to it, provide a more or less complete picture of the standard curriculum's concepts of nursing, nursing education, and professional nursing, which are the subject of the following analysis.

12.3. The standard curriculum's concept of nursing

As pointed out in the standard curriculum's rationale, nursing was conceived as `*a national service*'. This should not be taken to mean that nursing was making a valuable contribution to the war effort, although in fact it did. Instead, the term `*national service*', was used to identify nursing with its social value rather than the actual services provided by nurses (Stewart et al, 1916, p. 320):

`[Nursing] has arisen out of impulses which are almost purely social and humanitarian and in response to very definite social needs. The conservation of human life has always been its main consideration, though the kind of service that seemed to be needed at one time has differed a little from the demands of another time, and people even now, in various countries, interpret the functions of the nurse quite differently. For example, the religious function of the nurse as a church officer and spiritual adviser used to be one of primary importance, but it has almost entirely dropped out of sight, in our country, at least.'

As a result, the question of whether the nurse's raison d'être was the institutional service or the social service was effectively rephrased into the comparison between the kind of service needed at one time or another, on the one hand, and nursing's social value, on the other. The standard curriculum itself took this one step further by contrasting nursing as a service to the hospital and nursing as a national service (Table 9).

The word `*service'*, if used in combination with the word `*national'*, had a meaning distinctly different from the same word in the issue of `*the institutional service versus the social service of the nurse*', as it referred to nursing's value to society at large rather than the actual services provided by nurses.

12.3.1. Nursing: a national service

To what degree the rephrasing of the issue was intentional, can be inferred from the fact that, in the standard curriculum, nursing was not differentiated along the lines of institutional and social service of the nurse. Instead, public health work was differentiated from nursing care of the sick (NLNE, 1917, p. 6):

public health work
`Another limitation of the ordinary training is that it deals only or mainly with disease, neglecting almost entirely the preventive and educational factors which are such an essential element in the many new branches of public health work, such as school and visiting nursing, infant welfare, industrial welfare and hospital social service. Similarly the physical causes and evidences of disease have been recognized as important, but the social and economic conditions which lie at the root of so many of our disease problems, have usually been over-looked in the course of training. This knowledge is fundamental, particularly in the newer branches of nursing, and the lack of it is a distinct handicap to the nurse in her work.'

nursing care of the sick
`It is not only in public health work that the need for a sounder and more adequate foundation is felt. If the sick patient is to have the most skilful and competent kind of nursing care, and if nurses are to keep pace with the advances of modern medicine, they must have something more than a mere deftness in precise manipulations and the scattered fragments of scientific knowledge which are all that can usually be given in the scant time allowed by most hospital training schools. The development of more highly complicated procedures in diagnosis and treatment, and the increased emphasis especially on dietetic, hygienic, occupational and mental factors in the treatment of disease, make it necessary that the nurse should assume an increasing measure of responsibility in the care and treatment of the patient. To safeguard her in those responsible duties, she must have a larger measure of scientific knowledge and a more highly trained judgment.'

In other words, the discussion was not about the institutional or social service of the nurse but about nursing itself. Moreover, the differentiation between public health work and nursing care of the sick effectively foreshadowed the use of Nightingale's distinction between `*health nursing*' and `*sick nursing*' in the second edition of the Curriculum (NLNE, 1927, p. 11). In 1917, however, the lines of division were drawn between public health work and nursing care of the sick.

12.3.2. Hospital service versus national service

The changes in nursing, both in public health work and nursing care of the sick, indicated the following areas of overemphasis and neglect in nursing education:

over-emphasis	**neglect**
disease	the preventive and educational factors
the physical causes and evidences of disease	the social and economic conditions which lie at the root of so many of our disease problems
a mere deftness in precise manipulations	a more highly trained judgment
the scattered fragments of scientific knowledge	a larger measure of scientific knowledge

Whereas the areas of over-emphasis were associated with nursing as a hospital service, the areas of neglect pinpointed some of the categories associated with the concept of nursing as a national service. These categories reflected the increasing emphasis upon the social causes of disease as opposed to its physical causes, as well as nurses' desire to do what Flexner called `*original'* work as opposed to `*secondary'* work. Unless these new elements were incorporated into the curriculum, it was argued, a nurse could not be expected to `*serve the whole community and to meet conditions as she finds them in many different kinds of communities*'.

Nursing is a hospital service	Nursing is a national service
The training of the nurse is a matter of vital concern only to her hospital and to herself	The training of the nurse is a matter of vital concern to the country at large
It is enough that she should serve the needs of a single institution or a limited group of people	A nurse must be ready to serve the whole community and to meet conditions as she finds them in many different kinds of communities
The over-emphasis placed upon the practical aspects of the training	More emphasis on the theoretical foundation on which really good practical work must always be built
A training that deals only or mainly with disease	A training that deals with the. preventive and educational factors which are such an essential element in the many new branches of public health work
Emphasis upon the importance of the physical causes and evidences of disease	More emphasis on the social and economic conditions which lie at the root of so many of our disease problems
A nurse needs no more than mere deftness in precise manipulations and the scattered fragments of scientific knowledge	A nurse needs a larger measure of scientific knowledge and a more highly trained judgment
Lack of well-trained nurses in positions of leadership	Unless the hospital selects good women and gives them a broad substantial foundation to begin with, there is little hope that we will develop many of the kind of leaders who are needed for our very responsible educational and administrative work
There is no need for a better organised and more thorough course of instruction than is commonly given in the average training school	The need for a better organized and more thorough course of instruction: • a kind of training more commensurate with the tasks which are laid upon the nurse • a course of study which compares more favourably with, the courses given in other technical and professional schools

Table 9. The standard curriculum's model of nursing (NLNE, 1917).

12.4. The standard curriculum's concept of nursing education

To return to the standard curriculum's rationale: granted that nursing was indeed `*a national service*', it was further pointed out that `*the training of the nurse is a matter of vital concern not only to her hospital and to herself, but to the country at large*'. This remark not only expressed the general feeling that the system of `service for education' was outdated but also referred to the gap between the actual educational offerings of the training schools, on the one hand, and what was expected from them as an educational institution, on the other. These problems were not new for, as early as in 1912, Beard, the `Father of the University School of Nursing', had pointed out that (Beard, 1912, pp. 784-785):

> *`The modern hospital has become a Friendly Inn in its health restoring and life-saving capacity and the modern nurse is now the recognized instrument, in either home or hospital, of trained scientific service to the sick. The evolution of the hospital has been the evolver of the nurse. Without the agency of the hospital, as the training ground, as the practical laboratory of the nurse, her so rapid evolution would have been impossible. The profession of nursing, - for it has achieved the dignity of a profession, - owes much to its foster-mother, the modern hospital. If, in turn, the hospital has demanded much of its pupil-nurses, it must be remembered that a mutuality of loyalty and service an Alma Mater has a right to claim. If the hospital's need of the nurse in training has been great, the hospital of the past half century has made the existence of the trained nurse a possibility. If the training school has sometimes been exploited*

for the benefit of the hospital, the fact is condoned by the circumstances of the developmental period through which hospital and school have been alike passing. Such exploitation is no longer either necessary or permissible.
To-day the evolution of the modern hospital is complete and the position of the trained nure in society is an established one. The hospital which through endowment, appropriation or means of self-support is unable to stand upon its feet and to provide fit educational opportunities for its pupil nurses, without taxing their labor too heavily for its own benefit, should forego the privilege of teaching. The nursing profession is organized and that organization which has already determined the conditions of the legalized practice of nursing, in many states, will speedily dictate also the standards of the education of the nurse. ... At the present juncture,it behoves the profession of nursing to rise to its waiting occasion, to follow in the footsteps of the related profession of medicine [e.g. Flexner, 1910] in dictating the terms upon which schools for nurses shall be legalized and their graduates received into practice. ... The day of professional privilege has gone by; the day of professional service has come. The educational standards of the profession of nursing must be set with an eye single, a spirit loyal, to the public good. For, after all, it is the public need for which the trained nurse exists.'

Beard's description of the situation in the early 1910s thus corroborated the two closely related but conflicting positions to be analysed here, viz.:

- nursing service versus nursing education, and
- training versus education.

12.4.1. Nursing service versus nursing education

In the discussion about the aims of training schools for nurses referred to earlier, it was pointed out that (Stewart et al, 1916, p. 321):

`whereas there are few people well-known for their reactionary principles, who are violently opposed to any extension of the nurse's powers, and who affirm that the present facilities for her training are already more than adequate to fit her for her present duties, the great majority expect much more of the nurse than she seems able, with her present equipment, to perform. Their idea of what a nurse should be, what she should know, and the kind of things she should be able to do, is pretty definite and the range of the duties and responsibilities on which most of these people agree, seems rather appalling.'

The opinions of the reactionary few and the great majority corresponded with two clearly identifiable groups in society. The former group consisted of the schools and the institutions (Stewart et al, 1916, p. 320):

`Most schools feel that they have fulfilled their full duty when the work of the hospital runs smoothly, when the local doctors are fairly well satisfied and the graduates are in steady demand by private patients ... Local pride and loyalty influence opinions largely and you will rarely find any institution which will admit that its surgeons or its nurses are not the best that could be produced.'

Obviously, this group was not very keen on nurses having more power and being overtrained. By getting away from the local situation a little and studying the question in its broader aspects, however, another group could be identified made up of (Stewart et al, 1916, p. 321):

- `*recognized authorities in fields related to ours, such as those of medicine, sanitary science education and social service*',
- `*nurses themselves, those who have been doing work in various fields*',
- `*the man in the street, who is in the last analysis the one most affected by good or bad nursing*'.

It was thus the expanded concept of nursing as a national service, as opposed to nursing as a hospital service, which, once again, exposed the ambiguity of the aims of the training school: nursing service versus nursing education. Nevertheless, one of the major assumptions of the standard curriculum (NLNE, 1917, p. 9) was that training schools would not be established `in the ordinary type of school, but in hospitals and under a well-

established system which requires that the practical training shall be obtained through student service in the various departments'.

Because the practical training of the nurse was considered of such importance as to occupy `*almost the entire time and energy of the student*', in many schools up to 90 per cent of the training period, the hospital operating the training school had to be of `*proper character and standing*', and to provide `*in its clinical resources, teaching facilities and administrative policy, a suitable field for the training of nurses*'. The Committee on Education, therefore, could ill afford the luxury of not spelling out what `the general conditions and main requirements in hospitals should be in order to ensure the satisfactory implementation of the standard curriculum'. For this reason, the standard curriculum included Adelaide Nutting's `Relation of hospital and training school organization and administration to the curriculum' (NLNE, 1917, pp. 9-35) which covered the following subjects:

- the general purpose, character and standing of the hospital,
- form and functions of training school control,
- type and capacity of hospital,
- financial resources,
- the teaching field (range, variety and character of services),
- conditions of life and work of students (ratio of nurses to patients, hours of duty, housing and living conditions, etc.),
- the administrative and teaching staff,
- standards of entrance to schools of nursing,
- standards and methods of good teaching,
- teaching equipment,
- records,
- university affiliations.

What all these subjects, and the more specific problems related to them, added up to was the question of the proper organisation, adminstration and endowment of training schools for nurses. This question was to take three decades to be answered (Brown, 1948), let alone solved.

The main reason for this delay was the lack of a proper system of coordination between the nursing service and the nursing school. Whereas the hospitals were dependent on student nurses to ensure nursing care at a low cost, the schools were dependent on hospitals for the practical experiences offered to their pupils. Although the national nursing organisations accepted responsibility for both service (ANA) and education (NLNE), they conspicuously failed to bring home to the hospital administrators that nursing service and nursing education were so different that they should not be placed under one and the same management. In spite of the pressure exerted by the changes in public health work to adapt the training of nurses for participation in the newer branches of nursing, it took until the mid-1930s before this distinction, at least in principle, was accepted.

12.4.2. Training versus education

The issue of `*nursing service versus nursing education*' thus remaining unresolved for many years to come, the Committee on Education called attention to the neglect of `the theoretical foundation on which really good practical work must always be built' (NLNE, 1917, p. 6).

Except for the reasons related to the changing role of nursing, the committee also pointed to the lack of well-trained women in positions of leadership like superintendents, supervisors, teachers and technical experts in many different departments. As for this problem, it was stressed that `*Unless the hospital itself selects good women and gives them a broad substantial foundation to begin with, there is little hope that we will develop many of the kind of leaders who are needed for our very responsible educational and administrative work*' (NLNE, 1917, p. 6). This was not, however, to say that the `*average hospital should undertake anything further than the fundamental subjects which would be required in any of the commoner branches of nursing practice*' (NLNE, 1917, p. 7), only that graduates should be given such a theoretical foundation as to enable them, after graduation, to take on positions of leadership.

In addition, it was argued, nurses themselves became increasingly aware of `*the necessity for a better organized and more thorough course of instruction than is commonly given in the average training school*,' a

course which not only provided `*a kind of training more commensurate with the tasks which are laid upon them*', but also compared `*more favorably with the courses given in other technical and professional schools*' (NLNE, 1917, pp. 6-7).

Although the Committee on Education organised the standard curriculum `*as nearly as possible on the same lines as other professional and technical schools*' (NLNE, 1917, p. 7), it failed to address the criteria of `*good training*' as specifically and in as much detail as the nurses responsible for the `Department of Nursing Education' in the Journal. By analysing their criteria, several categories relevant to the standard curriculum's concept of nursing education will emerge. These criteria were (Stewart et al, 1916, pp. 323-325):

> *`good health and the ability to maintain it'.*
>
> *`an adequate body of knowledge':* If the nurse lacked this body of knowledge, nursing became *`merely automatic, rule-of-thumb routine*' as opposed to the nursing care of the nurse who was `*equipped with the information necessary to enable her to act intelligently and safely*'. Apart from the variety of subjects to covered, the nurse should have a thorough knowledge of:
> - *`the principles underlying the nursing art, and the domestic or household duties that are associated with it',*
> - *`the profession and its ideals, including the study of nursing history and ethics',*
> - *'the fields of nursing and their requirements',*
> - *`the social conditions in the community which nursing aims to help'.*
>
> More importantly, *`It should be the kind of knowledge which is needed by the nurse, not by the medical student or social worker, or any other kind of person. It should be given from her point of view, and directed to the solving of her particular problems'.* The latter requirement indicated the attempts to identify the domain of nursing in response to the influences from both medicine and social work.
>
> *`technical skill ... of a rather expert kind'.*
>
> *`a certain kind of intellectual or mental ability which we associate with good nursing'.*
>
> *`character and that intangible thing which we call personality'.* The qualities to be developed in the nurse corresponded with *`the traditional virtues of the good nurse'* like *`obedience, the spirit of self-sacrifice, courage, patience, conscientiousness, and discretion'.* On the other hand, it was thought necessary to emphasise *`the more positive and vigorous qualities'* like *`self-reliance, power of leadership, and initiative'* too. This change of emphasis reflected the contrast between *`old religious devotion',* and the *`modern social spirit which is not satisfied with personal service only, but aims at constructive community service'.*

These criteria, between them, reflected the educational implications of nursing as a national service, and amounted to a change of emphasis from training to education (Stewart et al, 1916, p. 326):

> *`The word `train' is used generally to indicate a type of education which is mainly achieved through the forming of habits by drill or exercise. Education is something more, to educate means to develop mind and character and attitude, as well as conduct, and to give information. It also means the power of self-direction.'*

The training school, therefore, had to put the pupil nurse into possession of `*the necessary knowledge and skill, and to give her the right attitude toward her profession*' (Stewart et al, 1916, p. 419).

12.5. The standard curriculum's concept of professional nursing

Given that nursing was a national service, and nursing education was `*a matter of vital concern ... to the country at large*', the committee compared two types of nurses, viz. one who `*serves the needs of a single institution or a*

limited group of people' and the other who is `*ready to serve the whole community and to meet conditions as she finds them in many different kinds of communities*'. This comparison pointed to the fact that nurses who were trained according to the needs of the hospital and the local doctors proved of little value to society as a whole as they did not fit the requirements of nursing as a national service. As a result, their career prospects were severely restricted from the moment the training started. The standard curriculum was therefore aimed at giving both society and the nurses themselves a better deal in terms of education.

It speaks well of the insight of those responsible for the direction nursing education was to take that they realised that, at the end of the day, the needs and demands of society were the decisive factor in deciding upon which type of nurse was needed, a trained nurse or a professional nurse (Stewart et al, 1916, p. 320):

> *`If it is decided that it is in the best interests of society to limit the supply of skilled and intelligent nurses and to conceive of the nurse as a sort of capable and obedient servant, we shall have to plan our curriculum accordingly. If, on the other hand, it is found that the welfare of society is conserved and advanced by having a higher type of nurse, one who acts as the scientifically-trained assistant to, not the servant of the physician or the sanitary expert, one who is fitted to lead in certain important branches of social work, it is decidedly the duty of every school which trains nurses to do its utmost to meet this demand. This distinction in aim is fundamental, it is the difference between training for a more or less skilled handicraft and training for a profession.'*

The way in which these differences between nursing as a handicraft and as a profession were arrived at, is most revealing as to all the other issues involved. In fact, the two descriptions virtually mirror each other altogether:

> *decided versus found, thereby contrasting subjectivity and prejudice, on the one hand, and objectivity of the data, on which to base the decision-making on nursing matters, on the other,*
>
> *in the best interests of society versus the welfare of society is conserved and advanced, thereby emphasising the contrast between interests and welfare,*
>
> *to limit the supply of intelligent and skillful nurses versus having a higher type of nurse, thereby suggesting that, for some, nursing posed a problem of quantity, while for others, it was a problem of quality,*
>
> *intelligent and skillful nurses versus capable and obedient servants, thereby contrasting the new nurse and the old nurse,*
>
> *the scientifically-trained assistant, one who is fitted to lead in certain important branches of social work, versus the servant of the physician or the sanitary expert, thereby contrasting what Flexner had coined the `secondary' and `original' work of nurses,*
>
> *plan the curriculum versus meet this demand, thereby implying a contrast between a curriculum aimed primarily at efficiency, and a curriculum aimed at meeting the needs of society.*
>
> *training for a more or less skilled handicraft versus training for a profession, which reflected the `over-emphasis placed upon the practical aspects of the training' as opposed to the `consequent neglect of the theoretical foundation on which really good practical work must always be built'.*

Finally, and most importantly, this comparison indicated the concept of professional nursing underlying the standard curriculum, namely, that professional nursing required a thorough theoretical foundation. Therefore, the standard curriculum was aimed at helping nurses to live up to their claims of professional status which were based largely `*on service rendered to the public and on controlling ethical, and educational principles*' (NLNE, 1917, p. 138). Whereas the ethical principles, e.g. loyalty to the doctor, were part of a long-standing tradition at the time, the educational principles on which the standard curriculum was based were not. The emphasis upon

the service rendered to the public, for that matter, was new as well for it meant a break with the past in which the service rendered to the hospital came first.

12.6. A really educational curriculum

The analysis of the standard curriculum's model of nursing has shown that this particular curriculum, in stressing the need of a better theoretical foundation as opposed to the overemphasis upon the practical work, had a predominantly educational purpose. This would seem only natural, until this curriculum is compared with the two ensuing editions which were published with intervals of ten years (NLNE, 1927 and 1937) and emphasised different aspects instead. The standard curriculum's model of nursing as a whole thus represented, to all intents and purposes, as one nurse put it at the time (Gray, 1918, p. 791):

> *`the efforts of nurses to make the preparation for their work really educational.'*

To illustrate once again that education was indeed the central theme, the remaining part of this chapter is devoted to the course of study and the outline of subjects.

12.6.1. Course of study

The length of the course was three calendar years, divided into:

- the preparatory or first year, of which the first four months were designated as the preliminary or probationary period,
- the junior or second year,
- the senior or third year.

The schedule of hours suggested for both practical and theoretical work was such that it would occupy the student for not more than up to ten hours per day, `*with the exception of Sundays, when class work and study would be omitted, and the one day a week when an afternoon off is allowed*' (NLNE, 1917, p. 35). Applicants for the course had to present evidence of graduation from a four-year high school or the equivalent, although a `*temporary minimum*' of two years with approved and certified courses in English, mathematics, history, and elementary sciences was considered still acceptable.

The course of study of the standard curriculum was thus more or less consistent with the objectives of the early leaders of nursing education. Given, however, the standard curriculum's purpose to improve the theoretical preparation of the nurse, it is of paramount importance to look into its suggestions as to the desirable and workable ratio of the hours spent on theoretical and practical instruction.

The `*general scheme of practical instruction*' which, most significantly, preceded that of the theoretical instruction, covered a total of 36 months. Apart from the practical work during the preliminary period of 4 months in which the pupil was `not to be counted upon for any regular ward duties' (NLNE, 1917, p. 35), it was suggested that the remaining 32 months be divided thus:

- medical nursing (8 months),
- surgical nursing (8 months),
- nursing in diseases of infants and children (4 months),
- obstetrical nursing (3 months),
- nursing in special diseases (2 months),
- electives (to be arranged, `so far as possible, with reference to the special aptitudes and future plans of the pupil').

The `*general scheme of theoretical instruction*', on the other hand, amounted to between 585 and 595 hours of lectures and class work, divided over the three years of the course. The suggested ratio was thus 36 months of practical instruction and almost 600 hours of theoretical instruction. In the articles which were published in anticipation of the standard curriculum, using a slightly different ratio, it was shown how this worked out (Stewart et al, 1916, p. 622):

`This gives a total of 600 hours theory (of which about one-half is spent in laboratory or practice work in the class-room) and 33 months of experience in the wards of the hospital. At the lowest possible estimate (54 hours a week) and counting one month vacation each year, this gives us a total of over 7000 hours of practical work, so we need as yet have no fear that we are over-burdening the curriculum on the side of theoretical work. Six hundred hours would be about equivalent in time to one school year in an ordinary technical or professional school or college. This would not seem to be a very liberal allowance of theory for a woman who is preparing for an important branch of professional work.'

On the face of it, the outcome, at least in quantitative terms, thus seemed rather disappointing. On the other hand, the standard curriculum was but a first step in the long process of putting things right. Also, maybe it was not so much a quantitative as a qualitative improvement of the nurse's training which the Committee of Education was striving for (Stewarts et al, 1916, p. 511):

`Everyone agrees that it is not the time one puts in that counts in hospital training, nor even the number of cases that pass through one's hand, but the thoughtful, careful observation and study of a wide variety of cases, with good teaching and head-nurses and doctors to check up one's work and call attention to the significant features which otherwise are overlooked in the headlong rush of a busy ward.'

As for the quality of the instruction, it speaks well of the increasing educational sophistication of the nurses preparing the standard curriculum that they included some standards and methods of good teaching (NLNE, 1917, pp. 27-30). It listed, for example, the following teaching methods:

- the lecture method,
- the recitation method,
- the demonstration or clinic (including the excursion method),
- the laboratory method,
- the conference or case-study method,
- the study period (supervised study).

Also, the outline of subjects included ample suggestions and advice as to how to conduct the lectures and classes to the maximum educational benefit of the students. In this respect, the standard curriculum apparently offered much more than was bargained for, because it (Gray, 1918, p. 792):

`is truly an encyclopedia for the nursing profession. ... Some of its pages almost visualize our ideals of what training schools might become and present the hospital graphically as an educational institution.'

12.6.2. Outline of subjects

The outline of subjects was divided into the following groups or areas:

- **General Science**
  Anatomy and Physiology, Elementary Bacteriology, Elements of Pathology, and Applied Chemistry.

- **Household Science**
  Nutrition and Cookery, Diet in Disease, Hospital Housekeeping, and Housekeeping Problems of Industrial Families.

- **Disease Prevention**
  Personal Hygiene and Public Sanitation.

- **Therapeutics**
  Drugs and Solutions, Materia Medica and Therapeutics, Massage, and Special Therapeutics (including Occupation Therapy).

- **Nursing and Disease**
  Elementary Nursing Principles and Methods, Elementary Bandaging, Nursing in Medical Diseases, Nursing in Surgical Diseases, Nursing in Communicable Diseases, Nursing in Diseases of Infants and Children, Gynaecological Nursing (including Diseases of the Genito-Urinary Tract), Orthopaedic Nursing, Obstetrical nursing, Nursing in Diseases of the Eye, Ear, Nose and Throat, Nursing in mental and Nervous Diseases, Nursing in Occupational, Skin and Venereal Diseases, Operating-Room Techniques, Emergency Nursing and First Aid, and Special Disease Problems.

- **Social and Professional Subjects**
  Historical, Ethical and Social Basis of Nursing, Elements of Psychology, Principles of Ethics, Survey of the Nursing Field, Professional Problems, and Modern Social Conditions.

- **Special Branches of Nursing**
  Introduction to Institutional Nursing, Introduction to Private Nursing, Introduction to Public Health Nursing and Social Service, and Laboratory Technique.

The first area to look into in more detail, to see whether the outline of subjects lived up to the standard curriculum's model of nursing, is, of course, `Nursing and Disease'. This area, as its title already suggested, was concerned primarily with the physical care of the sick patient in the hospital. Moreover, the majority of the subjects in this area not only dealt with nursing care in different kinds of diseases but supplied the relevant medical information as well, while the subjects `Elementary Nursing Principles and Methods' and `Elementary Bandaging' covered those aspects of nursing which could be best dealt with separately. In spite of these somewhat disappointing features, the texts, at times, also referred to preventive measures and the social conditions causing disease in order to give the nurse a thorough foundation for her work, not only in the hospital but in the community as well.

However, on the basis of the area of `Nursing and Diseases' alone, it would be wrong to say that the outline of subjects corresponded with the standard curriculum's model of nursing. For this conclusion to be justified, the other areas have to be taken into account too; for example, the areas `Disease Prevention', covering both public sanitation and personal hygiene, and `Social and Professional Subjects', covering, amongst others, the subject `Modern Social Conditions'. A major impetus for including these subjects was the pressure exerted by the National Organisation for Public Health Nursing's Committee on Education. In 1916, this committee published a report, entitled `The training school's responsibility in public health nursing education' (Tucker, 1916) which was unanimously accepted by the National League of Nursing Education.

Apart from the somewhat predictable subjects like `Anatomy and Physiology' and `Drugs and Solutions', the outline of subjects also contained subjects aimed at preparing the students for the special branches of nursing which were to be combined with practical experience in these branches (electives).

12.6.3. Conclusion

In educational terms, the standard curriculum has indeed been shown to be a major leap forward. So impressive was it thought to be that the following question could be raised (Gray, 1918, p. 794):

> *`Will it not be evident that since we have developed such a large body of theory, the present system is a thing outworn? Have we not here a strong argument for a central school where the nurse may spend at least one year in a three years' course in close application to study?'*

However, as for the question of the model of individualised nursing, the conclusions are apparently less positive. The analysis of the standard curriculum's model of nursing was, however, necessary to identify two opposing bodies of opinion as to the nature of nursing, nursing as a hospital service versus nursing as a national service, and all the accessory differences which are elaborated on in this chapter and summarised in figure 5. These differences were at the source of the conceptual development of nursing in the second and the third edition of the Curriculum which, ultimately, was to lead up to two opposing models of nursing.

13.
‘A CURRICULUM FOR SCHOOLS OF NURSING’

In the mid-1920s, the Committee on Education of the National League of Nursing Education started the preparation for the revision of the Standard Curriculum because, less than ten years after its publication, it became ‘*evident that certain changes were needed to keep the Curriculum in line with the newer developments in the field of nursing and the newer ideas in nursing education*’ (NLNE, 1927, p. 8).

13.1. The revision of the standard curriculum

The analysis of the standard curriculum has exposed two more or less opposing bodies of opinion with regard to the training of the nurse which were divided along the following lines:

- **nursing**
  hospital service versus national service

- **nursing education**
  nursing service versus nursing education
  training versus education

- **professional nursing**
  the trained nurse versus the professional nurse.

Whereas the lines of division in the standard curriculum appeared to be drawn between the nursing profession and other groups with vested interests in nursing education, the revised curriculum pointedly acknowledged these lines of division to be present within the nursing profession as well (NLNE, 1927, p. 8):

> *‘In such a large professional body it is inevitable that there should be rather wide differences of opinions on certain phases of nursing education. Every profession has its conservatives and its liberals. There are, moreover, the specialists who are mainly concerned in securing the right- of-way for their own particular subjects and the “generalists” who want to have a more varied and “all-round” program of study. While it is of course impossible to satisfy all groups, every effort has been made to incorporate the suggestions which have come in and at the same time to strike a balance between extreme points of view.’*

Both points of view mentioned were indicative of the change of emphasis in curriculum development. Whereas the standard curriculum was inspired primarily by educational motives, its revision rested upon a concept of nursing which was made more explicit than in 1917. The need to articulate a concept of nursing was in turn prompted by the crisis in public health nursing which gave rise to the first field study on nursing and nursing education in the United States (Goldmark, 1923).

13.1.1. Conservatives versus liberals

The words ‘*conservative’* and ‘*liberal’* were typical of the language used by Stewart (1935b, pp. 157-158), and should be interpreted alongside her judgement of the attitudes which people take ‘*in relation to the status quo*’ from ‘*reactionary,*’ via ‘*conservative,*’ ‘*moderate,*’ and ‘*liberal,*’ to ‘*radical*.’

Whereas the conservative attitude represented people ‘*who are rooted in tradition - prefer the familiar, well-established ways and hold their ground as long as possible. When they see that changes are inevitable, they make concessions slowly and carry with them all that they can salvage from the past*,’ the liberal or progressive attitude stood for people who ‘*are inclined to be critical and impatient with established and traditional forms and static conditions. They are decidedly favorable toward new ideas and willing to experiment along new lines, but are inclined to proceed at a moderate pace so as not to upset things too much in the process*.’

Both these positions, referred to in the revised curriculum (NLNE, 1923, p. 8), can therefore be seen to coincide with the two sorts of people mentioned in the standard curriculum (NLNE, 1917, p. 5), viz. those who were inclined to revise their '*old ideas about the nurse's training*' and those who were not.

13.1.2. Specialists versus generalists

The '*specialist-generalist*' debate was related to the difficulty in differentiating clearly between the '*general branches of nursing service and the more specialized positions which require advanced training*' (NLNE, 1927, pp. 9-10). The differentiation the Committee on Education came up with, reflecting both its '*generalist'* position and its preference for an '*allround'* programme of study, was this:

- **general branches of nursing service:**
  '... this group will represent the work of those nurses who are in direct contact with patients and who are practitioners of the fundamental nursing art.' This would include:
  - general private duty nurses,
  - hourly nurses,
  - office nurses,
  - staff nurses connected with public health nursing organisations (e.g. visiting nurses, school nurses, etc.),
  - institutional nurses and those on general duty.

- **specialised positions which require advanced training involving:**
  - teaching,
  - supervision or administration,
  - highly specialised technical branches of nursing.

Underlying this differentiation was the committee's acceptance of the '*principle of the basic course,*' in the sense that (NLNE, 1927, p. 9):

> *'the training offered in the undergraduate nursing school should be a general as opposed to a specialized training and that it must supply the foundations on which all additional training and experience should be built. It must therefore be sound and substantial so far as it goes, and should also be broad and varied enough to serve as a preparation for those fundamental branches of nursing which occupy the large majority of the graduates of nursing schools.'*

Probably the committee felt it necessary to state its position on this issue so unequivocally because of the tendency to limit clinical training to preparation for institutional nursing and to exclude elements of other more specialised branches of nursing, notably public health nursing, thereby effectively restricting the basic course to training for nursing the sick.

The committee's position was, moreover, in line with the position taken in the first conclusion of 'Nursing and nursing education in the United States,' the Report of the Committee for the Study of Nursing Education, generally known as the Goldmark Report after the committee's secretary who also wrote the report, Josephine Goldmark. In this conclusion, it was stated that (Goldmark, 1923, p. 11):

> *'... since constructive health work and health teaching in families is best done by persons:*
> *a. capable of giving general health instruction, as distinguished from instruction in any one specialty; and*
> *b. capable of rendering bedside care at need;*
> *the agent responsible for such constructive health work and health teaching in families should have completed the nurses' training. ...'*

The '*specialist-generalist*' debate thus added a new dimension to the argument between conservatives and liberals to the effect that the scope of curriculum development was widened from the standardisation of the

nurse's training to discussions about the lines of division between general branches and specialised positions in nursing. To appreciate the significance of this new dimension for the revision of the standard curriculum, it is necessary to dwell upon the Goldmark Report first.

13.1.3. 'Nursing and nursing education in the United States'

At the time of its publication, the Goldmark Report was considered to be of equal importance to nursing as the Flexner Report to medicine (Beard, 1923, p. 358). Although it dealt with educational matters in considerable detail, its major impetus was not so much an educational problem as the shortage of well-trained public health nurses in the late 1910s. The latter problem was brought about by the adjustments to the exigencies of military demands as well as the accelerated development of the public health movement. To study the shortage of public health nurses, the Rockefeller Foundation appointed the Committee for the Study of Public Health Nursing Education (1919) which, under the chairmanship of Professor C.-E. A. Winslow, decided to embark on a study of 'the proper training of public health nurses' (Goldmark, 1923, p. 7).

The most popular shortcut to meet the increased demand for public health nurses at the time were the widely advertised short courses of five to six weeks' duration, which was supposed to be long enough to train young women without prior hospital training for public health work. It soon became clear that these courses not only were damaging for the public esteem in which public health nurses were held but challenged existing methods of preparation for this branch of nursing as well. Not surprisingly, the first short study of the committee brought out the fact that (Goldmark, 1923, p. 7):

> *'the entire problem of nursing and of nursing education, relating to the care of the sick as well as to the prevention of disease, formed one essential whole and must be considered if sound conclusions were to be attained.'*

The Goldmark Report did not explain precisely how this conclusion was arrived at, although its wording hinted at the need to take into account '*the care of the sick*' as well as '*the prevention of disease*.'

In 1920, the committee, under its new name 'Committee for the Study of Nursing Education,' widened the scope of the study to include 'a study of general nursing education, with a view to developing a program for further study and for recommendation of further procedure' (Goldmark, 1923, p. 7). However, unlike Flexner, the committee never got to the stage of grading the hospital schools of nursing.

The Goldmark Report (Goldmark, 1923) was divided into two parts. The first part was concerned with the functions of the nurse, encompassing the branches of public health nursing (pp. 39-161), private duty nursing (pp. 161-184), and institutional nursing (pp. 184-185). The second part was concerned with the training of the nurse, covering not only the hospital school of nursing (pp. 187-473) but also training courses for the subsisidiary nursing group (pp. 473-485), the university school of nursing (pp. 485-499) and postgraduate courses (pp. 499-561). These two parts, between them, provided all the data on which the committee's report (pp. 7-33) and that of its secretary (pp. 33-39) were based.

13.2. The revised curriculum's concept of nursing

The emphasis in the first part of the Goldmark Report was on the role of the nurse in public health and far less on the private duty and the institutional nurse. Over the years, the public health nurse's role was increasingly identified with the social and health aspects of nursing rather than the physical care of the sick which was more or less associated with the two other branches of nursing. Also, it is important to recall that, whereas the existence of the hospital antedated the evolution of modern nursing in the United States, public health nursing was already established when, in the 1910s, the new public health movement started to gain momentum.

The distinguishing mark of the new public health movement, as mentioned earlier, was its '*emphasis on the individual - man, woman, and child; and their education in habits of hygienic living*' (Goldmark, 1923, p. 39). As a result of this movement's emphasis upon popular education, more and more public health nurses were enlisted to become the '*bearers of the new gospel of prevention as well as cure, to become the teachers of health*' (Goldmark, 1923, p. 42).

In the 1920s, public health nursing rested on three guiding principles which reflected its evolution, viz. the care of the sick, the prevention of illness, and the promotion of health. In spite of the emphasis upon the second and third principles, the care of the sick was as inviolate then as it was in the days of district nursing but the approach had changed from a '*purely palliative measure*' into an '*educational process*' (Geister, 1923, 682). In fact, so successful were they in this educational role, that the question was raised of whether public health nurses should not leave bedside nursing to other nurses and concentrate exclusively on their preventive health work altogether. This question resulted in the controversy between specialised and generalised nursing, or as the report put it, the discussion about (Goldmark, 1923, p. 134):

> *'the relative merits of combining or of separating curative and preventive nursing; and the relative merits of the system of "generalized" nursing, wherein one nurse gives all nursing care and instruction in a given area, as contrasted with the "specialized" system, wherein the nurse devotes herself to one field of nursing only, irrespective of geographical areas, and usually to instructive work only, in her own field.'*

13.2.1. Specialised versus generalised nursing

In the late 1910s, the question of whether the public health nurse should or should not also render bedside care was a hotly debated issue, although it was hinted at as early as in 1906, in an article on the question 'Do district nurses do nursing?' (AJN, 1906, pp. 210-212).

Specialised nursing. The arguments in favour of the system of specialised or instructive nursing were (Goldmark, 1923, p. 9):

- the administrative difficulties involved in the conduct of private sick nursing by official health agencies,
- the danger that the urgent demands of sick nursing may lead to the neglect of preventive educational measures.

In addition, it was argued that '*nurses cannot successfully combine instruction in the various specialties; to do good work they must be restricted to the single field which they may elect*' (Goldmark, 1923, p. 135).

The arguments used against specialised nursing rested on its suffering from certain defects which, although less obvious than those of generalised nursing, were in reality more serious because they were inherent in the very organisation of the work itself and therefore not subject to control (Goldmark, 1923, p. 9):

- the introduction of the instructive but non-nursing field worker creates at once a duplication of effort, since there must be nurses from some other agency employed in the same district to give bedside care,
- the field worker who attempts health education without giving nursing care is by that very fact cut off from the contact which gives the instructive bedside nurse her most important psychological asset.

Moreover, it was argued by some, '*purely instructive nursing renders no actual service and offers only words of counsel for aid*,' an argument which the committee considered '*inaccurate as well as unfair*' (Goldmark, 1923, p. 136).

Generalised nursing. On the whole, the committee acknowledged that the arguments in favour of specialised nursing had a point as far as the weaknesses in generalised nursing were concerned, but admitting these weaknesses was '*not therefore to deny the theoretical and practical benefits of the generalized system*' (Goldmark, 1923, p. 135). These benefits were (Goldmark, 1923, p. 9):

- the nurse who approaches a family where sickness exists, and renders direct technical service in mitigating the burden of that sickness, has an overwhelming advantage, then and thereafter, in teaching the lessons of hygiene,
- the bedside care it offers and its stress on a local unit of work for each nurse are, in our opinion, irreplaceable assets, opening doors to the nurse at which she knocks in vain with instruction only.

Probably because of the Goldmark Report's preference for this system, it did not mention any disadvantages other than those implied by the arguments in favour of specialised nursing. In one of the reviews of the Goldmark Report (Gardner, 1923), however, it was argued that, contrary to what the report suggested, the generalised system was still at an experimental stage. And, as to its second advantage, the reviewer asked her readers '*Is the day not passed when a good specialized nurse knocks in vain at the doors of those needing her*,

and as our instructive work continues to grow, are there not very many homes in which no bedside care will be required either at the first contact or at any subsequent time?' (Gardner, p. 262).

Individualised nursing. Most of the arguments pro and con either specialised nursing or generalised nursing focused on practical details. The conclusion of the committee, however, was based on the need of an individualised approach in nursing requiring a system of generalised nursing (Goldmark, 1923, pp. 136-137):

> *'The essence of this problem is plainly the approach to the individual, the contact. How, among the vastly increased conflict of motives, interests, and objectives in man's modern life, shall we obtain for a given idea that degree of attention which is needed to give it some degree of permanence and to release its dynamic power? How shall we combat for a given object not only mental inertia - the natural human inclination to think only when we must - but also the active opposition of natural human prejudices in favor of our own way of life, however mistaken? ... Again and again in our study, ... this principle that curative care provides an approach to the preventive has been illustrated. Gratitude for relief in suffering, or for the relief of those who are dear to them, is a potent motive in opening the minds as well as the hearts of men. ...*
> *This is, in our opinion, the strength of generalized nursing, combining bedside care and instruction as against instruction alone, that it offers a natural, an unforced approach to the individual and the family, because it is itself sought. It works with, instead of against, deep ingrained instincts of normal adult life. This is, again, in our opinion, the great asset for preventive health work of the nurse, that she stands in the minds of the ignorant as well as of the better informed, for a person who has at her command a training in the treatment of disease which at any emergency is indispensable; a person who through her clinical experience can give bedside care at need and is thereby entitled to a hearing from those to whom she has ministered in sickness or to whose family or friends she has ministered.*
> *The instructive work of the generalized nurse starts from this vantage ground. Her concern for the health of the entire family further reinforces this initial advantage. Each member of the family whom she can aid by nursing care and advice adds to the sum of her influence.'*

In this conclusion, the Goldmark Report first of all stressed the need to individualise nursing care. This was not to say that public health nurses had demonstrated no interest in the individual before. But, whereas this interest did not go much further than the individual insofar as his health was affected by the social conditions in which he lived, the Goldmark Report urged nurses to focus on the individual as an individual. Secondly, individualised nursing could not be achieved unless instructive nursing went hand in hand with bedside nursing, i.e. generalised nursing. The primary objective of public health work, however, remained the health of the community (Goldmark, 1923, p. 43):

> *'Public health nurses are to be differentiated from institutional nurses, working in hospitals or other institutions, and private duty nurses who take care of private patients. The public health nurse is any graduate nurse who serves the health of the community, with an eye to the social as well as the medical aspects of her function, by giving bedside care, by teaching and demonstration, by guarding against the spread of infections, insanitary practices, etc.'*

This definition of the role of the public health nurse, by inference, threatened to split up the nursing profession into two different groups, for public health nurses, although they provided some bedside nursing, primarily served the health of the community. Consequently, this group had to be complemented by yet another group of nurses caring for the sick, i.e. hospital nurses and private duty nurses. Because the former group focused upon the social aspects of nursing, the latter, it was implied, aimed at the physical aspects of nursing. On the other hand, both groups were concerned with the medical aspects of nursing, too, but the former did so for preventive, and the latter for curative purposes. It was this division between health nurses and sick nurses, prompted by the issue of generalised versus specialised nursing, which was at the source of the revised curriculum's concept of nursing which encompassed both.

13.2.2. Nursing: sick nursing and health nursing

Given its acceptance of the principle of the basic course, the Committee on Education opted for a general and all-round programme of study, and decided, therefore, to (NLNE, 1927, p. 10):

> *'omit the special elective courses which were included in the old curriculum for the purpose of giving a brief introduction to the student's chosen field of work, and to concentrate in the basic course on those fundamental principles and methods which underlie all nursing, leaving to supplementary instruction "in service," those very special techniques and adjustments which are peculiar to special branches.'*

Nursing was thus not viewed in terms of '*branches of nursing*' but in terms of the '*fundamental principles and methods which underlie all nursing*.' This interpretation is vindicated by the committee's explanation for including the elements of public health and social service in the basic course (NLNE, 1927. pp. 11-12):

> *'It has long been contended by those who are concerned mainly in increasing the supply of "bedside" nurses, that the basic course should deal with sick nursing only and that all preventive and social aspects of nursing should be considered as belonging to the specialized field of public health nursing and relegated to a period of postgraduate training.*
>
> *This is not the opinion held by the large majority of nurses and it is not the idea which has been incorporated into this Curriculum. Briefly stated, our position is that health nursing is just as fundamental as sick nursing and the prevention of disease at least as important a function of the nurse as the care and treatment of the sick. Indeed these functions cannot be separated though they are undoubtedly represented in different proportions in the different fields of nursing. Moreover, the nurse is essentially a teacher and an agent of health whatever field she may be working in, though here again the emphasis varies. All nurses must also be concerned with the social conditions which so directly affect the condition of their patients and their prospects of cure. The subordination of the "human" element in our work to the physical and technical is one of the severest criticisms we have to meet in nursing today, and it seems strange that there should be any question about the necessity for a much stronger emphasis on these human and social factors in the training, whether we are dealing with sick nursing or health nursing.*
>
> *Every one of these elements was incorporated into the system of nursing established by Florence Nightingale over sixty- five years ago and the principles may still be found very strongly expressed in her writings. With the recent rapid development of the public health movement, there seems to have been some tendency to identify these social and preventive elements with the work of the public health nurse and the social service nurse instead of with the basic practice of nursing itself. This was perhaps natural since there has been more opportunity to stress these elements in community health work, but it would be unfortunate if we should begin to consider them as "extras" in the nurse's training, to be obtained only through experience in public health nursing or social service, enlightening and vital as those experiences are. The curriculum has been developed on the assumption that the social, preventive and teaching elements of nursing should be taught in all good nursing schools. Indeed it is just as essential for the private nurse or the hospital nurse as for the future public health nurse, to have this broader conception of her duties and responsibilities. It would be desastrous indeed if we should allow the great taproot of our professional training to be impoverished by the loss of those vital elements that should nourish the whole body and not one special branch.'*

As far as the conceptual development of nursing is concerned, this text is undoubtedly one of the classics in nursing literature for it heralded the inclusion of social aspects and health into nursing which, until then, was dominated by physical aspects and disease. This expanded concept of nursing was to have far reaching consequences as it not only required the subsequent inclusion of public health nursing in the scheme of practical instruction but was also conducive to a view of nursing as one indivisible whole. The latter consequence can be illustrated by a comparison with the development of nursing in the Netherlands where public health nursing was relegated to postgraduate education as early as in the 1920s. As a result, institutional nursing and public health

nursing were separated right from the start with the effect that, at present, these branches of nursing are difficult to reconcile in one common concept of nursing.

Also, the position taken by the Committee on Education took the discussion about nursing an essential step further in that the resulting concept of nursing was based upon the fundamental principles and methods of nursing rather than either its social value as a national service, or, for that matter, the institutional and social services provided by nurses. Close reading of the text itself, moreover, reveals the contrast between sick nursing and health nursing, as it was understood in 1927, to have been at the source of the revised curriculum's concept of nursing which encompassed both (Table 10).

The basic course should deal with sick nursing only	**Health nursing is just as fundamental as sick nursing**
All preventive and social aspects of nursing should be considered as belonging to the specialised field of public health nursing	These elements should be identified identified with the basic practice of nursing itself
All preventive and social aspects of nursing should be relegated to a period of postgraduate training	The social, preventive and teaching elements of nursing should be taught in all good schools of nursing
The function of the nurse is the care and treatment of the sick	The prevention of disease at least as important a function of the nurse. Moreover, the nurse is essentially a teacher and an agent of health
The subordination of the 'human' element in nursing to the physical and technical	All nurses must also be concerned with the social conditions which affect the condition of their patients and their prospects of cure
The social, preventive, and teaching elements should come as a special illumination at the end of the basic training. They are'extras' in the nurse's training, to be obtained only through experience in public health nursing or social service branch	These elements must come into the training early so that they can be applied all the way through. The great taproot of our professional training includes these vital elements that should nourish the whole body and not one special
Emphasis upon the processes of disease and the technic of treatment and the neglect of the causes and the measures of prevention	A change of emphasis in existing courses with their tendency to over stress the processes of disease and the techniques of treatment and to prevention pay less attention to the causes and the measures of
Emphasis upon the scientific and technical side of the nurse's work	More emphasis on the human and social side of the nurse's work, while not neglecting the scientific and technical side
Emphasis upon the study of disease and the nursing care of the sick	Health protection and health teaching are brought forward and carried right along with the study of disease and the nursing care of the sick
Professional nursing is defined as the duties, functions, and responsibilities of the nurse	Professional nursing is defined as both a personal and community service

Table 10. The revised curriculum's model of nursing (NLNE, 1927).

Finally, what enhanced its historical significance even more was the reference to this concept's being identical to the '*system of nursing established by Florence Nightingale*,' the principles of which, it was said, '*may still be found very strongly expressed in her writings*.' This observation was attributed to Nutting who had pointed out that Nightingale had a clear vision of the new developments in their main outlines many years before they actually took place (Winslow, 1911, p. 916). At the time that she made this observation, it may have been correct, as the public health movement was still dominated by sanitary science. It should, however, be pointed out that the concepts of sick nursing and health nursing, as they were used in the revised curriculum, had lost virtually all their sanitary connotations. Moreover, these concepts were related to an approach which, according to the distinction made by Ten Have (1983), was essentially biological rather than sociological. It was this

'*biological'* approach which not only brought out the '*human'* element in nursing but which established the concept of individualised nursing too.

13.3. The revised curriculum's concept of nursing education

The revised curriculum's concept of nursing education was not only based upon the '*principle of the basic course*' but was also prompted by the experiences of the Yale University School of Nursing. This experimental school demonstrated that the social, preventive and teaching elements of nursing could indeed be incorporated into the basic training. Also, this school proved the value of the case method as a tool for individualising nursing care. Both these elements were at the source of the revised curriculum's concept of nursing education. However, for the sake of continuity, it is necessary to dwell upon the conclusions of the Goldmark Report first.

13.3.1. The training of the nurse

The second part of the Goldmark Report was devoted to the problems related to the training of the nurse. At the time, these problems were exacerbated by the indifference of young people to a nursing career due to the authoritarian discipline and other undesirable conditions in the hospital schools. It was, therefore, decided to make a field study of 23 schools of nursing which represented a fairly representative sample of nursing education at the time (there were over 1,800 hospital schools in the United States). Both the data and recommendations of this study took up nearly half the 600 pages of the Goldmark Report.

More importantly, the report also drew attention to two conflicts of interests which, in 1917, had given rise to the dichotomy between nursing service and nursing education, on the one hand, and training and education, on the other. In the Goldmark Report, however, these issues were slightly rephrased, thereby indicating how the essence of the problems confronting nursing education gradually came to the fore.

Hospital administration versus nursing education. Due to the difficult patch public health nursing had been going through, the aims of the training school, initially, continued to be discussed within the framework of the conflicting demands of the hospital and the community (Gray, 1921, p. 313):

> *'Granted that the claims of the hospital are urgent, that the sick must be cared for, are hospitals justified in conducting schools of nursing that offer* education *in return for three years of service and then deliberately aim to produce a skilled worker conversant with all the details of work in that particular institution and capable of rendering efficient bedside care* only*?*
> *Or are the claims of the community to be considered? The claims are loud and persistent and call for women of education, with a broad social background, of democratic ideals and ability to translate these ideals in terms of service, with a knowledge of the underlying principles not only of nursing care, but of the maintenance of health and the prevention of disease; with organizing and executing ability, and for many positions with the personality essential to leadership.'*

The Goldmark Report, however, focused upon the educational nature of the nurse's training itself rather than the claims of either the hospital or the community (Goldmark, 1923, pp. 194-195):

> *'On entering upon a study of nurse training today we are confronted by this dual character of the training school. It is indeed, as we shall see, the crux of our problem, the heart of our difficulty. For the school of nursing has sought to perform two functions: to educate nurses and to supply the nursing service for the hospital. But in these two functions there lies an ever present possibility of conflict. The needs of training and of hospital services may not coincide, and when the two are in conflict, the needs of the sick must predominate; the needs of education must yield.'*

Accordingly, the conflict of interests was rephrased in terms of a conflict between '*a policy of hospital administration, which properly aims to care for the sick at a minimum cost*,' and '*a policy of nursing education which with equal propriety aims to concentrate a maximum of rewarding training into a minimum time*'

(Goldmark, 1923, p. 17). As to the solution of this problem, the report pointed out that '*adequate funds should be available for the educational expenses of the school itself, and for the replacement of student nurses by graduate nurses and hospital help in the execution of routine duties of a non-educational character*' (Goldmark, 1923, p. 23). Up to the late 1920s, however, general duty was the most unpopular branch of nursing because nurses had to work broken hours and to accept accomodation in nurses' dormitories. The lack of status of graduate nurses in American hospitals apart, general duty provided little opportunity for caring for individual patients.

Apprenticeship training versus professional education. The other conflict of interests was similar to the earlier noted issue of training versus education but was rephrased in terms of '*apprenticeship training versus professional education.*' Whereas most other young professions, it was argued, sooner or later abandoned apprenticeship training to replace it with '*independent institutions, organized and endowed for a specifically educational purpose*,' the training of nurses was '*still in the main, actually if not technically, directed by organisations created and maintained for the care of disease, rather than for professional education*' (Goldmark, 1923, p. 17). This assessment demonstrated the growing awareness of the evolutionary stages in vocational education. Beginning with the '*pick-up*' stage where the training is entirely unorganised, followed by the stage of training by means of apprenticeship, vocational education (Stewart, 1922, p. 332):

> *'comes at the point when the work of training is transferred to a school whose primary purpose is not production, not service to some individual or institution, but, first and last, education.'*

It was believed that nursing education found itself in the second stage and was ripe to move on to the third (Meyers, 1924; Stewart, 1922). To achieve this objective, not surprisingly, the Goldmark Report suggested that the school '*be directed by a board or a committee, organized more or less independently for the primary purposes of education*' (Goldmark, 1923, p. 17), but it conspicuously failed to take this recommendation to its logical conclusion, i.e. the substitution of collegiate schools for the hospital schools. Apart from the many practical problems involved, such a recommendation would have met fierce opposition from physicians and hospitals. The former held the opinion that nurses were overtrained, and the service they gave was too expensive. Moreover, it was argued, women with a brief training in bedside routines would be just as satisfactory. As to the hospitals, they conceived nursing education as the acquisition of technical skills and manual dexterity for which the nurse needed neither much intelligence nor much knowledge.

The position of the Committee on Nursing Education. The Goldmark Report expressed the view that both conflicts of interests added up to the question of the educational, administrative and financial independence of the training school. Giving due recognition to the value of collegiate schools of nursing for the education of nursing leaders, the Committee on Nursing Education nevertheless held the opinion that (Goldmark, 1923, p. 17):

> *'So far as the trained nurse is concerned, whether she is to function in private duty, in public health or in institutional service, it is clear that her basic professional education must be acquired in the hospital training school.'*

This optimism as to the feasibility of improving the hospital training school was based upon the field study which revealed that the shortcomings of the schools were not chargeable to deliberate neglect on the part of hospital authorities or nursing superintendents, and that every one of the shortcomings had been corrected in one or more of the training schools studied by the investigators (Goldmark, 1923, p. 20). Probably, the committee also attempted to make a virtue out of necessity as it would have been practically impossible to do away with the hospital schools altogether. In order to make the training of the nurse more educational, the Goldmark Report, basically, made two sorts of recommendations. Whereas some were geared to strengthen the hand of the hospital school against the pressures of the hospital administration, others were aimed at bringing the nurse's training more in line with other fields of professional education.

Towards a policy of nursing education. The first recommendation entailed the shortening of the course by eight months to 28 months to be effected by the following measures (Goldmark, 1923, pp. 459-460):

'By the elemination of services of least value to the student training such as private duty.
By the radical reduction of other services in which students spend time totally disproportionate to the educational value of the service, such as the surgical wards, the surgical supply room, the diet kitchen.
By the saving of time now educationally barren in the first year for lack of theoretical instruction later given to explain the nursing and treatment of diseases encountered; and finally
By the saving of training educationally barren in the third year through the monotonous repetition of duties.'

Shortening the training of the nurse, it was argued, meant '*an increase of over 20 percent in the potential output of the training school through the saving of time alone.*' But the main consideration was that '*the shorter course projected would not imply a lowering but a raising of educational standards*' (Goldmark, 1923, p. 22).

Towards professional education. In order to transform the apprenticeship training into a more professional kind of education, the Goldmark Report recommended (Goldmark, 1923, pp. 21-22):

- the completion of high school or its equivalent as entrance requirement,
- a preliminary term of 4 months' training in the basic sciences and in elementary nursing procedures with appropriate ward practice but without regular ward service,
- a period of 24 months devoted to a carefully graded and progressive course in the theory and practice of nursing, with lectures and ward practice so correlated as to facilitate intelligent case study and with the elimination of routine duties of no educational value,
- a working day for the student nurse, including ward work and classroom periods, which should not exceed 8 hours, and a working week not exceding 48 hours and preferably 44 hours.

13.3.2. The Yale University School of Nursing

Although the recommendations for the improvement of the hospital school, at least in principle, had a mitigating effect on the two conflicts of interests discussed earlier, they admittedly fell far short of a solution of the underlying problem, i.e. the lack of financial independence of the hospital school (Goldmark, 1923, p. 34):

'Until the general public by taxation for public institutions, by endowments and gifts for those privately supported, makes the hospital independent of the school for its permanent staff, the hospital must continue its paradoxical attempt to maintain a school without means; the school in its turn must remain in part at least crippled by work in excess of any educational program.'

Effectively admitting its inability to bring about more radical changes in the training of the nurse, the Committee on Nursing Education prodded the Rockefeller Foundation into financing an experiment with a university school of nursing to demonstrate the viability of its recommendations. This was the starting point for the Yale University School of Nursing as a separate university department with an independent budget and its own Dean, Annie W. Goodrich (AJN, 1923). The conditions of the endowment were specific and provided (Goodrich, 1932, p. 308):

'that the course be given in the shortest possible period of time through the elimination, so far as wise, of non-nursing procedures; that the theory be correlated with the practical experience; that emphasis throughout the course be placed on preventive medicine.'

The historical significance of the Yale University School of Nursing which started in 1924 was not limited to implementing the recommendations of the Goldmark Report as the school practised a patient-centred philosophy of nursing as well as a student-centred philosophy of education. Both were heavily influenced by the educational ideas of John Dewey and were aimed at producing what Goodrich called '*creative'* nurses.

The case method. The keystone of the curriculum was the use of the case method. At the time, this was a rather revolutionary method of teaching nursing which put high emphasis upon the social, psychological and physical

aspects of patient welfare. This patient-centred approach was matched by a student-centred program of clinical experience designated as the case assignment method which entailed that the student was allocated one or more patients rather than a series of nursing procedures. Through this method, it was believed possible for the student (Goodrich, 1932, p. 309):

> *'not only to master the required skills but to attain that intelligent and sympathetic understanding of the patient and his mental and physical needs that will awaken an interest extending to a shared responsibility in achieving the best end results.'*

Moreover, the case method was intended to assist the student to develop a method of caring and studying (Hodgman, 1929, p. 1359):

> *'with the object of centering the student's attention upon the individual and the effect of the disease upon the individual rather than upon the disease itself, or upon the technic of nursing procedures. In the hospital this method is opposed to the so-called "efficiency method" of assignment by duties, as temperatures, treatments, Senior work, Junior work, and so on. It is based upon the idea that "Real Nursing begins where efficiency leaves off." (This is not a denial, however, of the need for efficiency!).'*

The idea of responsibility for the care of the whole patient had its origins with dean Goodrich and preceded by many years the psychosomatic approach to medicine as well as the integration of psychosocial aspects of nursing into the basic curriculum (Curtis, 1972, p. 235). Consequently, the social and health aspects of nursing as well as the mental aspects of nursing came to be regarded as integral parts of nursing.

Social and health aspects of nursing. Although the Yale University School of Nursing emphasised public health nursing, the school's primary aim was to educate women as nurses (Hodgman, 1929, p. 1355):

> *'The object is not to prepare them for any one of the various fields in nursing, nor is it to prepare them as "administrators, supervisors, or leaders" as has often been suggested. ... The object of the school is based upon the belief that basically nursing is one thing, whether carried on in the hospital, in connection with one patient, in private duty, or in some public health activity. If the needs of the public health field seem to be emphasized, it is because of the belief that in these aspects the public health nurse is functioning more fully at the present time as a nurse, than in other phases of work.'*

This statement is most illuminating as to the state of affairs in nursing in the late 1920s. Hospital nurses were increasingly subjugated to efficiency criteria prompted by the philosophy of scientific management and the accessory time studies. Public health nursing, on the other hand, was thriving and offered the 'original' work Flexner had hinted at, while unemployment among private duty nurses was rising. In response to these developments, the Yale University School of Nursing, while giving due recognition to the advanced position of the public health nurse, stressed that, at the end of the day, nursing was 'one thing.'

Mental aspects of nursing. Another interesting feature of the Yale University School of Nursing was the emphasis upon psychiatry at a time when the care of the mentally ill was only just beginning to be influenced by Freudian and neo-Freudian theory, and few hospital schools included this subject in their curriculum. This innovation was due to the influence of one of the nursing teachers at the school, Effie J. Taylor, who was actively involved in the so-called mental hygiene movement to be discussed in the next chapter, and was advocating the incorporation of psychiatry into nursing education. During a meeting of the ANA mental hygiene section at the Joint Convention in 1928, for example, she is reported to have said (in: Roberts, 1954, p. 211):

> *'Modern psychiatry and education are pointing the way to the development and care of the total human being, particularly through the formative years of childhood and on through the adolescent period. With this new thought in education, nursing must change its viewpoint and embrace the idea that good nursing care of the physically ill patient involves a knowledge and an appreciation of the influences which the emotional and intellectual life bear on the physical well- being of the patient and* vice versa*.'*

This philosophy was in line with both Goodrich's concept of nursing the whole patient as well as the climate at Yale University which was rather favourable to this expanded concept of nursing, or as Dean Winternitz of the Yale School of Medicine put it (Goodrich, 1932, p. 333):

> *'The public health problem is not only the problem of infectious disease, metabolism, etc., but it is also the problem of the adjustment of the individual to his environment from a psychic standpoint. This is the most pressing problem that public health and nursing and medicine have to face in the future.'*

These references to the mental aspects of nursing foreshadowed some of the changes to be made in the third and last edition of the Curriculum in 1937.

13.3.3. The revised curriculum

In due course, many elements of the Goldmark Report and the Yale University School of Nursing found their way into the revised curriculum and helped to strengthen the position of nursing education. However, because the time was not yet ripe for the nursing schools to be transferred to institutions for higher education, the revised curriculum included an edited version of Nutting's contribution to the standard curriculum, this time entitled 'Some essential conditions in the education of nurses' (NLNE, 1927, pp. 17-44). In addition, the Curriculum spelled out the educational implications of its concept of nursing in general, and of individualised nursing in particular.

The revised curriculum's concept of nursing. The Committee on Education held the opinion that the social, preventive and teaching elements belonged to nursing but if these elements were to have their maximum value to the patient, the hospital and the student nurse (NLNE, 1927, pp. 11-12):

> *'... they must come into the training early so that they can be applied all the way through. They should not come as a special illumination at the end or as a corrective for that peculiar derangement of social vision which unfortunately affects many nurses, a sort of hospital astigmatism or myopia which makes them indifferent to everything outside their own walls, or beyond their technical duties. An effort has, therefore, been made to put more emphasis on the human and social side of the nurse's work from the beginning, while not neglecting the scientific and technical side. In the same way the idea of health protection and health teaching is brought forward and carried right along with the study of disease and the nursing care of the sick. Because of the very close relationship between social conditions and public health it has been decided to combine these two subjects in one called Modern Social and Health Movements. On the whole it is not so much a question of extra subjects and extra hours for these newer phases as a change of emphasis in existing courses where we have always tended to over stress the processes of disease and the technic of treatment and to slight the causes and the measures of prevention.'*

This statement added some educational categories to the revised curriculum's concept of nursing education which were remarkably similar to the ones in the standard curriculum (see tables 9 and 10). What was different though, was the motive for including these categories. In the standard curriculum, these categories resulted from the need to improve the theoretical preparation in order to keep abreast with the changes in nursing practice rather than an articulated concept of nursing as in the revised curriculum.

Further, with regard to the scheme of practical experience, there was some difference of opinion as to whether community nursing experience which the hospital was unable to offer should be included in the scheme of practical instruction as '*an essential part of an undergraduate course in nursing for all students*' (NLNE, 1927, p. 12), and understandably so, because in the past hospitals had used student nurses to procure extra income by sending them to private cases outside the hospital. In the end, it was decided to make no recommendation at all and to wait for new data from a projected NOPHN study of undergraduate courses in public health nursing.

Individualised nursing. The revised curriculum's concept of nursing was closely related to the model of individualised nursing as expressed in the Goldmark Report and Goodrich's writings. It was therefore to be expected that the Committee on Education would make some provision in order to teach students how to individualise nursing care. For this purpose, the revised curriculum included a special course on the use of the case method in nursing (NLNE, 1927, pp. 112-115). This course put great emphasis on the patient's personality and social background in relation to his health as well as the preventive and educational measures in the follow up or after care. As for the educational value of the case method, it was noted that (NLNE, 1927, p. 40):

> *'the individual patient is used as the subject of study, and the student learns to gather together and organize all the relevant material belonging to the case in hand, and to use this material in working out a plan of nursing care for the patient.'*

The innovation implied by this description becomes clear if compared with the explanation of the conference or case-study method given in the standard curriculum (NLNE, 1917, p. 29):

> *'This [method] is used with more advanced pupils, who are capable of gathering together their own material and presenting reports on their observations or practical work, which are then discussed and criticized by the class and teacher.'*

The main difference between the 1917 and 1927 versions was that the case study, which only required gathering data, critical evaluation, interpretation of data as well as the analysis and comparison of results, was complemented by case work requiring in addition 'the formulation of a plan, treatment, supervision and records' (NLNE, 1927, p. 112).

In the revised curriculum, the case method was thus not only used as a teaching tool but as the method of choice to apply the revised curriculum's concept of nursing as well. The extended application of the case method exemplified the change of approach of the Committee on Education which was inspired by its concept of nursing rather than its wish to standardise the nurse's training.

13.4. The revised curriculum's concept of professional nursing

In the last chapter, it was concluded that the purpose of the standard curriculum was the standardisation of the nurse's training in order to meet the changing demands of society. At the time of the revision of the standard curriculum, however, the study of curriculum had become a specialised field of study within educational science. Four major factors of change were (Lommen, 1925):

- John Dewey's philosophy of education according to which education had to assist the individual to his best self-realisation and to free the life processes for their own most adequate fullfilment,
- the increasing employment of the scientific method of study in education,
- the new definition and the functional character of educational psychology in which the unit of analysis was the so-called Situation-Response Unit,
- the introduction of social and industrial matter into the curriculum to make it as broad and rich as life itself.

Also, the emphasis shifted from the content of the curriculum towards the process of curriculum development by means of practical objectives. In the revision of the standard curriculum, these objectives entailed the generally accepted duties, functions and responsibilities of the average nurse and were, therefore, seemingly conducive to a functional approach of nursing. In fact, it is contended here, these objectives were meant to articulate the revised curriculum's concept of professional nursing.

13.4.1. Practical objectives as a basis for curriculum development

The two pioneers in the field of curriculum development were J. Franklin Bobbitt and W. W. Charters (Murdock, 1986). Using industry as his controlling metaphor, Bobbitt viewed the school as a factory, the child as the raw material, and the curriculum as the kind of processing which the child needed in order to change him into the ideal adult. '*The key to Bobbitt's theory was this emphasis on a standard product, the ideal adult*,' and '*the*

criteria for this ideal adult should be set by the community and could be determined by an analysis of adult activities' (Murdock, 1986, p. 21).

Charters, on the other hand, focused on developing and testing a specific method of curriculum construction in which teachers actively participated and which was at the source of the methods used in the revision of the standard curriculum. Whereas the subjects of the Standard Curriculum had been assigned to individual 'members specially qualified in those branches' (NLNE, 1917, p. 8), the revision was the work of '*twenty-two subcommittees composed of nurses representing all parts of the country and all branches of the profession*' (NLNE, 1927, p. 8). As a result of the democratisation of the curriculum development, more and more nurses were actively involved in the continuous process of improving the training of the nurse. The reports of the sub-committees were published, on a monthly basis, in the American Journal of Nursing (AJN, 1925 and 1926) so that '*all might have a chance to try out and to critise the new outlines before they should be compiled in book form*' (NLNE, 1927, p. 8).

It was, moreover, the use of practical objectives in curriculum development which evoked from the Committee on Education the following remarks (NLNE, 1927, p. 8):

> *'In all branches of education people are beginning to question traditional courses of study and to demand that we get back to the concrete practical activities for which the system of education is designed to prepare and that we build up courses of study on this foundation.'*

In addition, the committee stated its reasons for going along with this approach (NLNE, 1927, pp. 8-9):

> *'Such a detailed statement of objectives seems to be particularly needed in nursing education since so many people seem to be confused and uncertain about the kinds of duties and responsibilities which the nurse of today is expected to undertake. Until we can arrive at some clear understanding on these fundamentals, we are not prepared to say whether any course of study for nurses is adequate or inadequate, good or bad.*
>
> *Another good reason for a clear and definite statement of our practical objectives is that we all may understand exactly what we are committed to when we undertake the education of student nurses. This would seem to be almost as important for the trustees, officers and medical staff of the hospital which conducts a nursing school, as for the nursing staff which is more directly responsible for the management of the school and for the teaching and supervision of the student nurse.'*

Whereas the former would indicate that the uncertainty as to the function of the nurse had little improved since 1917, the latter illustrated the committee's aim to offer nurses a better deal in terms of education.

It would, however, be wrong to interpret its position as in favour of a functional approach to nursing for such a position would have been inconsistent with the revised curriculum's model of nursing. A similar argument goes for the educational nature of the revised curriculum which represented an attempt to transform the system of apprenticeship training in which the central idea was '*training in return for service*' (Meyers, 1924, p. 1215) into professional education aimed at the education for service, albeit within the constraints imposed by the hospital setting.

It would therefore be more in line with the revised curriculum as a whole, to interpret the practical objectives as some sort of a profile of the nurse, entailing all the duties, functions and responsibilities which most rank and file nurses were expected to carry out at the time, and for which the school of nursing had to prepare them.

13.4.2. Practical objectives as the basis for a profile of the nurse

The first attempt to define a profile of the nurse in terms of her duties dates from as early as 1916 (Stewart et al, 1916, pp. 321-323):

> *'Leaving out of consideration the exceptional demands and the advanced specialties which the average training school cannot attempt to prepare for, what are those functions or duties which the average nurse will be called upon to render, not only to the patient and the physician, but to the community at large, to*

her own profession, and lastly to herself as an individual. ... Briefly stated, the duties on which most of us would probably agree are as follows:
1. Hygienic and sanitary duties,
2. Administrative and housekeeping duties,
3. Educational duties,
4. Social and civic duties,
5. Professional duties,
6. Duties to herself.'

Although this outline of the duties of the nurse was not included in the standard curriculum, it is noteworthy because it was definitely a first in using practical objectives as a basis for curriculum development as was to be done in the subsequent editions of the Curriculum (NLNE, 1927, pp. 44-50; NLNE, 1937, pp. 588-608).

In the revised curriculum, the duties and responsibilities of the nurse were grouped according to their relationship to (NLNE, 1927, pp. 45-50):

- the patient,
- the physician,
- the hospital and the school of nursing,
- the household and the friends of the patient,
- the community and its social and health agencies,
- the nursing profession,
- herself.

It was, however, stressed that all these duties and responsibilities were subordinated to and aimed at one central objective, viz. '*the best welfare of the patient and the public*' (NLNE, 1927, p. 44). On the same page, this was emphasised twice more:

> *'The nurse belongs to one of several professional groups within the general field of medicine, and shares with them in the effort to care for the sick, to cure disease, to prevent suffering, and to promote a high standard of health both in individual and in community life. The ultimate object is to make life safer, happier, and more useful for all members of the community. The nurse's service is both a personal and a community service.'*

In other words, three times in a row it was stated that the nurse's professional role related not only to the community, as stated in the standard curriculum, but to the individual as well. This, it is contended here, reflected the growing interest in the patient as an individual, a trend which came to be known as the so-called '*back to the patient movement*,' and which, according to Frost (1934), was aimed at counterbalancing the earlier emphasis upon the scientific and academic aspects of nursing which characterised the standard curriculum.

This shift of emphasis is matched by changes in the Curriculum's concept of professional nursing. Whereas the standard curriculum emphasised professional nursing requiring '*the theoretical foundation on which really good practical work must always be built*' (NLNE, 1917, p. 6), the revised curriculum in its turn stressed that nursing should entail '*the actual duties and responsiblities which the average nurse is expected to carry at the present time in the practice of her profession*' (NLNE, 1927, p. 44). The use of practical objectives as a basis for curriculum development was thus aimed at defining a concept of professional nursing which rested on the nurse's duties and responsibilities in relation to those served by her rather than the theoretical foundation needed for her professional work.

13.5. A nursing curriculum

The central theme of the revised curriculum was its concept of nursing. For all its educational improvements like the improved correlation between theory and practice, the revised curriculum's content was dominated by the concept of nursing which emerged in the wake of the Goldmark Report. This concept not only incorporated the social, preventive and teaching elements of nursing but was conducive to individualising nursing care too. To

illustrate that nursing was indeed the central theme, the remaining part of this chapter is devoted to the course of study and the outline of subjects.

13.5.1. The course of study

Whereas the Goldmark Report (1923) suggested a reduction in the period of training under certain conditions, the NLNE at its meeting in 1923 went on record as approving the three year curriculum. The length of the course therefore remained three years, although some suggestions were made for schools operating the shorter programme recommended in the Goldmark Report. The time spent on practical and class instruction as well as study was not to exceed ten hours a day. This was still in excess of the eight hours a day recommended by the Goldmark Report, but '*if rigidly enforced it would be a decided step in advance of what we are doing now in most nursing schools*' (NLNE, 1927, p. 51). The entrance requirement for the course remained the completion of high school or its equivalent.

The '*general scheme of practical instruction*' covered a total of 33 months to be divided over the different services (= 5,000 to 5,500 hours). These were basically the same as in the standard curriculum except for:

- communicable diseases, including work in special divisions for contagious diseases, tuberculosis, and venereal diseases (3 months),
- psychiatric and neurological diseases (2 months),
- out-patient department, especially medical, surgical and paediatric clinics including some home service if possible (2 months).

These additions reflected the revised curriculum's concept of nursing which stressed the social, preventive and teaching elements of nursing.

The '*general scheme of class instruction*' was extended from 585 or 595 to 825 hours (885 if the electives were included). This extension hardly affected the existing ratio of practical and class instruction. For this scheme of class instruction, the fifteen hour unit was adopted '*to make it easier to evaluate the work of nursing schools on the credit basis*' (NLNE, 1927, p. 50) as was common practice in colleges and universities. On the face of it, one could therefore agree with one of the reviewers of the revised curriculum who wrote that (McKee, 1927):

> *'There is no marked departure from the principles which were embodied in the original plan nor is the thought which prompted the construction of the first curriculum changed. The idea was then, as it is now, to furnish an outline for use in the instruction of nurses.'*

This judgement, it is contended here, failed to do justice to the revised curriculum in that its concepts of nursing and nursing education exemplified more coherence than the standard curriculum. This point can be illustrated by the use of the case method of assignment and the electives.

The case method of assignment. In order to familiarise the student with the idea of individualised nursing, the revised curriculum stressed the importance of both case study and case work. The Committee on Education took this one step further by also introducing the case method of assignment. The main reason for doing this was to impress the students with the fact that '*the ward is a place for study just as much as the classroom or library*,' and 'to connect the teaching in the ward with that of the classroom and vice versa' (NLNE, 1927, p. 52). In this respect, the committee followed up the recommendation of the Goldmark Report to improve the correlation of theory and practical instruction.

However relevant for the educational nature of the nurse's training, the case method of assignment was also introduced as a means of applying the revised curriculum's concept of nursing (NLNE, 1927, p. 52):

> *'Care must be taken that no student does only routine procedures as she goes from one department to another. Assignments should be made by the head nurse on the case basis rather than according to certain divisions of ward duties, such as taking all the temperatures, giving all the treatments, etc. ... As soon as she has good command of all the fundamental procedures (which are basic in every service), the student should be made responsible for the entire care of these patients while she is on duty. In this way*

the individual patient is uppermost in her mind, and she is able to care better for his needs. At the same time she should become familiar with the social and economic factors which may have a relation to his illness, and should have an opportunity to study and get a complete picture of the particular disease from which he is suffering. The preventive and teaching work grows out of this knowledge and the close contact she has with her patient.'

The case method of assignment was thus thought of not only as an educational tool but also as a method conducive to individualised nursing care. Moreover, this method of assignment was considered to be the opposite of nursing according to certain divisions of ward duties, i.e. functional nursing.

The use of electives. Given the revised curriculum's concept of nursing encompassing both sick nursing and health nursing, the Committee on Education could not but embrace the '*principle of the basic course*.' The acid test for its accepting this principle was the use of the electives.

Whereas, in the standard curriculum, the electives were used to prepare the pupil for the work of her choice after graduation, the revised curriculum stated that elective work was not intended for '*specialization, but for the rounding out of the fundamental experience, and for further exploration and testing along the lines of the student's major interests and aptitudes*' (NLNE, 1927, p. 10). Also because of the principle of the basic course, it was suggested '*to omit the elective courses which were included in the old curriculum for the purpose of giving a brief introduction to the student's chosen field of work*,' and to replace these with electives during the practical periods in order '*to get a practical insight into the main types of nursing service'* (p. 10).

These changes in both the practical and theoretical instruction go a long way to show that the revised curriculum's concept of nursing education was based not so much on a division between the different branches of nursing as on a concept of nursing common to them all.

13.5.2. The outline of subjects

The outline of subjects in the revised curriculum was divided into two groups:

- **basic subjects**
  - Anatomy and Physiology,
  - Bacteriology,
  - General and Applied Chemistry,
  - Personal Hygiene,
  - Dietetics,
  - Elementary Materia Medica,
  - Materia Medica and Therapeutics,
  - Elements of Pathology,
  - Principles and Practice of Nursing (Elementary),
  - Principles and Practice of Nursing (Advanced),
  - The Case Method (Applied to Nursing),
  - Nursing in General Medical Diseases,
  - Nursing in Medical Specialties: Communicable Diseases and Skin,
  - Nursing in General Surgical Diseases,
  - Nursing in Surgical Specialties: Orthopedics, Gynaecology, Urology, and Operating Room Technique,
  - Paediatric Nursing,
  - Obstetrical Nursing,
  - Psychiatric Nursing,
  - Nursing in Diseases of the Eye, Ear, Nose, and Throat,
  - Emergency Nursing and First Aid,
  - Psychology,
  - History and Ethics of Nursing,
  - Modern Social and Health Movements,

- Survey of Nursing Field and Related Professional Problems.

- **recommended supplementary subjects**
  - Elements of Sanitary Science,
  - Physiotherapy,
  - Occupational Therapy and Recreation,
  - Elements of Social Science,
  - Course to Supplement Community Health Experience.

This outline contained basically the same subjects as the one in the standard curriculum, albeit differently arranged. There were, however, some noticeable differences. First, the changing attitude toward the mental aspects of disease and nursing which prompted the Committee on Education to accept unequivocally a course in psychology as an essential subject of study. Also, the committee stressed that '*This course should be quite definitely applied to the nurse's needs, with special emphasis on mental hygiene and teaching principles*' (NLNE, 1927, p. 13).

Secondly, the outline reflected the increasing importance of '*the principles and practice of nursing*.' This resulted in the recommendation to distinguish between an elementary and advanced course in nursing. In the former, the simpler nursing procedures, '*a number of related skills' like housekeeping, bandaging, elementary massage, charting, surgical supplies, etc., were gathered. The latter course, on the other hand, covered 'the more advanced procedures*' which were organised '*in a more systematic way with more emphasis on nursing technique than is possible in connection with the courses in medical and surgical diseases*' (NLNE, 1927, pp. 13-14).

Thirdly, the arrangement of the subjects over the three years was such that the case study became of paramount importance (NLNE, 1927, p. 14):

> *'The case studies should bring together all the different elements of disease, diet, medications, nursing care, personality, social handicaps, etc., and should teach students how to adapt their nursing care to the needs of the individual patient.'*

The outline of subjects thus exemplified the increased emphasis on individualised nursing as the central theme of the Curriculum without, however, losing sight of the educational aspects.

13.5.3. Conclusion

The major contribution of the revised curriculum was evidently its concept of nursing which, although apparently the same as in the standard curriculum, was much better articulated. In fact, this concept of nursing which encompassed both sick nursing and health nursing was closely related to the idea of individualised nursing care which emerged from both the Goldmark Report and the Yale University School of Nursing. The position taken by the Committee on Education reflected its support for the liberal attitude in matters concerning nursing education rather than the conservative attitude.

In educational terms, this concept of nursing was, moreover, taken to its logical conclusion by accepting the '*principle of the basic course*' and by emphasising the case method. In this respect, the Committee on Education clearly felt more at home with the 'generalists' position rather than the specialists' position.

Also, the revised curriculum was remarkably more explicit as to the function of the professional nurse for, whereas the standard curriculum gave only a formal definition of the function of the nurse, the revised Curriculum provided a detailed statement of the practical objectives in nursing education which were in line with its concepts of nursing and nursing education.

The model of nursing underlying the revised curriculum can be summarised as follows:

- **nursing**
  sick nursing versus nursing: sick nursing and health nursing

- **nursing education**

hospital administration	versus	nursing education
apprenticeship training	versus	professional education

- **professional nursing**

the trained nurse	versus	the professional nurse.

Summing up, the revised curriculum represented a decisive step forward in the conceptual development of nursing, not least because of the increased coherence between its concepts of nursing, nursing education, and, to a lesser extent, professional nursing. The latter aspect, however, was to become the central theme of the second and last revision of the Curriculum.

Finally, as for the genesis of the model of individualised nursing, this chapter has demonstrated that it originated in the field of public health nursing from which it has been extrapolated into the mainstream of nursing. Also, it has become clear that the initial evolution of this model of nursing was furthered by the Yale University School of Nursing, mainly by applying the case method in nursing education, in the form of case study and case work, and the case method of assignment.

14.
‘A CURRICULUM GUIDE FOR SCHOOLS OF NURSING’

In the fall of 1934, the second revision of the Curriculum was started (Taylor, 1935a). At that time, the nursing profession found itself in the midst of an unemployment crisis and was flooded with facts and figures proving unmistakably the need for drastic reforms. This state of affairs was summed up in an editorial of the American Journal of Nursing (AJN, 1935, p. 358):

> *‘Evidence from many sources indicates incontrovertibly that much of the unemployment of nursing during the bitter years now passing was due to lack of adaptability on the part of individuals, many of them the victims of inadequate preparation.’*

The title of this editorial was ‘Adjustment to society’s nursing requirements,’ Incidentally, it was the concept of ‘adjustment’ which set the tone for the third edition of the Curriculum which will be referred to here as the curriculum guide. The new title, ‘A curriculum guide for schools of nursing,’ was adopted to stress that this was ‘a handbook to be used by the individual school in building its own curriculum’ (NLNE, 1937, p. 10).

The timing of the start of the revision work was determined by the publication of the final reports of the Grading Committee which had endeavoured to embark upon the grading of nursing schools. The committee’s programme was divided into three projects:

- a study of supply and demand of nursing service,
- a job analysis of nursing,
- the actual grading of nursing schools.

The first meeting took place on 4th November 1925. Although the committee was to become ‘noted for frank expression of opinion’ (Burgess, 1934b, p. 941), it was also plagued by differences of interests between its members and the organisations they represented (Logan, 1925a). In 1929, for example, the American Medical Association, ‘for some reason never clearly understood by the Committee’ (Burgess, 1934b, p. 940), withdrew from active membership.

On the other hand, the contributions from the members representing the institutions for higher education were very helpful in formulating the social and educational philosophy which furnished the committee with arguments in favour of professional education for nurses. Also, these members preferred one minimum standard and not the use of three or more grades advocated by the representatives of the American Hospital Association and the American Medical Association. At the second meeting Dr. May Ayres Burgess had been secured as director and the project was fully launched. At the third meeting, held on November 18, 1926, a five-year programme was adopted to undertake (Burgess, 1934b, p. 945):

> *‘... the study of ways and means for ensuring an ample supply of nursing service of whatever type and quality is needed for adequate care of the patient, at a price within his reach.’*

This objective reflected not only the consumer orientation in the discussions on the need for nursing to adjust to society’s nursing requirements (Goostray, 1935, p. 771) but the trend of individualising nursing care too. In the end, the committee however failed to achieve its main objective, an accreditation programme for schools of nursing, but its studies revealed much data upon which to base the curriculum guide, or as it was put in the curriculum guide (NLNE, 1937, p. 5):

> *‘It was evident that something was needed to help in clarifying the educational aims and standards of nursing schools and redefining them in terms of the new situation.’*

The revision was undertaken by the Curriculum Committee of the National League of Nursing Education (formerly the Committee on Education) which was chaired by Isabel M. Stewart who was also the longest serving member of the committee. In the work of the revision, the Curriculum Committee sought to combine the technique of curriculum development with a philosophy of education (NLNE, 1937, p. 54). Murdock holds the

opinion that it was mainly Hollis Caswell's work which prompted this approach as '*He asserted that curriculum development was essentially a matter of judgment rather than technique. In the belief that these judgments would be enhanced by the widest possible participation in the decision-making process, he recommended that teachers and representatives of other interested professional and lay groups be actively involved*' (Murdock, 1986, p. 23). Accordingly, the actual revision, in which some 200 hundred nurses and more than 50 doctors, librarians, dieticians, and social workers participated, was based upon an explicit statement on the philosophy and aims of the curriculum (Stewart, 1935a and 1935b; NLNE, 1937, pp. 661-679).

As for the philosophy of education underlying the curriculum guide, however, the Curriculum Committee was influenced by many other curriculum theorists as well (Stewart, 1935c). By selecting the adjustment aim as the keystone of its philosophy of education, the committee effectively substituted the democratic ideals expressed by the progressive educators in the 1930s for the traditional aims of discipline, service, practical utility, and technical efficiency (NLNE, 1937, pp. 58-62).

Finally, there was yet another factor which helped to shape the curriculum guide, viz. the mental hygiene movement. In the literature dealing with the curriculum, this influence is consistently overlooked. Because of this lacuna, it is necessary to dwell upon the mental hygiene movement and its relation to nursing first.

14.1. The mental hygiene movement

The mental hygiene movement originated in the publication of 'A mind that found itself' in which the author, Clifton W. Beers (1908) related his experiences as a patient in a psychiatric hospital. The book immediately received wide and favourable attention. In the same year, Beers founded the Connecticut Society for Mental Hygiene. In 1909, the National Committee for Mental Hygiene (MCMH) was organised. The term 'mental hygiene' was suggested by the psychiatrist Adolph Meyer, one of the members of the NCMH, to express that organisation's intended work, viz. the improvement of the care of the insane and the prevention of mental disorders.

Adolph Meyer (1866-1950), also known as the father of dynamic psychiatry in the United States, was closely involved with Clifford Beers and was instrumental in the development of the mental hygiene movement. In his psychiatric work, Meyer rejected the neurophysiological explanations of mental illness and the accompanying diagnostic classification to replace them with psychological explanations based upon common sense. Instead, he regarded each person as a biological unit who experiences unique reactions to social and biological influences, an entity he called a psychobiological whole. He, therefore, refused to accept the exclusiveness of either brain disorders or an overwhelming environment as the cause of mental illness as both factors had to be taken into account. As a result, his prime concern was with respecting the whole range of factors in human personality growth. The individual must be understood in terms of all forces that affect him and his interaction with the social milieu. The individual was seen as a complete whole, a unique entity, a psychobiological unit. In his desire to understand the psychodynamics of individual patients, Meyer moreover advocated a holistic and integrative approach, and it was for this reason that he appreciated the value of an exact biographical history of each patient for, as a psychiatrist, he had to know about the patient's social environment and view his disorganised state as a maladjustment of the entire personality rather than the result of brain pathology. To this end, he enlisted the help of social workers, among them his wife Mary Potter Brooks, to visit the families of his patients in order to learn more about their backgrounds.

After the introduction of social workers in psychiatry, '*a trend appeared toward the individualization of patient care*' (Brown & Fowler, 1954, p. 246). As for nursing, it took, however, more than two decades for this trend to come to full fruition. The delayed effect of the mental hygiene movement on nursing was due partly to the movement itself gradually expanding its objectives, partly to the lack of vision among nurses.

14.1.1. The evolution of the mental hygiene movement

To grasp the significance of the mental hygiene movement for the development of nursing, it is important to bear in mind some of the stages this movement went through. Initially, the mental hygiene movement spent its energy in two directions which were both related to the care for the insane (Taft, 1917, p. 889):

> *'First the education of the public to a less prejudicial attitude towards mental disease through the publicity work of mental hygiene societies; second, the education of the hospital for the insane to an appreciation of the importance of prevention and the part played by social service and the readily accessible mental clinic, in the treatment of mental disease'*

At the celebration of the tenth anniversary of the National Committee for Mental Hygiene, however, Dr. L. F. Barker, one time president of the committee, stated (in: Haupt, 1922, p. 563):

> *'By a campaign for mental hygiene is meant a continuous effort directed toward conserving and improving the minds of the people, in other words, a systematic attempt to secure human brains, so naturally endowed and so nurtured, that people will think better, feel better, and act better than they do now.'*

In stressing the promotion of mental health, this new objective brought the mental hygiene movement in line with the more general trend of health promotion as exemplified by the new public health movement. This explains why public health nurses were among the first to pick up the ideas put forward by the mental hygiene movement. From the point of view of public health nursing mental hygiene came to be thought of as (Sandy, 1921, p. 23):

> *'assisting the individual, family, and various other groups to adjust himself or themselves to their environment. Life means a constant adaptation. Desires must be modified, passions curbed, impulses checked, ambition and industry stimulated, plans changed, dislikes concealed, disappointments borne and a thousand other similar conditions or situations met in such a way that life and its associations may continue.'*

As a result of Barker's definition of mental hygiene, the movement gradually moved from its concern with psychiatry to the psychology of daily life (PHN, 1928, p. 530):

> *'Mental hygiene is that body of knowledge which deals with the factors which modify the resistance of the individual to the stresses of life; its aim is that the individual shall be able not only to deal satisfactorily with the problems of nutrition and metabolism and with infective agents, but also with the much more complex tasks of man as a social unit; and that he shall work out a sound balance of the various conflicting trends of human nature.'*

Whereas these interpretations of mental hygiene portrayed the individual as adapting to or dealing with the environmental stimuli to which he, so to speak, was subjected, the emphasis gradually shifted towards the individual actively adjusting to his environment, taking into account the individual's hereditary endowment, his growth by experience, and his habit patterns. From this point of view, mental hygiene was aimed at (Patry, 1933, p. 327):

> *'the rational development to the optimum, of each individual's potential assets, assisting him in balancing these with his liabilities, and in making wholesome compromises with the situational demands and stresses of life.'*

Summing up, the mental hygiene movement evidently went through different stages to the effect that its evolution can be discussed under such headings as:

- prejudices and the role of prevention in the care of the insane,
- the promotion of mental health,
- the psychology of daily life,
- the mental growth and development of the individual.

14.1.2. The mental hygiene movement and nursing

Nurses have been involved in the mental hygiene movement from as early as 1913 when Miss V. M. MacDonald, a nurse, was chosen as executive secretary of the Connecticut Society for Mental Hygiene (Blakeley, 1930; Ireland (1924). Nevertheless, it took the mental hygiene movement a long time to have some impact upon the development of nursing but, when this happened, it had a decisive influence on both nursing and nursing education. So much so, that in 1935, discussing the past 25 years in nursing education, Taylor stated that (1935b, p. 655):

> *'... the knowledge gained through mental hygiene has had a great influence on the trend which nursing education has taken, and the graduallly shifting emphasis from the practice of purely routine technical procedures to a study of the total individual in his natural environment, through the use of the case study method of teaching nursing, has changed from the concept described in 1873, when the first American training schools were established.'*

However, due to the lack of vision among nurses, this process did not so much correspond with the evolutionary stages of the mental hygiene movement itself as with the decreasing reluctance on the part of nurses to take the mental aspects of nursing seriously.

Some honourable exceptions like Dorothea Dix apart, early American nurses showed conspicuously little interest in psychiatric nursing. In a study on nursing schools in psychiatric hospitals, entitled 'Nursing care of the insane' (Tucker, 1915a), for example, the author observed (Tucker, 1915b, p. 198):

> *'Speaking generally, neither doctors, nurses, nor the public have felt the need of nurses in this branch of medical work. Nurses themselves have not been free from the general prejudice in regard to the insane. ... nurses themselves should be educated to the needs of the mentally sick, for until nurses see their opportunity they can scarcely expect the doctors and the public to recognize it.'*

Other nurses, for example, Linda Richards, Sara E. Parsons and Mary E. May had struggled with the same problem before, pleading for '*nursing care of the insane*' to be included in the mainstream of nursing, requiring education as well as registration of the workers involved. But, whereas nursing leaders failed to respond to these pleas, public health nurses were ready to seize upon the opportunities offered by the mental hygiene concept, not only because mental hygiene, as defined by Dr. Barker, was seen as an excellent tool for health teaching, but also because public health nurses thought of themselves as an excellent instrument of the mental hygiene movement (Allen, 1928), or as Pease put it (1933, p. 136-138):

> *'The integration of mental hygiene and public health nursing seems to fall naturally into two parts. One has to do with the content of teaching, in which are woven together facts from the fields of nutrition, medicine, habit training, and others. This teaching content in the hands of an experienced nurse is a powerful tool in the campaign for the prevention of disease, the promotion of health and for the increase of satisfactions in family life. The other part ... is concerned with the emotional attitudes of the nurse who is the teacher and of the patient who is the pupil. The relationship which grows up between them is the medium which carries the teaching.'*

It was not until the 1930s that other nurses became aware of the importance of psychiatry for general nursing too (Mather, 1937, p. 1196):

> *'In summary, the psychiatric aspects of general nursing concern primarily the relationship between the patient and his nurse and the ways in which this relationship can be utilized in molding attitudes and moods so as to decrease stress and facilitate recovery. Emphasis is placed on the individual way each patient experiences his illness. This is determined by his understanding of the significance of his condition, the influence of the illness upon his life, and by the nature of his personality. Responses to previous stressful situations give clues as to the way he is likely to experience the threats and frustrations incident to sickness.'*

In due course, the mental hygiene movement brought about the further individualisation of nursing care. Some of the key concepts used were the concept that '*people's behavior always serves some need connected with their adaptation to life*,' and the idea that '*nature works as constantly for health of personality as for health of body, surmounting unbelievable obstacles to attain good adjustment*,' as well as the idea that '*We cannot decide for an individual what his aims in life shall be. After all, it is his life, not ours. It will be his decision in the long run what he will do about his problems*' (Reynolds, 1936, pp. 646-648).

14.1.3. The acceptance of the mental hygiene concept in nursing

Yet another way of tracing the relationship between the mental hygiene movement and nursing is to follow the career of Effie J. Taylor who contributed so much to the acceptance of the mental hygiene concept in nursing. This was the way she herself described the first contacts between the mental hygiene movement and nursing (Taylor, 1935b, pp. 654-655):

> *'It was between 1909 and 1912 that we began to realize that nursing involved not only the care of the body but an understanding also of the more intangible conditions interpreted through reactions, responses, and behavior in their many and varied forms. It was approximately at this time, perhaps even a little later, that we became familiar with such terms as mental hygiene, mental therapy, child development, and child guidance, and began to talk of mental disease rather than of insanity.'*

The reason for the relationship of mental hygiene to nursing being so unclear at the time was that in those early days, '*even mental hygiene had not attained the broad conception of the total human being functioning as one complete organism with the mind and body in close relation and each dependent upon the other*' (Taylor, 1932, p. 775).

When, in 1912, the Phipps Psychiatric Clinic was opened and it was decided to offer nurses in general hospitals two months of experience in learning to care for the sick mind as well as the sick body and in learning the basic principles of mental hygiene and mental health, Taylor was one of the teachers participating in this innovative program.

It was in this job that she met and worked with the psychiatrist Adolph Meyer who was the director of the clinic. His influence on the nurses' training is easy to trace in Taylor's description of the courses on psychology and psychiatry. About the former, she wrote (Taylor, 1922, p. 535):

> *'The aim of these lectures is to present briefly certain aspects of psychology that may be helpful in meeting many nursing problems. The point of view adopted in the lectures is the drawing of attention away from formal Psychology of textbooks toward a concept of mind expressed in individual behavior and adaptation of life experiences. The real test of life is largely that of adaptive capacity. The latter depends partly upon intellectual equipment, and partly upon individual habits of training from childhood on.'*

And with regard to the course on clinical psychiatry, she added (Taylor, 1922, p. 537):

> *'The lectures are devised to present Psychiatry from the point of view of formal diagnosis and symptomatology on the one hand, and by contrast on the other, to present each patient as a personality problem, with the psychosis as the result of failure of personality adjustment.'*

In 1916, at the 19th Annual Convention of the ANA, Taylor and Goodrich were among the speakers at a session on 'The mental hygiene movement and the training of nurses for mental work.' From that time on, Taylor was one of the regular speakers at these sessions until, in 1934, the section was dissolved and transferred, under its new name 'mental hygiene in nursing education', to the National League of Nursing Education.

Her influence on the nursing program at the Yale University School of Nursing apart, Taylor helped to spread the message of mental hygiene abroad too. In 1930, for example, at the ICN-Congress in Brussels, she pointed out that (AJN, 1933, p. 913):

> *'To learn to interpret intelligently the principles of mental hygiene, a new type of teaching, a new group of subjects, and a new point of view must be woven into the basic curriculum of all schools of nursing and every nurse should have this point of view so as to understand the emotional reactions of patients to daily life and the inevitable situations with which every human being is confronted. ... all nursing in the future will be vitally concerned with the prevention of illness and with the teaching of the elements of health ... and nursing will be interpreted as the care of the patient in his mental, physical, and social relations in sickness and in health.'*

To what degree her views on nursing as well as nursing education were shaped by the mental hygiene concept, can be inferred from the fact that she saw both as (Taylor, 1932, p. 774):

> *'a study of human possibilities in the light of human realities and limitations.'*

Given, moreover, that she was a member of the Committee on Education at the time of the revision of the standard curriculum, and president of the National League of Nursing Education when the curriculum guide was prepared, she was in a strategic position to ensure that the mental hygiene concept would be incorporated into the Curriculum.

In all this, she was, admittedly, helped by some external factors like the growing interest in mental health in the United States. For example, the American Psychiatric Association and the nursing organisations worked together to adapt nursing to the needs of the mentally sick and to incorporate the principles of psychiatric nursing and mental health into the basic curriculum. These efforts resulted, amongst others, in Bailey's study on nursing schools in psychiatric hospitals (Bailey, 1936) as well as the first American textbook on psychiatric nursing, written by Bailey.

As a result of the depression, cooperative relationships developed between the professions of social workers and nurses. Given the adoption of Freud's psychoanalytic theory in social work in the 1930s, this relationship was conducive to the introduction of the psychiatric and mental aspects in nursing too.

Finally, there was the emergence of psychosomatic medicine which opened up the channels of communication between mentally and physically oriented nurses.

14.2. The curriculum guide's concept of nursing

Initially, the point of departure of the concept of nursing underlying the Curriculum was the problem of '*institutional service versus social service*.' In the standard curriculum, this issue was, however, rephrased in terms of the conflicts between the interests of the hospital operating a training school for nursing and the value of nursing for the nation at large, resulting in the problem of '*hospital service versus national service*' (NLNE, 1917).

Due to the influence of the Goldmark Report and the Yale University School of Nursing, the problem was gradually dissolved in the revised curriculum's concept of nursing encompassing both sick nursing and health nursing (NLNE, 1927, pp. 11-12). Although the elements of the former concept were included in the latter, the way in which the nature of nursing was articulated had changed. Whereas the standard curriculum's concept of nursing helped to expose '*the over-emphasis placed upon the practical aspects of the training and the consequent neglect of the theoretical foundation on which really good practical work must always be built*' (NLNE, 1917, p. 6), the revised curriculum's concept of nursing called attention to '*those fundamental principles and methods which underlie all nursing*' (NLNE, 1927, p. 10). As a result, the Curriculum's concept of nursing came to be articulated in terms of nursing rather than education. Yet another indication that the initial problem was dissolved was the fact that the revised curriculum's concept of nursing was adopted for the curriculum guide as well. Nevertheless, the Curriculum Committee noted that '*There is much confusion and many differences of opinion about the meaning and scope of "nursing"* (NLNE, 1937, p. 20). Because of this confusion, it went at some length to explain once more the differences of opinion involved, thereby effectively expanding its concept of nursing. This was done by comparing the meaning of the word '*nursing*,' if either narrowly or broadly defined.

14.2.1. Nursing redefined

If defined '*narrowly*,' nursing was to mean little more than '*the manual activities required in the routine physical care of the sick*' (NLNE, 1937, p. 20), resulting in the following list of categories:

- manual activities,
- routine care,
- physical care,
- care of the sick.

On the other hand, nursing could also be interpreted '*broadly'* to include the following elements (NLNE, 1937, p. 20):

- health conservation in its widest sense, including the care of normal children and adults,
- the nursing or nurture of the mind and the spirit as well as the body,
- health education as well as ministration to the sick,
- the care of the patient's environment, social as well as physical,
- health service to families and communities as well as to individuals.

The discussion on the nature of nursing was embedded in a chapter on the 'philosophy and aims of the curriculum'. From this wider context as well as other sources (Stewart, 1935a; 1935c), it can be inferred that the contrast between nursing narrowly and broadly defined paralleled the differences of opinion between '*conservatives'* and '*liberals'* discussed earlier.

In contrast to the revised curriculum's concept of nursing, the broad interpretation of nursing emphasised the normal growth and development of man and the mental aspects of nursing, thereby reflecting the increasing influence of the mental hygiene concept on the conceptual development of nursing (table 11). These new elements notwithstanding, it was stated that the curriculum guide's concept of nursing (NLNE, 1937, p. 20):

> *'was accepted for the earlier editions of the Curriculum and it still stands, although the full content of the word and its educational implications have grown with the extension of the nurse's field, the increasing emphasis on public health, and the accumulation of knowledge ... This position has been strengthened in the last ten years and schools of nursing are now better able to interpret and support it. In the present edition of the Curriculum every effort has been made to provide a program of education which will embody this concept of basic nursing.'*

In other words, in the opinion of the Curriculum Committee the mental hygiene concept had always been included in its concept of nursing, albeit in a somewhat less explicit form.

14.2.2. The incorporation of the mental hygiene concept into nursing

The opinion that the mental hygiene concept had always been included in the Curriculum's concept of nursing was justified only insofar as it was also believed that all subjects other than nursing contributed to the Curriculum's concept of nursing for it was not until the third edition that the mental hygiene concept was used in the courses on nursing to emphasise the principle of individualisation.

In the standard curriculum, for example, mental hygiene was referred to only twice, viz. in the courses on 'Personal Hygiene' and 'Nursing in Mental and Nervous Diseases'. In the revised curriculum, on the other hand, as a result of the changing attitude toward the mental aspects of disease and nursing (NLNE, 1927, p. 13), mental hygiene was much more in evidence, notably in the courses on 'Psychology' and 'Psychiatric Nursing.' In the former course, only the last class was devoted to mental hygiene, covering the following topics:

- mental hygiene like physical hygiene concerned first with preservation of mental health and the prevention of maladjustments,
- function to build mind, personality and character,
- a well integrated, socially efficient, personality is the goal,
- differentiate from psychiatry,
- 'nursing the mind' as distinguished from mental nursing.

Nursing narrowly defined	Nursing broadly defined
• manual activities • routine care • physical care • care of the sick	• health conservation in its widest sense, including the care of normal children and adults • the nursing or nurture of the mind and the spirit as well as the body • health education as well as ministration to the sick • the care of the patient's environment, social as well as physical • health service to families and communities as well as to individuals
Nursing education for a static society at home in an autocratic type of social and political organisation	Nursing education for a dynamic and changing society at home in a democratic type of social and political organisation
military ideals and methods of training: • discipline imposed by others • self-sacrificing service that cripples the growth of the individual	democratic ideals and methods of education: • self-imposed discipline • self-sacrificing service that stimulates the growth of the individual
training which stresses: • practical utility requiring unquestioning obedience • technical efficiency requiring drill in fixed habits of behavior and standardized procedures	education based upon the principles and methods of modern science resulting in: • practical utility on the basis of intelligence • technical efficiency on the basis of initiative and self-direction
effects: subordination of the individual nurse too little emphasis on growth and self-realisation	effects: • the best opportunity for development of the individual nurse's capacity for service • emphasis on growth and self-realisation
Nursing curriculum of a technical type	Nursing curriculum of a professional type with more emphasis on thinking and understanding, social attitudes and skills, and the development of the student as a person, with a better balance between the technical, scientific, social, and cultural elements

Table 11. The curriculum guide's model of nursing (NLNE, 1937).

The influence of the mental hygiene concept was even more noticeable in the substitution of 'Psychiatric Nursing' for 'Nursing in Mental and Nervous Diseases.' This change reflected the mental hygiene movement's shift from its initial concern with prejudices toward mental disease and the importance of prevention in the treatment of mental disease towards the psychology of daily life and the growth and development of the individual. This conclusion is corroborated, firstly, by the comparison of both courses' objectives, and secondly, by the emphasis upon the use of the case method in this course (NLNE, 1927, pp. 55-56 and 143-144).

In the curriculum guide, the evolution of the mental hygiene concept in the Curriculum was finally taken to its logical conclusion. Whereas the principles of mental hygiene that were needed to assist the student in understanding herself, her co-workers and her patients were included in 'Psychology,' mental hygiene as applied to psychiatric patients, was discussed in 'Psychiatric Nursing.' As for the former, emphasis was placed upon '*the individual as he or she adjusts to new and changing conditions and requirements*' (NLNE, 1937, p. 195). As for the latter course, it was believed that '*emphasis should be placed on interpretation of the behavior of patients and the underlying dynamics of behavior rather than on diagnosis'* (NLNE, 1937, p. 492). In addition, and this was something new, the mental hygiene concept was also used for the courses on 'Nursing and Allied Arts.' As for these courses, the following recommendation was made (NLNE, 1937, p. 63):

> *'The consideration of patients as individuals and the individualizing of nursing care should be emphasized throughout.'*

The recurring references to the individual needs of the patient apart, this recommendation resulted in the inclusion of a unit on 'Planning individualized nursing care' (NLNE, 1937, pp. 357-361) which was aimed at helping the student to acquire the ability:

> *'to study the nursing needs of each individual patient and to plan nursing care based on these needs.'*

In the curriculum guide, the approach of the individual as an individual, as advocated by the Goldmark Report (albeit for different reasons) was incorporated into the Curriculum's concept of nursing at last. In contrast with the claims of the Curriculum Committee, it is contended here that this was indeed a new element which was added as a result of the influence of the mental hygiene concept on nursing.

14.3. The curriculum guide's concept of nursing education

The concepts of nursing education underlying the first and the second edition of the Curriculum were aimed at dissolving the original issue of '*service versus education*.' It was, however, not before the last revision was undertaken that the Curriculum Committee achieved this aim by articulating a philosophy of education, i.e. (NLNE, 1937, pp. 14-15):

> *'a characteristic attitude toward education and its problems with special reference to the purposes or goals to be achieved and the methods by which they are to be reached.'*

The curriculum's guide philosophy of education was based upon the concept of '*adjustment'* (NLNE, 1937, p. 17). The articulation of this philosophy of education would have been impossible, were it not for the attempts made in the earlier editions which have been shown to have resulted in a better understanding of the complex problems involved.

In the standard curriculum, for example, the original issue of '*service versus education*' was rephrased into '*nursing service versus nursing education*' in which the former was related to the need of the hospital and the local doctors to secure nursing care at a low cost and the latter to the nursing needs of the community. In addition, it was rephrased in educational terms too, viz. into '*training versus education*.' Whereas training was geared at '*the forming of habits by drill or exercise*,' the purpose of education was '*to develop mind and character and attitude, as well as conduct, and to give information. It also means the power of self-direction*' (Stewart et al, 1916, p. 326).

In the revised curriculum this was taken a decisive step further in that all the earlier issues were phrased in educational terms:

- hospital administration versus nursing education,
- apprenticeship training versus professional education,
- hospital school versus university school.

The rephrasing of the issues reflected the growing awareness of the need to enhance the educational nature of the nurse's training. To grasp the significance of the adjustment aim, it is however necessary to dwell upon the outcomes of two studies by the Grading Committee first.

14.3.1. 'Nurses, patients and pocketbooks'

The major impetus for the first project of the Grading Committee was the supposedly existing shortage of nurses. Surprisingly, however, the ensuing study of supply and demand of nursing service revealed the paradoxical situation of having too many nurses and yet too few nurses. Although many nurses were out of work, for many positions there was a serious lack of adequately prepared nurses. To solve this problem of overproduction and undereducation of nurses the Grading Committee recommended (Burgess, 1928a, p. 332):

> *'To reduce and improve the supply of nurses. Make a decisive and immediate reduction in the numbers of nursing students in the United States; and raise entrance requirements high enough so that only properly qualified women will be admitted to the profession.*

To replace students with graduates. Put the major part of hospital bedside nursing in the hands of graduate nurses and take it out of the hands of student nurses.

To help hospitals meet costs of graduate service. Assist hospitals in securing funds for the employment of graduate nurses; and improve the quality of graduate nursing so that hospitals will desire to have it.

Get public support for nursing education. Place schools of nursing under the direction of nurse educators instead of hospital administrators; and awaken the public to the fact that if society wants good nursing it must pay the cost of educating nurses. Nursing education is a public and not a private responsibility.'

These recommendations have played an important role in the awakening of nurses and hospital administrators to the fact that nursing education should be disengaged from the hospital nursing service. This was one of the major trends during the 1930s and is reflected in the publication of two separate manuals in 1936, one for the nursing schools ('Essentials of a good school of nursing'), and one for a nursing service which could be operated without dependence on a nursing school ('Manual of the essentials of good hospital nursing service'). The latter change was helped by the influx of private duty nurses in general nursing staff positions during and after the economic depression. Also, it helped to bring about a reduction in the number of hospital schools.

14.3.2. 'Nursing schools - today and tomorrow'

The objective of the Grading Committee from which it took its name was to identify a minimum standard below which no school could be called a nursing school and to classify the existing nursing schools accordingly. Due to the unexpected outcome of the study of demand and supply of nursing service, the delayed publication of the job analysis, and some other complicating factors, it proved, however, impossible to achieve this objective.

It was therefore felt to be more constructive to send out questionaires to all the schools of nursing which had agreed to participate and report back the standing of each individual school in comparison with the others (Capen, 1932). The first 'grading' took place in 1929, and the second in 1932.

The committee's inability to publish a list of approved nursing schools notwithstanding, the data resulted in a set of constructive and practical standards for nursing schools from which a school's progress could start on a course of steady self-development. More importantly though, it led the committee to the conclusion that (Burgess, 1934a):

'the fundamental cure for the twin evils of overproduction and undereducation can be effected only by the development of nursing schools which are directed with a primary educational aim and animated by professional ideals. They must cooperate with hospitals but they must have their own management and their own budgets if they are to function as educational institutions and to meet the social needs of the community.'

Given the disappointing results of this project, its influence is easy to underestimate as is often done, for it provided vast amounts of data on which to build an educational programme of a professional rather than an apprenticeship nature, albeit within the framework of a hospital school rather than an institution for higher education.

14.3.3. The adjustment aim

The Grading Committee has contributed much to the awareness of the problems of nursing and the issues involved, i.e. '*hospital administration versus nursing education*,' and '*apprenticeship training versus professional education*.' In addition, the Report of the Committee on Costs of Medical Care (1932) called attention to the need to replace hospital schools by educational institutions (in: Goostray, 1935, p. 767):

'There should be a rearrangement of curricula and a revision of the fundamental purposes of many nursing schools, so that they will produce socially-minded nurses with a preparation basic to all types of nursing service. The care of hospital patients is not, in and of itself, sufficient preparation for

professional nursing. Nurses should be prepared not only for the practice of a profession, but for life and its manifold home and community duties as well.'

Partly as a result of these issues, the adjustment aim became the curriculum guide's philosophy of education, i.e the '*adjustment of our professional service to the needs of the present day and adjustment of the individual*' (Goostray, 1935, p. 768). The former type of adjustment demonstrated the growing concern with the issue of '*ensuring an ample supply of nursing service of whatever type and quality is needed for adequate care of the patient at a price within his reach*' (Burgess, 1934, p. 945). The latter type of adjustment, on the other hand, focused on the nurse herself, or, as it was put in the curriculum guide itself (NLNE, 1937, p. 17):

'The changes in modern life are largely the result of science and technology. Nurses must be able to adjust to these rapidly changing conditions, and this means that they require a different type of preparation than would be needed for a relatively static society.'

However, the Curriculum Committee's choice for the adjustment aim as the keystone of its philosophy of education was prompted also by a comparison of the two opposing attitudes toward education discussed earlier, viz. the conservative and the liberal or progressive attitude.

Conservatives versus liberals. It speaks well of the increasing militancy among nursing educators in the 1930s, that the hallmarks of both these attitudes, and their respective effects on the curriculum, were spelled out in more detail than in the revised curriculum (NLNE, 1937, p. 15):

'... if the dominant attitude is conservative, opposed to change, rooted in tradition, sceptical of new ideas, the curriculum will be relatively static. If the attitude is on the whole liberal and progressive, experimentally inclined, and reasonably hospitable to new ideas, the curriculum will be dynamic. This does not mean that it is necessarily a good curriculum but the chances are that it will be more in keeping with current demands and conditions if there is a constant re-evaluation of the old materials and methods and a constant effort to discover better ways of doing things.'

The contrast between the two attitudes toward education was based on a range of differences of opinion which needed to be spelled out before the concept of '*adjustment'* could be arrived at. In one of the articles published in the run-up to the publication of the curriculum guide the 'conservatives-liberals' debate was phrased in terms of '*authority versus freedom*,' and '*precedent and tradition versus experimentation*.' It was further stated that (Stewart, 1935c, pp. 261-262):

'The first group [conservative] tends to favour repressive and coercive modes of discipline, to require conformity and strict obedience to orders, to rely on dril and memory work as a means of acquiring skill and knowledge. The second group [liberal] believes in the largest possible measure of freedom for the individual, tends to foster self-government and self-discipline, prefers informal to formal methods of teaching, depends for motivation on interest rather than on artificial incentives or punishments, and tends to be suspicious of any institutions or any kind of social order "that allows one part of the people to develop at the expense of the other part." They would agree with Pasteur in his definition of democracy as "that order in the state which permits each individual to put forth his utmost effort".'

That, in the nursing profession, the conservative attitude had prevailed for so long, was attributed to the '*the peculiar conditions under which nursing service and nursing education have developed*' since the conditions referred to had been conducive to a concept of nursing education whose purpose was '*to secure an amenable, if not entirely docile, army of student workers for hospital service, rather than to create a vigorous and independent group of professional workers for the service of the community*' (Stewart, 1935c, p. 262). A similar line of reasoning can be found in the curriculum guide itself too (NLNE, 1937, p. 16):

'The traditional aims of discipline, self-sacrificing service, practical utility, and technical efficiency will be found in many statements [on educational aims]. Obviously there is much of value in these aims but in

> *their interpretation too much emphasis has been placed on the subordination of the individual nurse and too little on her growth and self-realization. ... It is an accepted principle of democracy that all individuals must contribute to the service and welfare of society, but that they must also have the largest possible measure of freedom and initiative compatible with the welfare of the group. Moreover, it is generally agreed, that society is best served when individuals have the best possible opportunity for development.'*

Both in Stewart's article and in the curriculum guide itself, the liberal attitude was thus connected with a democratic type of social and political organisation. In Stewart's case, this democratic philosophy of education was contrasted with '*the dominant philosophy of education in communist Russia, Nazi Germany, and Fascist Italy*' (Stewart, 1935c, p. 260), while the curriculum guide referred to '*an autocratic type of social and political organization*' (NLNE, 1937, p. 16).

Adjustment. In the light of the debate between conservatives and liberals, it is easy to understand that the Curriculum Committee decided upon '*adjustment'* because this concept met the situation more nearly than any other (NLNE, 1937, p. 17):

> *'It is simple, comprehensive, easily interpreted in terms of nursing, in line with modern thinking in the sciences, psychology, and mental hygiene, and adapted to the present period of change and reorganization in nursing in a democratic society. None of the old aims are lost but they are reinterpreted and approached from a new angle.'*

Starting from the dictionary meaning of the word 'to adjust,' i.e. to set right, to bring to a true relative position, and to bring into right relationship, the concept of '*adjustment'* was explained primarily in terms of education (NLNE, 1937, p. 18):

> *'Life is a process of adjustment, of changes in the individual or the environment or both, to further better relationships and better functioning. Education is the means by which individuals learn to adjust. This process in normal human beings goes on from birth to death. It may be directed by educational agencies set up for the purpose or may proceed in "natural" fashion under the ordinary conditions of life. The results may be relatively successful or unsuccessful depending on various factors, many of which can be modified or controlled. The whole study and practice of education are for the purpose of securing a better understanding of the principles involved and a better mastery of the processes by which human beings adjust themselves to the world in which they live and work.'*

In order to emphasise that the adjustment aim was an educational concept more than anything else, the Curriculum Committee (NLNE, 1937, pp. 18-20) really was at pains to explain what this concept should be taken to mean (Table 12), while its significance in terms of nursing education was outlined by Stewart (1935c, pp. 264-265:

> *'It is not enough to fit nursing students to work under hospital conditions, they must be able to adjust to conditions in the world outside. It is not enough to teach them rule-of-thumb procedures and standardized technics, they must be able to adapt their methods to thousands of different situations and cases they will meet in their daily work. Moreover, we cannot assume any longer that what we teach in the period of training is going to be sufficient for the nurse's whole professional life. The school can give her a start but she will have to go on learning and growing if she is to be able to keep her place in the procession now and in the future.'*

The adjustment aim therefore required that nursing educators, instead of '*parcelling out subject matter in tight little bundles and building these up in logical sequences*,' tried '*to organize the curriculum materials around actual projects, problems, and situations as far as possible and to put much more emphasis on activities, especially those which students can carry on in groups*' (Stewart, 1935c, p. 267). To achieve this educational objective of learning by doing, it was not necessary for nursing schools to become academic for it was thought

preferable to combine the resources of the school and the hospital rather than copy an old-fashioned academic model as was attempted in the earlier editions of the Curriculum. More importantly, the individual learner was not thought of anymore as the passive recipient of environmental stimuli but as an active agent trying to bring himself into the right relationship to his environment.

What adjustment is not	What adjustment is
Adjustment as an educational process means only changes in behavior	Adjustment as an educational process changes means that make for better living, better relationships, and a better contribution to society It means growth of the whole individual and development of all her powers and capacities (physical, mental, emotional, social, spiritual)
This is a negative or passive process	It is a positive process The student shares actively in it and directs it to the extent that she is capable of self-direction and self-discipline. The school provides the conditions which are favorable to such learning and supplies guidance, stimulation, and a certain measure of control. But the student must do her own learning, because no one can do it for her
Adjustment is a one-way process	Adjustment is a two-way process which process results not only in the growth of the individual learner but in an improved environment. A nurse's adjustments should result in making the environment more fit for human living, more favourable to health Adjustments between people or groups such as professional groups should not be one-sided nor result in sacrificing one individual or one group to the other. It is true that what may seem to be a sacrifice may be a means of growth and self-realisation but it may also retard and cripple the individual and this is always a social as well as an individual calamity This process of adjustment should be continuous, taking place on progressively higher levels and leading each year to a greater measure of self-mastery and efficiency, to better disciplined powers, to better integrated, happier, and richer personalities.

Table 12. Education as adjustment (NLNE, 1937, pp. 18-20).

This interpretation is corroborated by Stewart pointing out that the adjustment aim covered all sorts of educational objectives like '*the idea of releasing capacity, stimulating growth and self-expression, participation in social life, the progressive reconstruction of experience and remaking of life, preparation for the duties and responsibilities of life, enriching the life experience and promoting individual happiness as well as social usefulness*' (Stewart, 1935c, p. 263).

Another indication of the changed view of the relationship between the individual and his environment was that '*the concept of adjustment as an educational aim and process*' was differentiated from '*the biological*

concept of "adaptation" by which animals and plants are fitted to their environment' (NLNE, 1937, p. 17). The differences involved were explained by Stewart (1935c, p. 263):

> *'Adaptation may be a more or less passive process but adjustment is active and positive and usually involves changes in both the individual and his environment. The meaning of the word is "to bring to a true relative position." The adjustment aim of education, therefore, implies not only such adaptations as help the individual to survive but the development of will and power to create a better environment for human living.'*

In the psychology of learning, the differences between adaptation and adjustment were paralleled by the method of learning by trial and error, on the one hand, and the growth of the learner, on the other. As for the latter, it was added moreover that not only the terms '*growth'* and '*learner'* were used almost synonymously in educational and in health work but also that to the process itself, in both cases, the term '*nurture'* was applied. It was by virtue of this term that the growth of the learner was closely linked with nursing.

Apart from hinting at an interpretation of the concept of '*adjustment'* in nursing, the two methods of learning focused on the either passive or active role of the individual more than anything else. It was probably for this reason that the Curriculum Committee did not want '*adjustment'* to be identified with '*the term as it is used in psychiatry where the emphasis is on the adjustment of maladjusted people*' (NLNE, 1937, p. 17).

Summing up, the concept of education as adjustment was aimed at the growth and development of the individual learner and not at him adapting to the influences of his environment. This point came to the fore once again at the end of the discussion on the philosophy and aims of education where a comparison was made between '*training'* and '*education'* (NLNE, 1937, pp. 30-31):

- **training**
  'Training is a matter of fixing habits and skills by a process of repetition, so that when a given situation presents itself, a certain definite response will automatically result. The individual may or may not understand why she acts as she does and she may or may not be acting on her own initiative. Where training methods predominate, the tendency is to emphasize obedience to the orders of others and to demand conformity to certain prescribed patterns of thought and behavior, to stress the practical utilitarian types of habits and skills, and to pay little attention to intellectual and social skills or to the development of personality.'

- **education**
  'Education, as contrasted with training, is concerned with the growth of the whole individual. While it includes training and discipline, it emphasizes the control of habit by intelligence and the variation of responses to meet the demands of each situation.'

To grasp the significance of the adjustment aim's stress on the growth and development of the individual, one has just to compare it with the concept of 'training' as Nightingale interpreted it. Whereas training in the latter sense emphasised the primacy of environmental influences over the individual, the former reversed this relationship.

What all the comparisons between adaptation and training, on the one hand, and adjustment and education, on the other, add up to is a decisive shift from a sociological to a biological approach (Ten Have, 1983), which, in the final analysis, has been at the source of the concept of education as adjustment too. This conclusion is vindicated by the adjustment aim in nursing education paralleling the purpose of helping the individual to adjust to his environment in nursing (Stewart, 1935c, p. 265):

> *'Nursing education, like all education, is for the purpose of helping individuals to adjust to the world in which they live.'*

The fact that the former was prompted by the democratic ideals of progressive educators and the latter by the mental hygiene concept did not preclude the Curriculum Committee from recommending that (NLNE, 1937, p. 63):

> *'Mental hygiene, as a point of view and a technique should enter into every aspect of the student's experience.'*

From this, it would appear that the curriculum guide's concept of nursing and nursing education were prompted by the 'Zeitgeist' more than anything else. As for the latter, this can be illustrated by means of the trends in education at the time (NLNE, 1937, pp. 58-62), i.e. the trends toward:

- greater emphasis upon social education,
- developing habits of critical enquiry,
- a greater consideration of individual differences,
- more truly functional experiences,
- greater stress upon mastery of curriculum materials,
- building more permanent interests.

14.4. The curriculum guide's concept of professional nursing

Given the curriculum guide's concepts of nursing and nursing education, it was of paramount importance to spell out the professional and personal criteria which the individual nurse had to meet at the time of her graduation (NLNE, 1937, pp. 22-23):

> *'We need to know in more detail what the nurse is expected to do, what kinds of patients and conditions she is expected to care for, and what kind of a person she needs to be in order to adjust successfully to these requirements. The aim of adjustment must be interpreted in terms of such concrete objectives, using the word "objectives" to describe the more specific goals or stepping stones which lead to the accomplishment of the larger aims of nursing education.'*

These objectives casted some light on the curriculum guide's concept of professional nursing and were analysed in terms of nursing functions, conditions affecting patients, and desired traits.

14.4.1. Nursing functions

The analysis of the functions of the nurse in the curriculum guide was in fact a continuation of the first attempts made in the revised curriculum. At that time, the Committee on Education had announced that 'Further work is being done on this analysis of nursing functions and probably in the next edition a more specific and complete list will be available' (NLNE, 1927, p. 9). The work referred to was the third study undertaken by the Grading Committee for, in 1927, the committee was asked by the Committee on Education to make a more extensive job analysis of nursing than they themselves had been able to.

This request was in line with one of the suggestions made at the preliminary meeting of the Grading Committee that '*You should, if possible, define the function of the profession before you define the functions of the school*' (Logan, 1925a, p. 304). In spite of initial reservations as to the necessity of such a study - it was felt that such a study could hardly hope to add to the knowledge available at the time - the committee decided to investigate what nursing schools ought to be teaching in order that nurses could do their job properly. This decision resulted in the study by Johns and Pfefferkorn, entitled 'An activity analysis of nursing' (1934). The conclusions of this study were subsequently used in the curriculum guide to outline the objectives of nursing education in terms of nursing functions. The opening chapter of 'An activity analysis of nursing' presented the following conclusions as to the question of 'What is good nursing?' (Johns & Pfefferkorn, 1934):

1. *All professional nurses, irrespective of the special field in which they have elected to practice, should be able to give expert bedside care. They should also have such knowledge of the household arts as will enable them to deal effectively with the domestic emergencies arising out of illness.*
2. *All professional nurses, irrespective of the special field in which they have elected to practise, should be able to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.*
3. *All professional nurses should possess the special knowledge and skill required in dealing effectively with situations peculiar to certain common types of illness.*
4. *All professional nurses should be able to apply, in nursing situations, those principles of mental hygiene which make for a better understanding of the psychological factor in illness.*
5. *All professional nurses should be capable of taking part in the promotion of health and the prevention of disease.*
6. *All professional nurses should possess the essential knowledge and the ability to teach measures to conserve health and to restore health.*
7. *All professional nurses should be able to cooperate effectively with the family, hospital personnel, and health and social agencies in the interests of patient and community.*
8. *Every nurse should be able, by means of the practice of her profession, to attain a measure of economic security and to provide for sickness and old age. It should be possible for her to conserve her physical resources, to seek mental stimulus by further study and experience, and to follow that way of life in which she finds those spiritual and cultural values which enrich and liberate human personality.*

These criteria were expected to furnish curriculum makers with the scientific basis needed to design an educational program to prepare the student nurse for a broad type of community service rather than service within the hospital in which she had been trained.

Probably because the major part of the study was taken up by extensive lists of nursing activities covering different branches of nursing, these criteria of good nursing have not become the classic in nursing literature which one of its reviewers expected it to become (AJN, 1934, pp. 1000-1001). These activities were listed under the following headings indicating the functions of the nurse (in: NLNE, 1937, pp. 24-25):

A. *Observing and recognizing symptoms, conditions and causes - mental, physical, and social (73 activities),*
B. *Carrying out curative nursing procedures (221 activities),*
C. *Carrying out preventive nursing procedures (42 activities),*
D. *Creating and maintaining proper psychological atmosphere (48 activities),*
E. *Preparing and administering diets (33 activities),*
F. *Giving medications and preparing solutions (49 activities),*
G. *Assisting physician in examining patients, giving treatments, and making diagnostic tests (48 activities),*
H. *Checking, recording, receiving and giving reports, and caring for records (41 activities),*
I. *Creating and maintaining proper physical environment and supervising other workers to this end (38 activities),*
J. *Teaching measures to conserve health and to restore health (143 activities),*
K. *Cooperating with family, hospital personnel, and health and social agencies in the interests of patient and of community (45 activities),*
L. *Giving attention to patient's possessions and protecting his interests (17 activities).*

Subsequently, these functions were reduced to four main groups covering (NLNE, 1937, p. 25):

- activities which have to do with the organisation and management of the patient's environment to secure for him maximum physical and mental comfort,
- activities concerned with the patient's immediate personal care,
- activities performed under the direction of and in cooperation with the physician,

- activities which have to do with family and community health services.

Finally, as for the question of whether a given nursing activity should be performed by a qualified nurse or assigned to one of her co-workers, it was concluded that (NLNE, 1937, p. 26):

> *'It takes a professionally qualified person, however, to make such decisions and to assume responsibility for the coordination of all these services and the general supervision of non-professional workers. This person should be able to perform every activity herself in order to properly supervise and teach those who assist in the nursing care of patients. Therefore, ... professional nurses ... must in any case know all the activities thoroughly and in addition, be able to analyze nursing situations, know what type of nursing activities are required, plan and carry out a well-coordinated program of nursing care (with or without assistants), and evaluate the results.'*

This first set of practical objectives in terms of nursing functions, as they were outlined in the curriculum guide, are interesting for two reasons.

First, they demonstrate that the lists of nursing functions were used to indicate the type of preparation needed to prepare nurses to function in a dynamic and changing society rather than to define nursing in terms of tasks. This conclusion is vindicated by the remarks on the role of the professional nurse in analysing nursing situations as well as in planning, carrying out and evaluating a well-coordinated programme of nursing care.

Secondly, the interpretation of the role of the professional nurse in the curriculum guide foreshadowed the views on professional nursing expressed in the Brown Report (Brown, 1948) and to be discussed in the next part of this study.

14.4.2. Conditions affecting patients

The second set of practical objectives of nursing education in the curriculum guide was related to the conditions affecting patients (NLNE, 1937, pp. 566-588). Although both the revised curriculum and the study by Johns and Pfefferkorn contained lists to that effect, it was decided to prepare a new list as '*neither of these studies gave a sufficiently detailed list of disease conditions to serve as a basis for the organization of clinical courses or for the determination of resources necessary for the students' clinical experience*' (NLNE, 1937, p. 27). The major assumptions underlying the master list of disease conditions in the curriculum guide were that the basic curriculum was expected to prepare for general nursing practice encompassing the preventive and educational, as well as the curative aspects of nursing, and that its main purpose was to help students of nursing '*to adjust successfully to the various kinds of nursing situations they are likely to meet before and after graduation*' (NLNE, 1937, p. 567).

It was, therefore, agreed that students should be prepared '*to give competent nursing service to patients of both sexes and of all ages, regardless of race, class, creed, or economic status*.' This included individuals in normal health (especially infants), patients mildly, acutely, and chronically ill, convalescents, as well as obstetric, operative, and accident cases.

As for the disease conditions listed, it was not thought necessary that the nurse had actual experience in nursing patients with all these diseases but '*she should have both instruction and experience in the care of typical conditions selected from all the main groups*' (NLNE, 1937, p. 27). These groups were Medical and Surgical Nursing, Obstetric Nursing, Nursing of Children, and Psychiatric Nursing.

14.4.3. Desired traits

The third set of practical objectives (Table 13) included a list of the '*outstanding characteristics which must be developed in fairly high degree in order that the individual may function satisfactorily as a professional nurse and in addition some behavior expressions which exemplify each characteristic*' (NLNE, 1937, p. 589). For too long, it was argued, nursing educators had thought of education in terms of knowledge to be acquired by the student. However, as to the personal qualities required, some went as far as to say that a nurse is born not made, while others appreciated the possibilities of developing new attitudes and strengthening desirable characteristics. Whereas the traditional method for developing such characteristics rested upon the assumption that '*the mere verbal expression of desirable qualities or traits would automatically result in their development*,' there was an

increasing body of opinion among educational psychologists and philosophers that the only truly effective method was '*to give the learners ample opportunities to express themselves in desirable activities*' (NLNE, 1937, p. 591). The articulation of desirable characteristics in the form of axioms, slogans, creeds, oaths and pledges, memory verses, and codes was therefore considered useless, unless they were amplified by descriptions of the type of behaviour that goes with these characteristics. For this reason, each of the characteristics listed, was accompanied by a list of behaviour expressions exemplifying the characteristic in question. As for the characteristic '*She is dependable*,' for example, these behaviour expressions were (NLNE, 1937, p. 596):

- she does equally good work with or without supervision,
- she answers the patient's signals promptly,
- she reports her own mistakes immediately,
- she remembers and fulfills promises made to co-workers and patients,
- she reads the order sheet and makes a record of treatment immediately after given,
- she gives treatments and medications on time,
- she checks on the immediate needs of the patient before leaving him,
- she safeguards the patient's belongings,
- she is scrupulously honest in business transactions.

The list of desired traits, compiled with the help of different panels of nurses, doctors, lay representatives and nursing students who had to differentiate the characteristics and behaviours of successful and unsuccessful nurses (Eads, 1935), was suggestive rather than prescriptive and had to be adapted to the individual student's personality and potentials.

Characteristics of a nurse able to adjust well to nursing situations
1. She is healthy, mentally and physically (wholesome, emotionally mature, has good resistance, endurance, good posture).
2. She is mentally alert (intelligent, observant, discriminating, has good judgement, keen insight).
3. She is technically competent (orderly, economical, systematic, knows the principles underlying techniques, performs procedures effectively).
4. She is dependable (trustworthy, thorough, conscientious, accurate, punctual).
5. She inspires confidence (is reassuring, sincere, firm when necessary, decisive).
6. She is resourceful (adaptable, versatile, ingenious, secures cooperation).
7. She is well poised (self-controlled, patient, composed, has a quiet manner).
8. She is considerate of others (tactful, intelligently sympathetic, discreet, courteous, kindly, thoughtful).
9. She is cooperative (intelligently loyal, fair-minded, a good "team-worker," understands personal relationships).
10. She is agreeable (cheerful, pleasant, amicable).
11. She is cultured (has good taste, is well groomed, refined, has a pleasing voice and manner, a sense of fitness of things, enjoys and appreciates the beautiful and worth while, has broad intellectual interests).
12. She derives personal satisfaction from her work (likes her work, is happy, enthusiastic).
13. She has a sense of social and professional responsibility (is tolerant, open-minded, courageous, interested in civic and professional affairs, has a strong sense of justice, a scientific and experimental attitude).

Table 13. The curriculum guide's image of the nurse (NLNE, 1937, pp. 588-608).

14.5. A really professional curriculum

The curriculum guide was, to all intents and purposes, a professional curriculum aimed at helping nursing students to adjust to the demands of the nursing profession, i.e. '*it is the preparation of beginners for entrance into the profession that is considered rather than the preparation of graduate nurses for advanced work*' (NLNE, 1937, p. 14).

As for the implications of this aim, it was stated that (NLNE, 1937, pp. 51-52):

'If the nursing curriculum is to be of the professional as distinguished from the technical type, there should be more emphasis on thinking and understanding, on social attitudes and skills, and on the development of the student as a person. The technical element is essential and should receive due emphasis, but there should be a better balance than there is at present in most nursing curricula, between the technical, scientific, social, and cultural elements.'

To illustrate the curriculum guide's professional nature, the remaining part of this chapter is therefore concerned with the programme of studies, and the outline of subjects.

14.5.1. The programme of studies

The programme of studies which took up the major part of the curriculum guide contained '*the schematic arrangement of all the offerings of a school*' (NLNE, 1937, p. 14) was based upon a total length of two and a half to three calendar years, exclusive of four weeks' vacation yearly. Whereas the workload for the student in the revised curriculum was a six day week of ten hours a day, the curriculum guide recommended a forty-four hour week, with forty-eight as a maximum. In addition, it was specified that '*these hours should include* all the organized teaching *as well as the hours of nursing practice*' (NLNE, 1937, p. 48).

As for the entrance requirement, the Curriculum Committee suggested an advance in minimum educational standards of one to two years beyond high school of either an academic or college grade. This suggestion rested upon the assumption that this would result in a more mature and stable student body, and give students a better chance '*to develop normally, to build a broader and sounder foundation for their professional preparation, and to become better oriented to the world in which they live*' (NLNE, 1937, p. 42).

As for the graduation standards, it was, moreover, added that students should not be allowed to graduate until they had given evidence that they were competent '*to practice safely and with a reasonable degree of independence*' (NLNE, 1937, p. 43).

Whereas the hours for theoretical instruction were increased from 885 to between 1,100 and 1,200 (mainly as a result of adding 250 to 350 hours of ward teaching formerly included in the scheme of practical instruction), the hours of practical instruction were reduced from between 5,000 and 5,500 in 1927 to beween 4,400 and 5,000 in 1937. As a result, the ratio of theoretical and practical instruction did change from 1.4 : 8.6 into 2 : 8.

These predominantly practical standards apart, the programme of studies was based upon principles which were most suggestive as to the professional nature of the curriculum guide in that they put high emphasis upon the growth of the student. Some of these principles were (NLNE, 1937, pp. 68-72):

'Adjustment is most easily thought of in terms of situations. ... It seems advisable, therefore, instead of focusing attention on subjects or even on general nursing experience, to build the program around carefully selected, typical nursing situations. ... The situation basis is preferred to the case basis of organization because it is more flexible and can be interpreted in terms of large situations as well as individual situations. In practically all nursing situations, however, the individual patient is the focus of study.'

'The idea of integration, which is a corollary of the adjustment aim, means the bringing together of the various parts into a whole. ... the learning experiences of the student should be in terms of the adjustment of a whole individual to whole situations. ... all courses should be taught in such a way that integration can readily take place in the student's mind and personality.'

'As far as possible, theory and practice should be integrated, not merely correlated. Correlation means relating the two things but not necessarily fusing them into one.'

'In organizing materials in the program of studies, a psychological rather than a logical order usually makes for more economical and efficient learning.'

On the other hand, these principles were all related to '*the principle of learning economy or efficiency which simply means that the work should be planned in such a way as to get the best educational results in the shortest time, with the least expenditure of effort, and with the greatest satisfaction to all concerned*' (NLNE, 1937, p. 71). This suggested that a student-centred approach was no hindrance to the emphasising of the utilitarian principles of efficiency and economy as well.

14.5.2. The outline of subjects

If nursing education should be taken to mean helping the student nurse to adjust to her personal and professional life, it is only a small step to say that nursing means helping the patient to adjust to his individual situation, or, as Nightingale had put it, '*helping the patient to live*.' Apparently, this idea had crossed the Curriculum Committee members' minds, too, when they decided upon the outline of proposed courses (NLNE, 1937, p. 73):

> *'The usual way is to organize the materials under the traditional curriculum subjects, setting up new subjects whenever a new type of material is to be introduced. Another plan used, ... is to group all the subject matter around projects or major activities of life.'*

In the end, the committee settled for a compromise by differentiating a few rather large strands or areas in which '*there can be different groupings of courses built around situations or organized as service courses and composed of materials from several subjects if this seems to be desirable*' (NLNE, 1937, p. 73). This educationally inspired differentiation explains why not all the areas distinguished were interpreted in terms of '*projects'* or '*major activities of life*.' In the outlines of the proposed courses, however, it was the adjustment of the nurse to the demands of the nursing profession rather than the adjustment of the patient to his environment which came to the fore. The resulting programme covered the following areas (NLNE, 1937, pp. 72-75):

- **Biological and Physical Science**
  Anatomy and Physiology, Microbiology, and Chemistry (20 % of the hours assigned to organised instruction). This area was largely concerned with '*man and his natural environment; the way in which his body is constructed and functions; the constituents of food, disinfectants, medicines, and other substances of a similar kind; the nature of the physical and other forces and agencies used in maintaining health and curing disease*.'

- **Social Science**
  Psychology, Sociology, Social Problems in Nursing Service, History of Nursing, and Professional Adjustments I and II (15 %). This area was concerned with '*man and society - their history, past and present; human nature and the social conditions that help to shape the individual and determine his behavior; social and economic conditions in their relation to disease and health; human relationships in professional and other groups*.'

- **Medical Science**
  Introduction to Medical Science, Pharmacology and Therapeutics, while Medicine, Surgery, etc. was included in Nursing and Allied Arts (25 %). This area was not so much concerned with man and his health as with what the nurse needed '*in relation to the study of disease itself; the causes, nature, symptoms, prevention, and treatment of the more common diseases; the work that the allied professions in medicine are doing in the relief of suffering and in the cure and prevention of disease*.'

- **Nursing and Allied Arts**
  Introduction to Nursing Arts, Nutrition, Foods, and Cookery, Diet therapy, Medical and Surgical Nursing, Obstetric Nursing, Nursing of Children, Psychiatric Nursing, Nursing and Health Service in the Family, Advanced Nursing and Electives (40 %). This area, it was pointed out, '*coordinates materials from all the other areas and from the accumulated experience of generations of nurses, in relation to the practical*

applications of dietetic, sanitary, hygienic, therapeutic, social, and educational measures used by the nurse in her care of patients and her health work with groups.'

The use of the word '*arts'* in this area, defined as '*knowledge applied and made efficient by skill*' and contrasted with the word '*science'* as used in the other areas, indicated that, whereas the latter were concerned with '*the principles derived from science or from organized knowledge which the nurse needs to apply in her work*,' the former focused on '*the application of these and other principles to nursing situations*.' All four groups together constituted what came to be known as '*the science and art of nursing*' (NLNE, 1937, p. 327). It is this distinction, it is contended here, which was at the source of Abdellah's definition of nursing science, mentioned earlier, as '*a body of cumulative scientific knowledge, drawn from the physical, biological, and behavioral sciences, that is uniquely nursing*.'

- **the Extra-professional Program**

Language arts, fine arts, and some other subjects usually listed under humanities, philosophy, and religion. This area of knowledge, by emphasising the nurse's life and development as an individual and as a citizen, contributed '*mainly to the cultural development of the individual and the broadening enriching of her personal life through literature, art, music, religion, philosophy, and other aspects of her general cultural heritage*.' Given these outlines which focused on the adjustment of the nurse rather than the patient, it remains to be seen what effect the concept of adjustment had on the courses dealing with the use of the case method in nursing, viz. Social Problems in Nursing, and Nursing and Allied Arts. This will show that '*education as adjustment*' did indeed go hand in hand with the individualisation of nursing care.

Social Problems in Nursing. In the curriculum guide, the course on 'The Case Method (Applied to Nursing)' (NLNE, 1927, pp. 112-115) was incorporated in a new course on 'Social Problems in Nursing Service' (NLNE, 1937, pp. 221-237). Although, as suggested by its title, the social factors in the illness of individual patients still figured prominently in this course, there was a noticeable shift towards the individual as an individual. More than half the course was taken up by the unit 'The individual in sickness' (15-20 hours), while the other unit dealt with 'Medical-social problems of the community' (10-15 hours). This division reflected nursing being both a personal and a community service. The former unit treated of:

- the individual's reaction to sickness as an experience,
- social factors that may play a part in the individual's reaction,
- the process of determining the significance of social factors in the individual case,
- the effect of the patient's illness on his family and those most closely associated with him,
- clues to favourable and unfavourable social factors as they may be discovered by the student nurse,
- medical-social treatment ('medical' referred to the entire field of medical care which included nursing and dental care and other related services, and 'social' included economic, civic, and ethical problems related to illness),
- the way in which the patient's attitude both affect and are affected by the attitudes of the community.

Although the treatment of the problems concerned was considered to be the medical-social worker's responsibility, the student nurse was expected to appreciate the importance of '*understanding the individual's reaction to illness, which affects his behaviour and his relationship to other people and to his environment*.' The awareness of such personal factors was held to be '*essential to complete nursing care*.'

To illustrate this point, a comparison was made between sickness as '*the body's reaction to a stimulus which checks life and growth*,' on the one hand, and sickness as '*a disabling experience in which he [the patient] behaves according to his powers as a person, with resulting growth or diminished social activity and satisfaction*,' on the other. To this, it was added that '*Many persons not recovering completely will suffer from chronic disability or lack of physical reserves; such disability and resulting satisfactions will be in proportion to assets and resources within the patient and his immediate surroundings, the demands life still makes on him, his acceptance of the limitations imposed, and his power of self-direction*.'

Finally, as for the conceptual development of nursing, it is important to note that such disability was defined as 'a condition of the whole indvidual characterized by deprivation of power to do something he needs or desires to do.' This definition somehow foreshadowed Henderson's definition of nursing.

Many other examples could be added to demonstrate the definite trend of approaching the patient as an individual per se and not as an individual insofar as he was affected by the social environment in which he lived.

Introduction to Nursing Arts. The area of knowledge, covered by 'Nursing and Allied Arts,' was headed by the 'Introduction to Nursing Arts' (NLNE, 1937, pp. 330-372) which was built around 'activities that are usually related in actual practice,' and 'problems that are presented to the student in the actual nursing situation.' As a result, the course's units more or less corresponded with the following nursing activities:

- **activities which have to do with the organisation and management of the patient's environment to secure for him maximum physical and mental comfort**
  1. Orientation to nursing and to the nursing school
  2. Health appraisal, health needs, health adjustments, and health conservation
  3. Orientation to the hospital, the patient, and the nursing service
  4. Organisation and care of the environment of the patient

- **activities concerned with the patient's immediate personal care**
  5. Providing for the patient's personal needs
  6. Providing for the patient's rest, comfort, and recreation

- **activities performed under the direction of and in cooperation with the physician**
  7. Assisting with physical examinations and other diagnostic measures
  8. Administering simple therapeutic treatments

- **activities which have to do with family and community health services**
  9. Planning individualized nursing care
  10. Recognising and providing for health education needs

In this course the student was taught that the purpose of nursing was '*to help the patient to attain and maintain health*,' and it helped her '*to study some of the more common nursing situations and to plan individual nursing care, modifying and adapting nursing measures according to each patient's needs*.'

As to the notion of '*health*,' the course stressed normal growth and development as a sign of good health, and as to th essentials of health, it differentiated between factors related to the conduct of the individual and the environment in which he lived. It was in this context that the term '*health needs*' appeared.

Keeping in line with the general principle that '*Much emphasis should be put on the study of the individual patient and the individualizing of nursing care*' (NLNE, 1937, pp. 329-330), the course subsequently elaborated on '*the patient's needs*' which were listed as bath and toilet, clothing, sleep, food service, elimination, rest, comfort, and recreation. The ratio of attention paid to the environment and the needs of the patient was favourable to the latter. The correspondence between this list of the patient's needs and what Henderson later called '*the fundamental human needs*' is far from coincidental as she chaired the sub-committee preparing this part of the curriculum guide (Henderson, 1966; 1982).

The rationale for putting such high emphasis on the individual can be inferred from the placing of the unit on 'Planning individualized nursing care' under the heading 'Activities which have to do with family and community health services.' At first, it seems strange that it was only in this part of the course that the student was taught how to plan individualised nursing care, viz. by studying '*the nursing needs of each individual patient*' and planning '*nursing care based on these needs*' (NLNE, 1937, p. 357). However, this is quite understandable once it is realised that the purpose of individualising nursing care was to help the patient to attain and maintain health which, in the curriculum guide, should be taken to mean to help the patient to adjust to his environment. Therefore, individualising nursing care (unit 9) as well as recognising and providing for health education needs (unit 10) were aimed at helping the patient to readjust to his usual activities of daily life after the period of hospitalisation.

14.5.3. Conclusion

The concepts of nursing, nursing education, and professional nursing underlying the curriculum guide, were of an unprecedented coherence to the effect that, between them, they amounted to a model of nursing, or, better still, individualised nursing. In this model of nursing, the principle of individualisation was used in two different ways. First, to individualise nursing care in order to help the patient to adjust to his environment. Secondly, to individualise nursing education in order to help the nursing student to adjust to the demands of the nursing profession. What this meant in terms of professional nursing, for which the nursing school had to prepare the student nurse, was outlined not only in terms of nursing functions and conditions affecting patients but in terms of professional and personal characteristics of the nurse too. Finally, and more importantly, the curriculum guide heralded the completion of a process in which nursing increasingly focused upon the patient as an individual. The curriculum guide's model of nursing can therefore be said to stand as a model of individualised nursing.

15.
THE CASE METHOD

In the previous chapters, the model of individualised nursing has been shown to have developed over a period of many years. Its emergence, however, was evidently hampered by the manifold problems which plagued the development of nursing education. As a result, it was not before 1937 when some coherence and consistency was achieved between the model's concepts of nursing, nursing education and professional nursing.

Also, the previous chapters have focused upon the presuppositions and implications of the model of individualised nursing, whilst the purpose of this chapter is to show that, as far as this model's application is concerned, the case method is its corollary. The case method came to be used in three different forms:

- the case study,
- the case method of assignment, and
- social casework.

These different applications had common ground in that the individual patient was the main unit of consideration. From the discussion of the case method, it will emerge that, whereas the evolution of the case study, and, to a lesser extent, the case method of assignment too, exemplified the changing views on nursing education, the evolution of social casework corresponded with the changing views on nursing in relation to social work.

The different uses of the case method not only highlight the practical bearings of the model of individualised nursing but can also be shown to have been at the source of the nursing care study and the plan of nursing care.

15.1. The case method in nursing education

The first book on the use of the case method in nursing education, entitled 'Student's handbook on nursing case studies,' was written by Jensen, a nursing teacher at the University of Minnesota School of Nursing. According to Jensen (1929a), the case method of teaching originated from Harvard University where it was articulated in 'A selection of cases on the law of contracts' (1871). This book, written by the Dean of Harvard Law School, created not only a radical change in the instruction in law but influenced other professional schools too. Dr. Richard Cabot at Harvard Medical School, for example, used the case method because '*In the best practice the students are required to bring their own powers into play at close range gathering their own data, making their own interpretations, proposing their own courses of treatment*' (Jensen, 1929a, p. 1), and at Harvard University's Graduate School of Business Administration it came to be known as the '*problem method*.' In due course, the case method was also introduced in engineering, social work, ethics, civics, general education and nursing.

15.1.1. The origin

Jensen, and she was by no means the only one (e.g. Munson, 1930), held the opinion that it was Nightingale who made the first steps toward the use of the case method in nursing education when she encouraged probationers to take careful notes of cases and discuss these with their teachers. Nightingale recommended the study of cases mainly for the reason of stimulating the nurse's powers of observation and reflection so as to ensure that her nursing actions were guided by her knowledge of the laws of God. This came most clearly to the fore in one of the requirements for training nurses to train others (Nightingale, 1882a, p. 336):

> *'Pre-eminently careful notes of cases - the touchstone for the future trainer. If she cannot observe and understand her own cases, how can she teach others to observe and understand them? If she never learns the reason of what is done, how can she train others to learn it?'*

The case method which developed in nursing education in the United States was, however, quite different from the study of cases as advocated by Nightingale. Whereas the latter focused upon environmental factors affecting health, the former's unit of consideration was the individual patient.

Subsequently, it was, again according to Jensen (1929a, p. 2), only in the 1920s that American nurses started to experiment with this method (e.g. Bertha Harmer at the Yale University School of Nursing), but, in fact, the case method was introduced in nursing education long before (Parsons, 1911). After the turn of the century, physicians in the Massachusetts General Hospital began to use this method during bedside clinics to teach medical and surgical nursing. Next, Sara Parsons who was teaching nursing in the same hospital borrowed this method from the social workers to use it first in nursing classes and later in classes on ethics. She is said to have been prompted to take this step by Ida M. Cannon of the Social Services Department who suggested this method's use in law, medicine and social training (Stewart, 1944, p. 166).

Finally, it is worth noticing that, in 1929, when Jensen's book was published, the pioneering work of Parsons had apparently sunk into oblivion as Jensen failed to mention her pioneering role. Also, she did not mention the references to this method in either the standard curriculum or the revised curriculum. The reason for these omissions was that, at the time of writing her book, the rationale for using the case method in nursing education had changed.

15.1.2. The evolution

The impetus for introducing the case method in nursing education was that this method served as a link between the scientific knowledge learned in the classroom and its application in the hospital ward. This was deemed necessary since the ward situation had become so complex that the teaching of nurses by cases on the part of the head nurses was virtually abandoned (Jensen, 1929a, p. 3). As a result, American head nurses lost the educational role attributed to them in the Nightingale system (Stewart et al, 1916, p. 739):

> *'Formerly one of the main functions of the head nurse was the instruction of the new probationers and the nurses under her charge, and many head nurses developed into excellent teachers and trainers. The tendency at present is to regard head nurses and supervisors entirely as administrative officers.'*

Given that student nurses in the second year of their training acted as head nurses from as early as the 1890s, it would therefore appear plausible to say that the use of the case method in nursing education dates from the first decade of this century.

The case method in the standard curriculum. At the time of the publication of the standard curriculum, the following rationale was given for the use of the case method (Stewart et al, pp. 737-738):

> *'The conference or case-study method is used mainly in more advanced courses where it is not so much a question of giving pupils facts in organized systems as of getting them to acquire a point of view and a method of working out things for themselves. They are usually given a concrete problem and are expected to read up sources, to collect data, to keep records, and to bring in suggestions which will be analyzed and discussed, and will probably form the basis for a thesis or case-history or written report. The method has been used successfully with law students and medical students and is being applied in such fields as charity organization work, social service work, etc.. ... It is an informal kind of teaching which may be applied to the simplest kind of a problem as well as to the most difficult. It requires some individual attention and direction from some one who is an expert in the branch studied, but the pupil is expected to work the problem out for herself so far as possible. Where several are working together, they get the benefits of each other's work, as all are expected to take part in the discussions. It is a splendid preparation for the more independent work they will have to do when they leave the hospital. It helps them to stand on their own feet, makes them acquainted with sources of information and shows them how to go about it.'*

This rationale reflected the standard curriculum's objective of setting standards for nursing education on two counts. First, the references to the use of the case method by the other professions were indicative of the standard curriculum's aim to raise the standards of nursing education to a level which compared '*more favorably with the courses given in other technical and professional schools*' (NLNE, 1917, p. 7). Secondly, the case method was viewed as an excellent method to prepare the student nurse, or, as the standard curriculum put it, '*to serve the*

whole community and to meet conditions as she finds them in many different kinds of communities' (NLNE, 1917, p. 5).

The case method in the revised curriculum. In the late 1920s, the case method came increasingly to be used to help student nurses to view their patients as individuals, and to improve the nursing care given to each patient. The emphasis upon the patient was prompted by the principle of individualisation, as expressed in the Goldmark Report, and gave rise to a special course on 'The case study method (applied to nursing)' in the revised curriculum. This course's objectives were (NLNE, 1927, p. 112; see also AJN, 1926, p. 403):

1. *To give the student a scientific method of study or approach to a problem in whatever field she may be working.*
2. *To improve the actual nursing care of patients by helping students to understand them as individual personalities.*
3. *To help the students consciously to plan a program of nursing care adapted to the individual needs of the patients.*
4. *To develop an attitude of mind toward the patient which makes him the centre or unit of thought, placing procedures and routines in their proper relationship as means rather than ends in themselves.*
5. *To stimulate the student to meet her problems by critical and reflective thinking, relating facts or events given in other courses to specific conditions and situations found in the wards.*
6. *To help relate the art and science of nursing and provide a means of building up a specific body of knowledge or content in nursing.*
7. *To promote a better relationship between the various groups cooperating in the care of the patients.*

The case method in nursing education thus came to be used not only for educational reasons per se but also to teach student nurses to individualise and improve nursing care, a change which was fully in line with the revised curriculum emphasising its concept of nursing.

More importantly, as a result of the case method the patient became the main unit of consideration as opposed to the procedures and routines carried out by the student nurse. This contrast between an individualised and functional approach to nursing was taken one step further by introducing the case method of assignment for assigning student nurses' work as opposed to the '*efficiency'* method of assignment (Hodgman, 1929, p. 1359).

The case method of assignment. In the more recent literature, it is not uncommon to attribute the origin of the case method in nursing to the case method of assignment in private duty nursing (e.g. Brown, 1966; Douglas, 1977; Hegyvary, 1977; Marram et al, 1979). According to this body of opinion, the case method of assignment is the opposite of the functional method of assignment. Whereas the former is thought conducive to the professional autonomy of the nurse, the latter supposedly results in some sort of a nursing automaton. It may well be that the tradition of private duty nurses to nurse one patient at a time had something to do with the introduction of the case method of assignment but it was not the decisive factor. When patients, mainly as a result of the economic decline in the early 1930s, couldn't afford the services of the private duty nurse anymore, be it in their homes or in the hospital, private duty nurses switched to nursing more than one patient at a time, either on an hourly basis, mostly in the patient's home (hourly nursing), or on a group basis, mostly in the hospital (group nursing). The case method of assignment was thus not essential for this oldest branch of American nursing since it was easily subordinated to the economic reality of the day.

In fact, the case method of assignment was introduced as a method of assigning student nurses' work first. This was done primarily '*to connect the teaching in the ward with that in the classroom and vice versa*' (NLNE, 1927, p. 52). At that time, however, the bulk of nursing care was provided by student nurses and hardly any distinction was made between nursing education and nursing service. It can, therefore, be argued that, right from its inception, the case method of assignment was used as a modality of nursing care as well.

It was not before the early 1930s, when large numbers of private duty nurses took up general duty positions on the wards in the hospitals and it was accepted that nursing education should be distinguished from nursing service, that the case method of assignment developed into a method for assigning nurses' work to be distinguished from its educational use. This conclusion is supported by the fact that it was not before 1938 that

the first articles on the case method of assignment as a modality of nursing care appeared in the American Journal of Nursing (Perry, 1938; McCough, 1941).

Finally, both applications of the case method of assignment had common ground in that they helped the nurse to focus upon the individual patient, thereby effectively providing an alternative for the functional method of assignment.

The case method in the curriculum guide. In the curriculum guide, the evolution of the case method in nursing education to date was summarised in the following definition of the case study, which incorporated the case study and the case method of assignment as a way of correlating theory and practice in nursing education (NLNE, 1937, p. 612):

> *'A written study of the whole patient in which the student nurse under teacher guidance studies a patient. Through the study, she learns to select and organize all pertinent information and to use it in developing her own insight and understanding of the nursing care. The case method is included in the ward study of a patient cared for or observed over a period of time. The student should have opportunity to apply and test the knowledge gained in a nursing situation.'*

Far less emphasis was placed upon the case method as a method of individualising nursing care, and understandably so, because the adjustment aim underlying the curriculum guide's philosophy of education was more easily thought of in terms of situations than cases. The individual patient nevertheless remained the focus of the case study.

Although the case method and the adjustment aim were not explicitly linked in the curriculum guide itself, the combination was definitely intended. This relationship was, however, expressed more clearly in an article on teaching methods (Sleeper, 1935, pp. 660-61):

> *'The* case method, *as used in nursing, has made the patient the center of a study in which the student learns to select and organize all the pertinent information relative to the patient and to use this information in developing her own insight and understanding of the nursing care. This method provides pupil activity under teacher guidance, - a broadlife situation different in every case study; an opportunity to see a problem in all of its relationships and to organize knowledge to solve the problem; a chance to see the relationships between principles learned and the patient's problems, to test conclusions in a small but effective way through the teaching of the appropriate principles to the patient. The case method stimulates interest, and should aid in growth in the ability to adjust through a better understanding of patients and their problems.'*

This description of the case study was in line not only with the curriculum guide's objective to help student nurses to adjust to the demands of the nursing profession, thereby enhancing the professional nature of the program of studies, but also pointed out its potential in adjusting nursing care to the individual needs of the patient.

15.1.3. From case study to nursing care study

The evolution of the case method in nursing education is reflected in the references to the case study in the American Journal of Nursing. Between 1900 and 1923, little more than ten articles were devoted to the case study. From 1923 onwards, however, the case study gained momentum and was increasingly presented as a method of teaching student nurses how to individualise and improve their nursing care. The major impetus for this new approach came from the collegiate schools of nursing, most notably from the Yale University School of Nursing. The second Yale Bulletin, dealing with case studies in paediatric nursing and setting the standard for the use of this method, was welcomed in an editorial (AJN, 1929, p. 444):

> *'The method presented and the studies themselves are full of interest. Above all else two things shine out from every record. The first is evidence that the Yale students are taught not to nurse diseases but to care for human beings with sick minds and bodies and groping souls all needing understanding care. A second*

striking feature of the records is the clear distinction between what is medical diagnosis and treatment and what is nursing care.'

The 1930s saw a spectacular increase in the number of articles on the case study. Most articles contained a case study, whilst others dealt with the different ways of using the case method. Houston (1936), for example, listed the following variations:

- the illustrated case study,
- the precaution technic study,
- the comparative case study,
- the ward problems study,
- the health teaching study,
- the specialised technic study.

Houston's article was followed up by others, dealing with the different ways of presenting the case study; for example, the demonstration-symposium case study (Rufus, 1939) and the oral case study (Tuttle, 1939).

Yet another group of articles were concerned with the educational value of the case study. Most authors were so much in favour of this method that, at times, it seemed to be a panacea for all sorts of problems in nursing education ranging from teaching nursing students how to use the literature to helping them to think of the patient as an individual and to consider all his health needs (e.g. Buell, 1930; Petry, 1931; Grant, 1934; Lewis, 1934; Perkins, 1934; Leader et al, 1936; Nicholson & Gardner, 1937).

Others, however, felt it necessary to put some question marks on the case study. Munson, for example, pointed to the evidence suggesting that '*at times emphasis is placed on method rather than on that which use of the method might achieve*' (1930, p. 307). Much stronger criticism was expressed in a letter to the editor by a registered nurse from Ohio (AJN, 1938, p. 835):

'Why do student nurses write such poor case studies? Is it because they are uninterested, pressed for time, do not have the available reference books, or are not imbued with the spirit of nursing? If a nurse is interested in her patient, shouldn't she be able to describe this patient and the care that she gave him in a study?I have always felt that the case study was an excellent way of seeing the care which the individual patient needs. But so many case studies are devoted to descriptions of the disease, anatomy and physiology, medications, laboratory reports, and the doctor's case notes rather than to a description of the nursing care the patient needed, why it was needed, how it was given, and how the patient responded to it.'

In the same year, the American Journal of Nursing published an article, entitled 'Case study or nursing care study?' (Taylor, 1938), in which the same problem was discussed in more detail. In practice, Taylor pointed out, the case method in nursing education fell far short of its expectations. The reason was that case studies were written from a medical rather than a nursing point of view and focused on the patient, his disease, and the related medical treatments and not the patient, his problems and needs, and the nursing care he received. Worse still, many case studies were written about a patient for whom the nurse had not cared. As a result, case studies were not a study of nursing care but simply an abstracted clinical record, and offered little more than an exercise in composition.

As for the first criticism, Taylor recommended that the student should devote at least two-thirds of her case study to the nursing care of the patient. In addition (Taylor, 1938, pp. 1010-1011):

'The emphasis should be upon the patient, his nursing needs during illness, convalescence, and recovery, and the nurse's method of meeting these needs.
We want to know how *she kept her patient's mouth in good condition,* how *she made him comfortable,* how *she explained the nursing procedure or treatment to him, or* how *she protected herself and the patient.* What we want is a description of just how the nurse took care of that particular patient and why she selected these particular methods.*'*

The second criticism was answered by putting forward the following question '*Isn't it basic for the nurse to know her patient before she attempts to plan care for him?*' To deal with this question, Taylor offered two maxims, viz. '*Own your own patient,*' and '*Every patient belongs to some nurse*' (Taylor, 1938, p. 1008).

What both Taylor's suggestions added up to was that the case study should be used to help student nurses, firstly, to nurse the patient with due emphasis on all his needs and the nursing care he received, and secondly, to do this on the basis of a one-to-one relationship. These suggestions took the evolution of the case method in nursing to its logical conclusion in that they established it as the method of teaching of the concept of individualised nursing.

Finally, Taylor proposed the substitution of the term '*nursing care study*' for '*case study*.' Such was the impact of Taylor's article that Jensen could not but change the title of her book into 'Nursing care studies' (Jensen, 1940, p. vii) and the American Journal started to index articles formerly indexed under 'case study' under 'nursing care study' in 1940.

15.2. The case method in nursing

Its applications in nursing education apart, the case method also found its way into nursing practice. Surprisingly, this happened not so much because nurse practitioners made use of the case study and the case method of assignment but as a result of the introduction of the principles and methods of social case work in nursing. Social casework, although originating in social work, was a method used by social workers and nurses alike. As a result of using the same method, both groups gradually discovered that their work had developed along similar lines to the effect that, over the years, both in nursing and social work the individual patient or client became the main focus of attention.

15.2.1. The origin

In the United States, case work, or social casework as it came to be known, originated in the crying need to deal with the problem of poverty in the mid-nineteenth century. At the time, poverty was regarded as the punishment meted out to the poor for their indolence, inefficiency or improvidence, or else it was interpreted in terms of heredity, intoxicating drink, and degeneration. On the other hand, traditional religion taught that poverty also was a fortunate necessity which stimulated the poor to improve their situation and the rich to give generously. Both views complemented each other with the effect that poverty and disease were considered to result from the moral inadequacy of the pauper who was to be found chiefly among the dependent, the delinquent and the criminal classes. As a result, the ensuing development of the charity organisation movement which started with the first Conference of Charities in 1874 was at first preoccupied with the suppression and control of pauperism by means of charity. After that, interest moved towards social action and, subsequently, to social casework.

Charity. Granted that poverty was due to moral failure, the history and character of paupers as individuals had to be carefully studied so that a distinction could be made between so-called '*deserving'* and '*undeserving'* poor. This investigation was the task of the friendly visitor, the forerunner of the social worker, or, as it was put in the Proceedings of the first conference (in: Woodroofe, 1962, p. 92, footnote):

> *'... great care ... should be taken in distributing benefactions, that they only be given after careful house visitation. ... The proper course is for the fortunate classes to district the poor classes, and visit carefully from house to house finding those who are the truly deserving recipients for charity.'*

In 1880, when the Conference of Charities and Corrections began, the delegates were torn between this traditional approach and a more humane individualising of the poor person. It was the latter approach which gave rise to what came to be known as the principle of individualisation of social casework. In 1886, George E. Buzelle told the national conference (in: Biestek, 1961, p. 24):

'Charitable work, in the best sense, must be done by the individual ... for the individual. ... Each case is a special case, demanding special diagnosis, keenest differentiation of features and most intense concentration of thought and effort.

Although this principle of individualisation continued to put the blame of poverty on the individual, it differed from the traditional approach on two counts. First, Buzelle implied that poverty could be dealt with only on the basis of a one-to-one relationship between the friendly visitor and the poor person. Secondly, he denied that the poor formed a class with interests separate from, if not antagonistic to, those of other classes (in: Woodroofe, 1962, p. 93):

'The poor, and those in trouble worse than poverty, have not in common any type of physical, intellectual or moral development which would warrant an attempt to group them as a class.'

Social action. In the 1890s, however, social workers turned their attention to the social and economic conditions which were considered at the source of poverty such as, for example, the influx of immigrants, bad housing, low wages and child labour. This shift was prompted by the growing awareness that poverty was not caused by the moral but the social inadequacy of the poor. As a result, the charity of prevention was substituted for the relief of poverty, and the task of the friendly visitor changed accordingly. In 1906, Edward T. Devine told the national conference that it was the duty of the social worker (in: Woodroofe, 1962, p. 95):

'to seek out and to strike effectively at those organized forces of evil, at those particular causes of dependency and intolerable living conditions which are beyond the control of the individuals whom they injure and whom they too often destroy.'

This was not, however, to imply that the friendly visitor should set out to alter the social order but only to mitigate its worst effects by means of employment bureaus, woodyards, laundries, work rooms, special schools, wayfarers' lodges, loan societies, penny banks, fuel societies, creches, district nursing, sick diet kitchens, accident hospitals. The new approach also opened up new areas of practice like housing, the prevention of tuberculosis, juvenile probation, legal aid and the care of dependent children.

Finally, it was also in this period of conscious social action that The New York School for Philanthropy, later called the New York School of Social Work, was founded (1899), and social work gradually changed from friendly uplifting, requiring skills in fact-gathering and helping by means of advice, persuasion, and exhortation, into the trained skill of using the individual, the group and the community to help people to lead happier lives.

Social casework. A new impetus toward the individualisation in social work was given in 1917 by Mary Richmond's classic book 'Social Diagnosis' in which she advocated 'the retail method of reform' which incorporated both a social and an individual approach. To the legal-like investigation of the friendly visitor, she added the warmth of the helping relationship. In Richmond's opinion, social casework entailed a process of:

- investigation,
- accurate diagnosis,
- co-operation with all possible sources of assistance, and
- treatment.

'Social Diagnosis' admittedly focused on the methods of social work to diagnose the problem of the client. Also, the book definitely bore the hallmarks of the social approach, but, within a few years' time, Richmond shifted towards a more individualised approach and described it as consisting of (Richmond, 1923, pp. 98-99):

'those processes which develop personality through adjustments consciously effected, individual by individual, between men and their environment.'

The process and skills required for this line of work were (Richmond, 1923, pp. 101-102):

'direct and indirect insights, and direct and indirect action upon the minds of clients.'

Whereas direct action presupposed an understanding of the individuality of the client, indirect action required an understanding of his environment, but both were directed at the mind of the client.

In short, Richmond is said to have bequeathed to social casework the following three concepts (Woodroofe, 1962, pp. 114-115):

- the concept of a systematic method by which a social diagnosis could be made to serve as a basis for treatment,
- the concept that a knowledge of human behaviour was necessary for a better understanding of the individual, his family life and the personal and social relationships by which he lived,
- the concept of the process of social work as a democratic process in which the caseworker and client could co-operate to their mutual advantage.

The shift of emphasis in Richmond's major publications reflected the growing awareness that social action in itself was insufficient for individual happiness, and that a person's main source of help lay within himself (Woodroofe, 1962, p. 132):

> *'Whereas in the period from 1900 to the First World War, the caseworker, faced with the problem of man's adjustment to his social environment, had been concerned primarily with the environment and the possible ways in which social action could repair individual failure, now in the post-war years, it was assumed that if adjustment was not achieved the individual was to blame. Moreover, it was believed that individual therapy was the process by which a better world could be achieved.'*

This trend of individualisation was prompted by the fact that, during and after the First World War, social workers were confronted with problems such as war neurosis, the shell shock syndrome and the readjustment of soldiers to civilian life. These problems not only indicated the need for more medical and psychiatric knowledge among social workers but also drew their attention to the potential of the mental hygiene concept in social casework. Consequently, many of the discussions at the national conferences between 1915 and 1920 were devoted to the relationship between mental hygiene and social casework.

Next, the economic prosperity of the roaring 1920s led to an increased optimism as to the possibility of banishing poverty from the nation, as well as the belief that it was primarily the individual's psychological inadequacy which was at the source of his problems (Woodroofe, 1962, p. 135):

> *'The conviction, deeply rooted in the soil of American individualism, that moral inadequacy lay at the root of most problems of poverty and dependency was now reinforced by an over-emphasis upon psychological inadequacy, and little, if any, attention was paid to the social realities which the individual had to face in a highly industrialised and fiercely competitive society.'*

The individualisation of social casework was also furthered by the subsequent economic depression which revolutionised social work, placing it among the primary functions of government, and by the introduction of the Freudian vocabulary in social casework in the 1930s. The latter influence was reflected in the use of technical terms like ego, superego, libido, and ambivalence as well as the growing importance of the concept of relationship in social casework.

Summing up, after moving through the stages of charity and social action, it was by means of social casework that the profession of social work developed the principle of individualisation as it is understood at present (Biestek, 1961, p. 25):

> *'Individualization is the recognition and understanding of each client's unique qualities and the differential use of principles and methods in assisting each toward a better adjustment. Individualization is based upon the right of human beings to be individuals and to be treated not just as a human being but as this human being with his personal differences.'*

15.2.2. The evolution

The evolution of social casework in nursing followed more or less the same pattern as in social work, and understandably so, because both professions were perceived to have close historical links in the humanitarian idea of relieving the individual from the suffering from disease and poverty in the mid-nineteenth century. In the course on 'Historical, ethical and social basis of nursing' in the standard curriculum, for example, it was suggested that a brief survey of nursing history should be given to show '*the identification of nursing with all forms of social and philanthropic work in the past*' and, more importantly, that nursing was still '*essentially a form of social work*' (NLNE, 1917, p. 124). The identification of nursing and social work, however, did not hold for the explanation of these problems being the result of moral failure on the part of the individual. Although this explanation was very much in evidence in the Nightingalian model of nursing, it failed to become part and parcel of the tradition of American nursing.

In the first quarter of this century nursing and social work grew more or less apart. This process of estrangement came most clearly to the fore in the development of hospital social work and public health nursing where nurses became most acutely aware of the social conditions affecting health as well as the need for prevention. As a result, nurses and social workers contested the relationships between social conditions and health as their exclusive area of practice. In due course, both groups developed more generalised ways of dealing with the problems of disease and poverty, chiefly by isolating general causes and building up national agencies to take over the responsibility for treatment. This trend was at the source of the nationalisation of public health nursing in the 1920s and social work in the 1930s, both of which culminated in the Social Security Act (1935). However, in the late 1920s and the early 1930s, public health nurses and social workers discovered that they had common ground in their interest in the individual problems of the patient or client (Robinson, 1929, p. 516):

> *'The public health nurse, like the social case worker, is working in a field where certain problems have been handled to the point where general causes are known and where treatment agencies have been successfully developed. ... But in other aspects of the contact with the public health problem, it presents itself in as individual and unique a manner as it does to the social case worker. Here it is the individual patient, his attitudes, his needs, his emotional reactions which determine the effectiveness of any treatment.'*

This interest, prompted by the mental hygiene concept gaining momentum in nursing as well as in social work, also made them aware of the fact that, over the years, they had been using the very same principles and methods of casework. But, whereas social casework increasingly focused on the psychological adjustment of the individual to his environment, social casework in nursing developed into a method for planning individualised nursing to meet the nursing needs of the individual, physical, social as well as psychological.

The evolution of the case method in nursing will be discussed in more detail by tracing the development of hospital social work and public health nursing. Ultimately, this evolution led to the introduction of the unit on 'Planning individualized nursing care' in the curriculum guide (NLNE, 1937, pp. 357-361).

The hospital social service. Hospital social work in the United States dates from the first decade of this century. In 1905 when Dr. R. Cabot was working at the dispensary of the Massachusetts General Hospital in Boston, he created a hospital social service department because, during his work with patients suffering from tuberculosis, he realised how important it was to study not only the patient but his background and his surroundings as well. For this purpose he employed two nurses - Miss Isabel Garnet Pelton and Miss Ida Cannon - to visit the homes of the patients so that he could take the social background into consideration in their treatment. In this department, from the first, social service was made part of the nurse's work. One year before, the psychiatrist Adolf Meyer had enlisted the help of his wife, Mary Potter Brooks, to visit the families of his patients. About this work, the forerunner of psychiatric social work, he once wrote '*We thus obtained help in a broader social understanding of our problem and a reaching out to sources of sickness, the family and the community*' (Alexander & Selesnick, 1966, p. 329).

Without detracting from the historical significance of both Cabot's and Meyer's initiatives, it must be said that the early visiting nurses had been demonstrating interest in the social conditions of the patient too. Miss Ida Cannon, in her authorative book 'Hospital social work,' even paid tribute to the social awareness of the early

visiting nurses having contributed so much to the development of the hospital social service, '*a service quite different from any that preceded it*' (Cannon, 1923, p. 6).

Casework in hospital social work. Nurses employed in the hospital social service, and visiting nurses for that matter too, undoubtedly used the method of social casework for, in the standard curriculum, these were the two main areas of nursing practice indicated for the use of this method. The method of social casework was dealt with in the course most significantly entitled 'Introduction to public health nursing and social service' (NLNE, 1917, p. 150-153) and the outline of classes was divided into the following subjects: theory and technique of social casework, source of cases and basis of selection, case work in visiting nursing and in the hospital social service, office methods, and modern tendencies and special problems. As for the theory and technique of social casework, the following topics were suggested (NLNE, 1917, p. 151):

> *'Meaning of social diagnosis and social treatment. Emphasis on family treatment. Factors to be considered in all case work - mental and physical heredity, family influences, education and training, occupation, income, recreation. The relation of these factors to health. Importance of first interview and first home visit.'*

With regard to the purpose of using the method of social casework, however, hospital social work differed from visiting nursing. Whereas hospital social work was aimed at cases requiring medico-social treatment, visiting nursing focused on constructive social casework which was just another name for prevention of disease by influencing the social conditions in which the patient lived.

Finally, under the heading 'Methods of teaching,' it was suggested that '*There should be constant use of cases seen in the ward and Social Service Department or Visiting Nursing Society*' (NLNE, 1917, p. 152). This suggestion not only shows that, as early as in the 1910s, the case study was used as the basis for teaching the method of social casework, but, more importantly, it also demonstrates that the reason for using the case method in nursing education was different from the reason for the use of the case method in nursing.

Hospital social workers versus nurses. Despite the fact that, initially, most hospital social workers were recruited from the nursing ranks, hospital social workers increasingly identified themselves with the profession of social work. The major impetus for the estrangement between nurses and hospital social workers was the increasing incompatibility of nursing and social work. On the one hand, there was the emphasis upon the physical aspects of nursing in the nurse's training, and, on the other hand, the shift towards the development of personality through a better adjustment between individuals and their social environment in social work, or, as Cannon put it (1923, p. 191):

> *'Time has shown that much of the technical bedside training of the nurse is unused in social work, and that much definite medical information - such as the causes and progress of disease, the treatment of long convalescence, the elements of sanitation, the multiform ramifications in special branches of medicine dealing with tuberculosis, contagion, hygiene, and public health methods are not emphasized in the nurse's training, though all are vitally important in social work.'*

This conclusion was not unfounded for, as a study by the American Hospital Association had revealed (1921), less than 50 % of the hospital social workers in the 61 departments studied were nurses. Moreover, hospital workers were feeling the need for preparation, as was put in this study, '*adequately adapted to the special and somewhat complex requirements of hospital social work*' (Roberts, 1954, p. 167). The self-confident and independent stance of the hospital social workers came also to the fore in the definition of the hospital social service's function (Cannon, 1923, p. 1):

> *'The hospital social service department aims to throw a new light on medical practice in institutions. It seeks to understand and to treat the social complications of disease by establishing a close relationship between the medical care of patients in hospitals or dispensaries and the services of those skilled in the profession of social work; to bring to the institutional care of the sick such personal knowledge of their social condition as will hasten and safeguard their recovery.'*

Hospital social workers could thus be seen to differentiate their work from both nursing and medicine, and quite understandably so in the wake of Flexner's conclusion that they were just middle men. Because, in the end, the hospital social service became the exclusive domain of medical social workers, it did not contribute much to the development of the case method in nursing.

Public health nursing. As for the relationship between public health nurses and social workers, they went through a period of estrangement, too. So much so, that the question was raised as to whether a nurse could make a good social worker. Frequent arguments against the nurse as a social worker were (Beard, 1917, p. 21):

- she has received orders for so long that she cannot think independently,
- she is hardened to suffering, therefore unsympathetic,
- she is prone to emphasise unduly the health aspect in human problems,
- a doctor will treat her as an assistant, rather than as a colleague.

On the other hand, Beard, a nurse herself, considered hospital and private nursing experience to be 'a real asset in that so many habits, useful in social work, have already been developed and directed, consciously or unconsciously, along altruistic lines, and the ideals of service are similar' (p. 21). Pointing out the many similarities between social work and nursing, she stated (p. 24):

> *'But our greatest assistance comes in the social case record, which corresponds to our clinical charts, giving the history of the agency's contact with the individual or family. Facts must be recorded promptly, briefly, accurately and fully. They must be relevant, noting whether they are subjective or objective; but conclusions and impressions should be rarely expressed. The record must be comprehensive and intelligible to subsequent workers, the subject developed logically and following the form used by the organization, as social records are not uniform. The initial statement by the client and the investigation, might be compared to a medical history and a physical examination. Even plotting a temperature chart trains us in making graphs. Thus conscientious observation and faithful recording are essential qualities both for treatment and for scientific data which will lead to better diagnosis. We need hardly be told the confidential nature of these records. In short, the same general rules of professional ethics hold for both lines of work.'*

Some public health nurses even went as far as introducing their own version of the case record such as, for example, the '*patient's history card*' (Foley et al, 1917) which was designed for the fact-gathering process more than anything else. This was, incidentally, fully in line with the purpose which the social case record was used for before the publication of Richmond's 'Social diagnosis' in 1917. Looking back upon this period, Tucker (1923, pp. 614-615) observed:

> *'A remarkable phenomenon has arisen recently in the development of social work and public health work, the practical implications of which we are just realizing. ... The social worker is constantly becoming more and more concerned with health while the public health nurse is increasingly observant of social problems with their health implications. ... The situation is realized with consternation on the part of both more often than with congratulation. Such remarks are heard as this: "What does a social worker know about health? She has had no medical training. Why does she not keep within her own field?" while the social worker says with bitterness, she "should think there were enough sick people to keep the nurse busy nursing, instead of trying to do social work which is not her concern."*

Tucker's observation illustrated the changes in the relationship between nursing and social work since the end of the First World War.

Social and health aspects: a battleground for nursing and social work. After the First World War social workers, influenced by the mental hygiene movement, increasingly focused on health in relation to personality development. This approach rested upon the belief that '*by its very nature personality depends in considerable part upon healthy action and reaction between the total social environment and the individual*' (Richmond, 1923, p. 111).

Public health nurses, on the other hand, although fully aware of the effects of social problems on health, were confronted by the rapidly increasing demand for health care which forced them to concentrate on care for the sick rather than the social and health aspects of their work, a development exacerbated by the shortage of qualified public health nurses. Consequently, public health nursing's objectives of preventing disease and maintaining health were jeopardised, and it was this problem which was at the source of the issue of generalised versus specialized nursing, discussed earlier. In the end, this crisis of public health nursing however proved to have a beneficial effect in the enunciation of the principle of individualisation in the Goldmark Report.

Despite both groups having shifted their attention from the environment to the individual, the controversy about each group's exclusive area of practice remained unsolved. Whereas social workers looked for more knowledge on healthy personality development in the circles of the mental hygiene movement, public health nurses took special courses on the social aspects of nursing, for example, at Teachers College, the New York School of Philanthropy and similar institutions. One of the subjects invariably taught in these courses, as Goldmark found out (1923, pp. 531-532), was the method of social casework.

One solution put forward was '*to study the tasks to be done and to train for these tasks not in accordance with our professional backgrounds or even according to our predilections, but in accordance with what the task demands*' (Public Health Nurse, 1925, p. 299). This was precisely what the Committee on Education was urging too (e.g. NLNE, 1927, pp. 8-9). This solution seemed the more appropriate as, too often, the nurse or the social worker saw the job only from the angle of what she herself could contribute and neither one appreciated the contribution of the other (Public Health Nurse, 1925, p. 299):

> *'The public health nursing group needs, perhaps, more appreciation that there is a body of principles and a definite technic of social work for which a certain fairly extensive type of training is required. The social workers, perhaps, need more appreciation of the medical tradition and of what they themselves ought to know before venturing into cases which touch medical problems. Both groups certainly need to make careful study of methods of health education.'*

What all this added up to was that two relatively young professions were contesting the same areas of practice such as the home, the school, the workshop, the hospital social service and the court. This controversy also came to the fore in the explanation of the revised curriculum's concept of nursing which, most significantly, was headed by the title 'The place of public health and social service in the basic course,' (NLNE, 1927, p. 12) as well as in the addition of a special course on 'Modern Social and Health Movements' aimed at impressing on the students the importance of the close relationships between social conditions and public health for nursing as a whole (NLNE, 1927, pp. 164-168).

The case method: a meeting ground for nurses and social workers. In spite of the divisive effect of the controversy between public health nurses and social workers, both groups made use of the case method, and it was this method which was used to differentiate social work as well as nursing from medicine.

Richmond, for example, called attention to the different meanings of the word '*case'* in medicine and social work. Whereas the doctor's case was the patient, the social worker's case was '*the particular social situation or problem - not the person or persons concerned*' (Richmond, 1923, pp. 27-28). For the person, as distinguished from his problem, the term '*client'* was used. In addition, she contrasted social work's case-by-case approach with the '*dogmatic same-thing-for-everybody*' approach in medicine, reflected in its '*more or less scientific classification of diseases and a standardized treatment for each*.' The only point of contact between the professions of medicine and social work, she was able to point to was socialised medicine which '*begins to treat not only the disease but the patient in his individual environment*' (Richmond, 1923, p. 111). In nursing, on the other hand, it was in this period that nurse instructors endeavoured to introduce the case method in the practical training of the nurse by means of the case method of assignment, but (Roberts, 1954, p. 249):

> *'... routines and technical procedures were so demanding that there was little time in most schools for ward teaching and for the practice of the more subtle arts of nursing through which nurses make a constructive contribution to the recovery of the sick and to the peace of mind of their families. As the director of nursing in a busy teaching (university) hospital put it, "We don't nurse patients anymore. We have time only to follow doctors' orders."*

So in nursing, too, the case-by-case approach was at the source of the perceived contrast between the routines and technical procedures of medicine, on the one hand, and the preferred individualised approach of nursing, on the other. This came also to the fore in the revised curriculum which incorporated a special course on 'The Case Method (Applied to Nursing)' containing the following suggestions for teaching the application of this method of work to the field of nursing (NLNE, 1927, p. 112):

> *'Discussion of the value of this method in helping the student to understand thoroughly her patient in order that she may render the highest type of nursing service. The adaptation of general nursing measures to meet the special needs of the patient. The importance of a systematic plan for nursing care to be worked out on the basis of facts studied and treatment prescribed. Typical case studies presented emphasising nursing care.'*

This description was typical of the stage at which nurses were transforming social casework into a method of nursing. The use of this method, such as in the standard curriculum, was said to rest upon the students having '*obtained a general idea of the method of making case studies*' first (NLNE, 1927, p. 114).

The development of cooperative relationships. In the 1920s, the relationship between public health nurses and social workers was based upon their differences of opinion with regard to the social and health aspects of their work. In the late 1920s, however, there was a noticeable shift towards more cooperative relationships between the two professions.

The major impetus for this change was the discovery of having common ground not only in the use of the method of social casework insofar as it incorporated both social action and a case-by-case approach, but also in the increasing concern with the individual. As for this trend towards individualisation, both public health nurses and social workers were strongly influenced by the mental hygiene concept in stressing the importance of the individual differences between either patients or clients. The controversy about the social aspects of public health nursing and the health aspects of social work was rephrased accordingly. Although the differences between the two groups of workers were, admittedly, transcended by their concern with the individual, there remained one essential difference (Robinson, 1929, p. 517):

> *'As long as the point of contact remains on a health problem, where the nurse's equipment is assured, her effectiveness with the client is apt to be greater than the case worker's, who must establish slowly a confidence the nurse achieves by virtue of her title and her uniform. But in the field of behavior, so inseparable from health, where the nurse has little knowledge and correspondingly little capacity for acceptance of differences in behavior, her succes in dealing with individual difference is far less assured.'*

The reason for drawing the lines of division between health and behaviour was that public health nurses, despite their interest in mental hygiene, were considered ill-prepared to deal with personality problems. Many public health agencies filled this gap by means of psychiatric social workers because '*the training in psychiatry which the nurses received was not equal to the training in psychiatry which the social workers received in the schools of psychiatric social work*' (Blakeley, 1930, p. 26). It was thus the knowledge of psychiatry rather than the knowledge of social casework which nurses lacked.

In the short term, public health nurses had much to gain from the knowledge of psychiatric social workers in that it stimulated them to interpret mental disorders in terms of mental hygiene. In the long term, however, the training of the nurse evidently had to be adapted to include mental hygiene because '*the physical and mental cannot be separated. If the nurse's goal is health, good and all round health, she will not be content to do only a mechanical job which will not lead the person to health*' (Blakeley, 1930, p. 27). As far as public health nursing was concerned, it was this development which gave rise to the growing influence of the mental hygiene concept in the curriculum guide (NLNE, 1937).

Having arrived at the same interest in mental hygiene, albeit along different routes (Table 14), the confusion as to the objectives and functions of public health nursing and social work remained. Surprisingly, this confusion existed only in their more remote and complex activities rather than in the fundamental services provided by each (Frost, 1932, p. 349):

'In these fundamental services, there is no disposition to dabble; no social worker seems to have the least stirring of ambition to minister to the physical needs of a sick person, however eager she may be to undertake instructive or preventive functions. In other words, bed-side care is always the absolute and undisputed dead line. Likewise, no public health nurse seems to have any ambition to tinker with the difficult problem of financial relief. Too often she is willing to undertake advice and adjustment, but when the bug-a-boo of material relief raises its head, she looks anxiously around for a social worker to whom it may be referred. These simple fundamental services seem, at times, to be looked upon as the "dirty work" of the professions rather than their raisons d'être *and, if mentioned at all, are spoken of apologetically.'*

Notwithstanding the remaining confusion, the introduction of the mental hygiene concept in public health nursing and social work focused the attention on the patient or the client as an individual rather than his respective illness or problem. As for nursing, this called for a method adapted to individualised nursing care.

SOCIAL WORK	NURSING
Charity 'Social work had its beginning in a simple service of relieving the poverty-stricken or otherwise distressed individual.	**Physical aspects** 'In the early days of nursing, the humanitarian idea was uppermost. Ease of body and peace of mind for. the individual were its aims. With the development of medicine and its manifold and complicated treatments, nursing was occupied chiefly with processes and techniques, and its ethic was concerned mostly with the physician, since he stood out then, as now, the beloved Chief, with responsibility for direction and guidance.'
Social action 'Recognition of the various factors which contributed to his condition, and better understanding of the connections between illness and poverty, led to the development of "Family Welfare." The increasing number of community organizations for meeting these needs necessitated the organization and coordination of these resources and hence the stages of "Charity" and later of "Community Organization."	**Social aspects** 'Preventive medicine, in its search for causes, turned our attention to the contributing factors in the home, and enlarged our circle of interest to include the family. Community influences and the use of community resources brought us into contact with a new group - the social workers.'
Social casework 'Finally, ... there is a decided movement back to the individual, realizing that his main source of help lies within himself, and the contribution of social work is the stimulation and reinforcement of that vital spark. So, this emphasis upon the individual leads out also into the realms of "mental hygiene," which we discover is only another name for the older term of "case work."	**Psychological aspects** 'Gradually, the pendulum has swung back again to the individual, whether sick or well, as our chief concern. The patient is more important than his attitude toward illness more important than techniques. No matter what our starting point in public health nursing today, we find ourselves groping in that nebulous territory called "mental hygiene." From prenatal to post-mortem age, no program of any kind is complete today without its "mental hygiene aspects."

Table 14. The development of social work and nursing (Frost, 1932).

Planning individualised nursing care. As mentioned earlier, the curriculum guide contained a unit on 'Planning individualized nursing care' (NLNE, 1937, pp. 357-361) which, in fact, amounted to a nursing version of social casework and was the forerunner of what later came to be known as the nursing process.

Because of its historical importance, this method of planning individualised nursing is described here in more detail. The essential steps taken in planning nursing care were (NLNE, 1937, p. 358):

- adaptation to planning nursing procedures,

- method of putting plan into execution in terms of the means provided for organisation and coordination of activities performed by nurses caring for the patient,
- analysis and evaluation of results in terms of what constitutes good nursing.

In accordance with precedent (NLNE, 1917 and 1927), the case study as a basis for planning was included (NLNE, 1937, p. 358; see also Henderson, 1982, p. 104).

Adaptation to planning nursing procedures. The first step required the nurse, firstly, to define the aims of the plan in terms of the patient's needs, and, secondly, to describe procedures in terms of nursing activities. Between them, these requirements demonstrated the newly emerged concept of nursing which put such great emphasis on the individualisation of nursing care:

- **the aims of the plan defined in terms of patient's needs**
  - to provide for the patient's complete nursing needs while in the hospital (as determined by his age, sex, physical and mental condition, intelligence, education or former experience, economic and social status, tastes, prejudices, etc.),
  - to plan for or assist in planning for provision of these needs after he leaves the hospital.

- **procedure described in terms of nursing activities**
  These activities were concerned with:
  - carrying out the programme prescribed by the physician (including all activities performed under his direction and in assisting him in diagnostic and therapeutic measures),
  - general nursing care (including organisation and care of the patient's environment, his personal care, activities concerned with physical and mental comfort, diversions and occupations, instructions incidental to his care and guidance).

Method of putting plan into execution. The second step in planning individualised nursing care involved:
- applying principles and methods for securing continuity of service,
- applying principles and methods to insure consistency and continuity in service,
- attention to day by day scheme of care,
- principles and methods which provide for flexibility in plan.

Analysis and evaluation of results. As to the third and last step in planning nursing care, the following criteria of good nursing were suggested:
- measurement of results obtained by application of standards of good nursing to all nursing procedures (i.e. safety, therapeutic effectiveness, comfort and happiness of the patient, economy, simplicity, and adaptability),
- measurement of success of the total programme in terms of economy of vital energies of the patient, promotion of health and well- being, promotion of increased knowledge, and promotion of increased ability to meet future health problems,
- measurement in terms of the satisfaction of the patient and his friends, the physician, other associates, and the nurse herself.

15.2.3. From social casework to the plan of nursing care

In the end, the evolution from social casework to the planning of individualised nursing care, ultimately, culminated in the plan of nursing care as described in Harmer's 'Textbook of the principles and practice of nursing' (Harmer, 1939). The content of this textbook was reorganised for the fourth edition in order to conform with the recommendations made in the curriculum guide. In the second part of the book, 'Fundamentals of nursing care,' a special chapter was devoted to 'The plan of care of the patient,' which rested upon the assumption that (pp. 60-61):

'... everyone, young and old, is likely to have an individual and comparatively habitual way of taking care of himself, or being cared for, and a time schedule for the activities involved. As long as he is well he is satisfied with his plan, but when he feels a lack of vigor, fears illness, gets sick, or is incapacitated, he may realize that his scheme is no longer adequate and may very naturally and properly ask for advice from the medical professions. He expects them to suggest modifications that will either prevent disease, re-establish health, or relieve pain and discomfort when a return to health is impossible.'

This '*modification of the patient's manner of living and the provisions for making these modifications*' (p. 60) was what was meant by the plan of care of the patient. It entailed the '*total program of care*' (p. 62) which was worked out in case conferences attended by physicians, nurses, dieticians, social workers, and others concerned with the care of the patient.

The case-by-case approach. In the light of the parallelism in the evolution of social work and nursing, it is interesting to note that the social worker's function was said to be that she '*assists both sick and well patients to find suitable institutions to give such care and attention as they may need; she gives advice on financial problems; she assists in securing companionship, diversion, and employment and in the adjustment of many other social factors in the care of the patient that bear directly or indirectly on his health*' (p. 63). The nurse, on the other hand was considered responsible for '*executing the nursing aspects of the plan*' (p. 62) by means of her own '*plan of nursing care*' encompassing the following activities (p. 64):

1. *Activities that are concerned with hygienic care.*
   A. The methods by which the environment is regulated.
   B. The ways in which personal care is provided.
      (1) Cleanliness of skin, mouth, hair, and nails
      (2) Elimination
      (3) Healthful posture
      (4) Exercise
      (5) Rest and sleep
      (6) Variety, diversions, occupations, companionship
      (7) Nutrition
2. *Nursing measures used for the relief of pain and discomfort.*
3. *Activities prescribed by the physician for their therapeutic and relief-giving effects.'*

The resulting division of labour between nurses and medical social workers goes a long way to show to what degree nursing's area of practice was differentiated from that of social work. A similar conclusion holds for the case-by-case approach underlying the plan of nursing care as Harmer did not connect this approach with social work but with medicine (p. 63):

'In giving medical and nursing care to patients, each person's case should be looked upon as a problem ...'

The case method of assignment. The foregoing conclusion is corroborated by the way in which the plan of nursing care was subsequently connected with the case method of assignment (p. 67):

'It is generally recognized as a principle of good medical care that each patient is under the care of a particular physician. ... Some nurses believe that a similar principle applies to nursing care. It is becoming more and more general to assign a patient to one nurse who makes it her business to study the patient's particular needs. The nurse is as dependent upon a thorough knowledge of the patient in planning nursing care as the physician is in mapping out a plan of therapy. The nurse to whom the patient is assigned becomes responsible for his nursing care. Other nurses who relieve her when she goes off duty or who help her when she needs assistance follow the nursing plan she makes for the patient.'

This description illustrates how, when the case-by-case approach was transferred from public health nursing to general nursing, this approach was perceived to originate in the practice of medicine rather than social work. Given that general nurses were closer to the physicians than the social workers, this perception was quite understandable. Also, it explains why the fact that the plan of nursing care originated in the method of social casework has faded away in the collective memory of the nursing profession. It is, incidentally, worth noticing that this description of the case method of assignment embodied the self-same idea as what, at present, is known as primary nursing.

The case study. Yet another indication of the individualising effect intended by the plan of nursing care was the inclusion of the case study as a condition sine qua non for individualised nursing care (p. 69):

> *'It seems self-evident that the nurse cannot make a really intelligent and individualized plan for the care of the patient without making some sort of a case study. When the particular needs of a patient are not analyzed, the inevitable result is that he is fitted into a routine pattern of care.'*

The contrast between an individualised and a routine pattern of care apart, these remarks demonstrate to what degree the plan of nursing care was believed to depend upon the nurse knowing '*a good deal about the person and the way he lives*' (p. 66). The collection of the data needed for this knowledge was a requirement which nursing had in common with medicine as well as social work (p. 87).

15.3. The nursing care study and the plan of nusring care

The analysis of the origin and the evolution of the case method has been shown to culminate in the nursing care study in nursing education and the plan of nursing care nursing.

As far as nursing education is concerned, the case method originated in other forms of professional education (Jensen, 1929a) and bedside clinics for nurses (Parsons, 1911; Stewart, 1944). After its introduction into nursing education, however, its evolution corresponded with the changing concerns of the three consecutive editions of the Curriculum, viz.:

- the educational nature of the nurse's training (NLNE, 1917),
- the nature of nursing implying an individualised approach, (NLNE, 1927), and
- the nurse's adjustment to the demands of the nursing profession (NLNE, 1937).

As a result of these changes, the case study not only came to be regarded as the method par excellence to teach nursing, or better still, individualised nursing, but was given another name as well, viz. the nursing care study (Taylor, 1938; Jensen, 1940).

The case method which came to be used by nurse practitioners, on the other hand, originated in social work and its evolution was dominated by the continuing differences of opinion as to the exclusive areas of practice of nurses and social workers respectively. This evolution took place in the hospital social service and public health nursing. In the end, however, public health nurses and social workers became aware that they had common ground in the use of the case-by-case approach of the patient or client (Robinson, 1929; Frost, 1932). Thereafter, the case method evolved into a method of planning individualised nursing in general nursing (NLNE, 1937). The evolution of the case method in nursing resulted in the plan of nursing care incorporating not only the case-by-case approach but also the case method of assignment and the case study (Harmer, 1939). At this stage, the case method of nursing came also to be connected with the case method in medicine rather than in social work.

Finally, the evolution of the case method in both nursing education and nursing goes a long way to show that, as far as the application of the concept of individualised nursing is concerned, this particular method was its corollary.

16.
THE MEANING OF INDIVIDUALISED NURSING

The model of individualised nursing has taken many years to emerge. This was due to two factors. First, this model had to evolve in spite of opposition from the simultaneously emerging model of functional nursing. Secondly, for this model to emerge, nurses had to come to terms with the legacy of the Nightingalian model of nursing. The following discussion of the meaning of individualised nursing will therefore focus upon the similarities and differences between this model of nursing and the model of functional nursing, and the Nightingalian model of nursing.

16.1. Functional nursing versus individualised nursing

The curriculum guide undoubtedly was a landmark in the history of American nursing in that it not only heralded the completion of the model of individualised nursing but also the coming of age of nurses as a professional group, or, as Stewart put it in the introduction (NLNE, 1937, p. ix):

> *'The general feeling seems to be that we have all learned a good deal through participation in this project. It has helped us to clarify our ideas on many points. We see a little more clearly where we stand as a professional group and where we want to go. We have become better acquainted with our nursing colleagues and with many people in other fields who are genuinely interested in our problems. We understand better where the opposition to changes in nursing education comes from and the basis of such opposition. We have discovered some of the values in mixed group discussions which bring out different viewpoints, help to clear the air, and put controversial issues on a more rational and less emotional basis. Whatever may be said of the contributions of the Curriculum Guide, there seems to be an unanimous feeling that the professional group in nursing education is more wide awake, better oriented, more articulate, and better prepared to tackle the problems of the future because of the work on this revision program during the past years.'*

This is precisely the feeling which emerges from a comparison between the models of functional nursing and individualised nursing as the following comparison will show.

16.1.1. Nursing

The most persistent theme in the controversy between the functional and individualised concepts of nursing, although its wording was slightly changed over the years, was whether nursing was aimed at meeting either institutional and medical or social and human needs. In the final analysis, however, the latter has been shown to be the steady aim of nursing. In the process, nurses disengaged themselves from both the hospital and the medical profession which tried to impose a functional concept of nursing upon them, and responded to the needs of society by developing the concept of individualised nursing instead. This conclusion is justified by the comparison of the two models' concepts of nursing as to their key-elements, viz. person, environment, health, and nursing:

Person. Whereas functional nursing rested upon a reductionist view of the person as a mere physical being, the person emerging in individualised nursing implied the total individual, psychological as well as physical. This view of the person was prompted by the influences exerted by public health nursing and the mental hygiene movement. The evolution leading up to this view of the person was reflected in the concepts of nursing underlying the consecutive editions of the Curriculum.

Standard curriculum. In the standard curriculum, the person was discussed only indirectly by means of the contrast between the physical causes and evidences of disease, on the one hand, and the social and economic conditions which were at the source of so many disease problems, on the other. This was typical of the stage at

which nurses realised that disease, apart from its physical causes, was brought about by social and economic conditions too. The concept of nursing underlying the standard curriculum, therefore, encompassed both a physical and a social view of the person, albeit within the context of disease.

	functional nursing	**individualised nursing**
	deals with	*deals with*
person	the body	the total individual, psychological as well as physical,
	in relation to	*in relation to*
environment	its physical environment,	his natural environment, social as well as physical,
	and is aimed at	*and is aimed at*
health	treating disease	attaining and maintaining health
	by means of	*by means of*
nursing	the manual activities required in the routine physical care of the sick	the activities required to meet all the nursing needs of the individual, sick or well.

Revised curriculum. In the revised curriculum, on the other hand, the words '*physical'* and '*social'* came to be used in connection with the patient and nursing rather than disease. Thus, it was stated that the nurse should be concerned not so much with the physical condition of the patient as with the social conditions affecting him and his prospect of cure. As a result, nurses' chief concern shifted from the relationships between social conditions and disease to the relationships between social conditions and health.

Subsequently, the contrast between the physical and social conditions affecting the patient's health was identified with the contrast between the technical and human element in nursing:

patient	**nurse**
physical conditions	technical element
social conditions	human element
affecting the patient's health	in nursing

Thus, in one and the same breath, the social conditions affecting the patient's health were linked up with the human aspects of nursing. This link was prompted by public health nurses' concern with the prevention of disease and the promotion of health, on the one hand, and, the 'discovery' of the individual in public health nursing and the subsequent enunciation of the principle of individualisation in the Goldmark Report, on the other. The person emerging in the revised curriculum was, therefore, an individual whose health was affected by the social conditions in which he lived. This view of the person was in sharp contrast with the reductionist view of the person amounting to the diseased body of the patient.

Curriculum guide. In the curriculum guide, the evolution from the social aspects of disease to the social conditions affecting the individual's health was taken to its logical conclusion by focusing on '*the total individual in relation to his natural environment' as opposed to the traditional emphasis upon 'the practice of purely routine technical procedures*' (Taylor, 1935b, p. 655).

This final shift towards the individual was brought about by the individualising effect of the mental hygiene concept on nursing, and was reflected in the comparison made in the curriculum guide itself, viz. between a narrow and a broad definition of nursing. Whereas the former stood for the physical aspects of nursing care, the latter entailed (NLNE, 1937, p. 20):

- the total individual: '*the nursing or nurture of the mind and the spirit as well as the body*,' in relation to his
- natural environment: '*the care of the patient's environment, social as well as physical*.'

Finally, the mental hygiene concept also made sure that the individual was attributed an active rather than a passive role in attaining and maintaining healthy relationships with his environment.

Environment. The contrasting views of the person in functional and individualised nursing were matched by the different roles attributed to the environment. From the functional point of view, the environment of the diseased body of the patient was primarily conceived as his physical environment, whilst the environment in individualised nursing evolved simultaneously to this concept's view of the person.

In the standard curriculum, for example, it was not only the physical but also the social environment which was considered to be at the root of disease. In the revised curriculum, however, there was a noticeable shift towards the social environment affecting the patient's health, whilst the environment in the curriculum guide encompassed both the physical and social environment. But, contrary to the revised curriculum in which the environment was attributed an active role, in the curriculum guide it was the person who played the active part in that the total individual, both physically and mentally, was seen as striving for adjustment to the social and physical conditions in his environment.

Also, the evolution of the conception of environment was most suggestive as to the places where nursing care was supposed to be given. Whereas, in functional nursing, the environment for nursing care was the hospital, the environment in individualised nursing gradually shifted from the community at large to the unique situation in which each individual found himself.

Health. The simultaneous evolution of the person and the environment in individualised nursing was matched by a gradual shift of emphasis from curing disease, via the prevention of disease and the promotion of health, to the attainment and maintenance of health. This evolution contrasted sharply with the continuous emphasis upon physical disease in functional nursing.

In the standard curriculum, the discussion was about the causes and evidences of disease which were held to be either physical or both social and physical. In the revised curriculum, however, the conception of disease being related to social conditions was taken one step further in that health, too, came to be regarded as a social phenomenon. Finally, because, according to the curriculum guide, nursing was aimed at helping people to attain and maintain health, it was health rather than disease which became the focus of attention. Moreover, health increasingly came to be regarded as reflecting the individual's physical, social and psychological adjustment to his natural environment.

This evolution from a disease-oriented towards a health-oriented concept of nursing contrasted sharply with functional nursing which kept focusing on disease. Moreover, this conception of health, although taking off from the social conditions affecting health, led to an individualised view of health.

Nursing. Functional nursing, as mentioned before, entailed '*the manual activities required in the routine physical care of the sick*' (NLNE, 1937, p. 20). Individualised nursing, on the other hand, gradually came to entail the activities aimed at meeting all the nursing needs of the individual, sick or well. This evolution of nursing activities came to the fore not only in the physical aspects of nursing care gradually being complemented by its social and psychological aspects, but in the use of the case method in the form of the plan of nursing care which required a case study, a case-by-case approach, as well as a case method of assignment.

However significant the idea of individualising nursing activities may have been for the conceptual development of nursing, it is well worth pointing out that the actual practice of nursing reflected a functional rather than an individualised concept of nursing. This paradoxical situation arose as the result of hospitals and physicians requiring nurses, as Leone reportedly put it, '*to begin her work with the system and not with the patient's needs*' (Miale, 1959). This is borne out by the fact that, among nurses themselves, the functional approach evidently failed to gain the kind of warm-hearted support it enjoyed among hospital administrators and doctors. This was demonstrated by the small number of articles devoted to this approach, or to the underlying methods of scientific management for that matter, in the American Journal of Nursing. The same cannot be said about the individualised approach which, in the same period, gave rise to many more publications.

16.1.2. Nursing education

In terms of education, the differences between the models of functional nursing and individualised nursing were mirrored by the ambiguity of the aims of the American training school for nurses which gave rise to the controversy between service and education. Initially, the decision made was in favour of the former as reflected in the slogan '*service for education*,' but in the end, this slogan was reversed into '*education for service*.'

The educational controversies underlying these slogans came to the fore in the differences of opinion between the two groups which Stewart (1935c, pp. 261-262) labelled as conservatives and liberals. From all the discussions surrounding the three consecutive editions of the Curriculum, it can moreover be inferred that, whereas the former stood for functional nursing and a traditional concept of nursing education (apprenticeship training), the latter advocated individualised nursing and a progressive concept of nursing education (professional education).

Standard curriculum. In the standard curriculum, the differences of opinion came to the fore in the controversy between nursing service and nursing education. This issue was related to the opposing concepts of nursing, viz. nursing as a hospital service versus nursing as a national service. In sofar as the differences of opinion were phrased in educational terms, the practical aspects of the training were contrasted with the theoretical foundation on which really good practical work must always be built.

A first attempt to dissolve the argument was made by Nutting in her contribution to the standard curriculum in which she spelled out the conditions which the hospital had to meet to ensure the satisfactory implementation of the nurse's training.

Revised curriculum. Over the years, the discussion about the development of nursing education was phrased in educational terms only. The major impetus for this change was the Goldmark Report which outlined the conflicts of interests between:

- hospital administration and nursing education,
- apprenticeship training and professional education.

The report's recommendations to resolve these conflicts of interest amounted to a policy for professional nursing education which was proved to be both viable and successful by the Yale University School of Nursing. These events were at the source of the decisions to accept the so-called principle of the basic course and adopt the case method for both the theoretical and practical instruction of the nurse.

Both decisions were related to the revised curriculum's concept of nursing. The impetus for accepting the principle of the basic course, for example, was to ensure that the hospital schools would operate on the basis of a concept of nursing encompassing both the physical (sick nursing) and the social conditions affecting the patient's health (health nursing). The reasons for adopting the case method in education were the increasing concern with the individual as well as the improvements expected from individualising nursing care.

As a result of these changes, teaching a concept of individualised nursing was contrasted with teaching a concept of functional nursing with its over-emphasis on sick nursing and its consequent neglect of health nursing (NLNE, 1927, pp. 11-12):

areas of over-emphasis	**areas of neglect**
the processes of disease	the causes of prevention
the technic of treatment	the measures of prevention
the scientific and technical	the human and social side
side of the nurse's work	of the nurse's work
the study of disease and	health protection and
the nursing care of the sick	health teaching

Curriculum guide. According to Stewart's historical perspective upon nursing education in the United States, mentioned earlier, the curriculum guide was published when the first movements towards fundamental readjustments were made. These readjustments should be taken to mean that the slogan '*service for education*'

began to be replaced by another slogan, viz. '*education for service*' which was just another way of expressing the new aim and philosophy of nursing education, i.e. the student's adjustment to the demands of the nursing profession.

According to Effie J. Taylor, the new concept of nursing education emphasised 'the reconstruction of educational ideas so that they may accord with the newer knowledge of the causes and cure of disease available today, and also with our changing social and economic conditions' (Taylor, 1935b, p. 656).

Education as adjustment. The first element mentioned by Taylor referred to the democratic ideals of the progressive educators in the 1930s which gave rise to the adjustment aim in the curriculum guide. These democratic ideals were in sharp contrast with the military ideals of traditional nursing education (NLNE, 1937 p. 16):

traditional education	**progressive education**
discipline imposed by others	self-imposed discipline
self-sacrificing service that cripples the growth of the individual individual	self-sacrificing service that stimulates the growth of the
practical utility requiring unquestioning obedience	practical utility on the basis of intelligence
technical efficiency requiring drill in fixed habits of behaviour and standardised procedures	technical efficiency on the basis of initiative and self-direction

Nursing as adjustment. The second element, the newer knowledge of the causes and cure of disease, referred to the mental hygiene concept underlying the adjustment aim. Because this concept stressed the growth and development of the individual, it was considered identical to the ideal of democracy as, for example, Pasteur had put it: '*Democracy is that order in the development in the state which permits each individual to put forth his utmost effort*' (NLNE, 1937, p. 16). As far as its effects on the nurse were concerned, too, the concept of education as adjustment was different from the traditional concept of nursing education:

traditional education	**progressive education**
subordination of the individual nurse	the best possible opportunity for development of the individual nurse's capacity for service
too little emphasis on growth and self-realisation	emphasis on growth and self-realization

Nursing education as adjustment. The third element, in turn, connected the concepts of democratic education and mental hygiene with the social and political climate since the economic depression. This relationship should be interpreted against the increasing concern with democracy in the United States, on the one hand, and the emergence of national-socialism in Germany and fascism in Italy. From this social and political point of view, too, there was a noticeable contrast between the traditional and progressive concepts of nursing education:

traditional education	progressive education
Nursing education for a static society at home in an autocratic type of social and political organisation	Nursing education for a dynamic and changing society at home in a democratic type of social and political organisation

The concept of nursing education as adjustment moreover reflected the end of a period of transition from the rugged individualism of the nineteenth century to the socialisation of health and education in the United States. In the process, health and education came to be regarded not so much as a privilege but as a right every citizen was entitled to. As for nursing education, it also implied a change from the system of apprenticeship training to professional education.

Towards professional education. As a result of the studies made by the Grading Committee, the leaders of nursing education began to re-examine nursing and the type of contribution it should make to society as well as the development of nursing education. As for the latter, it was Capen, the chancellor of the University of Buffalo and one of the members of the Grading Committee, who gave the lead in the discussion by outlining the developmental cycles leading to professional education (Capen, 1934, pp. 67-68):

- the apprenticeship cycle,
- the cycle of expansion,
- the cycle of regulation and standardisation,
- the cycle of critical analysis.

It was this scheme of development which was at the source of Stewart's historical perspective on nursing education (NLNE, 1937, pp. 3-4; and Stewart, 1944):

- 1873-1893: pioneering period,
- 1893-1913: the 'boom' period,
- 1913-1933: the period of standard setting and stock taking,
- 1933-1944: the period of fundamental readjustments.

But, whereas Stewart tended to see the actual development of nursing education from the bright side, Capen was more pessimistic (Capen, 1934, p. 68):

> *'I am struck by the fact that nursing education is passing through all four of these cycles of development at the same time, that today it is recapitulating practically the whole history of American professional education.'*

On the basis of this assessment, he drew attention to the need for (Capen, 1934, pp. 68-69):

- financial investment to establish and maintain a satisfactory professional school,
- professional nursing schools being conducted by trained teachers,
- a reasonably high level of preliminary education as a prerequisite for succesful professional study,
- the transfer of emphasis from apprenticeship methods to academic procedures.

This was the historical perspective underlying the slogan '*education for service*' as opposed to '*service for education*.' The differences between these two slogans corresponded with the contrast between the traditional and the progressive concept of nursing education, as well as the contrast between functional nursing and individualised nursing.

16.1.3. Professional nursing

Over the years, the discussions about professional nursing were dominated by the issue of the trained nurse versus the professional nurse which gave rise to differences of opinion which were similar to the ones with regard to nursing and nursing education.

Standard curriculum. The standard curriculum was primarily an 'educational' curriculum, based upon the changing role of nursing. Therefore, it was only natural that its concept of professional nursing was not further elaborated on than that the nurse should be prepared '*to serve the whole community and to meet conditions as she finds them in many different kinds of communities*' (NLNE, 1917, p. 5). On the other hand, it can be argued that this position was also contrasted with the body of opinion which held that it was '*enough that she should serve the needs of a single institution or a limited group of people*' (NLNE, 1917, p. 5).

This contrast was matched by similar differences of opinion as to the concepts of nursing and nursing education. Whereas the former position corresponded with nursing as a national service, the latter was more in line with nursing as a hospital service. Accordingly, dependent upon the position taken, it was either the practical or the theoretical instruction that was emphasised. For that reason, it can be concluded that the standard curriculum's concept of professional nursing implied that '*the welfare of society is conserved and advanced by having a higher type of nurse, one who acts as the scientifically-trained assistant to, not the servant of the physician or the sanitary expert, one who is fitted to lead in certain important branches of social work*' (Stewart et al, 1916, p. 320).

Revised curriculum. Whereas the standard curriculum's concept of professional nursing was geared to the conservation and the advancement of the welfare of society, the revised curriculum went into more detail as to the type of nurse needed for this work. This line of approach resulted in a list of duties and responsibilities of the nurse which '*the average nurse is expected to carry out at the present time in the practice of her profession*' (NLNE, 1927, p. 44).

Although the items on this list were used as practical objectives as a basis for curriculum development, this was not done because the revised curriculum rested on a functional approach to nursing. On the contrary, for it would be much more in line with the revised curriculum's concept of individualised nursing to interpret these practical objectives as a profile of the nurse. The more so, because it was stressed that all duties and responsibilities listed were subordinated to '*the best welfare of the individual and the public*' (NLNE, 1927, p. 44).

Curriculum guide. Given that the curriculum guide was dominated by the adjustment aim, it was argueably a curriculum not of a technical but a professional type, with relatively '*more emphasis on thinking and understanding, social attitudes and skills, and the development of the student as a person, with a better balance between the technical, scientific, social, and cultural elements*' (NLNE, 1937, p. 51). This contrast between a technical and a professional curriculum reflected not only the transition from a system of '*service for education*' to a system of '*education for service*,' but also the new concept of nursing (Taylor, 1935b, p. 657):

> *'The whole patient in all of his relationships becomes a fascinating study which can be made only by persons scientifically trained, those who have a sound background of knowledge in the biological and social sciences, and who have also acquired a profound grasp of these sciences in their application to the art of nursing. The art of nursing has a deeper connotation than the practice of nursing procedures. It means more than the application of therapeutic measures in the cure of disease and an intellectual knowledge of many subjects. It embodies all of these - but more - for in addition it is the art of living with people, of knowing them intimately, of understanding their strengths and their weaknesses, of sharing their lives and having that deep though illusive knowledge of how and when to help them.'*

How the adjustment aim should be interpreted in concrete, educational terms was spelled out in the curriculum's practical objectives. These objectives were analysed in terms of nursing functions, conditions affecting patients, and the desired traits of the nurse, and amounted to a profile of the professional nurse as it was conceived at the time (Taylor, 1935b, p. 656):

> *'In 1873 the concept we received was that of a follower always faithful in service, disciplined to obedience, and subservient to authority. Today we conceive the nurse to be a scientific worker, questioning in her interest, trained to lead and to teach intelligently. She is also prepared by education to assist the physicians and research workers, who are striving through investigation, observation, and study to find new knowledge through which to protect and preserve the health of our people.'*

16.2. From a sociological towards a biological approach to nursing

The analysis of the model of individualised nursing, and the Nightingalian model of nursing for that matter, has shown it to entail more than just a concept of nursing. A comparison between the two models therefore has to take account of the accessory concepts of nursing education and professional nursing as well.

16.2.1. Nursing

Nightingale's concept of nursing, this mixed bag of religious presuppositions and sanitary implications, exerted relatively little influence upon the emergence of the model of individualised nursing between 1873 and 1937. As a matter of fact, both concepts of nursing were in many respects each other's opposite, but, above all, as to the role attributed to the elements of person and environment. These differences, obviously, influenced both concepts' notions of health and nursing.

Person and environment. In Nightingale's concept of nursing, the person was attributed a passive role and the environmental an active role. As a result, man's physical mode of being was supposed to be subject to the uniform relations between him and his environment. The person came into play only insofar as man had to take a moral descision for or against improving the circumstances in which he lived.

According to the concept of individualised nursing, on the other hand, the person played an active role in that the total individual, psychological and physical, was seen to strive for adjustment to his environment, social as well as physical.

Health. In both concepts of nursing, the purpose of nursing was health, albeit differently defined. Whereas Nightingale viewed health as living in accordance with God's law as to man's physical mode of being, American nurses identified health with the individual's psychological and physical adjustment, taking into account his hereditary endowment, his growth by experience and his habit patterns.

These definitions of health corresponded with the respective concepts' view of the relationship between the person and his environment. In Nightingale's definition, health was determined by factors external to man, whilst, according to the concept of individualised nursing, health depended upon the individual's capacity for adjustment.

Nursing. As for the nursing actions of both concepts of nursing, a similar difference can be identified. Although nursing actions were directed at both the sick and the healthy, there was a noticeable difference of approach.

Given that the point of departure in Nightingale's concept of nursing was the environment, she viewed nursing as the application of the sanitary principles discovered by sanitary science and manifesting God's laws. In individualised nursing, however, nursing entailed the activities aimed at meeting all the nursing needs of the individual by means of the case method.

In other words, whereas the former had to do with the uniform relations between man and his environment, the latter was concerned with the adjustment of the individual to the unique situation in which he found himself.

16.2.2. Nursing education

The differences between Nighingale's environmentalist and American nurses' individualised orientation was also reflected in their respective concepts of nursing education.

Nightingale's concept of nursing education was based upon the maxim of learning from experience, either in the sickroom or in the patient's home. Learning, as she viewed it, entailed (sanitary) observation and (theological) reflection resulting in (practical) knowledge as to how to bring about circumstances which accorded with God's law. In this process, God was regarded as the Trainer, and the nurse as the trainee. The nurse was attributed a passive role insofar as she registered the (by necessity) uniform relations between man and his environment, and an active role insofar as she was free to interpret her observations as manifestations of God's laws or not.

American nurses, on the other hand, advocated a thorough scientific preparation, if possible in a university school of nursing rather than a hospital school, for nursing as a science and an art. Whereas the science of nursing covered the principles derived from biological and physical science, social science, and medical science which the nurse needed to apply in her work, the art of nursing was concerned with the application of these principles in actual nursing situations.

In addition, nursing education was viewed as offering the best possible opportunity for the development of the individual nurse's capacity for service. Within the framework of education as adjustment, the nurse was attributed an active rather than a passive role as demonstrated by the emphasis upon her growth and self-realisation.

16.2.3. Professional nursing

In the evolutionary process which gave rise to the model of individualised nursing, American nurses soon departed from Nightingale's idea of nursing being a calling rather than a profession. In their view, nursing undoubtedly was a profession. This issue was, however, not quintessential as there was a more fundamental difference between the two models. Whereas, in Nightingale's concept of nursing as a calling, the role of the nurse was determined heteronomously, viz. by God, American nurses demonstrably attempted to define the nurse's role autonomously and in spite of opposition from other groups with vested interests in nursing. This is reflected in the concepts of professional nursing of the consecutive editions of the Curriculum.

With regard to the standard curriculum, professional nursing was defined as a service to the community rather than the hospital, and the nurse's role as the scientifically trained assistant rather than the servant of the physician or the sanitary expert. Accordingly, the nurse was supposed to be intelligent and skillful rather than capable and obedient.

In the revised curriculum, there was a noticeable pressure from those who were concerned in increasing the supply of bedside nurses and who thought that the basic course should deal with sick nursing only. The nurses' response to this pressure was to define professional nursing as both a personal and a community service.

In the curriculum guide, nurses defined professional nursing as the individual nurse's adjustment to the unique situation in which the individual patient found himself, thereby effectively combining the community-orientation of the standard curriculum with the individualised approach of the revised curriculum. This definition should be interpreted in the light of the opposition from those who had vested interests in a narrow definition of nursing as well as the traditional concept of nursing education.

It was this characteristic of self-direction resulting in the nurse giving priority to the patient and to society rather than the interests of certain groups which distinguished American nurses' concept of professional nursing from the Nightingalian concept of nursing as a calling.

16.2.4. Conclusion

What the comparison of the Nightingalian model of nursing and the model of individualised nursing adds up to is the difference between what Ten Have (1983) coined a sociological as opposed to a biological approach (see pp. 189-192). This change of emphasis set the tone for the conceptual development of nursing in the United States during and after the Second World War, resulting in the emergence of the models of comprehensive nursing and patient-centred nursing.

PART IV
COMPREHENSIVE NURSING AND PATIENT-CENTRED NURSING

The end of the Second World War signalled the beginning of a new era in the conceptual development of nursing in that the traditional preoccupation with nursing education became subordinated to a growing concern with the professional nature of nursing. The major impetus for this shift of emphasis was the shortage of nurses after the Second World War and the increasing utilisation of nonprofessional workers in the nursing service. As a result of these changes, nurses were compelled to be much more articulate as to the professional nature of nursing and the kind of education needed to prepare nurses for professional practice.

The first chapter of this part of the study is devoted to a comparative analysis of three reports published in 1948, which were concerned with these problems (chapter 17). This analysis will show that, although these reports had common ground in their concern with the shortage of nurses, the interpretations of the problem as well as the solutions put forward differed markedly. So much so, that, between them, they gave rise to the emergence of not one but two models of nursing, namely the models of comprehensive nursing and patient-centred nursing.

The following chapters are concerned with the presuppositions and implications of both models by comparing their respective concepts of nursing (chapter 18), professional nursing (chapter 19) and nursing education (chapter 20). This comparison will show that both models concerned amounted to a new interpretation of the concept of nursing underlying the model of individualised nursing. Notwithstanding this similarity, these models were distinctively different, chiefly because of their different concepts of professional nursing and nursing education.

What the case method was for the model of individualised nursing, the team approach was for the models of comprehensive nursing and patient-centred nursing. For this reason, the practical application of these two models is illustrated by means of a comparative analysis of two different versions of the team approach in nursing, i.e. the team plan and the nursing team (chapter 21). From this analysis it will emerge that the differences between the team plan and the nursing team, too, were related to two different concepts of professional nursing and nursing education.

The final chapter of this part deals with the meaning of comprehensive nursing and patient-centred nursing respectively, as well as in relation to that of individualised nursing (chapter 22).

17.
THE NURSING SHORTAGE AFTER THE SECOND WORLD WAR

Throughout the years, both before and during the Second World War, leaders in nursing education struggled to implement the measures recommended by the Goldmark Report and the Grading Committee as well as the curriculum guide. The results were, however, rather meagre if compared with the efforts put into it so that many of the 1,245 schools in existence at the end of the war still had a long way to go before they could achieve true professional standing. As in the First World War, the wartime problems proved to be only accentuations of questions that had faced nursing for so many years. As the war drew to a close, nursing leaders realised that (Nelson, 1948, p. 756):

> *'profound and basic changes must be made in the fields of education and service if the profession was to meet its obligations for the future.'*

The need for reform was brought home to all groups concerned by the shortage of nurses after the end of the war. Whereas, since the turn of the century, the number of doctors had doubled to keep pace with the growth of the population, the number of nurses had increased twentyfold. In spite of that, the demand for nursing service far outstripped the supply.

Figures from the Women's Bureau of the U.S. Department of Labor, quoted by all studies concerned with the nursing shortage, demonstrated that intensified efforts at recruitment during the war had raised the enrolment in nursing schools from its pre-war average of 35,000 to 38,000 in 1940, 41,397 in 1941, 47,500 in 1942, 53,074 in 1943, and to a then all time high of 67,051 in 1944.

Given the withdrawal rate of approximately 30 % during the training period, these figures needed considerable adjustment when it came to the numbers of nurses who graduated three years later. From the class of 1944, for example, only 44,700 graduated in 1947. The following years saw a marked decrease in enrolment in nursing schools to 57,000 in 1945, 31,000 in 1946, and 38,000 in 1948. The effects of this decrease were exacerbated by the annual withdrawal from the profession as a whole which was estimated at 6.33 %. As a result, the number of nurses available in 1948 was 342,737 which was some 50,000 short of the number needed to maintain the then current standards of nursing service.

However, given the post-war plans for expansion of the health and welfare services, the shortage of nurses was even more serious. For the year 1960, for example, the requirement for nurses was expected to be 500,000 to 550,000 nurses. To achieve this, some 45,000 students had to graduate each year between 1950 and 1960, requiring an annual enrolment of 65,000 to 75,000 student nurses. In fact, so alarming was the scarcity of nurses, that it came to be known summarily as 'the nursing problem.' These figures could not but lead to the conclusion that changes in education and service were indeed necessary.

The nursing shortage after the Second World War had a beneficial effect in that nursing became the matter of national interest that nurses had wanted it to be as early as in 1917. This was reflected, amongst other things, in articles appearing in magazines with titles like 'The flight from nursing,' 'What happens when trained nurses won't nurse the sick,' and 'What's wrong with nursing.' The thrust of these articles was that nurses themselves were not interested in giving bedside nursing care, against which nurses argued that they were forced to give up bedside nursing due to influences beyond their control.

Because of these external influences, it seemed appropriate and wise to solicit the opinions and views of experts in fields related to nursing like economists, educators, doctors, hospital administrators, and last but not least, the lay public, before embarking upon programmes of reform. Consequently, nurses had to enter into discussions with other groups representing bodies of opinion and interests which, at times, were quite at variance with theirs.

Generally speaking, the public interest in the problems of nursing and nursing education was welcomed but it could not have emerged at a worse moment since the national nursing organisations were preoccupied with the 'Structure Study,' dealing with the reorganisation of the nursing profession which was to result in two national nursing organisations in 1952, viz. the American Nurses' Association (formerly: ANA) and the National League of Nursing (formerly: NLNE, NOPHN, and ACSN). The National Association of Coloured Graduate Nurses

(NACGN) was disbanded, whilst the American Association of Industrial Nurses (AAIN) retained its original organisation.

However, as far as the rank and file nurses were concerned, they perceived the shortage as well as the solutions put forward as a threat to their laboriously acquired professional status. Not only were they compelled to accept practical nurses and other auxiliary personnel but they also had to face the threat of their own replacement by collegiate educated professional nurses.

The three most influencial reports on the '*nursing problem*,' all of which were published in 1948, were:

- 'Nursing for the future' (Brown, 1948), better known at the time as the 'School Study,' and later, as the Brown Report,
- 'A program for the future' (Ginzberg, 1948), also known as the Ginzberg Report after the name of the chairman of the committee that produced it, and
- 'Report of the AMA Committee on Nursing Problems' (Murdock et al, 1948b) which will be referred to here as the Murdock Report.

The comparative analysis of these reports undertaken in this chapter will provide a clear picture of the predicament of American nursing after the Second World War.

17.1. The Brown Report

To view the Brown Report in the right perspective, it is important to point to the fact that it was the National Nursing Council which in 1945 decided to initiate the School Study. The NNC was a continuation of the former Nursing Council on National Defense (July 1940) which, subsequently, became the National Nursing Council for War Service. This council was organised to coordinate the war efforts of the American Nurses' Association (ANA), National League of Nursing Education (NLNE), National Organization for Public Health Nursing (NOPHN), Association of Collegiate Schools of Nursing (ACSN), National Association of Colored Graduate Nurses (NACGN), and the American Red Cross Nursing Service (ARCNS).

In September 1945, it was decided to continue as the National Nursing Council until the Structure Study was completed in order to ensure the initiation and coordination of the comprehensive programme for nationwide action in the field of nursing (AJN, 1945b) and all related projects basic to the future of nursing. One of these projects was the School Study.

17.1.1. Impetus: the need for educational reform

Before the war was ended, the leaders in nursing education realised that the existing system of nursing education was unable to produce the requisite number of nurses adequately prepared for specialised nursing services which were needed as a result of the ever- expanding health services. The NLNE therefore urged the National Nursing Planning Committee of the NNC to make plans for 'the reconstruction of the traditional system of nursing education, especially with respect to organization, control and support of nursing' (Newell, 1948, p. 84). After a first trial in 1945 to initiate a large scale study that exceeded by far the immediate needs of the situation, the scope of the study was subsequently restricted to basic nursing education. Financial support was secured from the Carnegie Corporation.

Because of the wealth of data available it was concluded that 'one expert, with adequate professional help to explain the data and a widely representative committee to serve in an advisory capacity, should be able to complete the study within six months' (Newell, 1948, p. 85). The expert to whom the study was committed was Dr. Esther Lucille Brown, a social anthropologist and Director of the Department of Studies in the Professions, of the Russell Sage Foundation. Dr. Brown was known in nursing circles as the author of 'Nursing as a profession' (Brown, 1936) and as a brilliant participant in a panel discussion about 'Who shall pay for nursing education,' held at the 50th annual convention of the NLNE in Atlantic City (AJN, 1947a). From May 26th, 1947, Dr. Brown started to work full-time on the study, assisted by both professional and a lay advisory Committee.

The major purpose of the study was to find an answer to '*the question of who should organize, administer, and finance professional schools of nursing'*, viewing '*nursing service and nursing education in terms of what is*

best for society - not what is best for the profession of nursing as a possibly "vested interest" (Brown, 1948, pp. 11-12). In addition, it was agreed that Dr. Brown should make as many field trips as finances allowed, rather than consult representatives of the professional nursing organisations. The purpose, the viewpoint of the study, as well as the field trips, rested upon certain assumptions as to the nature of the shortage of nurses.

The shortage of nurses. Initially, the School Study was planned to investigate the basic preparation for specialised nursing services, including specialised clinical nursing, thereby suggesting that the shortage was of a qualitative rather than a quantitative nature. Consequently, the study was expected to deal with the need of nursing service on a professional level, and the kind of education professional nurses should have.

When the study finally got under way, however, it had become increasingly difficult not to think of the shortage in terms of numbers as well, especially since enrolment in nursing schools had dropped so dramatically since the end of the war. Because of this change, both Brown and the NNC expected '*that, in view of the scanty distribution of nursing service, a study, ostensibly concerned only with preparing a relatively small number of highly specialized nurses would be received with indifference, if not with open hostility; it was not enough for those associated with the project to be cognizant of its larger implications; the laity and all professional groups employing nurses must be convinced that specific measures for supplying more nurses were being considered*' (Newell, 1948, p. 87; see also Brown, 1948, pp. 12-13).

In the end, the School Study was therefore directed at the need for nursing services on both a professional and non-professional level, and the kind of preparation needed for professional nurses and practical nurses alike. Notwithstanding this adjustment for the sake of public relations, the primary concern of the study remained the qualitative rather than the quantitative shortage of nurses. This conclusion is justified by Dr. Brown's preliminary report at the NLNE convention in Seattle (September, 1947) where she assured her audience that she, although committed to represent the interests of the nation's public welfare, had not forgotten that her mandate for directing the preparation of the report related '*exclusively to professional nursing education*' (Brown, 1947, p. 821).

17.1.2. 'Nursing for the future'

Both the structure and the content of the Brown Report reflected the way in which the study underlying this report was conducted. Before it was possible to address '*the specific question to which the National Nursing Council was directing attention*' (Brown, 1948, p. 12), it was thought necessary to discuss the demand for nursing services, on the one hand, and its implications for nursing education, on the other, first. The former question was the subject of a workshop in New York (April, 1947) aimed at (AJN, 1947c):

> *'the preparation of a working memorandum defining the area of professional nursing and how it blends into the other areas of auxilliary services and medical and social service practice.'*

This memorandum was prepared by nineteen women (22 to 38 years old) with a collective experience of 87 different types of positions. They were chosen for their knowledge of the whole area of nursing services, their daily experience with nursing services, and because they represented the nurses who would be living and working in the period for which the study was to provide a blueprint.

The educational implications of the workshop memorandum were discussed at three regional conferences in Washington (October, 1947), San Franscisco (November, 1947), and Chicago (December, 1947). The report of these conferences, entitled 'A thousand think together' (National Nursing Council, 1948), contained (AJN, 1948c):

> *'opinions and beliefs about education for "nurse of the future," providing a record of "grass roots" thinking on the question at issue.'*

Apart from that, it also reflected the increased interest in 'group dynamics' as a method to enhance the productivity of conference sessions and work groups.

The Brown Report was subdivided into two parts, one on nursing service, and the other on nursing education.

Nursing service. The first half of the study rested heavily on the memorandum prepared by the workshop and covered the extension of the health services, the future demand for nursing care, the differentiation of nursing service according to function, and the future role of the professional nurse.

Extension of the health services. In the first chapter of the report, Brown drew a picture of '*the probable nature of health services in the second half of the twentieth century*' (Brown, 1948, p. 12). The major changes envisaged by Brown were:

- the new role of the hospital as a community centre,
- the expansion of public health services
- the increased expenditure on health services.

Apart from the increase in the social function of the health services demonstrated by these changes, an even more fundamental change was envisaged, viz. the maintenance of health as the future goal of health services. These changes in the health services, it was suggested in the Brown Report, had to be matched by the improvement of the social effectiveness of the nurse.

Future demand for nursing care. The excursion into the future of the health service provided the basis for the discussion about '*the nursing services likely to be demanded by those evolving health services*' in chapter two (Brown, 1948, p. 12). This discussion led to the conclusion that there was an unbridgeable gap between '*the enormous supply of nursing care*' as well as '*the greatly increased competence*' needed to operate the health services (Brown, 1948, p. 42), on the one hand, and the bleak prospect of '*obtaining a supply of nursing care that is quantitatively and qualitatively sufficient*' (Brown, 1948, p. 57), on the other.

The undesirable conditions in nursing education (e.g. inadequate preparation, inadequate schools, and inadequate clinical experience) apart, one of the chief causes for this gap was held to be job dissatisfaction rather than insufficient remuneration of the nurse (Brown, 1948, pp. 46-47):

> *'Hospitals predominantly are operated on the authoritarian principle rather than that of a cooperative team relationship. The nursing service is caught between the authority exercised by the medical administration, on the one hand, and the hospital administration, on the other. Unfortunately, the nursing service also tends to be highly authoritarian. Hence, the individual nurse finds herself with little freedom of movement and of initiative for other than specified duties, even within that service of which she is a part. In an institution where planning is done at - and administrative orders are issued so largely from - the top, slight opportunity is provided the staff nurse to participate in policy formulation that, however simple, would give her the sense of being an active member of a team. Rarely, in fact, is she accorded so much as the prestige of being considered the colleague of the physician. She is primarily a person who takes and carries out orders. As a consequence she tends to develop those socially undesirable characteristics of subservience to persons above her in the hierarchical structure and of mastery over those below her.'*

The solution for bridging the gap between the demand for nursing services and the supply of nurses, proposed in chapter three, was a functional differentiation of nursing service.

Differentiation of nursing service according to function. This solution was put forward by raising two questions; first, '*What kind of nursing functions need to be performed?*' and, secondly, '*Can persons be found and prepared to fulfill these functions effectively, whether they be graduate nurses or not?*' (Brown, 1948, p. 57). This was, typically, a solution which resulted from asking the right question in the first place because (Brown, 1948, pp. 57-58):

> *'So long as attention is centered on the graduate nurse, no other avenue is open except of that of the present frantic and probably futile effort to recruit more prospective R.N.s. ... Once emphasis is shifted to nursing, however, several roads seem to point to potentially larger supplies of service and to possibly increased efficiency both on the nonprofessional and the professional levels.'*

Finally, this rephrasing of the problem was taken to its logical conclusion by the proposal to create a team made up of professional nurses and practical nurses (Brown, 1948, p. 60):

> *'a functional system in which, through coordination, training, and supervision, persons of many different skills may render efficient service in the area of the health services.'*

Future role of the professional nurse. Finally, it was typical of the report's emphasis on professional nursing education that the fourth and last chapter on the requirement for nursing services in the future was devoted almost completely to the role which a nurse prepared on this level was expected to play. The role of the practical nurse was discussed earlier, but only to indicate how nongraduate personnel could be built into integrated service teams (Brown, 1948, pp. 66-73).

The professional nurse was envisaged to work either in clinical practice or in nursing specialties. In the former case, she was expected to fulfill the function of both a skilled technician and a minister of the healing art (Brown, 1948, pp. 78-95), whilst the nursing specialities encompassed supervision, administration, teaching, consultation, planning and promotion of professional activities, public health nursing above first level positions, and specialities in clinical nursing (Brown, 1948, p. 95).

Nursing education. The second half of the study was devoted to '*the kinds of training and of academic and professional education requisite to prepare nurses to render those various kinds of nursing services would be essential*' (Brown, 1948, p. 12). In line with the differentiation of nursing functions, Brown advocated a corresponding differentiation in '*the kinds of preparation requisite for performance of those functions*' (Brown, 1948, p. 101). Accordingly, the discussion about education was divided over three chapters covering the whole spectrum of nursing education, viz. the education of practical and graduate bedside nurses, and professional nurses, as well as resources for the future.

Education for practical nurses and graduate bedside nurses. This title of the first chapter on education apparently confirmed the worst fears of many registered nurses who saw the practical nurse as a threat to their own future. So great was the fear that practical nurses might 'take over,' or gain 'control of nursing policies,' not to speak of the consequences when the demand for nursing care would decrease as it had done in the early 1930s (Brown, 1948, p. 63), that a group of nursing educators sought to influence the outcomes of the study (Brown, 1948, p. 14):

> *'In that instance an appreciable large and important segment of nursing education had become profoundly disturbed about what it thought the report might include, and the use to which other segments of nursing education might put the recommendations. These representatives of schools were momentarily afraid of change that not only seemed to be imminent, but which they feared would come so rapidly that they could not adjust to it.'*

To allay these fears, Brown expressed her doubts as to whether enough trained practical nurses could be produced to pose a numerical threat to the registered nurse, if only because there were just 58 schools for practical nurses, divided between private schools, hospital schools and public vocational schools. Despite concerted efforts to improve the curriculum of these schools, the provisions for the preparation of practical nurses fell far short of what was needed, both quantitatively and qualitatively. Furthermore, Brown thought it still more unlikely that practical nurses would pose any qualitative threat, granted that they would become readily available, '*provided graduate nurses move in the years ahead to true professional status*' (Brown, 1948, p. 63). Finally, there was reason for some optimism, for (Brown, 1948, p. 109):

> *'Whether one approves the system of hospital schools or not, the continued existence of a considerable number is essential for an interim period until adequate other facilities have been established and are sufficiently patronized to garantee a steady flow of personnel into nursing. ... If all hospital schools were to terminate their existence this year, the consequences would be disastrous.'*

This explains why most of the first chapter on nursing education was taken up with a discussion about ways of improving the hospital schools of nursing rather than the education of practical nurses. This discussion rested upon the assumption that, as far as the graduate nurse was concerned, emphasis needed to be placed only on '*the preparation for bedside care and some understanding of what constitutes a complete health service*,' as it was not her task '*to engage in those forms of community nursing where teaching of groups of persons plays an important role, or to undertake the practice of nursing specialties*' (Brown, 1948, p. 121).

The central theme was that, in the interest of the public, the traditional system of service for education had to be reversed into a system of education for service. With regard to the implications of this U-turn, Brown distinguished, apart from schools of specialised hospitals, three groups of hospital schools of nursing (Brown, 1948, pp. 109-138).

The first group consisted of the socially undesirable schools. These were the often inefficient and small schools which existed only for the reason of '*the procurement of nursing service*' and perpetuated '*an injustice to the student, the patient, and the community at large*' (Brown, 1948, p. 110). In Brown's opinion, unless these schools could be made to improve the training of the nurses, if not by the hospital boards and the state boards of examiners, most certainly by means of an obligatory accredition programme '*as a form of social control exercised in the public interest*' (Brown, 1948, p. 116), they had to be closed immeditately.

The second group consisted of the relatively good schools. These were the schools with facilities which were '*reasonably adequate for sound preparation, at least of a traditional nature, for general bedside nursing*' (Brown, 1948, p. 116). Given the uncertainties surrounding the hospital school of nursing at the time, Brown recommended that these schools should make '*concerted effort through various types of experimentation to increase their vitality and social usefulness and to point the way to an ultimate solution of the "hospital school problem"* (Brown, 1948, p. 127).

As for the former, she suggested a shorter period of training which was admittedly dependent 'upon the condition that the school devote its entire time to education and be freed of responsibility for nursing service' (Brown, 1948, p. 119), combined with an improved course of study and the use of selected nursing practice.

As for the latter, Brown thought it necessary to create central schools of nursing and to use the teaching resources of junior colleges, otherwise these relatively good schools were likely '*to go the way of those socially undesirable schools for which little but extinction remains*' (Brown, 1948, p. 124).

The third group consisted of the distinguished schools. These were the schools '*which are most nearly professional in educational program and whose graduates quickly move into complex clinical nursing or into supervisory and administrative positions*' (Brown, 1948, p. 117). Although some of these schools were integral parts of a university, others were hospital schools of nursing affiliated with a college or university. Given the disappointing number of students of the latter schools obtaining a degree, it was clear that these schools had to settle either for an existence as a semiprofessional school or to become an integral part of universities too. If not, their '*contribution to the public welfare*' was likely to be greatly weakened (Brown, 1948, p. 131).

Education for the professional nurse. The subsequent chapter was concerned with those distinguished schools of nursing which had become an integral part of a university. According to Brown, it was from this point in the spectrum of nursing education that education for professional nurses came within reach (Brown, 1948, p. 109):

> *'Two distinct but closely interrelated kinds of preparation that only higher education is broadly equipped to provide are essential for the making of such a nurse. The first is the laying of a foundation that permits continuing growth of many kinds ... The second kind of preparation is the more technical training for professional practice. But this training must transcend that for the care of the hospitalized sick. It must be preparation for the broad field of community nursing service.'*

The professional education of nurses, it was argued, moreover required an integrated curriculum, combining academic or general education with professional or technical training, preferably within one programme of education.

These recommendations were based upon Brown's conviction, expressed at the NLNE-convention in 1947, that, given future changes in the health services and the need for nurses capable of fulfilling the increased social obligations of nursing, '*the control and administration of both preprofessional and professional education for*

nursing should be vested in the university or in some other institution for higher learning' (Brown, 1947, p. 824).

Resources for the future. The final chapter was concerned with the few schools of nursing which offered a basic curriculum leading to a degree and came closest to what Brown regarded as the ideal for the education of the professional nurse. Due to the fact that out of 66 of such schools only 26 were recognised by the Association of Collegiate Schools of Nursing (ACSN), the discussion did not go much further than expressing the need for more of these schools, at least 70 with a student body of 20,000 students, and the desirability of better statewide or regional planning for these schools.

17.1.3. The National Committee for the Improvement of Nursing Services (NCINS)

The publication of the Brown Report in September, 1948, was followed by the dissolution of the NNC. The implementation of Brown's recommendations was subsequently entrusted to the Committee for Implementing the Brown Report (CIBR). The forerunner of this committee was the Committee to Consider Ways and Means of Implementing the School Study which met as early as in May 1948 and was chaired by Mary Connor. The nucleus of the CIBR met for the first time in September 1948. Despite considerable discussions about the report's implications, there was agreement that a long-term programme for the improvement of nursing service and nursing education was needed. The tentative planning for this programme was the dissemination and interpretation of the report (first year), the coordination of plans (second year), and the initiation of plans (third year). In November, a National Nursing Planning Conference was held in Battle Creek, Michigan. The recommendations emerging from this conference provided the following objectives for the CIBR (AJN, 1949c):

- to secure the cooperation of colleges and universities in providing additional facilities for the preservice preparation of professional nurses and programs of advanced study for graduate professional nurses,
- to devise a plan for providing nursing information to educational institutions and hospitals planning to open schools of nursing,
- to promote research in nursing service and nursing education,
- to encourage the establishment of more schools for practical nurses,
- to survey schools of nursing and publish a list of acceptable schools,
- to help with the recruitment of nursing students, and
- to explore ways of securing additional funds to promote better educational programs for nurses.

On the face of it, this list suggests that the CIBR was to focus its attention almost exclusively upon nursing education, but this impression was rebuffed when, in 1949, the name of the committee was changed into the National Committee for the Improvement of Nursing Service (NCINS). The philosophy of the NCINS rested upon the principle that 'good nursing service, in the final analysis, will depend upon nursing personnel who have received sound preparatory training' (Sheahan, 1950, p. 794).

The lifespan of the NCINS can be divided into two periods. From 1949 until June 1952, it operated as a joint committee of the six national nursing organisations (NLNE, ANA, NOPHN, ACSN, AAIN, and NACGN) sub aegis of the NLNE. In June 1952, the committee was incorporated into the newly formed National League of Nursing and became known as the NLNE Division of Nursing Services.

Despite this reorganisation, there was considerable continuity in the committee's activities, thanks to Marion W. Sheahan, who was appointed director of programmes in September 1949 and became director of the NLNE Division of Nursing Services in June 1952.

The programme of action of the NCINS was implemented by its various subcommittees (Sheahan, 1950 and 1951; AJN, 1951d, pp. 364-365). The first action undertaken by the NCINS was the organisation of the school data analysis which started in December 1949. The resulting interim classification of schools of nursing was published in September, 1950, in a report, entitled 'Nursing schools at the mid-century' (NCINS, 1950).

In May, 1951, the NCINS considered its work in this field completed since the National Nursing Accrediting Service, organised in 1949 too, assumed the responsibility for the next listing of schools as part of the long awaited programme for the accredition of nursing schools. Subsequently, the NCINS could turn its attention to regional planning for nursing education. Two months after the publication of 'Nursing schools at the mid-century,' two other subcommittees of the NCINS were appointed.

One was the Advisory Subcommittee for Coordination of Improvement of Nursing Education. The objectives of this subcommittee, assisted by two consultants, viz. Mary Shields (curriculum and abilities) and Hortense Hilbert (regional planning), were to promote a curriculum project conducted by the NLNE, draft a statement of principles of regional planning for nursing education, and spearhead planning for research in experimental programs in nursing education.

The other was the Advisory Subcommittee for Improvement of Service. The objectives of this committee were to develop self-evaluation guides for nursing services, conduct institutes for nursing service personnel, and prepare manuals on the organisation and management of units within the nursing services.

Finally, the NCINS paid special attention to the promotion of nursing by appointing a public relations officer (May, 1951) charged with public relations and editorial assistance. This resulted in the publication of the 'NCINS Newsletter' (later: 'Hospital Nursing Newsletter') whose circulation increased from 2,000 in 1951 to 15,000 copies in 1953.

17.2. The Ginzberg Report

Whereas the Brown Report resulted from an initiative taken by the NNC which represented the national nursing organisations, the second report to be discussed in this chapter originated from an institution for nursing education, i.e. Teachers College.

17.2.1. Impetus: curriculum revision at Teachers College

After the Second World War, the Division of Nursing Education of Teachers College undertook a curriculum revision which was based upon three principles, namely that curriculum development is the joint responsibility of the entire staff, the students and the public, that it is a continuous process, and that there should be provision for concurrent, co-operative experimentation and tryout of new ideas (Connor & McManus, 1948, p. 397).

On May 19, 1947, the homecoming of the alumnae of the Division of Nursing at Teachers College was held. This meeting, attended by some 200 former students, was devoted to a discussion on the 'Perspective on demand and supply in nursing.' One of the speakers that day was Dr. Eli Ginzberg, professor of economics in the Columbia University School of Business.

These were the events which were at the source of the Ginzberg Report (Ginzberg, 1947). In accordance with the first principle of the curriculum revision and the suggestions advanced at the homecoming, a committee, composed largely of men and women who were not nurses and chaired by Ginzberg, was formed to make '*a philosophical approach to the study of the function of nursing in modern society*' (Connor & McManus, 1948, p. 397). In fact, the committee's approach turned out be somewhat pragmatic, geared at suggesting solutions for the shortage of nurses rather than a thorough analysis of the problem itself. This was demonstrated by the fact that the committee's proclaimed aim was not so much a 'comprehensive study of all phases of the nursing profession' as a review of *'a selected group of problems centering around the current and prospective shortages of nursing personnel*' (Ginzberg, 1948, pp. ix-x).

Nevertheless, as McManus later explained, this review resulted in certain assumptions about the function of nursing which subsequently could be tested in actual work situations by means of action research. This research method required the researcher to look into all factors of a complex situation which make a difference rather than keep things 'pure' by selecting a single factor, and not only to observe the complex situation but to participate in it as well. Apart from that, this method required the researcher to collaborate with the persons involved in the situation under investigation, and to investigate similar complex situations at the same time for the sake of comparing the findings (McManus, 1951, p. 739). The rationale for this research method was the improvement of the co-operation between nursing groups involved with either nursing or nursing education (McManus, 1951, p. 740):

> *'An organized co-operative action research program in nursing and nursing education should not only seek ways to bring about improvement in practice, but should also endeavor to reduce the lag in the application of educational theories and nursing knowledge in nursing practice. The system of nursing education must adjust continuously if it is to cope with problems that are raised by rapidly developing*

health and medical welfare programs. The program of action research undertaken by a group or several groups who want to find out how to do the job better will facilitate this adjustment and improve practice in research situations.'

Thus, the Ginzberg Report, by clarifying the function of nursing, provided the basis for an action research programme aimed at the improvement of nursing care and nursing education. The resulting research programme was directed at nursing functions in team organisations and centred on the professional role of the nurse more than anything else.

Consequently, it can be argued that, whereas the Brown Report represented the interests of society, the Ginzberg Report, at least in its effects, stood up for the interests of the nursing profession. Moreover, this would explain the title of the report, i.e. 'A program for the nursing profession.' Its point of departure, however, was the nursing shortage.

The shortage of nurses. The Ginzberg Report rested upon the assumption that the shortage was '*permanent, not temporary*,' and that it promised '*to grow worse, not lessen*' (Ginzberg, 1948, p. 2). Because the enrolment in nursing schools was not likely to exceed 40,000 per annum, some 30,000 student nurses short of what was needed, it was argued that intensified efforts at recruitment to overcome the shortage in nursing personnel would continue to prove ineffective as long as nothing was done about other contributing factors.

What these factors added up to were basically two things: first, that recruitment was hampered by the lack of economic incentives in rewarding nurses, and secondly, that the available numbers of nursing personnel were utilised at considerably less than full efficiency. These were incidentally the very same economic and occupational assumptions mentioned in Ginzberg's paper. In addition, the report rested upon the assumption that the shortage of nurses was not a quantitative but a qualitative problem (Ginzberg, 1948, p. 20):

'The problem is not entirely what it seems to be, one of numbers. It is rather a problem of attracting and retaining properly qualified and potentially competent personnel. The leaders of the nursing profession would like to attract recruits with a minimum educational background of high school graduation, plus two years of college. It is these educational standards that make the prospect of adequate recruitment so bleak.'

It was primarily this assumption which made the committee look for ways to reduce the need for highly qualified nurses by redefining her function. This approach was expected, moreover, to improve both the economical and occupational status of nursing; economically, because redefining the function of the nurse would ensure that scarce nursing skills were not dissipated but used to full efficiency, and occupationally, because it would prevent nurses from becoming dissatisfied because of assignments which made too little demand on their specialised knowledge and training.

Given the shortage of qualified and competent nurses as well as the less than optimal utilisation of the available nurses, it was thus clear that the solution the committee was looking for lay in redefining the function of the nurse rather than that of nursing. The study was, therefore, aimed at investigating how the total nursing function might be re-allocated in the light of a persistent shortage of qualified individuals by assessing '*the work nurses now perform*' (Ginzberg, 1948, p. 30).

Finally, it was argued in the Ginzberg Report, even if no gap existed between the supply of nursing personnel and the demand for nursing service, there would still be good reason to reassess the function of nursing, if only because of the changes in medical and health care such as the increased use of antibiotics, advances in surgical techniques as well as the emphasis upon early ambulation requiring more attention and emotional support for the patient. On balance, these factors had brought about a reduction in the total number of nursing hours per illness. On the other hand, the very same factors had raised the requirements for nurses with high levels of skill and mature judgment as well as the total number of nursing hours per patient per day in the hospital.

17.2.2. 'A program for the nursing profession'

The Ginzberg Report was published in 1948, and contained the following recommendations (Ginzberg, 1948, pp. 105-106):

'In brief, we propose that:

a. *The nursing function be divided among two groups of personnel - professional and practical nurses.*
b. *Relations be clarified and improved between the nurse and the other members of the medical and health team.*
c. *Suitable relations be developed among the various groups of nursing personnel who together comprise the nursing team.*
d. *The professional nurse complete a four-year course in a college- or university-affiliated school of nursing.*
e. *The practical nurse be graduated from a 9- to 12-month program in an approved school for practical nursing.*
f. *A goal of approximately 200,000 professional nurses for 1960 be established.*
g. *A goal of approximately 400,000 practical nurses for 1960 be established.*
h. *Conditions of pay and work in nursing be substantially improved, and differentials in reward be instituted.*
i. *Research receive a heightened emphasis.'*

The draft of the report was written by the committee's chairman, Ginzberg, and the executive secretary. Therefore, to understand the meaning of the recommendations made in the report, it would appear relevant to consider Ginzberg's views of the status of the nursing profession, expressed in his paper read at the homecoming in 1947, first. The more so, because his views foreshadowed the recommendations made by the committee. In his paper, Ginzberg discussed the three "r's" of nursing - recruitment, the role of the nurse and the rewards of nursing - from three different viewpoints, viz. the army's experience, economic trends and occupational research (Ginzberg, 1947).

Ginzberg's point of departure was that the shortage of nursing personnel was there to stay for the near future, due to the increased economic resources for expansion of the health service and the unattractiveness of nursing as an occupation. Looking for a solution to this problem, Ginzberg drew attention to the army's experience in solving the severe shortages in nursing personnel during the war. Instead of relying on intensified efforts at recruitment, he pointed out, the army had sought to '*heighten the efficiency of the nurses it had through the employment of supplemental personnel*.' In addition, acting on the belief that proper medical care required a team in which the nurse was an important member, '*it placed the nurse on its medical team*.'

As for the delineation of the work of the nurse, Ginzberg referred to the principle of economics '*never to use high-priced personnel for low-priced work*,' as well as the lesson industry was learning about the division of labour, namely that '*functionalization can go too far*.' Both points were made to draw attention to the domestic or menial tasks of the nurse and the functional division of labour in nursing as two causes of the less than optimal utilisation of the nurse. Again, it was the army which had found the solution, in that it delegated the full responsibility for the nursing care of all patients to the Nurse Corps, albeit within certain professional limits laid down by the Medical Corps. As a result, the nurses not only contributed much to the improved survival rate of the wounded soldiers but also helped many of them to regain partial function.

Finally, Ginzberg referred to the economically inspired exploitation of student nurses and graduates and the consequent lack of job satisfaction among nurses. In this respect, too, he pointed out, the army had done remarkably better as it 'not only raised the prestige of the nurse but also, in comparison with civilian life, improved her pay and other emoluments.' As a result, many nurses were reluctant to return to their former positions unless the administrative policies in the nursing services had been improved.

The content of 'A program for the nursing profession,' it is contended here, closely resembled Ginzberg's personal views. As in his paper, the report dealt with recruitment, the function of the nurse, and career incentives. In addition, the report contained specific recommendations with regard to nursing education.

Recruitment. Given the committee's view that the nursing shortage was basically a qualitative rather than a quantitave problem, it recommended a qualitative solution by means of the specialisation of functions within nursing. Right at the beginning, moreover, it was pointedly stated that (Ginzberg, 1948, p. 3):

'it is our considered opinion that nursing is a profession, and that nurses have a significant role to play on the medical and health team.'

This statement should be interpreted against the background of the committee's conviction that (Ginzberg, 1948, p. 26):

> *'the most effective recruiting agent of all is a satisfied registered nurse. More skilful and more democratic administration of the nursing service would undoubtedly enhance the satisfactions the registered nurse derives from her job. Until World War II, most nurse administrators and nurse educators continued the custom, established during the 1920's, of treating registered nurses as ancillary to the student-nurse service. Administration of nursing service was taught from the standpoint of the student, with little regard for the registered nurse. The principles of adult education are only now being applied to staff education programs, and not very generally at that. Few reforms would do as much to stabilize nursing services and improve recruitment as would additional efforts to treat staff nurses as adults capable of participating in planning the work of the nursing team.'*

Furthermore, once the provision of nursing care was considered '*as a team undertaking, rather than as an individual service*,' the prospect of meeting the essential nursing requirements would be much better (Ginzberg, 1948, p. 79).

The function of the nurse. The team approach envisaged by the committee was based upon a specialisation of functions. In such a team, the professional nurse, a better qualified nurse than the existing registered nurse, had to play the pivotal role in that, on the one hand, she had to supervise the practical nurses in her nursing team, and, on the other, she had to co-operate with the doctors in the medical and health team. The ensuing pattern of organisation of both the nursing team and the medical and health team rested upon the following conception of a team (Ginzberg, 1948, p. 65):

> *'In the present context, the word "team" pertains to the systematic co-operation of a self-directing group of individuals in the performance of certain tasks, each of whom has a job to do and knows how to do it, whether independently or under supervision. The members of the team have a sense of responsibility toward each other and toward the outcome of their efforts. Specifically, we refer to a number of associates, all subordinating personal prominence to the efficiency of the whole. The direction of the team comes from within, from its members.'*

Within the perspective of this team approach, a reappraisal of the function of the nurse was needed, entailing the elimination of non-nursing duties, the delegation of certain nursing duties to practical nurses, and the transference of medical duties to the nurse.

The elimination of non-nursing duties. Given that 30 % of the nurse's work load was taken up by housekeeping and clerical duties, substantial savings were thought possible by freeing the nurse from these duties. This measure was prompted not only by the shortage of nurses but also by other factors which originated in tradition more than anything else (Ginzberg, 1948, p. 31):

> *'Long ago, housekeeping duties - the original area of special nurse competence - should have been relinquished by the profession and made the responsibility of domestics. Retention of these functions by nurses can largely be explained by the mistaken belief of hospital administrators that the hiring of additional personnel would have raised costs. Moreover, the less well-trained members of the profession feared that if they relinquished these responsibilities, they might destroy their uniqueness. A serious weakness in nursing education and nursing service has been the failure to apply the advances in adult education and refresher training which would have enabled the nursing profession to keep abreast of the changing structure of medical care. At this time, when nurses are recognized to be performing a unique professional service, there is no point whatever in perpetuating a system which continues to saddle them with the duties of hostess, housekeeper, messenger, and clerk.'*

The line of the committee's thinking, as expressed in this quotation, is interesting because, once again, it shows the interelatedness and interdependence between hospital administration and medical care, on the one hand, and

nursing education and nursing service, on the other, in determining the function of the nurse. However, in the opinion of the committee, it was imperative to stress the proper task of the (professional) nurse, viz. '*nursing care and nursing administration*' (Ginzberg, 1948, p. 32), and it was this line of thinking which was at the source of the committee's central recommendation, viz. the delegation of certain nursing duties to practical nurses.

The delegation of certain nursing duties to practical nurses. As to the pattern of organisation within nursing itself, it was the committee's belief that (Ginzberg, 1948, p. 36):

> *'Requirements for professional nurses would decrease if some portion of total nursing care were performed by other types of nursing personnel. Further reductions in the total requirement for nursing care would then depend on the future of medical research and on the adoption of a long-range program of health education and preventive measures.'*

This idea had far-reaching consequences for the structure of the nursing profession, as it implied not only the formal acceptance of the practical nurse but, more importantly, the need for professional nurses rather than registered nurses. On the other hand, the delegation of nursing duties to practical nurses also held promises for a significantly upgraded function of the nurse because she would be responsible for the nursing care of the individual patient (case management) as well as the supervision of the practical nurses (team management).

Allowing for the differences between the various branches of nursing, the committee further suggested a ratio of one professional nurse for two practical nurses. Between them, these nurses would make up a team of nursing personnel responsible for the effective discharge of the nursing mission. The committee, however, omitted to delineate the respective functions of the professional and the practical nurse. It only stated that the practical nurse needed to be supervised by the professional nurse (Ginzberg, 1948, pp. 40-41):

> *'The professional nurse, who has had the advantage of basic academic work as well as good professional training, is the head of the team. Her primary responsibilities are planning, teaching, and supervising - activities that she can discharge effectively only if she has a thorough background of clinical nursing. In addition, she herself must perform tasks which are beyond the competence of the other members of the nursing team. There is general agreement that practical nurses who have had nine to twelve months of good nursing training superimposed upon a minimum of two years, and preferably four years, of high school can acquire most of the skills essential for nursing. However, the successful utilization of practical nurses will largely depend on the quality of supervision they receive from the professional group.'*

The transference of medical duties to the nurse. The third recommendation made by the committee was aimed at increasing the range of the nurse's work to include certain complex technical procedures delegated to her by the doctor.

The line of reasoning underlying this recommendation which was seemingly at odds with the shortage of nurses, was that (Ginzberg, 1948, p. 69):

> *'certain medical specialists are in even more limited supply than nurses; further, the assumption of these additional responsibilities is predicated not so much on an increase in the number of professional nurses as on improved preparation and heightened utilization of those available.'*

In other words, the function of the nurse, as envisaged by the committee, implied that she should be trained and utilised '*to the maximum limits of her competence*' in order to '*relieve the medical specialist of part of his work load*' (Ginzberg, 1948, p. 69). This was not, however, to say that the nurse should be regarded as the doctor's servant, gifted with very limited thinking faculties. On the contrary, for she had to make some unique contributions to the medical and health team. The precise nature of these contributions, however, remained somewhat vague, except for this statement (Ginzberg, 1948, p. 68):

> *'Without the nurse, there would be disorder, confusion, filth, extra discomfort, and even ignorance on the part of the doctor of the actual course of illness. For the nurse is a master at the skillful and precise execution of details.'*

Therefore, it was argued, just as the professional nurse had to accept the practical nurse as her assistant in nursing care, the doctor had to accept the professional nurse as his assistant in therapy (Ginzberg, 1948, p. 71):

> *'From the standpoint of total medical and health care, the medical profession has a responsibility to recognize nursing as an essential component and to take steps to integrate the work of the nurse into the over-all medical plan.'*

Career incentives. Apart from the specialisation of functions in nursing and the improvement of team relationships among nurses themselves as well as between doctors and nurses, the committee thought it necessary to do something about the rewards of nursing. It, therefore, recommended that nurses should be offered career incentives at least equal to those offered to young men and women by comparable professions and occupations. The suggestions made by the committee pertained to shorter hours, and the abolition of split shifts, better pay, and the introduction of differentials in wages according to qualifications and experience, as well as the protection of social security (Ginzberg, 1948, pp. 79-95). Finally, it was also recommended that the nurse's preparation to perform research in clinical as well as in administrative and educational problems should be improved.

Nursing education. The committee's general idea was that (Ginzberg, 1948, p. 4):

> *'Only a radical break with the past, which would relieve nursing of its romantic heritage and its "service for education" and place it on a comparable social and economic footing with other professions, holds promise of solving the major difficulties which now confront it.'*

In outlining the implications of 'A program for the future' for nursing education, the committee first drew attention to the undesirable effects of schools of nurses controlled by hospitals. Next, it criticised the nursing profession for directing its recruiting efforts at individuals with increasingly higher educational qualifications (Ginzberg, 1948, p. 53), and questioned the wisdom of overestimating the value of academic work as a preparation for all nurses for reason that (Ginzberg, 1948, p. 55):

> *'the requisite numbers of college-trained personnel cannot be secured; ... training people in excess of the probable demands that will be made on their skills and knowledge is unwise; and ... emotional predisposition plays such an important role in effective nursing.'*

Instead, and in line with the '*marked expansion of the number of trained practical nurses and a lesser expansion in the number of professional nurses*,' envisaged by the committee, it was recommended that they should strive for nursing education on a professional and a nonprofessional level, whilst making the needed provisions for the continued training of registered nurses (Ginzberg, 1948, pp. 45-65).

The professional nurse. Giving due recognition to the practical difficulties involved, the committee recommended that professional nurses should follow an education programme comparable to that of teachers and engineers. Without entering into the intricacies of curriculum development, it recommended an integrated curriculum, encompassing both the academic and professional preparation of the nurse and putting high emphasis upon the fundamentals of clinical nursing, the responsibility for planning total nursing care, the preparation for supervising the work of practical nurses, and adequate instruction in psychiatry and mental hygiene.

The practical instruction of the professional nurse should preferably take place in institutions where practical nurses were being trained so that the former could gain experience in supervising the latter.

The practical nurse. With regard to the training of practical nurses, the committee recommended that schools for practical nurses should be introduced in the adult and high school vocational system of the country and that the community's hospitals should be used for training, adding that, if the required practical nurses were to be trained at all, '*hospital schools which previously concentrated on the three year program will have to assume the major responsiblity*.'

The registered nurse. As a result of the committee's recommendations, the registered nurse was doomed to disappear. For the time being, however, it was thought necessary to continue to train substantial numbers of registered nurses and to shorten their training period to two years or eighteen months. This recommendation was predicated on '*the shift of emphasis from the service requirements of the teaching hospital to the educational needs of the trainee as well as the evidence that so much of the clinical work is needlessly repetitive*.'

17.2.3. The follow-up

The Ginzberg Report has provided the impetus for Teachers College to participate in many activities which proved highly relevant to the conceptual development of nursing in the 1950s.

Given that the proposals for educational reform, both in the Brown Report and the Ginzberg Report, were expected to result in a significant reduction in the number of nursing schools, regional planning was considered a very important issue at the time. To discuss this issue, a Work Conference on Regional Planning for Nursing and Nursing Education was organised in June, 1950. This conference was sponsored by Teachers College and was concerned with the topics like the general principles of regional planning which could be applied to nursing and nursing education, the functions of nursing as well as the organisation of the profession for the performance of these functions, and the preparation for these functions as a basis for regional planning, and the health needs of the people in relation to the resources to meet these needs, especially as they involve nursing (Columbia University, 1950).

Another activity was concerned with curriculum development. Before the National Nursing Accrediting Service was to assume responsibility for the listing of professionally accredited educational programmes, the Department of Services to Schools of Nursing of the NLNE organised two conferences to stimulate and facilitate curriculum development in individual schools. The first conference, 'Nursing organization curriculum conference' (NLNE, 1950b) was held in New York (December, 1949), and the second, 'Joint nursing curriculum conference' (NLNE, 1951), was hosted by Teachers College (November, 1950). As a result of these conferences, the NLNE Committee on Nursing Curricula, sponsored by the NCINS, embarked upon the 'nursing abilities study' aimed at producing a checklist on abilities needed by nurses (Shields, 1952a and 1952b; Mercedes et al, 1952).

Both in the Brown Report and the Ginzberg Report, it was suggested that nursing education should be introduced in junior colleges. In 1952, following up this suggestion, Teachers College started a research project on nursing education, directed by professor Mildred L. Montag, and aimed at organising a training programme for nurses comparable to the semiprofessional education available for medical, dental, and engineering technicians, testing the quality of the programme, and developing patterns for nursing education in the junior college. The major purpose of the project was, however, to determine if a two-year programme, which prepared (registered) nurses for junior, general duty positions, was feasible. This was relevant because of the need, first, to reduce the still critical shortage of nurses by producing more nurses faster, and, secondly, to further the integration of nursing education into the system of higher education. In 1958, the results of the five-year study indicated that the two-year programme was a success. Despite certain reservations on the part of the hospital schools, this research project resulted in the Associate Degree programmes which became very popular in the 1960s.

Yet another project that was prompted by the Ginzberg Report and which proved very important for the conceptual development of nursing, was concerned with nursing team organisation and functioning. Initially, research focused upon 'a plan for organizing hospital nursing staffs to achieve patient-centred care ... based upon utilization of all nursing personnel in the interest of economy and efficiency' (Lambertsen, 1953, p. iii). Over the years, however, the emphasis gradually shifted to '*the identification of principles of professional education and ... of learning experiences on the basis of these principles which will facilitate the development of competency in the functions of the nursing team leader*' (Lambertsen, 1958, p. vi). The emphasis upon both patient-centred care

and the leadership function of the professional nurse distinguished the team approach developed at Teachers College from what came to be known as the team plan.

Generally speaking, the activities undertaken by Teachers College in the 1950s demonstrated the staff's concern with the quality of nursing care and the need to improve preparation for clinical practice. This concern came also to the fore in McManus' assessment of what colleges and universities had to offer to the nurse practitioner (McManus, 1954, p. 1479):

> *'Among the 98 institutions of higher education that offer programs for graduate nurses today, most of them still prepare nurses for teaching, supervision, or administration. Many of these programs, however, are now beginning to offer practising nurses opportunities to enrol for the advanced study of clinical nursing, because teachers of nursing, like teachers of science and other content fields, are expected to have advanced study in the subject that they teach. It is also assumed that supervisors and administrators of nursing, too, should have advanced knowledge of the content and standards of nursing practice that they supervise or administer.*
>
> *The nurse who does not wish to be diverted from the practice of nursing to prepare to undertake teaching, supervisory, or administrative functions has had fewer opportunities in colleges and universities to keep pace with scientific advancement that is related to nursing and to continue with more advanced study of nursing for the practice of nursing on a broader professional scope, or to become more expert in a special clinical field.*
>
> *Graduate nurses seldom have opportunities to secure help from colleges and universities to undertake study and research that relates to the problems they meet in their own practice, but the rudiments of plans for such opportunities are being developed.'*

Contrary to accepted practice, however, McManus held the opinion that university programmes of nursing education should be used for '*helping graduate students add to the body of scientific knowledge through scholarship and research in professional content,*' and '*promoting the utilization of knowledge in the practitioner's professional services*' (McManus, 1954, p. 1480). It was precisely this stance which has been at the source of the enormous influence exerted by Teachers College in the 1950s in articulating the functions of nursing.

17.3. The Murdock Report

The third report to be discussed in this chapter originated from yet another source, viz. the American Medical Association. This report, which was published before the others, namely in January, 1948, exerted relatively little influence, which is why it is discussed last here.

17.3.1. Impetus: the nursing crisis

At the annual session of the AMA in Atlantic City in June 1947, Dr. E. L. Bortz, in his presidential address to the House of Delegates, recommended the appointment of a committee to study the nursing problem. In July 1947, the House of Delegates adopted a proposal to let the President appoint the AMA Committee on Nursing Problems, chaired by Dr. Thomas P. Murdock, to investigate the objectives of the nursing profession, the standards of education, the time involved for training, the various curriculums, the supply of nurses and quality of services rendered, remuneration, participation in the determination of administrative policies, and the question of security benefits, and to study the training of practical nurses.

Although the representatives of the various nursing organisations were said to 'have been very helpful to the committee' (Murdock & Others, 1948b, p. 879), many nurses reacted less favourably to the AMA initiative (Murdock, 1949, p. 440):

> *'Early in the study, the committee obtained a file of material from a special medical society which had made an opinion study of nursing. Every letter in the file was critical of the nurses of today. But soon thereafter the file of letters from nurses was larger than the doctor's file. A large majority were critical of*

the doctors and hospital administrators. One, in particular was great! It condemned the committee severely and told the chairman he could be better occupied practising medicine and leaving the business of nurses to nurses!'

Even the name of the committee, seemed to evoke adverse reactions as demonstrated by the Journal of American Nursing in which it was consistently referred to as the 'AMA Committee on Nursing.' The distrust on the part of the nurses was not without any foundation because, in the past, the medical profession had shown little interest in the problems of nursing and nursing education, except for some doctors like Beard and Winslow who deserved the title of honour 'friend of nursing' (thereby suggesting that the nurse was an endangered species). Worse still, most doctors' outlook on nursing education was dominated by their deeply felt concern about the dangers of overeducating the nurse. The latter concern came to the fore in the discussions about the AMA Committee on Nursing Problems when one of the participants, whilst recognising the 'nursing crisis,' put forward the amendment that (JAMA, 1947):

'in recent years too much stress has been laid on the technical and scientific preparation of the prospective student nurse rather than on her sympathetic understanding of the problem of patient handling, comfort and ordinary technics of treatment.'

From remarks like these, it can be inferred what the doctors were really worried about, viz. the adequate supply of bedside nursing care. This was demonstrated once again by the remark in the final report of the committee that the '*staggering and alarming figures with regard to the nursing shortage tell American medicine a story of what is before it in the years to come*.' (Murdock et al, 1948b, p. 878). This conclusion is also vindicated by the committee's assumptions with regard to the nursing shortage.

The shortage of nurses. The committee's assumptions were explained in an article about the report of the AMA Committee on Nursing Problems, written for readers of the American Journal of Nursing (Murdock, 1949). In this article, the shortage was said to be '*more relative than real*,' because, for a start, the shortage '*would be very much less if nurses were engaged in nursing duties only, instead of in work which rightfully comes under the duties of subsidiary workers and others*.' Secondly, and at this point Murdock put his cards on the table, the advocates of professional nursing (Murdock, 1949, p. 439):

'must realize that, out of the great pool of American womanhood, it would be impossible to obtain enough women to be given collegiate training to provide America with this type of nursing completely. Neither would it be possible to provide enough teachers or the physical equipment necessary to train them. The economics of such a situation seems to be very unsound. Certain duties in the care of the sick require only limited skills. It is not necessary to assign highly trained people to such work. The nursing profession should accept, and I believe is beginning to accept, the necessity for the trained practical nurse and for attendants trained on the job.'

Thirdly, whereas the Ginzberg Report arrived at a ratio of one collegiate nurse to two practical nurses, the committee suggested a ratio of 15 % collegiate nurses, 25 % clinical nurses, and 60 % trained practical nurses, thereby limiting the number of collegiate nurses to 50 % of the number recommended by the Ginzberg Report. Finally, Murdock urged the nursing organisations to '*sponsor, endorse, and aid in the recruitment of the trained practical nurse as well as of the professional nurse*.'

This line of reasoning suggests that the committee assumed the nursing shortage to be a problem of a quantitative rather than a qualitative nature, or better still, a problem of too few practical nurses and too many professional nurses. Consequently, the AMA committee sought to solve the nursing shortage not so much by strengthening the role of the professional nurse as by increasing the number of trained, practical nurses.

17.3.2. Report of the Committee on Nursing Problems

In January, 1948, the AMA committee published an interim-report (Murdock et al, 1948a) that was followed in June, the same year, by the final Report of the Committee on Nursing Problems (Murdock et al, 1948b). At the end of this final report, the committee's analysis of the 'nursing problem' was summarised as follows (p. 879):

1. *'It is estimated that about 400,000 nurses will be required to care for the American people in 1949. The committee feels that this can be accomplished.*
2. *Labor Department statistics indicate that about 550,000 nurses will be needed in 1960. To accomplish this, about 50,000 nurses must be graduated each year between 1951 and 1960. This can be accomplished by the generous cooperation of all concerned.*
3. *The committee has proposed measures for the relief of the present situation and feels that much has been accomplished.*
4. *The committee recommends that changes be made in the present method of training nurses: that in the future nurses be made up of two main groups - the professional nurse and the trained practical nurse. The requirements, duties, and courses of training of both main groups have been outlined.*
5. *The economic situation has been reviewed and methods of correction suggested.*
6. *A permanent Conference Committee has been formed, made up of representatives of the American Nurses' Association, the American Hospital Association and the American Medical Association.*
7. *The committee believes that this permanent Conference Committee will be the organization to implement your committee's recommendations and the recommendations that come from other interested groups.'*

This summary reflected the lines along which the study was conducted. After a review of the figures concerning the shortage, similar to the one at the beginning of this chapter, the committee looked into the following avenues for solving the problem: measures for immediate relief, the future training courses to be recommended for the various grades of nurses, and the economic conditions. Finally, it recommended a permanent conference committee which turned out to be the Joint Commission for the Improvement of the Care of the Patient (JCICP).

Measures for immediate relief. Some of the measures for immediate relief proposed by the committee were (Murdock et al, 1948a and 1948b):

- to bring out of retirement as many nurses as possible, even if married,
- a publicity campaign to stimulate doctors to help in recruiting student nurses,
- to use personnel trained on the job to supplement nursing services,
- to use trained practical nurses under supervision,
- to use nurses only in nursing duties and to assign other work to auxiliary personnel.

The future training courses to be recommended for the various grades of nurses. This part of the final report contained the committee's long term solution for the nursing shortage (Murdock et al, 1948b, p. 878):

> *'We have investigated and studied carefully the question of bedside nursing and the required training for this grade of nurse. We recommend two main classes of nurses: (A) professional nurses, and (B) trained practical nurses.'*

In fact the report distinguished three groups of nurses, two of which belonged to the class of professional nurses:

- **Nurse educators**
  'Nurse educators are to be those with collegiate training and others who have shown an aptitude for teaching, administration and supervisory positions. These are to fill positions of directors of nursing schools, teachers, department and clinical supervisors, public health nurses, etc. The training for these nurses should be collegiate training before entering the nursing field or combined collegiate and nursing training.'

- **Clinical nurses**
  'The clinical nurse is to be comparable to the present day general duty or private duty nurse. Selected clinical nurses with an aptitude and ability for teaching may well be considered for some of the subordinate teaching positions. We recognize that there are many duties to be assigned to this grade of nurse which could not be filled by the trained practical nurse. We recommend that the course of training for the clinical nurse be reduced to two years.'

- **Practical nurses**
  With regard to the practical nurse, the report first emphasised that she was to be trained in a one-year course made up of three months' theoretical and nine months' practical training. The committee further expressed its feeling that '*this group of trained practical nurses, under proper supervision of professional nurses and medical staff, will be able to do much of the routine bedside nursing now being done by professional nurses, but that the more delicate and intricate duties must be left to the professional nurse. We believe that sufficient bedside nursing care can be obtained economically and efficiently if the professional nursing staff is augmented by trained practical nurses*.' Finally, it was recommended that schools should make provisions and allow credits, to enable the more capable practical nurses to advance to the grade of clinical nurse.

The economic conditions. With respect to the economic conditions, it was recommended (Murdock et al, 1948a and 1948b):

- that social security and retirement plans for all nurses should be provided as this was '*advised from the business and moral points of view,*'
- that hospitals should adopt a definite personnel policy for all institutional nurses, '*with a view toward making salaries, hours, sick leave and vacations comparable to other fields of endeavour for women with equivalent education and training,*'
- that the cost of essential special nursing care, i.e. private duty nursing, should be covered by prepayment nursing plans or be tied into prepayment hospital and medical plans, if practicable.

These recommendations were important because an increasing number of nurses wanted action - some even joined a trade union - to improve their economic conditions and social security. One of the reasons for this rebellious mood was that the three national hospital associations had managed to have hospital personnel excluded from the old age provisions of the Social Security Act. Taking sides with the nurses on this issue, the AMA committee, however, added (Murdock et al, 1948b, pp. 878-879):

> *'The committee feels that the nurses innocently erred in their action in Atlantic City in 1946 when they voted to have their state organizations act as bargaining agents for them. They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with that most priceless possession - life itself. It is hoped that the nurses will correct this in the near future.'*

This statement on contemporary ANA-policy, amongst others, made sure that the Report of the AMA Committee on Nursing Problems got a lukewarm, if not hostile reception on the part of the national nursing organisations. Also, it was not very helpful in gaining their support for the permanent conference committee recommended by the committee.

A permanent conference committee. Finally, the AMA Committee on Nursing Problems also recommended a permanent conference committee, to be composed of representatives of the national medical, hospital, and nursing organisations and operating in an advisory capacity to their parent organisations. This conference committee referred, to here became known as the Joint Commission for the Improvement of the Care of the Patient (JCICP).

However, the first impetus for the JCICP originated not from the AMA but the American Hospital Association when, in 1947, this organisation became worried about the way the medical profession and the nursing profession and the hospitals were all contending with each other in the public press. Articles appeared in

which hospitals were blamed for exploiting the nurses, and the AHA therefore suggested that there be a conference of five representatives from each group.

This initiative led to the inaugural meeting in March 1948 - three months before the publication of the report of the AMA Committee on Nursing Problems - organised by the AHA and attended by representatives of the national medical and nursing organisations. Ten years later, one of the nurses present at this meeting, recalled how 'the commission grew out of a conference on nursing at which ... the nurses lined up defensively on one side of the table and seated across from them on the offensive were physicians and hospital administrators' (Nursing Outlook, 1957). After the JCICP was formed, the AMA Committee on Nursing Problems were designated to represent the AMA.

17.3.3. The Joint Commission for the Improvement of the Care of the Patient (JCICP)

The major purpose of the JCICP was (Murdock et al, 1949, p. 616):

> *'to stimulate, implement, assist in and conduct activities which will contribute to the improvement of the care of the patient as may be mutually satisfactory to the appointing organizations. To achieve this objective, the commission performs as a service agency to the parent organizations.'*

In addition, it was agreed that the commission would operate '*without authority to act for its respective appointing organizations*' (AJN, 1949d, p. 321). Because the JCICP met only twice a year, it was not until September, 1949, that its regulations had been approved by the parent organisations (AHA, AMA, ANA, and NLNE).

In the meantime, many nurses remained sceptical. This response was reflected in the limited space devoted to the activities of the JCICP in the Journal of American Nursing. True, its editor accepted the commission's purpose being '*based on the assumption that improved care of the patient will result from better understanding of each other by the medical staff, nursing staff, and hospital administrator*' (AJN, 1948j), but this was not to say that she would necessarily agree with Murdock's account of 'teamwork through a commission' as he called it (Murdock, 1949, p. 441):

> *'Medicine must continue its research and clinical studies. Medical men must lead the way and captain the team. At the same time they must be co-operative and cordial and have an understanding viewpoint.*
> *Nursing must continue its studies for advancement and improvement, and show a willingness to accept changing concepts. The professional nurse becomes the lieutenant of the team with the actual direction and allocation of her work in her hands. The hospital is or will become the center of the healing arts.*
> *The hospital administrator acts as the co-ordinator of the groups. Each group must take the others into its confidence so that all will know the problems and procedures of the others.*
> *This plan having been accomplished, the care of the patient cannot help but be improved.*
> *Finally, let us think of this as a common problem and let our motto be the improvement of the care of the patient. With this objective before us and with the united effort of all concerned - the physician, the hospital administrator, the professional nurse, the trained practical nurse, and the subsidiary worker - we cannot and will not fail.'*

Apart from that, nurses were sceptical as to the integrity of the AHA, the originator of the JCICP, and, as mentioned earlier, not without good reason. However, relationships were to improve, albeit at a slow pace. In 1953, for example, the JCICP reported that (AJN, 1953b, pp. 308-309):

> *'From an atmosphere of polite toleration, which characterized the early meetings, barriers of communication have been broken down and all members speak from a firmer base of knowledge of nursing problems. Differences in points of view can now be discussed frankly with persistence and patience to reach mutual understanding. Trust in each group's goodwill has grown to the end that give and take is possible. ... The Commission feels that with the approval of this report a new era in relationship with "nursing" has been entered. Some common denominators to work toward have been*

defined. It is recognized that progress will be slow. The important factor is the acceptance of directions upon which our three professions are in accord.'

In 1957, when the JCICP had been in existence for ten years, the members of the commission reportedly agreed that the commission was serving a useful purpose and that it should be continued, although (Nursing Outlook, 1957):

'Many of the members' statements began with "I feel" and then went on to an expression of opinions rather than a recital of things accomplished, for most of the commission's achievements during the past ten years do not have a tangible or measurable quality. Better understanding, good rapport, and comfortable working relationships among the hospital, medical, and nursing representatives were the things referred to most frequently. None of the commission members wanted this opportunity to work together amicably to come to an end.'

Among some of the more tangible results of the JCICP that are worth mentioning was the creation of similar conference committees in many states and hospitals. Because of this development, the commission changed it name in 1955 into the National Joint Commission for the Improvement of the Care of the Patient. Further, in 1950, it was agreed that the JCICP should be utilised by the NCINS '*as a sounding board and source of information for its future deliberations and activities*' (AJN, 1950c, p. 691). As a result of this cooperation, a joint committee of the NCINS and the NJCICP identified four urgent areas needing immediate concerted action (AJN, 1953b, p. 309):

- well-prepared nurses for faculty of schools and for administrative and supervisory services,
- effective in-service education to improve workers on the job,
- more practical nurses properly prepared, and
- experimentation in nursing curriculums (the two-year program).

This conclusion of the joint committee was published in the only report of the JCICP to be printed in its entirety in the American Journal of Nursing (AJN, 1953b).

17.4. Towards two different models of nursing

The analysis of the Brown Report, the Ginzberg Report and the Murdock Report has resulted in a rather confusing picture. On the face of it, the reports were rather similar, and understandably so, for there were ample lines of communication. The Committee on the Function of Nursing, for example, not only had the preliminary report of Dr. Brown at its disposal but counted Dr. Murdock among its members. Moreover, between them, these reports undoubtedly gave direction to the discussions on nursing during the following years. Nevertheless, there were also some important differences which were to have a lasting effect on the conceptual development of nursing.

The summary of the outcome of the comparative analysis in this chapter (Table 15) suggests that, in most respects, the Murdock Report was the odd one out. This may have been caused by the fact that this report was the first to be completed but a more likely reason is that the report was based upon an altogether different frame of reference. This came most clearly to the fore in the report's impetus, purpose, point of departure, as well as its recommendations.

In other respects, however, the Murdock Report paralleled the Ginzberg Report. Contrary to the more principled approach of the Brown Report which rested upon a well-articulated view of the health services and the nursing services of the future, the Murdock Report, and to a lesser extent the Ginzberg Report too, demonstrated a more pragmatic line of approach based upon considerations of economy and efficiency. This contrast is corroborated by Murdock's observation that, whereas the Brown Report paralleled the AMA study in '*some respects*,' the Ginzberg Report did so in '*many respects*,' mainly because (Murdock, 1949, p. 440):

'it brings to the front certain aspects of the functions and economics of nursing that are important and must be faced by all concerned. It recommends two great groups of nurses - the professional collegiate

nurse and the trained practical nurse. It emphasizes the importance of teamwork of the professional nurse, the trained practical nurse, and all subsidiary workers.'

However, as far as its effects were concerned, thanks to the increasingly close relationships between the NCINS and the JCICP, the Murdock Report was linked up with the Brown Report rather than the Ginzberg Report.

Next, it remains to be seen what the position of the Ginzberg Report was. The summary of the comparative analysis of the three reports analysed in this chapter (Table 15) shows the Ginzberg Report to resemble both the Brown Report and the Murdock Report, albeit in different respects. On balance, however, it was closest to the Brown Report.

	BROWN REPORT	GINZBERG REPORT	MURDOCK REPORT
IMPETUS	the need for educational reform	curriculum revision at Teachers College	the nursing crisis
given by	NLNE/NNC	Teachers College	AMA
PURPOSE	integration of professional nursing education in the system of higher education	improvement of nursing care and nursing education	adequate supply of bedside care
study in the interest of	society	nursing profession	medical profession
ASSUMPTIONS as to the nature of the nursing shortage	qualitative shortage of professional nurses	• qualitative shortage of professional nurses • uneconomic and inefficient use of professional nurses	• quantitative shortage of practical nurses • uneconomic and inefficient use of practical nurses
POINT OF DEPARTURE	functions of nursing	functions of the professional nurse	nursing duties
APPROACH	principled	pragmatic	pragmatic
RECOMMENDATIONS	differentiation of nursing service according to function	specialisation of functions	new division of nursing duties
emphasising role of	professional nurse	professional nurse	practical nurse
nursing service	functional team approach	democratic team approach	hierarchical relationship between the two classes of nurses
education of practical nurses	school for practical nurses	school for practical nurses	school for practical nurses
education of professional nurses	collegiate education (integrated curriculum)	collegiate education (integrated curriculum)	• collegiate education (nurse educator) • two-year hospital diploma programme (clinical nurse)
education of registered nurses continued for the time being	shortened and improved improved programme (relatively schools)	shortened and improved programme	
FOLLOW-UP	NCINS NLN	Teachers College	JCICP

Table 15. The Brown Report, the Ginzberg Report, and the Murdock Report.

In its effects, however, it was markedly different for, whereas the Brown Report came to be associated with the model of comprehensive nursing, the Ginzberg Report - via the developments at Teachers College between 1948 and 1960 - was at the source of the model of patient-centred nursing (Abdellah et al, 1960). This is how Glaser, who was working at Columbia University at the time, summed up these developments at Teachers College (Glaser, 1966, p. 13):

'The T. C. faculty commended the collegiate schools and favored collegiate methods of teaching in place of the exclusive disciplined, practical apprenticeship derived from the Nightingale tradition. The professional model had seemed inappropriate to nursing because of the absence of a scientific and written body of nursing knowledge, but advocates of the new approach began to write textbooks and articles, and they developed lecture and seminar methods of teaching nursing knowledge. The graduate degrees necessitated the writing of theses; much of the research concerned nursing education and administration, but some dealt with nursing practice, and thus new professional knowledge was created. The professional model had seemed inappropriate to nursing as long as the hospital doctor was free to delegate his tasks to the nurse, but a few of the T.C. professors of nursing (and some other professional leaders) recommended that nurses specialize in distinctively nursing work and resist excessive delegations at the discretion of the doctors. The T.C. Department of Nursing Education devoted much attention to the development of public health nursing, because of its great practical importance and because it offered nursing the best opportunity for the autonomy idealized by the professional model.'

In the following chapters, this account will be shown to correspond with the rationale for the model of patient-centred nursing given by Abdellah herself, viz. the lack of a scientific body of knowledge which is uniquely nursing, whose emergence was hampered because nursing traditionally was determined by the exigencies of medical and hospital care.

Summing up, it can be concluded that the Brown Report, the Ginzberg Report, and to a lesser extent, the Murdock Report, set the tone for the conceptual development of nursing in the 1950s. This development, as will be shown in the remaining chapters of this part, resulted in a gradual shift of emphasis from comprehensive nursing to patient-centred nursing. Because of their mutual similarities, however, there was also a considerable overlap between these two models of nursing. So much so, that the best way to grasp the significance of each model is not to analyse them separately but to subject them to a comparative analysis as to their respective presuppositions and implications by analysing the concepts of nursing, nursing education, and professional nursing underlying each model.

Such a comparative analysis is all the more necessary because, in the period concerned, both models tended to be regarded as more or less interchangeable. But, even if this equalisation could be justified, it still remains to be seen why one model was designated comprehensive nursing and the other patient-centred nursing.

18.
TWO CONCEPTS OF NURSING

This chapter is concerned with a comparative analysis of the concepts of nursing underlying the models of comprehensive and patient-centred nursing. Each of these concepts of nursing should be interpreted against a distinctively different background. The main source of information about the model of comprehensive nursing is the Brown Report (Brown, 1948) which was written, as the editor of the American Journal of Nursing put it, to demonstrate (AJN, 1949b, p. 130):

> *'that our present system of nursing education will not produce adequate numbers of the types of nurses needed. ... that the financial support of nursing education has always been, and continues to be, shockingly inadequate.'*

As for the model of patient-centred nursing, the main source of information is 'Patient-centered approaches to nursing' (Abdellah et al, 1960). For convenience sake, only Abdellah will be referred to as the originator of the model of patient-centred nursing. Whenever reference is made to a particular publication, the others will be mentioned too.

'Patient-centered approaches to nursing' was precipitated by the fact that the authors were brought together as members of the NLN-Committee on Records (chaired by A. Martin) from which a subcommittee evolved to develop a clinical record for professional student nurses (chaired by F. G. Abdellah). This subcommittee found three barriers that stood in the way of achieving its objective, namely (Abdellah et al, 1960, p. vii):

> *'The first was that nursing had not clearly been defined; second, the present philosophy of nursing education was one that was cherished but not practiced; and, third, that present curriculums in nursing were not patient-centered.'*

So, whereas Brown dealt primarily with policies concerning the administration of nursing education, Abdellah focused her attention on the structure and content of nursing education. In both cases, however, it was necessary to articulate a concept of nursing

Both Brown's and Abdellah's concept of nursing built on the earlier concept of individualised nursing which should be taken to mean that nursing has to do with the total individual, psychological as well as physical, in relation to his natural environment, social as well as physical, and is aimed at attaining and maintaining health by means of the activities aimed at meeting all the nursing needs of the individual, sick or well.

Also, both concepts of nursing were prompted by changes in medical and health care. But, to the degree that these changes differed from each other, the evolving concepts of nursing were dissimilar too. As a result, each of these concepts of nursing gave a new meaning to the concept of individualised nursing.

18.1. Comprehensive nursing

The Brown Report fitted in with a historical sequence of analyses of nursing education in the United States. The first analysis of nursing education was made by the Committee on Nursing and Nursing Education and resulted in the Goldmark Report which '*concerned itself with the problem of the reorientation of professional practice to meet new health and social goals, and made specific recommendations for education for such reorientation*' (Brown, 1948, p. 7). The second analysis consisted of the studies made by the Grading Committee in an attempt '*to eliminate weak nursing schools and to raise appreciably standards in the remaining schools*' (Brown, 1948, p. 7). The third analysis of nursing education was provided by the Brown Report itself and was needed because the earlier analyses had failed to achieve the desired results. The Brown Report, therefore, offered little news to those conversant with the problems of nursing and nursing education (AJN, 1948i, p. 609):

> *'No weakness has been revealed that had not already been openly recognized by some nurses, and persistently kept below the level of frank recognition by others. No remedy has been recommended that*

has not already been considered by some individuals or groups. But Dr. Brown has performed the inestimable service of presenting her findings in right relationship to each other with convincing logic and with extraordinary insight into the strengths and weaknesses of the present situation and into the hopes and fears of nurses.'

There was, however, one significant difference. The nursing shortage in the postwar years created a climate more favourable to change than ever before, or as the editor of the American Journal of Nursing put it (AJN, 1948h, p. 549):

'Nursing is now generally recognized as an essential social service. The adequacy and availability of nursing service are matters of grave concern to the public.'

This explains why the Brown Report, although primarily concerned with the question '*who should organize, administer, and finance professional schools of nursing*' (Brown, 1948, p. 10), also elaborated on the need for change in nursing practice. The main thrust of the Brown Report, however, was the need for reversing the traditional system of '*service for education*' into a system of '*education for service*', or the transition from apprenticeship training to professional education. To substantiate the need for this change, Brown first had to demonstrate the need for professionally prepared nurses by articulating a concept of nursing which required this kind of preparation. The resulting concept of nursing in turn rested upon certain assumptions regarding the health services envisaged for the second half of the century, as well as the accessory demand for nursing care.

18.1.1. The future health services

Brown started her report with a description of the changes which she expected would take place in the health services. One of these changes, the nationwide programme for enlarging and rebuilding hospitals as a result of the Hospital Survey and Construction Act was already under way. Other changes which Brown considered more important had to do with the administrative and fiscal structure of the health services as well as the nature and the quality of health care to be rendered.

Administrative and fiscal changes. The expansion of hospital facilities in the postwar years might suggest that the hospital was expected to continue to function as a highly specialised centre for the diagnosis and treatment of disease, but there was also a growing awareness that the ever-increasing financial burden of hospital care was limiting the resources for 'positive living, such as schools, playgrounds, public housing, libraries, museums, and music' and appeared 'to do relatively little to improve the basic health of the nation' (Brown, 1947, p. 821).

In 1947, the Commission on Hospital Care consequently called for a reappraisal of the function of the hospital, stressing its potential as a community health agency. This reappraisal was expected to result in (Brown, 1948, pp. 26-27):

- provisions being made for the care of persons with communicable diseases, convalescent patients, and patients with certain types of tuberculosis and nervous, mental and chronic diseases,
- a progressive emphasis on the importance of the outpatient department, and
- laboratory and other diagnostic facilities being made available to the local general practitioners.

Its broadened intramural function apart, the hospital also came to be viewed in its relationship to other community health agencies within '*a co-ordinated system of health agencies*' (Brown, 1948, p. 27) consisting of one or two large medical centres to be complemented by regional and community hospital centres as well as specialised hospitals and public health agencies. Summing up these ideas, Brown concluded that (Brown, 1948, p. 30):

'the massive walls which for so long separated the hospital from the outside world are beginning to crumble. The hospital is moving out *into the larger community; the community is moving* into *the hospital. The implications are too large to be foreseen in their entirety.'*

A second change expected to take place was the further expansion of public health services coupled with a shift of emphasis from problems like morbidity, infant mortality, maternal mortality, and mortality from communicable diseases, to problems like the diseases of middle life (e.g. cardiac diseases and cancer), the degenerative process of old age, bad social and living conditions, and inadequate health education (Brown, 1948, pp. 30-31). These relatively new problems not only gave a new impetus to the teaching function of public health agencies but also called for improved working relationships with the social welfare agencies and the teaching profession, as well as a better organisational structure of the public health agencies.

A third change envisaged by Brown was the larger financing of health services as a result of the increasing demand for health services. This change was reflected in:

- the success of hospital insurance plans as a method for meeting the costs of medical, surgical, and (sometimes) nursing care,
- the emergence of group medical practice to provide efficient, co-ordinated care to the subscribers of a medical or health care programme.

Although most pre-payment plans for health care covered only therapy and hospitalisation in cases of acute illness, it was expected that future schemes would also include services related to the maintenance of health, if only because the public was '*near to insisting that the various professions engaged in therapy demonstrate equal ability to keep people well*' (Brown, 1947, p. 821).

The nature and the quality of health care. Other changes which Brown thought of greater importance for the future of the health services than most of the other changes she mentioned were related to the nature and the quality of health care (Brown, 1948, p. 33):

> *'Thus far, the major emphasis in medicine has been centered on organic disease. The teachings of preventive medicine, mental hygiene, and public health have progressively stressed not only the prevention of disease but the maintenance of health. Only slowly have the implications of these teachings made themselves felt on the medical profession at large; only in small part have they as yet competed with the physician's interest in pathology. But time has brought enough realignment of interest so that the dean of one medical school recently remarked that organic disease, as motivation for operating a medical school, had worn itself out and new motivation must be found.*
>
> *The pendulum has begun to swing farther in the direction of health; of emphasis upon the "normal" person, and sickness as a deviation from the normal; of an understanding of the emotional factors which are a component - if not the cause - of disease; of the responsibility of the health professions in aiding persons, individually and groupwise, to maintain positive health. This responsibility, many are coming to believe, is the challenge and the new source of motivation for the years ahead.'*

What these changes added up to was the maintenance of health as the future goal of health care. Unfortunately, Brown omitted to give a clear-cut definition of her conception of health. Significantly, Brown considered the maintenance of health as the goal of health care to be the outcome of two sets of influences which, between them, were most suggestive as to her conception of health as the goal of health care:

first set	**second set**
preventive medicine	emphasis upon the "normal" person, and sickness as a deviation from the normal
mental hygiene	an understanding of the emotional factors which are a component - if not the cause - of disease
public health	the responsibility of the health professions in aiding persons, individually and groupwise, to maintain positive health

The first set of influences, although admittedly stressing the prevention of disease as well as the maintenance of health, had failed to counteract medicine's preoccupation with organic disease and pathology. The second set, however, was expected to give new impetus to the maintenance of health, and was amply illustrated by means of advances in preventive psychiatry which were dominated by the battle against neurosis, paediatrics in which the prescription for '*Tender Loving Care*' first emerged, and the new approach in obstetrics to childbirth without fear. The conclusion drawn from these examples was (Brown, 1948, p. 41):

> *'The lessons that have been learned in how to allay fear and hence reduce tension and pain; in how to make the teaching process an instrumentality for conditioning persons in* positive *health - these are the lessons of paramount significance for all members of the health professions.'*

According to the interpretation offered here, Brown's description of the second set of influences indicated what should have been achieved by the first set in the first place. Also, it reflects the kind of health care envisaged by Brown in which, first, the normal person was substituted for the illness; secondly, the organic factors of disease were complemented by the emotional factors of disease; and, thirdly, the responsibility of the health professions was not so much to cure people from disease as to maintain their health. What these changes added up to, it is further contended here, was a conception of health care as a service to the individual and society.

Health care: a service to the individual and society. That Brown's conception of the maintenance of health included not only the individual but society as well can be inferred from her recommendation of the book 'Nursing in modern society' (Brown, 1948, p. 34). This book was written by Chayer (1947), a professor of nursing education at Teachers College, and contained three chapters which Brown considered pertinent to the discussion of the maintenance of health. These chapters were concerned with the significance of human behaviour, the newer approach to child development, and the fundamental concerns of parents. A second reason for recommending this book was that Chayer placed nursing within the larger societal process as reflected in the titles of the three parts of the book, viz. the impact of social forces upon nursing, the influence of social forces upon community health needs, and building a better future.

Another justification for the interpretation offered here is related to the function of the hospital as envisaged by Brown in her preliminary report to the NLNE-convention in Seattle. Assuming the shift from curative treatment to preventing the recurrence of disease and teaching positive health would take place, Brown foresaw two sorts of effects for the two functions of the hospital (Brown, 1947, pp. 821-822):

- **intramural function**
  'For its intramural function, the hospital would have to be staffed with a personnel equipped to view the patient, far more than now, as a total person - a person who would be found frequently to need either reconditioning to his environment or who would need to have his environment reconditioned to him. Knowledge currently available about the ro^le that insecurity, fear, frustration, and hate play as a cause or concomitant of physical sickness would have to be translated into therapeutic practice.'

- **extramural function**
  'In several blueprints for co-ordinated health care now being made, we see the hospital emerging as more truly a health centre, we see the artificial line of demarcation between private practice and public health more faintly etched; we see differentiation lessened between the quantity and quality of health care available to urban and rural areas. Above all, we see greater concentration of attention upon the community and normal individuals (well persons), less upon the institutional study by specialists of interesting pathological conditions.'

The social and health aspects of health care. Summing up, in so far as Brown's conception of the maintenance of health had to do with the individual, health care should be aimed at the total person, including the social and emotional as well as the physical aspects of health. It seems very likely, therefore, that she would have felt much at home with the following statement (Winslow, 1945, p. 991):

> *'In planning a health program for the postwar world, it is important to remember that our true objective is* Health, *not merely freedom from disease. A quarter or half a century ago, our yardstick was mortality. We were confronted with epidemics of typhoid fever and diphtheria, with a high death-rate from tuberculosis, with an appalling infant mortality. Today - in our fortunate United States - these scourges have been brought under control. Such elementary triumphs achieved, we must think more and more of the positive deals of health - a word which in its old Anglo- Saxon derivative sense meant "wholeness."*

Viewed within a wider perspective, however, the maintenance of health should also be taken to mean that the aim of health care was the social welfare of society rather than just the treatment of organic diseases. In this respect, it is worth noting that Brown cited from a letter in which a clinical psychologist wrote that the emphasis upon prevention of disease seemed (Brown, 1948, p. 34):

> *'to reflect a larger cultural trend in America, a growing recognition that we must conserve our resources, human and material, if our society is to continue. Perhaps it marks the end of an era of exploitation and rampant "individualism," and the beginning of a process of redifining the concepts of "self-interest" and "freedom".'*

Both perspectives, between them, reflected the shift of emphasis from the physical to the social as well as from the disease to the health aspects of health care.

18.1.2. The future role of nursing

Having established that the maintenance of health from both an individual and a societal point of view was the raison d'être of the health services in the second half of the century, the next step was to determine the future role of nursing. The thrust of Brown's argument was that, because the broadened functions of health care had to be matched by similarly broadened functions of nursing, there was a need for nurses prepared on a professional level. However, before she was able to address questions concerning the professional nature of nursing and professional education for nurses, she first had to articulate a concept of nursing which agreed with her conception of the future health services.

Nursing and the health of the individual. To substantiate the significance of nursing for meeting the health needs of the individual, Brown referred to the definition of nursing set down by Sister M. Olivia of the Catholic University of America (Brown, 1948, pp. 74-75):

> *'Nursing in its broadest sense may be defined as an art and a science which involves the whole patient - body, mind, and spirit; promotes his spiritual, mental, and physical health by teaching and by example; stresses health education and health preservation, as well as ministration to the sick; involves the care of the patient's environment - social and spiritual as well as physical; and gives health service to the family and community as well as to the individual.'*

This was not, however, to say that nurses were practising this concept of nursing at the time for, as Brown pointed out, '*it is true that the institutional staff nurse in probably the large majority of places is primarily engaged in physical care. Unfortunately the philosophy of essentials of patient care that has evolved from public health nursing, mental hygiene, social casework, the newer psychiatry, pediatrics, and obstetrics, or psychosomatic medicine has yet exerted but restricted influence over general duty nursing*' (Brown, 1948, p. 82).

This assessment of contemporary nursing practice is interesting for two reasons. First, because of the contrast between '*physical care*' and the '*philosophy of essentials of patient care*.' Secondly, because of the set of influences held to be at the source of this philosophy, for the sequence in which these influences were mentioned corresponded with the evolution of individualised nursing discussed earlier, at least as far as prewar developments in public health nursing, mental hygiene, and social casework were concerned. The other influences had to do with more recent developments in psychiatry, paediatrics, and obstetrics, or, in short, psychosomatic medicine.

Between them, these observations indicate that Brown intended to bring about a shift of emphasis from the physical care of the patient to nursing the whole person. This shift was prompted by developments related partly to nursing itself and partly to factors external to nursing. This conclusion is corroborated by the following text, written by a director of nursing service which Brown included in her report (Brown, 1948, p. 83):

> *'Quality of nursing care cannot be measured simply by whether or not separate therapeutic measures have been carried out specifically as ordered. A basic requirement for good nursing is that it must be individualized, that it must include sensitivity to respond to and deal with the mental and emotional reactions which accompany physical aspects of illness; that it must help the patient to understand his illness, plan to regain his health, or adjust to his limitations. No matter how full may be the provision for covering these latter points in the physician's conferences with the patient, it is the nurse who is with the patient at all hours of the day and night and must meet situations and answer questions which cannot be escaped. These things are essentials of nursing care.*
>
> *Trends in the care of specific medical conditions give new emphasis to the importance of individualized nursing care; for instance, newer concepts of maternal and infant care, getting away from rigid feeding schedules, the importance of a relaxed obstetrical patient before delivery, an increase in the recognition of psychosomatic conditions, the importance of mental hygiene in all care. These trends in medical care must be paralleled in nursing care.'*

What this concept of nursing thus added up to was that it stood for individualised nursing care as opposed to the physical care of the patient, and, according to Brown herself, it was given a new impetus by the emergence of psychosomatic approaches in medicine. For nurses conversant with the conceptual development of nursing in the prewar years, Brown's concept of nursing held few surprises, as it was virtually identical to the curriculum guide's concept of nursing. The crucial difference between both concepts of nursing was that the former was more or less sanctioned by the developments in medical and health care, whilst the latter was not.

Nursing and the health of society. The distinction between the physical care of the patient and individualised nursing care provided Brown with the stepping stone needed to substantiate the significance of nursing for meeting the health needs of society. In her opinion, the future functions of the health services had several implications for nursing:

- an increase of the administrative and supervisory functions of nursing service,
- a larger demand upon staff and head nurses to act in the role of the physicians' assistants,
- an increasing need for health teaching.

However, given the already critical problem of recruiting nurses for the physical care of the patient, it was difficult to see how nurses could possibly cope with society's demand for nursing services, especially the need for health teaching, unless they acted upon the suggestion made by Brown in her preliminary report (Brown, 1947, p. 822):

> *'Not until graduate nurses are freed from a large part of the burdensome load of providing bedside nursing care "around the clock," can they turn their attention to the broader needs of society for their services. Then, and only then, will they function in any considerable numbers as professional, rather than vocational, persons.'*

In other words, given the future functions of the health services, Brown definitely saw a need for nurses prepared on a professional level to provide individualised nursing care with an emphasis upon social and health needs, but only if these nurses were prepared to accept practical nurses and auxiliary personnel to perform most of the functions related to bedside nursing care.

18.1.3. Brown's concept of nursing

In Brown's view, bedside nursing care was just one of the elements of the broader concept of comprehensive nursing which encompassed meeting the social and health needs of the individual and society alike, especially by means of health teaching. That the latter combination of elements was quintessential to Brown's concept of

nursing is corroborated by Abdellah who summarised it by mentioning in one and the same breath '*the need to meet the total health needs of people*' and '*the growing emphasis that is being placed upon comprehensive nursing care, which includes the patient's physical, emotional, and sociological nursing needs as well as consideration of the psychosomatic origin of illness ...*' (Abdellah et al, 1960, p. 6).

Most surprisingly, however, Brown herself never used the adjective '*comprehensive'* to designate her concept of nursing, and neither did Ginzberg or Murdock. As a matter of fact, the research undertaken for this study has led me to believe that it was, at the earliest, in 1953 that this term surfaced in nursing literature. Given moreover that it is Brown who is usually credited with coining this term, it is even more remarkable that the first time the term '*comprehensive nursing*' showed up in nursing literature was in a report of the JCICP (AJN, 1953b).

Comprehensive nursing. Because of its historical significance, the JCICP's statement on comprehensive nursing is discussed here in some detail. According to the JCICP (JCICP, 1953, p. 309):

> *'Comprehensive nursing should be designed to provide physical and emotional care for the patient; care of his immediate environment; carrying out the treatment prescribed by the physician; teaching the patient and his family the essentials of nursing that they must render; giving general health instruction and supervision of auxiliary workers.'*

This description of comprehensive nursing closely resembled one of the definitions of nursing articulated at the Joint Nursing Curriculum Conference, held in November, 1950 (in: Roberts, 1954, p. 465):

> *'Nursing is one of the services in a community for the care of the sick, the prevention of illness, and the promotion of health, which is carried on under medical authority. Nursing is designed to provide physical and emotional care for the patient; to care for his immediate environment; to carry out treatment prescribed by the physician; to teach the patient and his family the nursing care which they may have to perform; to give general health instruction; to supervise auxiliary aides and co-ordinate the services of other workers contributing to patient and family care. This service may be given in hospitals or other institutions for the care of the sick, in homes, in community health agencies, in industries or in schools.'*

According to Roberts, this definition has been used, with some modifications, by other conference groups in the early 1950s too (Roberts, 1954, p. 530). One of these groups was the JCICP.

In addition, the fact that this definition emerged from a conference organised by the NLNE probably explains why its nucleus was so much in accord with the outline of the course on 'Introduction to nursing arts' in the curriculum guide. This course was built around four types of related activities or problems (NLNE, 1937, p. 330-372):

- activities which have to do with the organisation and management of the patient's environment to secure for him maximum physical and mental comfort,
- activities concerned with the patient's immediate personal care,
- activities performed under the direction of and in cooperation with the physician,
- activities which have to do with family and community health services.

The origin of the JCICP-definition of comprehensive nursing (1953) can thus be traced back, via the NLNE-definition of nursing (1950) to the curriculum guide's concept of nursing (1937). Minor shades of differences in the wording apart, the major difference between the curriculum guide's concept of nursing and the NLNE-definition appears to lie in the addition of the supervisory and co-ordinating functions of the nurse. The same holds for the JCICP-definition but for the use of the designating adjective '*comprehensive*.' This conclusion is vindicated by the texts which preceded and followed the JCICP's description of comprehensive nursing:

- **preceding text**
  'Nursing has developed in complexity over the years to the point that its services include a range of activities which can be differentiated in such a way as to be performed by individuals who have varying degrees of preparation for their jobs. In organized institutions, such as hospitals, the professional nurse is responsible

for immediate nursing care of patients and for delegating to other workers activities which they can perform for specified patients.'

- **following text**
  'The volume of nursing which is required for modern medical and health service and the range of activities indicated above have introduced into nursing a large number of auxiliary workers, whose services are classified under "nursing personnel." It is obvious that the nursing needs of the country can be met only through an enlarging group of such personnel in proper ratio and relationship to professional nursing personnel.'

Between them, these citations show the hallmarks of a compromise between the Brown Report and the Murdock Report. Whereas, according to the former, the growing complexity or the qualitative change of nursing indicated the need for professional nursing care, the latter pointed to the increasing volume or the quantitative change in nursing as the reason for introducing a large number of auxiliary workers. That it was indeed a compromise is justified by the way the JCICP's statement on comprehensive nursing was concluded:

> *'Better care for patients will depend to a large extent upon nurses who can practice comprehensive nursing including effective supervision of auxiliary aides. This involves an organization for the management of work in patients' units to provide coordinated care, the professional nurse being responsible for such care with fullest utilization of the services of practical nurses, nursing aides, and volunteers.'*

Comprehensive nursing was thus understood to encompass not only nursing care of the whole patient, along lines similar to the concept of individualised nursing underlying the curriculum guide (case management) but also the supervision of auxiliary aides (team management). In fact, the acceptance of the latter function was regarded an essential condition for performing the former function which raised nursing to a professional level as opposed to the vocational level of mere bedside nursing.

The origin of the word 'comprehensive.' What remains to be seen next, is where the designating adjective '*comprehensive'* came from, or who coined this term. To trace its origin, it seems appropriate to follow the lead offered by the report of the JCICP.

The report of the JCICP was considered so important that the editor of the American Journal of Nursing devoted an editorial to it (AJN, 1953a, p. 289). In this editorial, she pointed to the parallelism between this report and 'Building America's health,' the report of the President's Commission on the Health Needs of the Nation. Amongst other things, these reports were said to have common ground in that both (AJN, 1953a, p. 289):

> *'... point to the fact that nursing has become more and more complex in recent years and that the comprehensive kind of care which is now needed calls for an understanding of both the physical and emotional aspects of illness and health.'*

Given the emphasis upon the '*understanding of both the physical and emotional aspects of illness and health*' as a necessary condition for the kind of care intended, it can be inferred that, if nursing care deserved to be designated as comprehensive, it had to be focused on: the emotional, as well as the physical aspects of health, as well as disease. In this context, it is worth recalling that, in 1947, the World Health Organisation had proclaimed health to entail the physical, social and mental well-being of the individual, and not just the absence of disease. And it is precisely this conception of health which came to the fore in the concept of total patient care in the early 1950s. In the 'Hospital Nursing Service Manual,' published by the AHA and the NLNE in 1950, for example, the following description was given (in: Roberts, 1954, p. 490):

> *'The modern concept of adequate patient care interprets that care in terms of total patient needs, whether these needs be diagnostic, preventive, or therapeutic, physical, psychological, spiritual, or social. It recognizes the patient as a person, with an individual personality and with individual needs, who has come from a recognized place within the family and the community and must be helped to make his*

adjustment to his condition and to his new environment. The ultimate objective of adequate patient care is to return the individual to his family and community restored to health and productive capacity. The broad, social concept of total patient needs has many implications for the nursing department, as to both its activities and the competence and attitude of its staff.'

From putting such high emphasis upon '*total patient needs*' it is only a small step towards holism, i.e. '*the philosophical concept in which an entity is seen as more than the sum of its parts*' (Springhouse, 1984, p. 457), or, better still, holistic health care, i.e. (Mosby, 1986, p. 538):

'... a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; the response to his illness; and the impact of the illness on the person's ability to meet self-care needs. Holistic nursing is the modern nursing practice that expresses this philosphy of care.'

The concept of nursing designated by the adjective '*comprehensive'* was thus closely connected with, or maybe even evolving from, the concept of total patient care which paralleled Brown's concept of nursing the total person. However, in 1948, the concept of total nursing seemed to give rise to some confusion, for in that year Chayer wrote the following comment (Chayer, 1948, p. 753):

'Another large area in need of clarification is the term so glibly used today, "total nursing care." To some it means a well-integrated plan of 24-hour service. To another it means teaching the patient and the family as a part of all nursing care. To some it means teamwork among various professional and auxiliary workers. To some it means a plan for care and rehabilitation from hospital to clinic and from the cradle to the grave. A monograph on Total Nursing Care - Its meaning and Application *is imminently needed.'*

However meaningful the identification of total and comprehensive nursing may be, it does not point to the origin of the adjective '*comprehensive*.' In fact, this question must remain unanswered here but for the following hunches. One other lead to trace its origin may be the concept of comprehensive medical care (Tauber, 1957), i.e. '*the provision of health services to meet all medical needs, preventive and therapeutic, for individuals seeking medical care'* (McGraw-Hill, 1979, p. 218). Yet another lead may be the technical use of the word in insurance policies providing '*comprehensive'* cover. Because health insurance schemes were a hot topic in postwar America, it may well be that the use of the adjective '*comprehensive'* originated from this context. All in all, it emphasises the lack of interest in the conceptual history of nursing in the United States that no one has ever bothered to find out the origin of the word '*comprehensive*.'

Summing up, the indications are that there is a more or less direct line of descent from the model of individualised nursing, via the model of comprehensive (or total) nursing, to the philosophy of holistic nursing (e.g. Blattner, 1981). Moreover, the ideas underlying the concept of total or comprehensive nursing care closely paralleled the ideas which prompted Brown's concept of nursing. It would, however, be incorrect to credit Brown herself for coining the name of this concept of nursing.

18.2. Patient-centred nursing

To grasp the significance of the publication of 'Patient-centered approaches to nursing' in 1960, it is necessary to place it in its historical perspective first. According to Abdellah, the ideas expressed in this book represented a new stage in the development of professional nursing. The three milestones in this development, which were said to parallel the developments in the field of medicine, were (Abdellah et al, 1960, p. 5):

- **the Goldmark Report**
  This report was published at a time when nursing was characterised by the emphasis upon '*physical aspects of nursing and medical care of hospital patients*,' and, as far as schools of nursing were concerned, it '*led to a shift of the focus of nursing practice away from a primary emphasis of physical aspects of nursing of*

patients in clinical units of hospitals, to the inclusion of the general nursing of patients and families in home and health agencies.'

- **the Brown Report**
  This report heralded the shift towards '*more comprehensive care of the "patient as a whole" including individual and social aspects of care of patients in homes and health agencies*.' As a result, it '*led to the extension of the concept of professional nursing practice to include comprehensive nursing (nursing of the whole patient) which helped the individual to get well and to keep well. Nursing education also was broadened to achieve this goal. Physical and social sciences were applied to the field of nursing which permitted some development of a body of systematized knowledge and less reliance on rule-of-thumb procedures.*'

- **'Patient-centered approaches to nursing'**
  This book was seen to signal the start of a new stage which was characterised by the emphasis on '*a broader scientific basis for professional practice*' and was characterised by '*a sharp shift from the empirical to a scientific basis*' of nursing.

In this historical perspective, it is contended here, the Goldmark Report and the Brown Report were used to show how nursing had overcome its being limited to its traditional hospital environment as well as its physical and curative aspects. Consequently, it was established that nursing entailed definitely more than the physical care of the sick in the hospital.

However significant the gains made as a result of these reports, these were considered not enough yet for the reason that, in 1960, the bulk of the nation's actively practising registered nurses were still products of an educational system in nursing which was '*procedure- and diagnostic-centered and geared to the service needs of hospitals rather than to patients' needs*' (Abdellah et al, 1960, p. 2). In addition, approximately 90 % of the nursing schools in the nation had not advanced noticeably beyond the first stage and were still preparing for 'the nursing of the physical needs of the sick in the hospital' (Abdellah et al, p. 6).

This was the situation which provided the impetus for writing 'Patient-centered approaches to nursing,' which, as the advertisement in the American Journal of Nursing put it, was '*a book that focuses attention on the nurse's first responsibility, her patient.*' By inference, the patient-centred approach geared to the patient's needs was contrasted with the disease and procedure approach geared to the service needs of hospitals. Because of this contrast, it seems appropriate to see upon what conception of the health services this supposedly new approach was based first.

18.2.1. Patient-centred health services

Abdellah's approach to nursing rested heavily upon the contrast existing between the purpose of the health services and the health services actually provided to the patient (Abdellah et al, p. 39):

> *'The hospital is thought to be a social institution with socially acceptable goals of meeting the health needs of the community and of those who become patients.' On paper, the hospital's purpose is to meet the patient's needs. In practice, hospital administration accepts its purpose to serve the doctor who in turn can meet the patient's needs. ... Nurses are caught up in this dilemma and gear their practice toward hospital efficiency. ... Patients' needs are submerged ...'*

As a result of this contrast, nurses faced five dilemmas which were related to the negative effects upon patient care of:

- hospital efficiency (e.g. the patient was submerged in a mechanical, unfeeling assembly line approach to patient care),
- ritualism (e.g. policies were continued beyond their period of usefulness),
- hospital hierachy (e.g. the nurse saw less of the patient to the degree that she moved upwards in the hospital hierarchy),

- nursing leadership (e.g. nursing competency was measured quantitatively rather than qualitatively),
- specialisation (e.g. according to clinical subdivisions rather than the ability to meet specific patients' needs).

The only way out of these dilemmas, according to Abdellah, was to return the nurse to the patient by addressing the question of how nurses could be utilised more effectively in terms of meeting patient needs? The answer to this question required not only a different conception of nursing but of the health services as well. Obviously, both should be based on the patients' needs and not the differentiation of the functions of nursing as advocated by Brown. As for Abdellah's conception of the health services, this requirement was fully met for, as far as the health services were concerned, patient-centred approaches to nursing rested upon the following assumptions:

- the changing hospital population,
- the hospital as community centre, and
- the trend of hospital and community services to be tailored to meet patients' needs.

More importantly, Abdellah's description of these assumptions revealed the differences between health services geared either to the service needs of the hospital, or to the needs of the patients.

The changing hospital population. Whereas the comprehensive approach to nursing emerged at a time when the importance of early ambulation was discovered, the patient-centred approach was influenced by the need for rehabilitation after a short period of hospitalisation. It also had to do with the quantitative shift of patients with acute diseases to those with chronic diseases which lead up to the following conclusion (Abdellah et al, 1960, p. 31):

> *'More than ever before there is a need to prepare nurses who are able to meet the total needs of patients. The nurse who is only proficient in technical skills can no longer be equated with a professional nurse.'*

In other words, patient-centred nursing should be distinguished from mere technical nursing.

The hospital as a community centre. Just like Brown, Abdellah envisaged the hospital as a community health centre from which hospital personnel and public health personnel jointly planned how the patient's needs could best be met. In contrast to Brown, however, Abdellah could substantiate her views by pointing to some of the practical results of a U.S. Public Health Service study on '*the organization of facilities, services, and staff around the medical and nursing needs of patients*,' which had started in 1957. The most significant result of this study, however, was the Progressive Patient Care programme (Abdellah et al, 1960, p. 32):

> *'A progressive patient care program can help to provide a higher level of patient care in a shorter period of time, utilize better the medical and nursing staffs, and provide a physical plant and supply system which can operate in the most efficient way. Five elements are usually associated with the concept of progressive patient care (PPC) - intensive care, intermediate care, self-care, long-term care, and the extension of hospital services through an organized home care program that is hospital-based.'*

What distinguished this programme from the traditional hospital service was that it was not the facility but the patients' needs which dictated the kind of care that the patient was to receive.

The trend of hospital and community services to be tailored to meet patients' needs. As a result of the PPC programme, patients were classified not by clinical subdivisions but according to their need for medical and nursing care (Abdellah et al, 1960, pp. 32-33): intensive care (critically ill patients), intermediate care (patients requiring a moderate amount of nursing care, not of an emergency nature, who are ambulatory for short periods, and who are beginning to participate in the planning of their own care), self-care (patients who are physically self-sufficient and require diagnostic and convalescent care in hotel-type accomodation), long-term care (patients requiring prolonged care), and home care (extension of hospital services into the home to assist the physician in the care of his patients and to reduce the need for hospitalisation).

18.2.2. The role of nursing

In Abdellah's opinion, the patients' needs were the alpha and omega of health care and nursing. Although Abdellah was not very orderly in the composition of her writing, her views of nursing can be shown to be dependent upon her conception of patient-centred health services. This is not, however, to say that her patient-centred approach to nursing resulted from a logical deduction from her conception of patient-centred health care, for the former was articulated some years before the latter (when Abdellah was researching methods of identifying covert aspects of nursing problems). This study was carried out in partial fulfillment of the requirements for the degree of doctor of Education at Teachers College and the results were published in Nursing Research (Abdellah, 1957).

Nursing. For a start, it is important to note the contrasts hinted at by Abdellah when she discussed the changing hospital population, viz. between the nurse's technical skill and her ability to meet the total needs of the patient. What these contrasts should be taken to mean was explained when Abdellah summed up the limitations of the disease and procedure approach to nursing, both in nursing practice and nursing education (Abdellah et al, 1960, p. 4):

> *'If we believe that nursing is caring for a patient with a diagnosis, giving treatments and medications, then nursing is perceived in a very narrow way, for this is only one phase of nursing. The technical competencies which every professional nurse must develop are an essential part of nursing but represent only the overt or visible aspects of nursing. The present quantitative measures of nursing competency are inadequate. Nursing education and clinical practice have not prepared nurses to accept the supportive and counseling role; nor do hospitals provide a setting in which this can be carried out. Realistic evaluation of the situation shows that nurses receive little or no preparation in the social and psychological sciences.'*

This summary exposed some of the distinctive differences between two opposing views of nursing. Nursing narrowly conceived was focused on the overt or visible aspects of nursing care and the quality of this type of care was measured by quantitative criteria like the number of minutes per shift spent with the patients or the ratio of professional nurses and practical nurses.

By inference, nursing broadly conceived was focused on the covert or invisible aspects of nursing care. The overt aspects were related to '*apparent'* conditions, and the covert aspects to '*concealed'* conditions, '*faced by the patient or family which the nurse can assist him or them to meet through the performance of her professional functions*' (Abdellah, 1957, p. 4). The quality of the latter type of care should be measured, also by inference, qualitatively, for example, by asking to what extent the nurse had met the needs of the patient.

In addition, nursing narrowly conceived was connected with the accessory type of nursing education which was characterised by its neglect of the supportive and counseling role of the nurse as well as the social and psychological sciences and, by inference, its over-emphasis on physical aspects and the physical sciences. Summing up, Abdellah contrasted her patient-centred approach with the disease and procedure approach:

disease and procedure approach	**patient-centred approach**
disease	health
treatments and medications	patient
overt needs	covert needs
quantitative evaluation	qualitative evaluation
technical competence	professional competence
physical aspects of nursing	supportive and counseling aspects of nursing
physical sciences	social and psychological sciences

The distinction between these opposing approaches to nursing came close to Brown's distinction between the physical care of the patient and nursing the whole patient. This contention is corroborated by Brown's views with regard to the measurement of the quality of nursing which were remarkably similar to those of Abdellah. Good nursing care, according to Brown, was not dependent upon whether or not therapeutic measures were

carried out as ordered but whether nursing care was individualised or not. And '*individualised'* nursing, she continued, should be taken to mean that (Brown, 1948, p. 83):

> *'it must include sensitivity to respond to and deal with the mental and emotional reactions which accompany physical aspects of illness; that it must help the patient to understand his illness, plan to regain his health, or adjust to his limitations.'*

Because Brown's criteria of good nursing care corresponded with Abdellah's criteria of patient-centred nursing, one might be inclined to conclude that the distinction between the physical care of the patient and comprehensive nursing more or less coincided with the distinction made by Abdellah, viz. between technical nursing and patient-centred nursing. However, in spite of the significant similarities noted here, there was one major difference. Brown distinguished the physical care of the patient from comprehensive nursing in order to arrive at a new division of labour within the nursing service. Abdellah, on the other hand, distinguished technical nursing from patient-centred nursing to differentiate the overt and covert needs of the patient, thereby drawing atention to the needs for a patient-centred approach to nursing care.

The needs of the patient. The second characteristic of the health services envisaged by Abdellah was that it was not the hospital facilities but the patients' needs which determined the kind of care that the patient was to receive. As for nursing, this characteristic called for study on the needs of the patients (Abdellah, 1955; Abdellah & Levine, 1957a). For the purposes of this study, an unfulfilled need of the patient was defined as '*an omission in nursing care reported by the patient*' (Abdellah & Levine, 1957a, p. 47). Detailed investigation of such omissions revealed the importance of the covert aspects of nursing (Abdellah et al, 1960, p. 36):

> *'Thus far, study of the patient has taught us that the activities which the nurse carries out and which are most important to him involve human relations skills. These are best carried out as she provides physical care for the patient.*
>
> *The patient has told us that he wants more professional nursing care, not identified by uniform but by what the nurse does for and with him. He tells us he wants to be treated like an individual. He wants explanation of his care. He wants to be considered as a partner in the planning of his care. When he expresses his insecurity by such things as food, having his light on frequently, complaints about what might seem trivial items, he wants us, as nurses, to understand that he needs help in progressing toward emotional maturity.*
>
> *Above all, patients want a nurse who can understand and be tolerant of their querulous behavior; they want their nurse to know about the human personality. What the patients want most of all is mothering that is a type of human relationship which combines skill with wisdom, compassion, and firmness.'*

Nursing care. Abdellah's third assumption regarding the health services was that they were increasingly tailored to the needs of the patients. As for nursing, this trend implied that nurses should be able to deal with both overt and covert nursing problems. This implied a patient-centred approach (rather than the traditionally technical approach) to nursing, which focused 'on the patient and his problem as the core of nursing (Abdellah et al, 1960, p. 13).

Just as the comprehensive approach to nursing raised nursing from the level of bedside nursing care to a professional level, the patient-centred approach stood for a professional kind of nursing as opposed to nursing of a technical type.

18.2.3. Abdellah's concept of nursing

Unlike Brown who never used the adjective '*comprehensive*,' or '*total'* to designate her concept of nursing, Abdellah frequently used the adjective '*patient-centered*' to denote her concept of nursing. In so doing, she stressed that she viewed nursing as '*a problem-solving process related to health*' (Abdellah et al, 1960, p. 13). However, it remains to be seen what concept of nursing it has given rise to, as well as where the adjective '*patient-centred*' came from.

Patient-centred nursing. The differentiation of the overt and covert needs of the patient, on the one hand, and the distinction between nursing of a technical and a patient-centred or professional type, on the other, indicated the need for a new concept of nursing. This concept, according to Abdellah, should not be based upon '*ritualistic notions of what nurses do*,' but upon the question '*Why do nurses do the things they do?*' (Abdellah et al, 1960, p. 51). The most concise description of what she meant by a concept of patient-centred nursing was (Abdellah et al, 1960, p. 52):

> *'Determining the patient's impairment, his self-help ability, and his needs become essential steps in making a nursing diagnosis of the patient's problems which is essential for developing a coordinated nursing care plan.The next steps involve determining the nursing functions and specific nursing activities required to solve the nursing problem and meet the patient's needs.'*

The thrust of this concept of nursing was that the functions of nursing and the specific nursing activities should be tailored to the patient's needs to the effect that nursing care was more or less pictured as a geometrical projection of the patient's needs. As for the patient, regardless his impairment, he was assumed to have certain personal needs, either primary or acquired, which he might be able to satisfy or not. Dependent upon his ability to do so, his requirements for nursing care were classified into four categories (Abdellah et al, 1960, pp. 57-60):

- sustenal care,
- remedial care,
- restorative care,
- preventive care.

As for the nurse, apart from meeting the patient's nursing requirements by means of sustenal care, remedial care, restorative care, and preventive care, she was expected to fulfill two other nursing functions as well (Abdellah et al, 1960, p. 60):

- **evaluation**
  'the process of gathering information about the patient, such as vital signs, physical examinations, diagnostic tests, and any other data that would be pertinent in planning the patient's nursing care requirements and measuring the effects of care.'

- **planning**
  'the process of analyzing the information gathered through the evaluation procedures and developing an appropriate course of action in accordance with the patient's needs.'

This concept of nursing provided the framework within which the nurse could deal with both the overt and covert needs of the patient. After the publication of 'Patient-centered approaches to nursing,' this concept of nursing was criticised for several reasons (Stevens, 1979, p. 148). First, by emphasising the needs or problems of the patient, Abdellah is said to have pictured the patient both as '*a whole*' and as '*a constellation of problems*.' Against this, it can be argued that she was well aware of this and even warned against the negative consequences of losing sight of the patient as a whole (Abdellah et al, 1960, p. 14):

> *'Some nurses tend to categorize patients' nursing problems and do not view the patient as a total person. This may result in the function of nursing becoming a "high-powered referral mechanism."*

Secondly, Abdellah has been criticised for not distinguishing patient problems (experienced by the patient) from nursing problems (experienced by the nurse), an error which she later recognised. This criticism, however, seems a bit far-fetched because, in most cases, the context leaves the reader in no doubt as to what was meant.

The origin of the word 'patient-centred'. Finally, it remains to be seen where the designating adjective '*patient-centred*' came from. This adjective had been in use to designate a specific type of nursing care long before Abdellah articulated her concept of nursing. Roberts, for example, pointed out that the major activities of

the national nursing organisations during the Second World War were characterised by (Roberts, 1954, pp. 399-400):

> *'An accelerated trend toward the development of creative nursing or patient-centered nursing, nursing on a professional level, with its connotation of broad social usefulness ...'*

In her opinion, patient-centred nursing amounted to Goodrich's notion of creative nursing coming to fruition. The creative period in nursing had begun when '*a few nursing schools began tapping the resources of institutions of higher education and started weaving the social and health aspects of nursing into the basic curriculum*' (Roberts, 1954, p. 395). According to Roberts' historical perspective, creative nursing offered a solution for the nursing profession which for so long had been caught between the following opposing positions, viz. service versus education, institutional service versus social service, and the trained nurse versus the professional nurse.

Undoubtedly, Goodrich's notion of creative nursing was at the source of the model of individualised nursing. However, due to the nursing shortage, both during and after the Second World War, it became increasingly difficult to put the ideal of individualised nursing into practice, notwithstanding the fact that several factors added to the importance of this model of nursing. The major factor was the emergence of psychosomatic medicine which stressed the interdependence of the emotional, mental, and spiritual life of patients with the manifestations of disease. The increase of degenerative diseases and the trend toward early ambulation, moreover, gave rise to a shift from meeting physical needs to health teaching, and from the bed bath to supervision of the patient. In short, the aim of nursing became to help patients live with chronic disabilities to their optimum usefulness. Consequently, the nursing care plan became a plan for future living rather than a plan for the nursing care provided in the hospital.

As a result, the nursing profession was confronted with yet another dilemma, viz. to either water down the model of individualised nursing care in order to solve the nursing shortage or hold on to it. The first option, it is contended here, was advocated by Brown because, in her view, the professional nurse could not meet the social and health needs of her patients, unless she accepted practical nurses to perform most of the functions related to bedside nursing care. The second option, on the other hand, was advocated by Abdellah who held the view that the activities involving human relations skills and performed by the nurse were best carried out as she provided physical care to the patient. In other words, the technical competence needed to meet the patient's overt needs was inseparable from the professional competence needed to meet his covert needs.

In the final analysis, it was this issue which made patient-centred nursing distinctively different from comprehensive nursing. Whereas the latter approach effectively moved the nurse away from the patient's bedside, the former was intended to have the opposite effect. Although both approaches stood for a concept of individualised nursing, the role attributed to the professional nurse was markedly different, mainly because comprehensive nursing was connected with Brown's differentiation of the functions of nursing (team management), whilst the patient-centred approach was linked it with Abdellah's differentiation of the patient's needs (case management).

Generally speaking, the literature on nursing in the 1950s suggests a gradual shift from the comprehensive to the patient-centred interpretation of individualised nursing in those years. Major factors in bringing about this shift, as will be shown in the next chapters, were the changing views regarding professional nursing and nursing education. Furthermore, because both approaches to nursing were apparently identical, the term comprehensive nursing came to be used to designate patient-centred nursing and vice versa, even by Abdellah herself. As a result, in most cases it is the context in which each term is used that indicates which of the two approaches was meant. This point can be illustrated by means of two almost identical definitions of patient-centred nursing (Table 16). Both definitions were articulated in 1950. One originated from the Joint Nursing Curriculum Conference, the other from the Work Conference on Regional Planning for Nursing and Nursing Education. The definition emerging from the latter conference represented the more advanced position as to patient-centred nursing because it stated that the function of nursing belonged to nurses and nursing was always and not primarily patient-centred, and because it claimed a position of leadership for nurses. Apart from that, any reference to the physician prescribing the total therapeutic plan was left out.

Joint Nursing Curriculum Conference (November, 1950)	Work Conference on Regional Planning for Nursing and Nursing Education (June, 1950)
	The group accepts the concept of health proposed by the World Health Organization as a state of physical, mental, and social well-being and not merely the absence of disease or infirmity. The function of nursing is defined by this group as the work properly and rightfully belonging to nurses in the discharge of their responsibilities in meeting the health needs of people.
Nursing is one of the services in a community for the care of the sick, the prevention of illness, and the promotion of health, which is carried on under medical carried authority. Its distinctive function is the close and INDIVIDUALIZED service to the patient which may vary with his state of health from one of dependence, in which the nurse performs for him what he cannot do for himself, through supportive and rehabilitative care, physical and emotional, to self-direction of his own health.	Nursing is one of the services in a community for the care of the sick, the prevention of illness, and the promotion of health, which is carried on under medical carried authority. Its distinctive function is the close and INDIVIDUALIZED service to the patient which may vary with his state of health from one of dependence, in which the nurse performs for him what he cannot do for himself, through supportive and rehabilitative care, physical and emotional, to self-direction of his own health.
Nursing is primarily PATIENT-CENTERED. It gives service directly, through treatment, general physical care, and health instruction to the patient and his family, and through the co-ordination of nursing with other community services essential to patient's needs.	Professional nursing is always PATIENT-CENTERED, either through service given directly, or instruction given to the patient and his family, or the co-ordination of services given to the patient or his family during the period of nursing care.
Nursing is based on the understanding of the total therapeutic plan prescribed by the physician and of the concepts of preventive medicine and community health. Essential to effective nursing is the nurse's ability to judge the physical, emotional, and intellectual state and capacity of the patient and his family, as well as her ability to improve practice through research.	It is based on understanding of the total therapeutic plan, the concept of preventive medicine and community health, and judgment of the physical, emotional, and intellectual states and capacities of the individual and his family.
The further purpose of nursing in society increasingly aware of the values of positive health, is to participate actively in community efforts to achieve the well-being of all the population.	Its further function, in a society increasingly aware of the values of positive health, is to participate actively, or to assume a position of leadership, in community efforts to achieve physical, mental and social well-being of all the population.

Table 16. Two interpretations of patient-centred nursing (NLNE, 1951; Columbia University, 1950).

Between them, these differences indicated two different interpretations of individualised nursing. In one interpretation, nursing was primarily and not always patient-centred, probably because of the nurse's other responsibilities such as administration, supervision and assisting the physician. In the other interpretation, however, the nurse was thought to have no other responsibility than the patient. It is, therefore, contended here that the former interpretation should, rather, be associated with Brown's concept of comprehensive nursing, whilst the latter foreshadowed Abdellah's concept of patient-centred nursing. Finally, these definitions also show that Abdellah was not the originator of the ideas connected with patient-centred nursing nor did she coin this adjective to designate her concept of nursing.

19.
TWO CONCEPTS OF PROFESSIONAL NURSING

In the previous chapter, comprehensive nursing and patient-centred nursing were both shown to amount to a new interpretation of individualised nursing. In fact, both interpretations were aimed at the reconciliation between nursing as an institutional service and nursing as a social service, the two opposing positions between which the nursing profession was caught for so long.

Both concepts of nursing focused attention on the whole patient or the patient as a person. There was, however, one important difference. In the comprehensive approach, bedside nursing care was effectively handed over to practical nurses, whilst in the patient-centred approach, the physical care of the patient remained an essential part of the professional nurse's work. These divergent views as to whether bedside nursing care or the physical care of the patient should be delegated to another group of nurses or not, are important to keep in mind when it comes to the concept of professional nursing which evolved from either interpretation of individualised nursing.

Further, both interpretations of individualised nursing had common ground in the fact that a definite concept of professional nursing was implied. These concepts served to distinguish professional nursing from practical nursing. For this reason, it became imperative to answer the question 'What are the distinguishing characteristics of professional nursing?' The purpose of this chapter is to analyse and compare the answers given to this question within the framework of the models of comprehensive nursing and patient-centred nursing.

19.1. Comprehensive nursing

The big challenge presented by the Brown Report centred on the identification of nursing and nursing functions in order to arrive at a profile of the professional nurse, a description of the functions of the professional nurse, as well as a new division of labour between the professional nurse, the practical nurse and the auxiliary worker (according to the nursing functions identified).

19.1.1. The professional nurse

The Brown Report contained no definition of professional nursing, except for the one set down by Sister M. Olivia of the Catholic University of America. This is most significant, if only because of the report's insistence that emphasis should be '*placed squarely on nursing and nursing functions conceived of in their evolutionary and dynamic, not static, aspects*' (Brown, 1948, p. 57). However, most of the pages dealing with nursing on a professional level were taken up with a detailed description of the role of the professional nurse (Brown, 1948, pp. 73-101). This contradictory state of affairs can be explained by the fact that this description was needed to substantiate the need for nurses prepared on a professional level more than anything else (see chapter 4).

Professional versus technical competence. Outlining the future role of the professional nurse, Brown quoted some of the paragraphs of the workshop memorandum (Brown, 1948, pp. 73-74):

> *'... the professional nurse will be one who recognizes and understands the fundamental [health] needs of a person, sick or well, and who knows how these needs can best be met. She will possess a body of scientific nursing knowledge which is based upon and keeps pace with general scientific advancement, and she will be able to apply this knowledge in meeting the nursing needs of a person and a community. She must possess that kind of discriminative judgment which will enable her to recognize those activities which fall within the area of professional nursing and those activities which have been identified with the fields of other professional or nonprofessional groups.*
>
> *She must be able to exert leadership in at least four different ways (1) in making her unique contribution to the preventive and remedial aspects of illness; (2) in improving the nursing skills already in existence and developing new nursing skills; (3) in teaching and supervising other nurses and auxiliary*

workers; and (4) in cooperating with other professions in planning for positive health on community, state, national, and international levels.

To understand the characteristics and aptitudes which are needed by the effective professional nurse, it is necessary to visualize her in action against the backdrop of a rapidly changing and increasingly complicated civilization. In past eras nurses, like other groups, have often been expected to fit into traditional niches in a relatively static situation. In that kind of society the nurse might fill her place satisfactorily if she were a passive, obedient, and unquestioning individual. In a rapidly changing world the nurse's activity will require that she be alert and self- directing. The professional nurse must be able to evaluate behavior and situations readily, and to function intelligently and quickly in response to their variations. She must recognize physical symptoms of illness which are commonly identified with organic changes. She must also recognize those heretofore less considered manifestations of illness such as anxieties, conflicts, and frustrations, which have a direct influence on organic changes and are now thought to be the result of an incompatible interaction between a person and his environment.

Nurses in their longer contacts with individuals have more opportunities to observe behavior and to listen to expressions of thought under varying conditions than do physicians whose contacts are necessarily intermittent and brief. For this reason the nurse must be able to direct her actions and her verbal expressions on the basis of a sound understanding of human behavior and human relationships. If the nurse does not have this quality of understanding and cannot use it to deal effectively with persons, she may contribute to illness or counteract the efforts of other professional workers.'

This statement, in combination with Sister M. Olivia's definition of nursing, served to show that technical competence was just one of the components of professional nursing. What professional competence offered in excess of mere technical competence was (Brown, 1948, p. 75):

- discriminative judgment, alert self-direction, and skill in directing word and action on the basis of an understanding of human behaviour and human relationships (as suggested by the workshop memorandum),
- the ability to minister to spiritual health and the spiritual environment (as implied by Sister Olivia's definition).

Not surprisingly, this distinction very much resembled the curriculum guide's distinction between nursing conceived narrowly and nursing conceived broadly.

Professional competence. The main reason for emphasising the professional components of nursing mentioned above was that (Brown, 1948, p. 75):

'it is these very plus values, under whatever names given them, that leaders of the nursing profession since the days of Florence Nightingale have held truly essential. It is these values that raise nursing from the level of a craft to that of a profession; that distinguish the professional nurse from the person whose almost exclusive preoccupation is with the prescribed physical care of a sick person.'

Brown, admittedly, must be credited for calling attention to precisely these components of nursing, as they reflected the art or spirit of nursing which was in danger of being sacrificed under the pressure of the nursing shortage. In this respect, she was definitely more in touch with the concerns of the rank and file nurse than the committees which produced the Ginzberg Report and the Murdock Report. Apart from that, Brown held the opinion that nursing had moved far enough in the direction of meeting the Flexner criteria of a profession to be considered as a profession in its own right, or at least, as an evolving profession.

However, instead of elaborating on the professional nature of nursing, Brown went on to identify being a professional nurse with being a graduate from a professional school of nursing. In other words, the recognition of the professional status of the nurse did not so much depend upon the quality of nursing care given by her as her education for professional nursing practice. For this reason, the professional competence needed for the kind of nursing envisaged in the Brown Report was not elaborated on any further than to make just this point, i.e. that professional nurses should be educated in '*schools that are able to furnish professional education as that term has come to be understood by educators*' (Brown, 1948, p. 77).

This goes, incidentally, a long way to show to what extent the Brown Report should be seen as a deliberate attempt to emulate the famous Flexner Report, for, by taking the step toward professional education, '*notice would be served to a now dissatisfied public that nursing was really attempting to set its house in order; that it was seeking to profit from the experience of older professional groups; that it was striving to create a plan that would attract women with the ability, education, and interest necessary to serve the more complex needs of people, whether sick or well*' (Brown, 1948, p. 78). Allowing for the obvious differences, this was precisely what the Flexner Report had achieved for the medical profession and what it was hoped the Brown Report would do for the nursing profession.

19.1.2. The functions of the professional nurse

So far, it has become clear that the professional nurse (as envisaged in the Brown Report), more than anything else, was a nurse graduated from a professional school of nursing. This preoccupation with the educational requirements for professional nursing practice was typical of the report as whole. Not surprisingly, the analysis of the functions to be assigned to the professional nurse of the future, too, was aimed at substantiating the need for professional nursing education. Outlining these functions, Brown discerned the functions of the professional nurse in clinical practice and the nursing specialities.

Clinical practice. The functions of the professional nurse in clinical practice were subdivided in two groups (Brown, 1948, p. 78):

> *'One is the role of physician's assistant in carrying out technical procedures and treatments generally considered too complex or too dangerous to be entrusted to assistant personnel or to graduate nurses with only limited clinical training. The other is responsibility for critical observation of the patient, care of him sometimes for long periods without specific directions from the physician, and decision as to what should be reported, and when, to the doctor concerning the patient's condition.'*

In the former role, the nurse acted as a '*skilled technician*,' whilst in the latter one, she acted as '*minister to the healing art*.' Significantly, these functions of the nurse were listed in the very same sequence as in the curriculum guide, thereby suggesting that the priority given to the dependent functions of the nurse was higher than that given to her independent functions. This was done in spite of the following statements having been approved at one of the three regional conferences devoted to the School Study (National Nursing Council, 1948, p. 16):

> *'We believe that the* unique function of the nurse is a personal service *to the individual in relation to promotion of health and recovery from illness, which involves analyzing and supplying those aspects of personal care which the person cannot provide for himself. His inability to do this may be due to lack of strength, will, or knowledge. The nurse also* assists the patient *to carry out the program of therapy as prescribed by the physician and to interpret his condition to the physician.'*
>
> *'This function, as defined, implies a* complex service of a professional nature *regardless of the patient's condition, because it requires a deep understanding of human nature.'*

Both statements met with the approval of the conference (yes: 136; no: 22; undecided: 25; and yes: 157; no: 13; undecided: 25). More importantly, in the first of these statements the independent functions of the nurse came before her dependent functions. Apart from that, it also foreshadowed the definition of nursing to be articulated some years later by Henderson who attended this conference (see Henderson, 1966, pp. 13-14).

With regard to the priority given to the dependent functions of the professional nurse, the position taken in the Brown Report thus drew heavily on the long-standing tradition of loyalty to the doctor as the first principle of nursing ethics. Although distinguishing the dependent and independent functions of the nurse and advocating a proper balance between them, the Brown Report at times seemed to suggest that the independent functions were in fact more or less dependent functions too (Brown, 1948, p. 84):

> *'Like the physician, she [the nurse] needs proficiency in recognizing the many symptoms of illness and in carrying out complex technical procedures. Much more, however, she needs proficiency in acting as the doctor's ally and colleague in the healing art and in helping patients toward a more positive approach to health.'*

This interpretation of Brown's position is vindicated by the way she presented health teaching as an area of practice contested by doctors, dentists, social workers, health educators and nurses alike. It was, however, because other professional groups - except for the health educators - failed to pay sufficient attention to this part of their work that Brown was in a position to urge the nursing profession '*to decide whether it wishes to have and maintain supremacy in health teaching - a field with almost limitless potentialities for increasing the public welfare*' (Brown, 1947, p. 822).

This line of reasoning was not uncommon at the time when it came to the question of what the proper job of the professional nurse was, and what it was not. When Koos (1947), for example, urged nurses to develop methods for providing personalised health care, it was because advances in medical technology had given rise to impersonalised medical care. As a result, the patient, and therefore society, was left in an unenviable position, namely that of needing personalised care which was unobtainable. This need, Koos argued, could best be met by those '*who deal most directly and most frequently with the sick - the nurses*,' if only because of the shortage of psychiatrists and medical social workers. This solution would not work, however, as long as nurses were taught '*to think of the patient as one who gets specialized treatment, and not of the patient as an individual*,' and unless the nurse became less of '*a nursing automaton*' and more of '*a skilled interpreter of human relations*' (Koos, 1947, p. 307).

A second example is the concept of total nursing care as conceived by Gelinas, which was prompted by the doctors' lack of time for their patients (1949b, p. 307):

> *'Confused by the different levels of nursing, they [the doctors] are asking who shall be responsible for* total nursing care. *Rightly they are urging the profession to prepare more nurses who are skilled in observing, reporting, and nursing patients. They are asking why they cannot have more competent professional nurses on whom they can depend to function as their representatives in their absence - to see that the patients are understood and treated with consideration, bathed and fed, given medications, treatments, and tests as ordered, instructed appropriately regarding their convalescence and homecare, and placed in a safe and comfortable environment.'*

What these examples add up to is the ambiguous nature of the pressures exerted upon the nursing profession at the time. True, the nurse was said to provide a professional service to the patient and the community. But what was given to her by the one hand, i.e. the recognition of her professional status, was taken away by the other for, at the end of the day, the nurse was still seen as the person who took up the slack. This ambiguity speaks volumes about the general confusion about the status of nursing in society at the time.

It seems likely that Brown herself was not too concerned about the use of these double standards as long as she managed to bring home the message that the functions of the professional nurse in clinical practice required education on a professional level. The nurse's educational preparation should be such that she learned to carry out complex technical procedures and possessed the scientific knowledge and judgement to act as a skilled technician in complex clinical nursing situations (Brown, 1948, p. 81). To be able to act as a minister of the healing arts, on the other hand, required that the nurse was '*sensitized to human beings who are sick*' and attempted '*to understand them by learning to put herself in their place*;' having developed something of this sensitivity and understanding the nurse also had to '*have time at her disposal for establishing a nurse-patient relationship*' (Brown, 1948, p. 84).

Nursing specialities. The second large area in which the services of professional nurses were held to be indispensable was that of the nursing specialities. At the time, this was taken to mean positions in supervision, administration, teaching, consultation, planning and promotion of professional activities, and public health nursing at least above first level positions. In addition, Brown made a plea for more specialists in clinical nursing who were working at the bedside of the patient rather than being moved away from it (Brown, 1948, p. 95):

'Provision for the development of some specialists within clinical nursing has been viewed in this report as necessary if the base on which nursing service rests is to be strengthened, and if the profession is to look forward to a sound, healthy development.'

Such development was expected to increase the number of nurses who, for example, were able to work cooperatively with other professional workers in the health services. The preparation for this type of specialisation should take place in advanced courses at universities and colleges (see also McManus, 1954).

19.1.3. The division of labour according to function

Brown's forecasts with regard to the functions of the professional nurse were aimed at substantiating the need for nursing education on a professional level, and, given her educationally-inspired profile of the professional nurse, this was quite understandable. However, as far as the practice of nursing was concerned, these forecasts also indicated the need for a new division of labour, or, as Koos put it in his review of the Brown Report (Allen et al, 1948, pp. 737-738):

'If the theme of Dr. Brown's report were to be condensed into one short phrase it might well be: Wanted, a redivision of labor in nursing. ...

The book calls - by inference, at least - for a mutual approach by the physician, the hospital administrator, and the nursing profession to the question of what tasks are best delegated - rationally, not through expedience - to the "professional" nurse in the providing of health care; and for working out a reasoned division of labor between the "professional" nurse, and the other (auxiliary) members of the nursing team. This will not be an easy task to accomplish, but it is a necessary task if society is to have the best of health care at a cost which it can afford. ...

If nurses and all others who are concerned with bettering health care will read this book with the recognition that society's health is fundamentally at stake and that personal status is secondary to social need, they will find in it a not unreasonable blue print for solving one of the pressing problems of health care.'

This summary of the Brown Report hit the nail on the head, because it pinpointed one of the major problems of the years to come, namely the role of the professional nurse. Also, it urged nurses to subordinate their desire for professional status to the needs of society, i.e to subordinate individualised nursing care (case management) to the supervision and training of practical nurses (team management), thereby demonstrating once again the ambiguous pressures exerted upon the nursing profession at the time.

The team approach. In the wake of the publication of the Brown Report, nurses began to look for new methods to be used in the administration of nursing services. This trend was reflected in the increasing number of articles in the American Journal of Nursing devoted to the team approach. Generally speaking, nurses were quick to act upon the idea of applying the team approach to the provision of nursing care. The flavour of their initial endeavours was given by Phillips' portrayal of the role of the professional nurse in the team approach. To begin with, she expected the professional nurse to act on behalf of the physician who would say (Phillips, 1949, p. 504):

'Here, be a good scout, take over this and this responsibility. I will show you how and I will be there to turn to, should you need help. We'll work on this together.'

The professional nurse would subsequently turn to the practical nurse to delegate some of her own workload by saying (Phillips, 1949, p. 504):

'Here, be a good scout, take over this and this responsibility. I will show you how and I will be there to turn to, should you need help. We'll work on this together.'

A similar attitude came to the fore in discussions at the Joint Nursing Curriculum Conference. This description of the team approach was interesting because it was formulated only months after McManus's statement on the role of the professional nurse (Table 17).

Joint Nursing Curriculum Conference (November, 1950)	**Work Conference on Regional Planning for Nursing andNursing Education (June, 1950)**
In the health and the medical care of people the unique responsibility of the physician recognized by law is to identify the medical problem, diagnose, and plan and prescribe treatment. The physician may carry out some of the treatment, and the ultimate responsibility for it remains his. The pattern is well established whereby he delegates responsibility for some of the treatment to members of related professions, such as nurses, dieticians, physical therapists, on the assumption that they are capable of carrying out the treatment effectively and safely. Such a group may be considered the therapeutic team, of which the physician is the chief and the members are individuals for their appropriate functions.	The function of the nurse is conceived to parallel somewhat that of the professional physician. This unique responsibility of the physician recognized by law is to identify the medical problem, diagnose, and plan and prescribe treatment. Although the physician carries out some of the treatment and the ultimate responsibility for it all remains his, he may delegate responsibility for some of the treatment to members of related professions, such as nurses, dieticians, physical therapists, or he may delegate responsibility even to the patient and his family, provided he is confident that they are capable of carrying out the treatment effectively and with safety.
Likewise, nursing has developed in complexity to the extent that certain activities are performed by individuals who may be members of the family, or auxiliary aides with varying degrees of preparation. If a professional nurse is involved in the care of the patient, she becomes responsible for total coordinated nursing care, including delegation to others of activities which may safely be performed by them. This group may be considered the nursing team, and the physician and the public may expect from the professional nurse the understanding and self-direction sufficient to manage such a team effectively, in the interest of safe and economical patient care.	Similarly the unique functions of the professional nurse may be conceived to be: 1. The recognition or diagnosis of the *nursing* problem and the recognition of its many interrelated aspects. 2. The deciding upon a course of action to be followed for the solution of the problem, in the light of immediate and long-term objectives of nursing, with regard to prevention of illness, direct care, rehabilitation, and promotion of the highest standard of health possible for the individual. 3. The development with the assistance of other members of the nursing and health team, both intraprofessional and interprofessional, of a satisfying plan of nursing care, including therapeutic, preventive, and rehabilitative measures, and treatment for which the physician had delegated responsibility to the nurse. 4. The continued direction of the program of nursing toward its optimum accomplishment, with adjustments in the plan as the nature of the problem changes, and the performance of those aspects which demand expert skill and judgment. 5. The progressive evaluation of the process and the results of nursing for the continuous improvement of the care of the patient and the practices of nursing.

Table 17. Two views on the role of the professional nurse (NLNE, 1951; Columbia University, 1950)

The role of the professional nurse. As a result of the division of labour outlined above, the professional nurse had to perform two roles simultaneously, one as a member of the health team, the other as the leader of the nursing team. This division of labour was based upon the assumption that the range of activities in nursing was so wide as to make the utilisation of services of persons with varying degrees of abilities and preparation imperative.

Apart from that, such functional organisation of the nursing team, it was argued, should prove more economical and would afford each worker the opportunity of performing, for the major portion of her time, functions which utilised her most highly developed skills. These nursing activities were subdivided into three major categories for which groups of workers should be prepared:

- the total range of nursing activities,
- technical nursing activities,
- institutional or homemaking activities.

Other considerations were the increased interest in the theory and practice of group dynamics, the growing influence of the human relations movement in hospital administration (AJN, 1950e), and the general trend towards cooperative relationships among the professions in the postwar period.

Between them, these factors were conducive to over-emphasising the responsibility of the team whilst neglecting the development of the independent role of the professional nurse. This consequence is corroborated by the fact that the responsibility for the total range of nursing activities was laid on the shoulders of the team rather than the professional nurse. These activities were (NLNE, 1951, p. 23):

1. *Interpretation of the medical care plan.*
2. *Identification of the nursing aspects - in the family, in the home, and at work - in order to determine the course of nursing action.*
3. *Formulation of the plan for nursing care with members of the nursing team.*
4. *Administration, supervision, and execution of the plan either directly or through delegation.*
5. *Coordination or assistance in the coordination of the activities of the personnel involved in the medical care plan.*
6. *Participation in educational programs for allied professional workers and community groups.*
7. *Development, implementation, and evaluation of educational programs for nurses.*
8. *Improvement of nursing through continuous evaluational research.*
9. *Participation in the broad plan for social betterment as a member of a profession and as a citizen.*

In spite of the professional nurse's responsibility for the supervision, coordination and training of the team members, it was thus the team as a whole which was responsible for the total range of nursing activities. The professional nurse only had to see to it that the patient was nursed. The concept of professional nursing underlying the model of comprehensive nursing was thus conducive to a division of labour according to the different functions of the team members.

19.2. Patient-centred nursing

To grasp the significance of the concept of professional nursing underlying the model of patient-centred nursing care, it is important to recall Brown's recommendation that the emphasis should be placed squarely on nursing and nursing functions as this is precisely what Abdellah did, albeit with results which differed markedly from those of Brown. As shown earlier, both Brown's and Abdellah's concepts of nursing amounted to a new interpretation of individualised insofar as, in both cases, great emphasis was put upon nursing the whole patient. But, whereas the former concept served to differentiate between the functions of the practical nurse and the professional nurse, the purpose of the latter interpretation was to highlight the distinction between the overt and covert needs of the patient. As a result, Abdellah was much more articulate when it came to the identification of the characteristics of professional nursing, the principles underlying professional nursing practice, and professional nursing practice itself.

19.2.1. Professional nursing

Because of the '*absence of sufficient consensus in the profession regarding nomenclature and definition for the activities performed by professional nurses*,' Abdellah felt it necessary to articulate a definition of nursing first (Abdellah et al, 1960, pp. 24-25):

> *'Nursing is a service to individuals and to families; therefore, to society. It is based upon an art and science which mold the attitudes, intellectual competencies, and technical skills of the individual nurse into the desire and ability to help people, sick or well, cope with their health needs, and may be carried out under general or specific medical direction.*
>
> *This service may involve: (1) recognizing the nursing problems of the patient; (2) deciding the appropriate courses of action to take in terms of relevant nursing principles; (3) providing continuous care of the individual's total health needs; (4) providing continuous care to relieve pain and discomfort and provide immediate security for the individual; (5) adjusting the total nursing care plan to meet the patient's individual needs; (6) helping the individual to become more self-directing in attaining or maintaining a healthy state of mind and body; (7) instructing nursing personnel and family to help the individual do for himself that which he can within his limitations; (8) helping the individual to adjust to his limitations and emotional problems; (9) working with allied health professions in planning for optimum health on local, state, national, and international levels; (10) carrying out continuous evaluation and research to improve nursing techniques and to develop new techniques to meet the health needs of people.'*

What Abdellah wanted to express by means of this definition, more than anything else, was that nursing should be placed within the technologies as opposed to the sciences. This distinction was at the core of her concept of professional nursing.

Technology versus science. When Abdellah outlined the characteristics of professional nursing, she articulated her views by distinguishing technology from science. Technology, as she understood it, was a common denominator for 'all disciplines that aim to achieve controlled changes in natural relationships via relatively standardized procedures that are scientifically based,' as opposed to science which was aimed at 'the accurate description of the physical or social world' (Abdellah et al, 1960, p. 25). In the case of nursing, this distinction meant three things.

First, professional nursing was not to be regarded as a science because nursing's aims definitely went further than the discovery of a body of knowledge. If not, professional nursing would be tantamount to what Dickoff and James later called '*thought without action*.'

Secondly, professional nursing was not to be identified with the relatively standardised procedures on the basis of rules-of-thumb which were so typical of the traditional disease and procedure approach to nursing. Otherwise, professional nursing would, so to speak, add up to '*action without thought*.'

Thirdly, what Abdellah was really after was the resolution of this conflict between '*thought without action*' and '*action without thought*' by regarding professional nursing as a technology, i.e. '*action guided by thought*,' or as she herself put it (Abdellah et al, 1960, p. 25):

> *'Thus, while professional nursing is based upon a body of knowledge drawn from the related sciences, the practice of nursing consists of principles of control.'*

This interpretation of the position taken by Abdellah is borne out by her view of the nurse as a practitioner whom she regarded as a person who '*by virtue of his technical knowledge and community-sanctioned status possesses a form of power which he exercises to reach certain ends*' (Abdellah et al, 1960, p. 25).

Furthermore, the idea of knowledge used in order to reach certain ends was at the core of Abdellah's views regarding a professional service as opposed to a technical practice. This came to the fore in the definitions of a profession quoted by her (Abdellah et al, 1960, pp. 20-21) such as, for example, Shepard's summary of Plato's definition:

'... the occupation, if not purely commercial, mechanical, agricultural, or the like, to which one devoted himself, a calling in which one professes to have acquired some special knowledge used by way either of instructing, guiding, or advising others, or of servicing them in some art.'

Technology or the principles of control. The distinction between technology and science thus served to highlight that attribute of a profession for which Abdellah considered nursing to qualify the least, viz. '*a scientific body of knowledge that is truly nursing*' (Abdellah et al, 1960, p. 22). This body of knowledge, moreover, should not be taken to mean the scientific principles derived from the various sciences but the principles of control which constituted the unique body of knowledge underlying professional nursing practice.

Whereas, according to Brown, nurses could not claim professional status unless they secured professional competence by means of professional education, Abdellah held the opinion that nursing stood little chance of being fully recognized as a profession for lack of precisely this body of knowledge. This goes a long way to explain why Abdellah's concept of professional nursing centred on the principles of control underlying professional nursing practice, whilst that of Brown focused upon the professional competence of the nurse.

19.2.2. The principles underlying professional nursing practice

According to Abdellah, professional nursing practice thus rested upon certain principles of control which, although based upon scientific principles derived from the physical, biological, and social sciences, represented a unique body of knowledge that is nursing. By means of these principles of control, it could moreover be demonstrated that professional nursing practice, although consisting of relatively standardised procedures, should be based upon scientific principles. In fact, these principles of control were precisely what 'Patient-centered approaches to nursing' was all about (Abdellah et al, 1960, p. vii):

'The purpose of this book is to provide a basis upon which patient-centered approaches to nursing can be utilized by the nurse educator, the nurse practitioner, and the hospital administrator. The basis for the development of a scientific body of knowledge in nursing that is uniquely nursing is presented with the view that it will help to foster additional research and stimulate others to pioneer in this area. It is only by our combined scientific and professional efforts that nursing can become patient-centered.'

These remarks deliberately exposed the fact that the principles of nursing practice were susceptible to two different interpretations. On the one hand, they were presented as an existing body of knowledge ready to be used in the practice of nursing. On the other hand, it was suggested that these principles were yet to be discovered by means of research. In other words, Abdellah offered two methodologies to the reader, one was the operational method, the other the problematic method (Stevens, 1979, p. 149).

Because Abdellah and her associates intended to offer a method of converting the scientific principles derived from various sciences into the principles of control constituting professional nursing practice, they, understandably, have written their book in the former rather than the latter mode. This is borne out by the fact that they presented their typologies of nursing problems and nursing treatments as the last word on the subject. In fact, Abdellah and her associates were well aware that the typologies in this form were still far from final but represented, so to speak, the state of the art at the time rather than a once and for all given delineation of the domain of nursing.

The unique body of knowledge that is nursing. Abdellah referred to three studies which were instrumental in the identification of what she considered to be the unique body of knowledge that is nursing. The first study, carried out by the Division of Nursing Resources of the U.S. Public Health Service in 1953, was aimed at developing a typology of common nursing problems presented by patients and of the nursing treatments needed to solve these problems.

But, Abdellah argued, unless nurses were able to identify the problems presented by the patients, such typologies were meaningless. This gave rise to the second study carried out during 1953-1955 which was aimed at developing methods of identifying overt and covert nursing problems. An important part of this second study

was concerned with the steps used by nurses in identifying nursing problems presented by the patients, and resulted in the following description (Abdellah et al, 1960, pp. 13-14):

1. learn to know the patient,
2. sort out relevant and significant data,
3. make generalisations about available data in relation to similar nursing problems presented by other patients,
4. identify the therapeutic plan,
5. test generalisations with the patient and make additional generalisations,
6. validate the patient's conclusions about his nursing problems with your own, and indicate what generalisations are relevant and significant today,
7. continue to observe and evaluate the patient over a period of time to identify any attitudes and clues affecting his behavior,
8. explore the patient's and family's reaction to the therapeutic plan ad involvement of them in the plan,
9. identify how 'I' (the nurse) feel about this patient's nursing problems,
10. discuss and develop an over-all nursing care plan.

The third study was carried out by Abdellah and her associates in co-operation with the National League for Nursing from 1955 to 1958. This study led to the refinement and compression of the earlier classification of nursing problems to 21 groups of common nursing problems (Abdellah et al, 1960, pp. 16-17):

1. to maintain good hygiene and physical comfort,
2. to promote optimal activity; exercise, rest, and sleep,
3. to promote safety through the prevention of accident, injury, or other trauma and through the prevention of the spread of infection,
4. to maintain good body mechanics and prevent and correct deformities,
5. to facilitate the maintenance of a supply of oxygen to all body cells,
6. to facilitate the maintenance of nutrition to all body cells,
7. to facilitate the maintenance of elimination,
8. to facilitate the maintenance of fluid and electrolyte balance,
9. to recognize the physiological responses of the body to disease conditions - pathological, physiological, and compensatory,
10. to facilitate the maintenance of regulatory mechanism and functions,
11. to facilitate the maintenance of sensory function,
12. to identify and accept positive and negative expressions, feelings, and reactions,
13. to identify and accept the interrelatedness of emotions and organic illness,
14. to facilitate the maintenance of effective verbal and nonverbal communication,
15. to promote the development of productive interpersonal relationships,
16. to facilitate progress toward achievement of personal spiritual goals,
17. to create and/or maintain a therapeutic environment,
18. to facilitate awarenesss of self as an individual with varying physical, emotional, and developmental needs,
19. to accept the optimum possible goals in the light of limitations, physical and emotional,
20. to use community resources as an aid in resolving problems arising from illness,
21. to understand the role of social problems as influencing factors in the cause of illness.

In addition, a list of nursing skills was developed from which the following typology of nursing treatments evolved (Abellah et al, 1960, pp. 17-18):

1. observation of health status,
2. skills of communication,
3. application of knowledge,
4. teaching of patients and families,

5. planning and organisation of work,
6. use of resource material,
7. use of personnel resources,
8. problem-solving,
9. direction of work of others,
10. therapeutic use of self,
11. nursing procedures.

Finally, whereas Brown's description of the functions of the professional nurse served to substantiate the need for professional competence, Abdellah's description of the principles underlying professional nursing practice was aimed at identifying what nursing was, and what it was not, or as she herself put it (Abdellah et al, 1960, pp. 11-12):

> *'The assumption is made by the authors that the descriptions of the nursing problem and nursing treatment typologies are the principles of nursing practice and constitute the unique body of knowledge that is nursing.'*

19.2.3. Professional nursing practice

Granted that professional nursing practice should be based upon the typologies described above, Abdellah put the independent functions of the nurse before her dependent functions. In this respect, too, her position was in contrast with that of Brown. The major impetus for taking this position was undoubtedly McManus's statement on the role of the professional nurse (see table 18). Although apparently similar to the text formulated at the Joint Curriculum Conference, taking place some months later, the role attributed to the professional nurse was definitely different in that McManus put such great emphasis upon the independent functions of the professional nurse.

Another reason for stressing the independent functions of the nurse was Lesnik's differentiation between the independent and dependent functions of the nurse (Lesnik, 1953), which added new weight to McManus's statement because just one out of the seven functions mentioned by Lesnik was seen as a dependent function of the nurse. To make her point, Abdellah especially singled out one of the independent functions mentioned by Lesnik (Abdellah et al, 1960, p. 9):

> *'The second independent legal function is observation of symptoms and reactions including the limited responsibility of diagnosis without the right to prescribe treatment or medication, and limited by the individual nurse's background, training and experience.'*

Making a nursing diagnosis, i.e. the '*determination of the nature and extent of nursing problems presented by individual patients or families receiving nursing care*,' was thus considered an independent function of the professional nurse. The word '*function'* as it was used here should be taken to mean '*a group of nursing activities so related to each other that each activity contributes to the solution of the same nursing problem*' (Abdellah et al, 1960, pp. 9-10).

This, incidentally, shows to what extent Abdellah differentiated the functions of nursing according to the problems presented by the patient, rather than the activities to be performed by the members of the nursing team. Accordingly, designating adjectives like 'personalised' and 'total,' when used in relation to nursing, were given a new meaning in that they were linked with the needs of the patient rather than the functions of the nurse.

In the case of personalised nursing care, for example, Abdellah not only stressed the importance of the covert needs as opposed to the overt needs of the patient, but also quoted Leone saying (Abdellah et al, 1960, p. 8):

> *'[personalised nursing] means planning the day in terms of the therapeutic program and personal needs of each patient from his point of view. It means that at the end of each day a patient should be able to think back over what has happened to him and see it as a whole, a flow of integrated activities. ... the extent to which the nurse's idea of wholeness and the patient's idea of wholeness coincide or are identical would constitute one of the measures of effectiveness of nursing care.'*

A similar contrast was at the source of the meaning given to the concept of total nursing care. In Abdellah's view, a patient-centred approach to nursing demanded a new look at the methods of supervising nursing care on two counts. First, specialisation of supervisors, head nurses, or team leaders by type of service (medical, surgical, etc.) was no longer thought adequate. Instead, nurses should be given the opportunity to plan for total nursing care of the patient as opposed to medical nursing care or surgical nursing care. Secondly, the basic principles of supervision, management of the nursing unit, and concept of team leader remaining the same as before, nursing supervisors, head nurses, and team leaders were expected to work more closely together in planning for total patient care with emphasis upon the coordination as well as the continuity of care. So, in the case of total nursing care, too, it was the needs of the patients and not the needs of the (medical or health care) system which dictated the kind of nursing care to be given.

By stressing the independent function of nursing, Abdellah portrayed the nurse as an independently functioning, professional person in her own right. Apart from that, she also offered her the tools, i.e. the typologies of nursing problems and nursing treatments, to practice on a professional level. All this, however, was not enough (Abdellah et al, 1960, p. 11):

> *'Professionalization of nursing requires that nursing identify those nursing problems that depend for their solution upon the nurse's use of her capacities to conceptualize events and make judgments about them. Nurses need to become skilled in recognizing both overt and covert nursing problems, in analyzing them in terms of relevant principles, and in working out courses of action by applying nursing principles. It is not possible habitually to get at overt and covert nursing problems, or to identify areas and clusters of them, until the process of problem identification is fully understood.'*

Professional nursing practice was therefore viewed by Abdellah as '*a problem-solving process related to health' centering on 'the patient and his problems as the core of nursing*' (Abdellah et al, 1960, p. 13).

As a result, the position taken by her with regard to the division of labour in nursing contrasted with that taken by Brown. Whereas the division of labour suggested by the latter was based upon the differentiation of nursing functions, Abdellah hoped to offer the nurse practitioner new ways in which she could 'plan nursing care assignments based on the individual patient's needs and the levels of nursing skills required to meet these needs (Abdellah et al, 1960, p. 2). In her view, it was quintessential to professional nursing practice that the nurse, having identified the problems presented by the patient and worked out a course of action, should remain responsible for the nursing care given to the patient. Having said that, there was no objection to delegating some of the nursing tasks but not the nurse's professional responsibility.

20.
TWO CONCEPTS OF NURSING EDUCATION

As indicated earlier, the models of comprehensive nursing and patient-centred nursing emerged from attempts to address specific problems concerning the education of the nurse. Also, both models were aimed at making the education of the nurse truly professional. Each of these models could therefore be expected to culminate in a well-articulated concept of nursing education. To grasp the meaning of these concepts, however, it is necessary to dwell upon two different approaches to nursing education in the postwar period first.

20.1. Two approaches to nursing education

Traditionally nursing education in the United States was characterised by the system of '*service for education.*' After the publication of the curriculum guide in 1937, however, there was a call for the reversal of the old system into one of '*education for service*' as demonstrated by the theme of the 51st convention of the NLNE in 1947, i.e. nursing education for public service.

In the process of reversing the relationship between service and education, these two terms acquired a new meaning. The word '*service*,' which used to stand for service to the hospital, came to refer to service to the community, whilst the meaning of the word '*education'* changed from apprenticeship training into professional education.

In that same period, it also became increasingly accepted that the administration of nursing service and of nursing education were totally different (Holtzhausen, 1946, p. 550):

> *'... a nursing service is patient-centered, whereas the student is the center of a school program.'*

This was precisely what the adjustment aim of the curriculum guide was all about, viz. to help nursing students to adjust to the different situations encountered in their professional work. To achieve this goal, subject matter was organised around '*projects or major activities of life*' (NLNE, 1937, p. 73) resulting in a so-called correlated curriculum, i.e. (Heidgerken, 1955, p. 128):

> *'a subject curriculum in which two or more subjects are articulated and relationships between them or among them are a part of the instruction without destroying the subject matter boundaries.'*

Two things happened in nursing education in the 1950s. First, the focus of attention shifted from the student to the patient. Secondly, concerted efforts were made to find new ways to organise the curriculum content. Both changes were reflected in the gradual substitution of the model of patient-centred nursing for the model of comprehensive nursing in nursing education.

20.1.1. A student-centred approach

In the postwar period, the student-centred approach gave rise to '*integration'* as the key concept in nursing education (Johansen, 1950, p. 119):

> *'Integration, in its widest meaning, refers to the wholeness of the individual; the nurse is an individual who, for her own sake and for the sake of her patients, should be a whole or integrated personality. Her emotional, physical, and intellectual development should be the primary concern of her teachers.'*

This aim of nursing education was based on the assumption that '*Nurses who constantly grow - intellectually, emotionally, and socially - have a better understanding of their patients as persons and consequently give better nursing care*' (Murphy, 1954, p. 1464). Educational scientists, however, would argue that the word 'integration' is used here in its psychological meaning, denoting the unification of subject matter taking place within the individual, rather than the integration of teaching methods or the curriculum content. But this only goes to show

to what extent nursing education came to be envisaged as student-centred. All this came very close to the integrated curriculum with its emphasis upon the general or academic education of the nurse as recommended in the Brown Report.

20.1.2. A patient-centred approach

The kind of approach advocated by Abdellah was patient-centred rather than student-centred, and resulted in a so-called core curriculum which was in sharp contrast with the integrated curriculum. A core curriculum (Heidgerken, 1955, p. 128):

> *'... emphasizes a core of social values. Learning experiences are selected and organized around a social problem or issue, generally including factual content, descriptive principles, and socio-moral principles. The teacher and students attack cooperatively through problem- solving activities.'*

Within the model of patient-centred nursing, the core curriculum was characterised by the emphasis upon the patient and his problems as the core value in nursing and by the use of the problem-solving method. This was pecisely what came to the fore in Matheney's description of the application of patient-centred approaches in an associate degree programme. This programme was said to represent (in: Abdellah et al, 1960, p. 69):

> *'a cooperative effort to establish for students a patient- centered curriculum that emphasizes as a major learning goal the provision of comprehensive nursing care for patients with health problems, such care to be developed through a problem-solving approach.'*

The characteristics mentioned by Matheney were most informative concerning the differences between the concepts of nursing education to be discussed in this chapter. The mere fact that Matheney could proclaim the provision of comprehensive nursing care to be the aim of nursing education demonstrated that the concepts of nursing underlying the models of comprehensive nursing and patient-centred nursing were seen to be virtually identical, inasmuch as they both centred on the health needs of the whole patient. Any differences between the two concepts of nursing education to be compared here had, therefore, not so much to do with the related concepts of nursing as with the respective concepts of professional nursing.

The concepts of professional nursing underlying the models of comprehensive nursing and patient-centred nursing were rather different. The former concept, to begin with, stressed the professional competence of the nurse being dependent upon the professional nature of her education. What this kind of education had to offer in addition to traditional hospital training was general education as opposed to technical education. Enter the integrated curriculum, which fitted in so well with the increasingly student-centred approach in nursing education. The latter concept of professional nursing, on the other hand, focused upon the use of scientific principles in solving the nursing problems presented by the patient, thereby indicating the need for a kind of nursing education which was different on two counts. First, it required a patient-centred curriculum to make nursing students aware of the patient and his problems as the core value of nursing, or as Abdellah put it, '*Unless we recognize that the patient is the only reason for our existence there can be no justification for a nursing profession*' (Abdellah et al, 1960, p. 41). Secondly, nursing education should provide the student with the knowledge, skills and attitudes needed to help patients to solve their overt and covert nursing problems. These were the two main characteristics of the patient-centred approach in nursing education advocated by Abdellah.

20.2. Comprehensive nursing

This information on the two major approaches to nursing education in the postwar period has prepared the ground for the analysis of the concept of nursing education underlying the model of comprehensive nursing, and more particularly, its interdependence with the related concepts of nursing and professional nursing. If the message of the Brown Report with regard to nursing education were to be condensed into one sentence, it would read something like this: because the increasing social function of the health services has to be matched by the

equally increased social effectiveness of nursing, it is above argument that the preparation of the professional nurse belongs within the institution of higher learning.

As mentioned before, the Brown Report focused on the education of the professional nurse more than anything else. Consequently, Brown's concept of nursing education was about professional education rather than nursing education in general. If taken one step further, this would suggest that it was her concept of professional nursing rather than her concept of nursing which was at the source of her views on nursing education. This, it is contended here, is borne out by the concept of nursing education articulated by her.

As for this concept's relationship with Brown's concept of nursing, it is important to recall that the Brown Report called for a shift of emphasis from the physical and disease aspects of nursing to its social and health aspects. This broadened concept of nursing has been shown to be virtually identical to the curriculum guide's concept of nursing. Because the NLNE and NOPHN had been active in promoting this concept of nursing in the schools of nursing ever since the publication of the curriculum guide, Brown, therefore, did not need to elaborate on its practical consequences in terms of education.

However, the same cannot be said about the educational consequences of Brown's concept of professional nursing, for this concept was new insofar as it identified being a professional nurse with having graduated from a professional school of nursing and called for the education of the professional nurse to be transferred to institutions of higher learning. Consequently Brown could not but elaborate on the question of how to make the education of the nurse truly professional.

20.2.1. The social and health aspects of nursing

As far as nursing educators were concerned, Brown's stress on the social and health aspects of the nursing services of the future was not so new, for they had always tried to incorporate these elements in the Curriculum in one way or another. In the standard curriculum, for example, these elements were given attention in an elective course on public health nursing. In the revised curriculum, this was taken a step further by including the viewpoints of public health nursing throughout the basic course. The rationale for this change was that basically '*all nursing is public health nursing, and that 'every nurse is, or should be rendering social service*' (Goodrich, 1932, p. 62).

In the curriculum guide, on the other hand, there was a noticeable shift of emphasis from public health nursing to health nursing and health teaching, prompted by increasing interest in the adjustment of the individual to his environment (i.e. the mental hygiene concept). In addition, the health of the individual was seen as involving not only the physical but the emotional, mental, and social aspects of living as well.

These changes necessitated a change in teaching methods. So long as the aim was to familiarise student nurses with the elements of public health nursing, the chosen method was an affiliation with one or more public health nursing agencies where student nurses could gain some practical experience in this branch of nursing. As a result, the school left it to these agencies to help the student nurses to integrate the social and health aspects in their nursing practice. Due to the shortage of nurses during the war, these affiliations were replaced by short periods of observation, thereby placing the responsibility for the integration of the social and health aspects back upon the school. This change, combined with the emphasis upon health nursing and health teaching in the curriculum guide, made nursing educators aware of the need to reconsider the methods used for integrating the social and health aspects of nursing in the basic course.

The first steps in this direction were taken by a Joint Committee of the NLNE and NOPHN. This committee recommended that the integration of social and health aspects in the basic course should be looked at, not so much in relation to nursing education but as a means of improving the quality of nursing. Consequently, the integration of social and health aspects, and health teaching for that matter, was a responsibility which nursing educators shared with both the hospital and the community for, as Frost put it, '*No hospital can fully discharge its obligations to its patients without affiliating itself with other health and social agencies in the community. ... Only under such conditions will the student have opportunity to participate in such care*' (Frost, 1939, p. 169). The aim of this type of integration was the preparation of a nurse (Dunn, 1944, p. 265):

> *'who will always have an understanding of and ability to care for the whole patient; who will view the patient as an individual, as a distinctive person; who will see this person as a member of a family and of*

the community from which he has come and to which he will return; and who will have an awareness of the hospital as an integral part of the community.'

To clarify what this description should be taken to mean, it is instructive to read the following more general objectives for the integration of the social and health aspects of nursing in the school of nursing curriculum, which were (Carn, 1945):

'To develop an understanding attitude toward individual differences and difficulties through studying their social and psychological causes, and to use this understanding in individualizing the nursing care given.
To develop ability to recognize social problems and social assets through observing and studying individual patients cared for on the wards, in the outpatient department, or in the home.
To develop an understanding of the patient's reaction to his illness and of the effect of specific conditions on the individual patient, his family, his occupation, and the community.
To develop skill in constructive, tactful interviewing or conferring while giving nursing care to all patients.
To develop judgement and skill in teaching about (a) the care and treatment of disease, (b) the maintenance of health, and (c) the prevention of illness, in accordance with the patient's medical advisor.
To develop sufficient understanding of the services offered by other professional groups and by other community agencies to enable the nurse to use them and to co-operate intelligently with them on behalf of the patients for whom she is caring.
To develop an understanding of the value of medical research to the treatment and prevention of disease and to the maintenance of optimum health.
To develop an understanding of the major public health problems affecting the community at large and the nurse's role in the control of such problems.'

All this goes a long way to show that, as far as the social and health aspects of nursing were concerned, Brown did not do much more than build on an existing concept of nursing which, in one of the reports of the Joint Committee, was incidentally referred to as '*complete'* nursing care (AJN, 1945a, p. 564). More importantly, this concept of nursing in itself was not sufficient ground for transferring the education of the professional nurse to institutions of higher learning, so that the reasons for this change had to come from another source, notably the functions to be performed by the professional nurse.

20.2.2. Professional nursing education

One of the major assumptions of the Brown Report was that the introduction of the practical nurse and the auxiliary worker would enable the professional nurse to devote herself to those aspects of nursing that required true professional skill. Given the concept of nursing articulated by Brown, one would expect these skills primarily to be related to meeting the health needs of the whole patient. This would have resulted in a curriculum design geared at teaching '*nursing for health*' as discussed at the NLNE-convention in 1947. The following statement by Eva A. Davis can be considered to summarise the feelings expressed at this convention (NLNE, 1947e, p. 750):

'The major objective of the nursing curriculum is the preparation of a qualified community nurse who may practice essential nursing in the hospital, in the home, or in the community. And if we accept the basic concept of nursing as including prevention of illness, promotion of health, and care and rehabilitation of the sick, then the present goal of nursing service is to provide an adequate amount of this type of nursing care to all individuals, and nursing education is responsible for preparing students to function in this broader concept.'

Closer analysis reveals, however, that Brown's ideas went much further for, in her opinion, nursing skills were not the only requirements for the role of the professional nurse, because she was expected to exert leadership in at least four different ways (Brown, 1948, pp. 73-74):

> *'(1) in making her unique contribution to the preventive and remedial aspects of illness; (2) in improving the nursing skills already in existence and developing new nursing skills; (3) in teaching and supervising other nurses and auxiliary workers; and (4) in cooperating with other professions in planning for positive health on community, state, national, and international levels.'*

Thus, the professional nurse also had other roles to fulfil, notably in the area of research, teaching, supervision, and administration. These roles, more than anything else, made it imperative that she graduated from a professional school of nursing which was expected to produce nurses who were not only adept in nursing care but in research, teaching, supervision and administration as well. However, to fulfil these roles, the professional nurse needed something more than the training for bedside nursing care offered by most hospital schools of nursing, viz. higher education (Brown, 1948, pp. 138-139):

> *'Two distinct but closely interrelated kinds of preparation that only higher education is broadly equipped to provide are essential for the making of such a nurse. The first is the laying of a foundation that permits continuing growth of many kinds ... The second kind of preparation is the more technical training for professional practice. But this training must transcend that for the care of the hospitalized sick. It must be preparation for the broad field of community nursing service.'*

To make clear what Brown had in mind when she distinguished between these two kinds of preparation, it may be helpful to relate the examples given by her:

- **academic or general education**

Under this heading she listed the following topics:

- positive health and integration of personality,
- insight into one's own motivation, the behaviour of others, and cultural patterns that condition human behaviour,
- ability to use spoken and written language effectively as a method of communication,
- skill in analysis of problems, methods of obtaining needed data, and formulation of logical conclusions, principles, or theories,
- perspective, gained from the historical and anthropological record of human development, of contemporary social institutions and their functions,
- understanding of and conviction about the rights and responsibilities of intelligent citizenship and membership in a profession.

- **technical training for professional practice**

Under this heading, apart from stressing that the preparation should not only transcend that for the care of the hospitalized sick but also incorporate the broad field of community nursing service, she listed the following topics:

- the other relatively well-defined components of the course of study,
- understanding of the effect of nutrition, housing, employment, economic income, class and caste structure, recreational activities, and so forth, upon individual and national health,
- some knowledge of the principles and functions of social work and of how nurses and social workers can most effectively act as a team,
- experiments in analysing the health needs of individuals, families, and communities, and initiating action to meet these needs,
- preparation in the art of teaching health to persons, whether sick or well and whether individually or in groups.

Furthermore, Brown recommended that the academic or general education and the technical preparation for professional practice should be forged into one integrated curriculum design. This recommendation was in contrast with other types of professional education in the United States (except for engineering) where students

were admitted after two to four years of undergraduate education in a liberal arts college which provided the first kind of preparation, so that the professional school could subsequently concentrate its attention upon the technical preparation of the student. Although most university schools of nursing had copied this system by offering an advanced curriculum, the general trend was in the direction of the integrated curriculum. The two major advantages of this curriculum design were that it was expected to put an end to the preclinical period and to provide a challenge for experimentation with teaching methods and curriciculum organisation.

However, to gain insight into what Brown really expected from professional education in nursing, it is much more important to ask why it was that she advocated the combination of general and technical preparation for professional practice in the first place. This she explained at the NLNE-convention in 1947, using the example of education for business administration. On the basis of Dr. Wallace Brett Donham's book 'Education for responsible living,' Brown presented a strong case for developing the student's capacity to (Brown, 1947, p. 823):

> *'examine as many of the constantly changing facts and forces surrounding administrative situations in business as he can bring effectively into his thinking, and to use these facts imaginatively in determining current policies and action.'*

These were precisely the two qualities which Brown expected from a graduate of a professional school of nursing: first, the breadth of background needed to examine as many facts an forces surrounding nursing situations, and secondly, the capacity to integrate the outcome of this examination at the point of action, i.e. the practice of nursing. Whereas the former capacity had to be developed by means of the general or academic aspects of nursing education, the latter was to result from the technical training for professional practice. This, it is contended here, was what comprehensive nursing in terms of nursing education was all about.

An important corollary of this contention is that Brown did not envisage the professional nurse as a specialist in giving bedside nursing care, but as a generalist capable of grasping the total nursing situation and of providing comprehensive nursing care. In this respect, Brown's position was the opposite from the position taken by Abdellah.

20.3. Patient-centred nursing

Granted the shift from a student-centred approach to a patient-centred approach discussed at the beginning of this chapter, it next remains to be seen, first, what caused Abdellah to embrace the patient-centred approach to nursing education, and secondly, what this approach added up to in terms of her concept of nursing education. From the following analysis it will emerge that because of the close interdependence between Abdellah's concept of nursing education, on the one hand, and her concepts of nursing and professional nursing, on the other, the model of patient-centred nursing was relatively more coherent than the model of comprehensive nursing.

20.3.1. Curriculum development on the basis of a concept of nursing

Abdellah's views on nursing education originated in her deeply felt dissatisfaction with traditional ways of organising curriculum content, notably the subject-matter curriculum and the correlated curriculum, neither of which succeeded in preparing the professional nurse for the functions she was expected to carry out. Also, her concept of nursing education bore all the hallmarks of the drastic changes in curriculum development during the 1950s. These changes, in turn, created a climate favourable to widespread experimentation with curriculum designs based upon a concept of nursing. These are the factors which, between them, gave rise to the patient-centred curriculum advocated by Abdellah.

The traditional organisation of curriculum content. Prior to 1950, the curriculum content tended to be organised around either specific diseases, or body systems, or patient care areas. The dominant curriculum designs were the subject-matter curriculum and the correlated curriculum.

There are few things about which Abdellah showed herself so adamant, and so concise at the same time, as about the faults of these two curriculum designs. In the former, each subject was taught separately without explicit reference to the over-all aims of the nursing school. Also, learning was focused upon disease conditions, whilst little consideration was given to the patient as a person. Most importantly, however, this type of curriculum design was conducive to over-emphasising the overt aspects of nursing and neglecting the covert aspects. The correlated curriculum, though making the organisation of curriculum content slightly more effective, suffered from essentially the same defects as the subject-matter curriculum.

Judging by the fact that Abdellah did not explain her objections to the traditional curriculum designs in more detail, it can be inferred that the points of criticism were well-known to her readers, and this would in turn appear to result from the changes in curriculum development in the 1950s.

Changes in curriculum development. In the late 1940s, a new revision of the curriculum guide was due. In the wake of the publication of the Brown Report, the NLNE thought it wise, however, to postpone the revision until the directions in nursing and nursing education could more fully be determined. For the time being, it adopted the policy that curriculum development was the responsibility of each individual school. In addition, a national curriculum was thought to hamper experimental curriculum development on the local level, for which the Brown Report had given such an important impetus. As a result, the focus shifted from centralised efforts to standardise the curriculum to curriculum development efforts at the grass-roots level within individual schools of nursing. The major contributions to this process came from the curriculum conferences organised by the NLNE, and the Tyler rationale for curriculum development.

The curriculum conferences. After the decision not to revise the curriculum guide, it was felt that individual schools might need some assistance in developing a curriculum of their own. For this purpose, the NLNE organised the two curriculum conferences referred to earlier. The first conference, the 'Nursing Organization Curriculum Conference,' held in December 1949, revealed '*an extraordinary diversity of interests and the dangers implicit in the fragmentation of a curriculum*' (Roberts, 1954, p. 530). Out of the confusion which characterised the discussions during this conference, the following trends emerged (NLNE, 1950b, p. 4):

- the experience-centred curriculum,
- the need to examine every so-called clinical speciality in nursing from the point of view of what every nurse should know about it,
- the interdependence of the various areas of curriculum,
- the team relationship in nursing functions which points to a team relationship in curriculum planning,
- nursing education for the purpose of preparing nurses to give better nursing service,
- general concepts and knowledge common to all areas of nursing education: the understanding of human development, the dynamics of behavior patterns, community aspects of nursing in public health nursing.

What these trends added up to was the need for a unifying principle for the organisation of curriculum content as well as the suggestion that this principle was to be found in the practice of nursing. The second conference, the 'Joint Nursing Curriculum Conference' (November 1950) proved more illuminating as to the question of how to organise curriculum content (NLNE, 1951, p. 1):

> *'The use of the additive method in curriculum development is largely responsible for the confused state of various curricula and the difficulties we are experiencing in breaking through crystallyzed patterns of courses with their emphasis on subject matter rather than the problems of patients, and on rotation through wards rather than the learning experiences essential in nursing. So, it was decided to take the wholistic approach and to begin by considering all nursing, rather than the needs of particular groups, and by looking at a situation - any situation in which one might try to improve the curriculum.'*

This new approach was conducive to the use of a more or less explicit concept of nursing as the point of departure for curriculum development. Also, it explains why the definition of nursing (see table 19) formulated at this particular conference has played such an important role in the conceptual developments in those years. The three questions discussed at the conference were:

- how can we differentiate the functions of nursing sufficiently to develop appropriate curricula?

- how can each of us go about improving the curriculum in our own situation?
- how can we stimulate and share research in nursing in order to improve nursing and nursing education?

As for the first question, there was considerable agreement that nursing was aimed at helping to meet the health needs of the people, and that this was to be done by identifying the sickness and health needs of people, differentiating the functions that should be performed by different types of nursing personnel in meeting those total needs, and by organising the nursing personnel to carry out their functions. These activities, it was concluded, called for curriculum research with regard to nursing education on the functions of nursing as well as the organisation of personnel to carry out the functions of nursing. The next steps was to decide upon ways of preparing the various groups to carry out the functions of nursing and evaluating the educational product.

This second curriculum conference was followed up by the so-called 'Nursing Abilities Study,' under the aegis of the NLNE-Committee on Nursing Curricula. The study was sponsored by the NCINS (Shields, 1952a, 1952b; Mercedes et al, 1952) and will be discussed later in more detail. At this point, it may suffice to point to the description of the steps in the process of curriculum development as they were conceived by the investigator, Mary Shields (Shields, 1952b, p. 1085):

1. identify human needs of individuals,
2. differentiate the functions and relationships of health care workers,
3. split the function of nursing into specific tasks and duties or analyse it in terms of abilities and personal qualities,
4. having done both, determine the level of attainment for each ability or quality,
5. consider possible learning experiences,
6. organise these learning experiences.

This outline, as well as the procedure suggested by the curriculum conference, reflected the influence of Ralph Tyler, a curriculum theorist and author of 'Basic principles of curriculum and instruction,' published in 1949, and various articles on professional education (e.g. Tyler, 1949). His work has exerted a long-lasting influence on curriculum development in nursing education.

The Tyler rationale. In his book, Tyler outlined the theoretical basis for a method of curriculum development, i.e. the so-called Tyler rationale. According to this method, there were four basic questions to be answered while developing a curriculum (Murdock, 1986, pp. 27-28):

1. what educational purposes should the school seek to achieve?
2. what educational experiences can be provided that are likely to achieve these purposes?
3. how can these educational experiences be effectively organised?
4. how can we determine whether these purposes are being achieved?

The particular methods suggested for answering these questions constituted the so-called Tyler rationale. The Tyler rationale for curriculum development could not have been published more timely as it provided nursing schools with the theoretical foundation for developing their own curriculum.

The broadened concept of nursing. All the factors mentioned so far created a climate for experimentation with curriculum development at grass-roots level and were undoubtedly at the source of the patient-centred curriculum. Yet another factor to be discussed here was the increasing acceptance of the broadened concept of nursing upon which to base the organisation of curriculum content. What this concept of nursing added up to was explained by Nahm, who was credited by Abdellah and her associates for the early recognition of the need for a patient-centered approach to nursing (Nahm, 1959, p. 1588):

> *'Our concept of nursing has broadened markedly in recent years. We now think of nursing as incorporating the best of the traditional - which emphasized the ministering, nurturing, comforting functions of the nurse - with the newer emphasis on technical functions and the scientific knowledge essential in performing these functions skilfully and safely. The new concept, however, incorporates much*

more than these two ideas. It includes an intelligent understanding of underlying principles of human behavior and the nursing methods most likely to achieve desirable results in terms of patient and family welfare. It emphasizes total patient care and how cooperative arrangements among the various community agencies can provide such care. It focuses on the role of the nurse as it relates to that of the doctor, the social worker, and all who contribute to patient and family care. It emphasizes that the ultimate purpose of care is the return of the sick individual to as nearly normal living as is possible for him. It includes prevention of disease, promotion of health, and care during illness.'

On the face of it, the three ideas constituting this concept of nursing came remarkably close to a synthesis of Goodrich's emotional, technical, and creative nursing. However, the originators of this particular concept to which Nahm referred were Frances Reiter Kreuter (1957), Faye G. Abdellah (1957), Thelma Ingles (1957), Dorothy E. Johnson (1959), Lucille Petry Leone (1957), and Mary Kelly Mullane (1958). What all these authors agreed upon was that the nurse who practised at a truly comprehensive level needed '*not only broader preparation in natural and social sciences and the humanities, but she must also have a broader and more comprehensive preparation in nursing itself than many nurses had in the past*' (Nahm, 1959, p. 1589).

In terms of curriculum content, this should be taken to imply that, instead of specialising along the lines of specific diseases, body systems, patient care areas, or for that matter, along the lines of teaching, supervision, and administration, the professional nurse should, rather, specialise in aspects related to the direct care of the patient. This called for a patient-centred curriculum.

20.3.2. Professional nursing education

Curriculum development on the basis of a concept of nursing was, however, just the first step, as such a concept was not enough to lead to education of a professional nature. Enter Abdellah's concept of professional nursing that was connected with her concept of education by means of the ideas of Tyler. That Tyler's ideas have exerted considerable influence on Abdellah's thinking can be inferred from the fact that, to relate her views on professional nursing education, she quoted the following lines written by him (Abdellah et al, 1960, p. 20):

'... the distinctive characteristics of a profession, namely its ethical code and its operating basis on principles, suggest the distinctive attributes of education for the profession. From these characteristics, important educational objectives can be derived. Because these objectives are complex and involve understanding, problem- solving, attitudes, and skills, they require clear definition in order to develop effective methods for their attainment.'

In quoting this text, Abdellah indicated her agreement not only with Tyler's description of the distinctive characteristics of a profession, i.e. a code of practice and its operating on the basis of principles, but also with his method of curriculum development. The latter is borne out by the fact that she used his words to make clear what she meant by a patient-centred curriculum (Abdellah et al, 1960, p. 28):

'... planning a particular course will mean providing situations in which students will encounter (overt and covert) problems to solve so that they can gain understanding and develop critical thinking.'

Abdellah's intellectual dependence upon Tyler's thinking is further shown by the emphasis in her concept of education upon the value concepts of the learner and the principles of practice.

The value concepts of the learner. The code of ethics that Tyler considered one of the two characteristics of a profession not only '*commits the members of the profession to certain social values above the selfish ones of income, power, and prestige*,' but '*it expects the individual member seriously to dedicate himself to these higher values*' (Tyler, 1949, p. 50). The values concerned are, moreover, enforced by different forms of group discipline.

Abdellah acted upon this charactistic by stressing that nursing education should not be limited to learning about disease conditions and acquiring skills, as suggested by the subject-matter curriculum and the correlated curriculum. On the contrary, professional nursing education also required the transmission of professional values

to students, and opportunities to learn about these values. This requirement was based on the assumption that (Abdellah et al, 1960, p. 23):

> *'The solution to each nursing problem encountered by the student requires that she think constructively and cooperatively in the projection of personal health goals of individual and family and social goals which will lead toward a healthy society.'*

In other words, in Abdellah's view, the student had to be made aware of the professional values distinctively connected with nursing, i.e. the patient and his problems as the core of nursing and nursing as a problem-solving process related to health, in order to '*mold the attitudes, intellectual competencies, and technical skills of the individual nurse into the desire and ability to help people, sick or well, cope with their health needs.*' She elaborated on the professional values of nursing by outlining the characteristics of that which is distinctively connected with nursing, of which she gave the following examples. One way of determining the distinctiveness of nursing was to see to what extent the nurse's role required knowledge of:

- normal growth and development including the aging process,
- dynamics of group behaviour and interpersonal relationships,
- psychological, sociological, and economic concepts that are used to interpret individual behaviour,
- principles of learning and teaching,
- concepts of prevention and rehabilitation, and
- basic communication skills.

According to Abdellah, these subjects were, unquestionably, basic to all health professions but, dependent upon the role of each profession, some subjects needed more extensive coverage than others. The second example of the distinctive characteristics of nursing came from Finer's book 'Administration and the nursing services,' i.e. (Abdellah et al, 1960, p. 24):

- continuousness: nursing is distinct in that it goes on 24 hours of the day, carrying on 'uninterrupted vigilance and activity,'
- the diversity of needs: the adjusting of the total nursing care plan to meeting the individual needs of the patient, or as Finer put it, '*Each patient is a law unto himself and to all, therefore, who would care for him*,'
- contingency: the need to adjust the variety of skills to the needs of each patient and the fact that patients' needs change from day to day,
- high emotionality: the ever-present life and death situations with which the nurse has to cope and includes the compassion and understanding that are required of her.

What both these examples have in common is that they indicate which values Abdellah thought basic to carrying out the role of the professional nurse. This interpretation may be considered somewhat contentious because Abdellah herself did not say in so many words that these examples were meant to illustrate the professional values of nursing. It is, however, difficult to conceive of any other reason which might have prompted her to give these examples following her discussion of the value concepts of the learner.

Principles of practice. The second characteristic of a profession, as Tyler pointed out, is '*the basing of its technics of operation upon principles rather than rule-of-thumb procedures or simple routine skills*' (Tyler, 1949, p. 51). This characteristic was undoubtedly at the source of Abdellah's substitution of the patient-centred approach for the traditional, disease and procedure approach, as well as placing nursing within the technologies rather than the sciences. However, when it came to what this characteristic meant in terms of education, Abdellah apparently adopted Brown's description of professional education, but not without giving her personal interpretation of it. These are the lines which she quoted from the Brown Report (Brown, 1948, pp. 138-139), and it is most important to notice how selectively she quoted Brown's description (Abdellah et al, 1960, p. 6):

> *'Two distinct but closely interrelated kinds of preparation that only higher education is broadly equipped to provide are essential for the making of such a nurse. The first is the laying of a foundation that permits continuing growth of many kinds, such as in: ... skill in analysis of problems, methods of obtaining needed data, and formulation of logical conclusions, principles, or theories .... The second kind of preparation is*

the more technical training for professional practice. But this training must transcend that for the care of the hospitalized sick. It must be preparation for the broad field of community nursing service.'

In fact, Abdellah left out all the topics which Brown mentioned to illustrate what she meant by either the general or academic education of the nurse or the technical preparation for professional practice (see pp. 532-533), except for the one related to problem-solving skills. And, on the same page, she added moreover:

'The development of professional nursing care consistent with professional quality ... requires that nurses have practice in identifying and solving overt and covert nursing problems.'

So, on the face of it, Abdellah agreed with Brown's recommendation of the integrated curriculum with its combination of general education and technical training. However, when it came to deciding upon the content of the former, she exclusively focused her attention on problem-solving, or the use of principles of control underlying professional nursing practice, rather than the more academic education which Brown had in mind. In so doing, she effectively turned Brown's student-centred curriculum into a patient-centred curriculum.

Problem-solving. The use of problem-solving methods in nursing education was fundamental to Abdellah's concept of professional nursing education. One of the reasons for this was that (Tyler, 1949, p. 51):

'Many of the problems encountered by a member of a profession are in a certain sense unique. To solve such a problem he must draw upon certain basic principles. However, the application of these principles necessitates an analysis of the particular problem to see what are its unique aspects which will require adaptation of the principles. This adaptation is an artistic task, that is, it involves individual judgment and imagination as well as skill.'

Another impetus for using the problem-solving method came from the educational philosophy of John Dewey, which emphasised the act of inquiry rather than subject matter. Accordingly, Abdellah (who took her Ph. D. in educational science) preferred curriculum content to be organised around problems (rather than the patient, disease, or the student) and the problem-solving method (rather than subject matter), or, as she put it (Abdellah et al, 1960, p. 29):

'A true learning situation is a problem-solving situation.'

What may also have prompted Abdellah to advocate the use of problem-solving methods was one of the recommendations made by the second curriculum conference with regard to research in nursing education (NLNE, 1951, p. 39):

'The knowledge and use of adequate problem-solving methods are not only important in the conduct of research but provide a sound approach to nursing care itself, that is, they help the student to focus her attention on the patient and his needs rather than on the symptoms and treatment of the disease which the patient has.'

This influence appears to be justified by the fact that, in order to substantiate the need to provide experience in problem-solving, Abdellah referred to the Nursing Abilities Study that was undertaken in the wake of this conference. This study was somewhat special, in that it focused upon the nurse's abilities rather than the activities performed by her. For the purpose of this particular study 'ability' was defined as the 'power to perform' in terms of qualities including '*powers to do, to think, and to feel*' (Shields, 1952a, p. 5). This emphasis upon the nurse's abilities indicated some other distinctions as well, viz. between (Shields, 1952a, p. 4):

- the nurse and the job,
- what the nurse "is," and what the nurse "does,"
- qualities and procedures or tasks,

In short, it was a study in terms of the personal qualities needed for the beginning nurse practitioner rather than one of the more traditional function studies or job analyses. According to Abdellah, not less than fifteen abilities, identified as essential for professional competency, involved skills in problem-solving. On the other hand, the ability to use scientific knowledge and judgement in evaluating and improving nursing care was considered relatively unimportant, with the effect that the professional nurse, as envisaged by the respondents, (Shields, 1952a, p. 28):

> *'knows that she is supposed to understand "scientific principles" but really doesn't do much about it. - it's mostly lip service. In an empirical way she adapts procedures to patient needs but she is very shaky about the scientific basis for her action. She tends to accept given procedures without questioning their safety or effectiveness unless they contradict some "rule" she has learned. She doesn't understand statistical reports or studies and doesn't see why she should.'*

A more important impetus for advocating the problem-solving approach in nursing education, it would appear, was given by the new concept of nursing as summarised by Nahm (1959). The originators of this broadened concept of nursing generally agreed that the nurse should be skillful in observation and communication in order to be able to assess the needs of her patients and to plan with them in meeting these needs. These requirements came very close to the five basic elements of nursing practice outlined by Abdellah. Apart from the skills needed to take care of patients, these basic elements encompassed (Abdellah et al, 1960, p. 26):

- the ability to observe and interpret the signs and symptoms which comprise the deviation from health and constitute nursing problems,
- the analysis of nursing problems and the selection of the necessary course of action,
- the organisation of the nurse's efforts to assure the desired outcomes.

This process was referred to as nursing diagnosis and treatment. It was chiefly by virtue of this problem-solving method being used in both nursing education and nursing practice that student nurses could hope to gain experience in practising on a professional level, or in using the principles of control of which nursing practice was thought to consist.

A patient-centred curriculum. In order for the problem-solving approach to be effective in nursing education, it was necessary, first, to teach student nurses about the steps of the whole problem-solving process, and secondly, to help them to arrive at a correct nursing diagnosis and treatment. The latter required not only that the nursing problems presented by the patient were correctly placed within the already established typology of nursing problems, but also that the student knew how to select the nursing treatments which were necessary.

As a result, the typologies discussed earlier gave rise to a curriculum according to patient needs which were considered a more meaningful basis for organisation of curriculum content than diseases, body systems or patient care areas. The justification for developing a curriculum of this type, as given by Abdellah, was most revealing as to why she preferred a patient-centred curriculum to Brown's integrated curriculum (Abdellah et al, 1960, p. 28):

1. *Nurses cannot attain maximum realization of their potentialities unless they are able to solve successfully the problems with which they are faced.*
2. *The abilities of nurses to cope with problems as individuals and as members of a group affect the welfare of society. To develop these abilities, educational experiences should be related as closely as possible to key nursing problems.*
3. *Nurses as members of society are becoming more and more interdependent upon other members of society.*
4. *Nursing problems reflect the health needs of the people.*

This justification could, in fact, have been written by Brown, except for the references to nursing problems, and that was precisely the main point of difference between the concepts of nursing education underlying the models of comprehensive nursing and patient-centred nursing. The former concept was based upon Brown's concept of professional nursing only and amounted to an integrated curriculum focusing on the academic education of the

student. The latter concept, on the other hand, was based on Abdellah's concepts of nursing and professional nursing, and added up to a patient-centred curriculum focusing on the professional education of the nurse.

21.
THE TEAM APPROACH

In the previous chapters, both the models of comprehensive nursing and patient-centred nursing have been shown to amount to a new interpretation of the concept of nursing underlying the model of individualised nursing, resulting in two markedly different concepts of professional nursing. In one concept, it was the professional competence on the basis of academic education which was emphasised, and in the other, that nursing practice was based on scientific principles. Also, it has been established that nursing education in the 1950s was characterised by a gradual shift from a student-centred to a patient-centred approach.

However, in order to grasp the full meaning of comprehensive nursing, on the one hand, and patient-centred nursing, on the other, each model's practical application has to be taken into account as well. The best way of going about this is to embark upon an analysis of the use of the team approach, because what the case method was for the model of individualised nursing, the team approach became for the models to be compared here, viz. the chosen method to apply each of these models of nursing.

Although some nurses maintained that nurses always had been using the team concept in one way or another (e.g. Barron, 1949), its widespread application to the administration of the nursing service in the post war years was definitely new. One of the major reasons for the team concept's emergence at that time was that the problems which confronted the health services required new methods of providing health care. Rising costs, changes in medical practice and the increase in public demand for medical and health services, to mention just a few, made health care workers aware of the need for better working relationships, i.e. the health team comprising the physician, the nurse, the dietician, the social worker and other allied professional health workers.

The idea of the health team also fitted in well with the general climate of cooperativeness between the health professions and the increased interest in group dynamics in the post war years which were summed up so well by Nelson in her final report of the NNC (Nelson, 1948, p. 756):

> *'Together is one of the most inspiring words in the English language; coming together is a beginning; keeping together is progress; working together is success.'*

As for nursing, special impetus was given to the use of the team approach by the shortage of nurses after the second world war. This resulted in the nursing team comprising the professional nurse, the practical nurse, the auxiliary nurse as well as student nurses and student practical nurses. Whereas the physician was the leader of the professional health team, the professional nurse was the leader of the nursing team which was responsible for the discharge of nursing functions related to the over-all plan of medical and health care for the individual patient. The team approach in nursing has given rise to different patterns of organisation within the nursing service. As shown by the reports discussed earlier, basically two different implementations of the team approach were in the offering.

One of the solutions was the increased utilisation of practical nurses for giving bedside nurse care as recommended by the Murdock Report. This solution was based on the assumption of an increased demand for nursing services and a limited supply of nurses. In addition, it was disclosed by Murdock himself that the professional nurse could be better utilised as '*an advanced assistant to the surgeon, obstetrician, internist, and to practitioners of the other branches of medicine*' (Murdock, 1949, p. 440). This opinion rested upon the assumption that professional nurses were not interested in giving bedside nursing care anyway. Consequently professional nursing was identified with the technical aspects of nursing, and it was chiefly for this reason that most nurses resented this solution.

The other solution, put forward in the Brown Report, was to relieve the professional nurse of relatively simple procedures which could equally well be carried out by practical nurses, so that her professional competence could be utilised to increase health teaching and to ensure intelligent and safe nursing care for patients. This solution rested upon the assumption that it was the change in complexity, rather than the volume of nursing care, that was at the source of the nursing shortage. Moreover, it was argued by Brown on the basis of her field trips across the United States, nurses both wanted and liked to do bedside nursing but '*they want an opportunity to give nursing care as they believe it should be given*' (Brown, 1948, p. 53). What the changes they

wanted to see added up to, in fact, was a radical shift from the predominantly functional to the individualised approach to nursing care.

The Ginzberg Report, while accepting the need for more practical nurses, was closer to Brown's views regarding the need for individualised nursing to be provided by the professional nurse. However, irrespective of the recommendations made to solve the nursing shortage, all three reports implied the formal acceptance of nonprofessional workers, i.e. the practical nurse and the auxiliary worker, in the nursing service. In welding together professional and nonprofessional workers into one team, it was surprisingly not the latter but the former group which posed the major problem. This was probably due to the fact that the nonprofessional worker was far less of a new phenomenon in nursing than the professional nurse whose function in relation to the patient, the nursing team and the health team had yet to be developed. Also, this would explain why it has taken the nursing profession so many years to identify and differentiate their respective functions. The outcome of this process has proved the prescience of a statement made by Thompson, a strong advocate of the practical nurse, to the effect that (Thompson, 1949, p. 232):

> *'Every step toward the development of a qualified practical nursing group is a step toward the elevation of the status of professional nursing.*

In other words, 'to the degree that the practical nurse was accepted as a member of the nursing team, it became more and more clear what the role of the professional should be.

Given the nursing shortage, the team method of assignment was also considered a middle of the road solution for the dilemma between the functional and the case method of assignment in nursing. As a result of the nursing shortage, no one could overlook the fact that it became increasingly impossible to hold fast to the ideal of individualised nursing by means of the case method of assignment. However, the functional approach to nursing, although admittedly a good method of getting the job done, was not considered a good alternative either. Enter the team method of assignment which provided a method of getting the job done with a personal touch, or as Phillips put it at a special interest conference of the ANA-convention in 1948 (AJN, 1948e):

> *'The nursing team decentralizes routine care and, by giving every worker more time and definite assignments on the team, lends a human touch to nursing care often lacking.'*

In this chapter, it will be shown, how the roles of both the professional nurse and the practical nurse gradually came to be differentiated, and secondly, how these two groups of nursing personnel, dependent upon the role attributed to the professional nurse, were conceived to work together in a nursing team by means of the team method of assignment.

21.1. Two classes of nurses

Ever since the times of Florence Nightingale, there have been two, and at times even more classes of nurses. Nightingale herself (Nightingale, 1882a, p. 324), for example, distinguished the '*lady-probationer*' from the '*nurse-probationer*' to the effect that (Barrii 1973, p. 34):

> *'The special probationers, who were gentlewomen by birth and education - daughters of professional men, clergymen, officers, merchants, and others of the upper and middle classes - aged from 24 to 30, were educated to be future heads of hospitals or departments of hospitals or later on as specialists in midwifery nursing or district nursing. The ordinary probationers were trained to be efficient nurses.'*

Both the lady-probationer and the nurse-probationer were to graduate as nurses. In the United States, on the other hand, things were different. In 1893, at the meeting during the International Congress of Charities, Corrections, and Philanthropy in Chicago, for example, the final paper was devoted to the training of attendants at the Massachusetts General Hospital for the care of convalescents, chronic invalids, feeble elderly persons and little children by so-called attendants (Hampton et al, 1893, pp. 204¬209). The latter name was said to be carefully chosen in order to distinguish the attendant from the registered nurse.

Twenty years later, however, a committee of the AHA found no less than nine types of workers who were calling themselves nurses. To simplify matters for the public, the committee suggested a system of grading nurses which would include all those who nursed for hire. The recommended grades were:

- registered graduate nurse,
- certified nurse: those who had taken courses of not less than one year in special or very small general hospitals or had acquired experience under certain specified conditions,
- household nurse: all nurses not eligible for either of the other grades.

At a subsequent joint meeting with the AHA-committee, the ANA, NLNE, and NOPHN, went on record as approving two classes of workers for the care of the sick (in: Roberts, 1954, p. 111):

> *'the nurse with the proper training under suitable conditions and the trained attendant, the minimum educational qualifications for each being determined by law.'*

21.11. The Goldmark Report

The issue of two classes of nurses was also very much in evidence in the Goldmark Report in which it was pointedly stated that '*subsidiary service is an existing fact, whether we like it or not*' (Goldmark, 1923, p. 26). Viewed against the background of the general shortage of qualified nurses at the time, this position was quite understandable. However, the only branch of nursing for which the preparation and registration of a '*subsidiary'* worker was recommended was private duty nursing (Goldmark, 1923, pp. 161-184). As to the reasons for distinguishing two classes of nurses, two extreme views were identified. One of these views was held by many doctors and added up to the position that nurses were '*overtrained*' and their charges '*so exorbitant as to be prohibitive for all but the very rich,*' and that the nurse was *'merely the doctor's extended hands;*' hence, '*any biddable girl*' could be quickly trained '*to obtain the necessary deftness and skill to carry out his orders*.' The other view was held by many nurses who refused to admit '*the need for persons less highly trained than themselves for any bedside care ofsickness,*' chiefly because they feared '*abuses of all sorts*' (Goldmark, 1923, p. 162).

The opposing position, taken by the doctors and the nurses, paralleled the ones discussed earlier in relation to the standard curriculum. What all the evolving discussions added up to was the question of how to arrive at a sound basis for differentiating the nursing care to be provided by either class of nurses. In this respect, it was pointedly stated in the Goldmark Report that a distinction must be made '*not on economic grounds, but according to the type of illness involved*' (Goldmark, 1923, p. 14), or '*not as to the financial status of the patient, but as to the nature and degree of seriousness of the sickness in question*' (Goldmark, pp. 162-163).

With regard to the financial basis for differentiation, there was, moreover, considerable doubt as to the possibility of substantial economies by the introduction of the subsidiary worker, if only because the private nurse's annual income, even if allowing for the many weeks she was out of work, was too low to make the introduction of a subsidiary worker economically feasible. However, with regard to the differentiation on the basis of the illness in question, it was stated that there was no need for a graduate nurse '*in the long list of minor illnesses which keep patients in bed, during convalescence, including after-care in maternity, and in chronic cases*'(Goldmark, 1923, p. 164). In many nurses' minds, however, it remained doubtful whether this was a workable differentation.

A more emotive aspect was the name to be selected for the subsidiary worker (Goldmark, 1923, 16):

> *'As is so often the case the root of disagreement lies largely in nomenclature. The title "attendant" ... is distasteful to those who bear it and tends to discourage the enlistment of those who may desire to enter this field. On the other hand the term "practical nurse" assumes a most unfortunate antithesis between education and practice; and the splendid professional and public service rendered by "the nurse" in war and peace, entitles her to the protection of her existing professional status. We are inclined to believe that the term "nursing aide" or "nursing attendant" best meets the need for a clear differentiation, while providing the subsidiary worker with a suitable name.'*

In subsequent years, nurses successfully managed to hold back the evolution of the subsidiary worker, helped by the rising unemployment among nurses during and after the economic depression.

21.1.2. The economic depression

Whereas the Grading Committee preferred hourly or group nursing rather than the so-called short-course nurse, the Committee on the Costs of Medical Care (1931) recommended the training of '*nursing attendants who are competent to furnish simple nursing service under the supervision of visiting graduate nurses, who are willing to do housework when necessary, and who accept somewhat lower rates of pay*' (in: Roberts, 1954, p. 266). This recommendation widened the utilisation of the subsidiary worker to a second branch of nursing.

In the second half of the 1930s, the nursing organisations increasingly felt the need to outline their position with regard to the issue. Consequently, the ANA, NLNE, and NOPHN declared that the responsibility for outlining principles and policies for the control of subsidiary workers in the care of the sick rested with the nursing profession, that all who nurse for hire should be licensed, and that no formal courses for the preparation of practical nurses should be approved until such time as a method for the control of the practice of subsidiary workers was devised (Roberts, 1954, p. 267).

Distinguishing two classes of nurses was one thing, but how to differentiate their respective duties and responsibilities was a rather different matter. In the curriculum guide, for example, the decision as to whether a given nursing activity should be performed by a qualified nurse and when it could be assigned to nonprofessional workers was left to the professional nurse (NLNE, 1937, p. 26):

> *'who carries responsibility for the nursing situation* as a whole, *who knows what the conditions are and what nursing objectives are to be accomplished in any given situation. If the main aim of nursing is to help the patient regain and maintain health, or as Miss Nightingale states it, "to help the patient to live," and if in certain cases activities such as cleaning the room, bathing the patient, taking temperatures, and serving diets, can be carried on by a non professional person in such a way as to achieve these results satisfactorily, such duties should be assigned to those who can do them at the lowest cost commensurate with good results. It takes a professionally qualified person, however, to make such decisions and to assume responsibility for the coordination of all these services and the general supervision of non-professional workers. This person should be able to perform every activity herself in order to properly supervise and teach those who assist in the nursing care of patients. Therefore, so far as the education of professional nurses is concerned, they must in any case know all the activities thoroughly and in addition, be able to analyze nursing situations, know what type of nursing activities are required, plan and carry out a well-coordinated program of nursing care (with or without assistants), and evaluate the results.'*

These criteria for differentiating the duties of the professional nurse from those of the non-professional workers paralleled the distinction discussed earlier, viz. between a broad and a narrow definition of nursing (NLNE, 1937, pp. 20-21). The responsibility for the nursing care given to the patient remained, however, with the professional nurse. That this was the position taken in the curriculum guide is vindicated by the distinction made between a nursing curriculum of a professional and a technical type (NLNE, 1937, pp. 51-52):

> *'If the nursing curriculum is to be of the professional as distinguished from the technical type, there should be more emphasis on thinking and understanding, on social attitudes and skills, and on the development of the student as a person. The technical element is essential and should receive due emphasis, but there should be a better balance than there is at present in most nursing curricula, between the technical, scientific, social, and cultural elements.'*

All this goes a long way to show that the distinctions made between the professional nurse and the trained practical nurse did not just come out of the blue after the end of the Second World War.

21.1.3. The National Association for Practical Nurse Education

In 1940, there were some 190,000 practical nurses and other nonprofessional workers working in the field of nursing. In subsequent years, there was growing evidence that these workers might usefully be employed not only in the care of the sick in their own homes and public health nursing but in institutions as well. The questions of the rationale for and the use of the subsidiary worker gradually being resolved, the main breakthrough came as a result of the actions taken by the National Association for Practical Nurse Education.

The National Association for Practical Nurse Education (NAPNE) was founded in 1941 following a number of informal conferences held by the nurse directors of the few existing schools for household or practical nurses and soon became a member of the National Nursing Council. Over the years, the NAPNE developed into the champion of the interests of practical nurses as the subsidiary workers came to be called, especially after the end of the war.

The first major project undertaken by the NAPNE was a job analysis of the practical nurse in terms of what she was expected to do, to use, and to know. This job analysis resulted in the following definition (National Association for Practical Nurse Education, 1947, p. 1):

> *'A trained practical nurse is a person trained to care for semi-acute, convalescent and chronic patients requiring service under public health nursing agencies, or in institutions, or in homes; she works under the direction of a licensed physician or the supervision of a registered, professional nurse and is prepared to give household assistance when necessary.'*

The next step was the development of a curriculum to be used by the schools for practical nurses which was published in 1950. The basic outline of this curriculum looked like this (Thompson, 1950):

- **basic nursing skills and related instruction**
  - meeting the health needs of apparently well families,
  - meeting the nursing needs of the mildly ill and of the
  - convalescent patient,
  - meeting the nursing needs of the patient with long-term illness
  - or disabling conditions,
  - meeting the nursing needs of the mother and infant,
  - meeting common emergency needs of individuals and families.

- **concurrent units of instruction**
  - basic homemaking skills,
  - meal planning and preparation,
  - cleaning the sick room,
  - care of linen and flowers,
  - some instruction in the structure and function of the body and
  - other related subjects.

In 1947, the ANA, traditionally representing the professional interests of graduate nurses, at last gave way and accepted that practical nurses were indeed giving nursing care and should therefore be licensed, but not so the auxiliary workers. The latter group were considered to consist of '*persons carrying out duties necessary for the support of nursing service. Minor services for patients may be included if such services are performed under the direct supervision of professional or practical nurses*.' In addition, it was emphatically stated that '*Their activities do not constitute the practice of nursing and therefore there is no reason for them to be licensed*' (ANA, 1947).

It says a lot of the growing cooperation between the national nursing organisations and other organisations with vested interests in nursing that, in 1951, the Joint Committee on Practical Nurses and Auxiliary workers in Nursing Services in cooperation with NAPNE and National Federation of Licensed Practical Nurses agreed upon a new definition of the practical nurse (ANA, 1951):

'The practical nurse is a person trained to care for selected convalescent, subacutely and chronically ill patients, and to assist the professional nurse in a team relationship, especially in the care of those more acutely ill. She provides nursing service in institutions, and in private homes where she is prepared to give household assistance when necessary. She may be employed by a private individual, a hospital, or a health agency. A practical nurse works only under the direct orders of a licensed physician or the supervision of a registered professional nurse.'

In other words, the practical nurse was at last recognised as a member of the nursing team but the problem of how to differentiate her duties and responsibilities from those of the professional nurse remained. Granted that it is one of the responsibilities of a profession to decide on its functions, it goes without saying that the ANA had a major role to play in solving this problem.

21.1.4. A programme for the study of nursing functions

In 1950, the ANA initiated a programme for the study of nursing functions (AON, 1950a):

- to determine what should be the functions and relationship of institutional nursing personnel of all types - professional nurses, practical nurses, and auxiliary workers - in order to improve nursing care and to utilise nursing personnel most economically and effectively,
- to determine what proportion of nursing time should be provided by each group in various situations,
- to develop techniques for achieving these purposes, which can be applied to all types of hospitals so that a national picture can be obtained.

Although the first aim of this programme was in line with the programme of studies undertaken by the NCINS, there were no formal links between the two. Moreover, in the ANA-study, great emphasis was put upon what was being done by each type of nursing personnel, and what each of them should do, rather than upon their respective responsibilities. Not surprisingly, this programme of studies was praised for '*shedding new light on how effective the present allocation of functions is and, in many instances, how the services of all groups of workers can be used to better advantage*' (Karabasz, 1952, p.443).

From 1953 onwards, the American Journal of Nursing regularly carried ANA-statements on the functions, standards and qualifications for virtually every position in nursing. The data upon which these statements were based were analysed in 'Twenty thousand nurses tell their story' (Hughes, 1958). The most important conclusion to be drawn from the ANA-study was that all nursing functions of whatever level pointed to the core of nursing, viz. '*the care-of-the-patient functions*' (AJN, 1957a, pp. 79-81). The latter also came to the fore in the ANA-definition of nursing practice which was needed primarily for legal purposes. For years nurses had been working to prepare a conclusive definition of nursing, a difficult task that was complicated by the need to distinguish between differently prepared categories of nurses. In 1955, however, the ANA board approved the following definitions (AJN, 1955b):

- **professional nursing**
  'The practice of professional nursing means the performance for compensation of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licenced physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of principles of biological, physical and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.'

- **practical nursing**
  'The practice of practical nursing means the performance for compensation of selected acts in the care of the ill, injured, or infirm under the direction of a registered professional nurse or a licensed physician or a licensed dentist; and not requiring the substantial specialized skill, judgment, and knowledge required in professional nursing.'

As to the former definition, it is important to note the sequence in which the independent and dependent functions of the nurse were mentioned. In the curriculum guide, for example, the nursing activities involved in the plan for nursing care were listed in the opposite sequence: first, the '*activities concerned with carrying out the program prescribed by the physician*,' and, secondly, the '*activities concerned with general nursing care*' (NLNE, 1937, p. 359). This reversal, it is contended here, was not coincidental but heralded a shift of emphasis from the dependent to the independent functions of the nurse. Another significant feature of this definition was the reference made to scientific knowledge as the basis for professional nursing practice.

The definition of practical nursing was followed up by the ANA-statement of functions of the licensed practical nurse. These functions entailed (AjN, 1957b):

1. Assisting with the preparation, implementation, and continuing evaluation of the nursing care plan by:

- *providing for the emotional and physical comfort and safety of patients,*
- *observing, recording and reporting to the appropriate person symptoms, reactions, and changes,*
- *performing selected nursing procedures in those circumstances where a professional degree of evaluative judgement is not required,*
- *assisting with the rehabilitation of patients according to the medical care plan.*

2. Contributing to the attainment of the goals of the agency through:

- *utilizing opportunities in contacts with patients' relatives to promote better understanding of agency policies,*
- *fostering cooperative effort among personnel by understanding the functions of other persons involved in patient care and by active participation in team and staf conferences,*
- *utilizing community relationships to contribute to better public understanding of health services.*

3. Assuming responsibility for personal and vocationalgrowth and development through:

- *active participation in nursing organisations,*
- *promoting and participating in inservice programs,*
- *learning on the job,*
- *promoting and participating in workshops and institutes and other educational programs.*

Summing up, the attendant of the 1890s came a long way before she was recognised as a person who was both trained and licensed to nurse. In the process, her work was continuously upgraded to end up at a level that did not differ that much from that of the registered nurse in the late 1940s. In contrast to the latter, however, the practical nurse was expected to work under the supervision of the professional nurse.

In the process, it was also firmly established that the practice of professional nursing required '*substantial specialized judgment and skill*' and was based on '*knowledge and application of principles of biological, physical and social science.*' In addition, the dependent functions of the nurse were subordinated to her independent functions.

However, this development was somewhat complicated by the increasing differences which were perceived to exist between the nurses graduating from the collegiate-based baccalaureate programme and the new two-year associate degree programme in community colleges respectively. Before very long, the latter nurses came to be seen as competent technicians dealing with the physics of machines as well as the physiological reactions of the patient, while working under close supervision of the physician to help the patient recover from his disease. The baccalaureate nurse, on the other hand, was given responsibility for total patient care with an emphasis upon the patient's psychological and social problems.

21.2. The team method of assignment

The next subject to be dealt with is how professional nurses and practical nurses were expected to work together by means of the team method of assignment. Unfortunately, the originators of the models of comprehensive nursing and patient-centred nursing have written disappointingly little about their views regarding the team method of assignment. Brown, for example, although recommending experiments with the team approach in

nursing, did not discuss it in very great detail, probably because it was such a relatively new idea at the time. Abdellah, on the other hand, was so preoccupied with the nature of professional nursing that she apparently saw no need to discuss the team approach at any great length either. What all this adds up to is that the Brown Report (1948) and 'Patient-centered approaches to nursing' (1960) mark the beginning and the end of an era in which the team method of assignment in nursing blossomed.

This conclusion is borne out by the fact that one of the hot topics in the period between the publication of the Brown Report and 'Patient-centered approaches to nursing' was the team approach in nursing. In 1949, the American Journal of Nursing, acting upon the recommendations made in the Brown Report, started to publish articles about teamwork in nursing on a fairly regular basis. Only a few years later, in one of the editorials, it could be concluded that '*The team concept is no longer news*' (AJN, 1953d, p. 1075). Thereafter, the number of articles devoted to the team approach dropped sharply. Also, in 1953, the reports of both the JCICP and the President's Commission on the Health Needs of the Nation singled out *'... the team plan as a desirable pattern for providing nursing care*' (AJN, 1953a, p. 289). Generally speaking, the literature on the team method of assignment written in those years indicates a gradual shift from a predominantly functional to a patient-centred pattern of organisation within the nursing team which paralleled the more general shift from comprehensive nursing to patient-centred nursing.

To illustrate this development, the remaining part of this chapter is devoted to a comparative analysis of two applications of the team method of assignment, viz. the team plan and team nursing. The former was the subject of a book, entitled 'The team plan,' written by D. Newcomb Perkins (1953a) and advertised as '*a workable method of meeting the nurse-shortage problem*' (Nursing Outlook, 1953, p. 607). The book was based on experiences with the team approach in the Massachusetts General Hospital in Boston from 1950 until 1993, which were first published in the American Journal of Nursing (Perkins, 1952a; Heslin, 1952).

The latter application of the team method was described in Lambertsen's 'Nursing team organization and functioning,' which was followed up by yet another book entitled 'Education for nursing leadership' (Lambertsen, 1957). Both of Lambertsen's books were concerned with the experimentation and study of nursing them organisation and functioning by the Division of Nursing Education, Teachers College, Columbia University from 1949 to 1956. Between them, they moreover reflected the development of team nursing at Teachers College in the 1950s. Whereas, in the former book, Lambertsen reported on the initial study which was aimed at finding the '*best means in order to achieve the most objective patient-centered care*,' in the latter she set out to explain '*the principles of the professional role of the nurse*' (Lambertsen, 1957, p. v).

However different the aims of the books written by Newcomb, on the one hand, and Lambertsen, on the other, between them they were most illuminating as to how differently the team method of assignment could be put to use, dependent on what was seen as the main reason for using this method in the first place. Basically, there were two reasons (Glasoe & Gould, 1952, p. 92):

> *'First and most important, the patient needed to be treated as a person - someone with a past, a pres,ont, and a future - and knowledge of him as a person would enable us to give total patient care. This was not being done where the "assembly line" or functional type of care was given, as the diagnosis was being treated and little else.*
>
> *Another need was for coordination of the duties performed by the various workers and the utilization of nursing power for nursing. This would bring about an improvement in the working relationships and in most cases an elevation of the status of each worker.'*

The team method of assignment thus supposedly provided the method par excellence to provide personal or total nursing care in spite of the shortage of professional nurses and the increased use of nonprofessional workers in the nursing service. Both Newcomb and Lambertsen would agree with the rationale for the team approach given here, albeit - as will be shown in the remaining part of this chapter - that the former would emphasise the coordination of duties and the latter total nursing care as the primary objective of the team method of assignment. The purpose of the comparative analysis embarked upon here is to identify the distinctive characteristics of the team plan and team nursing.

21.2.1. The team plan versus team nursing

For a start, it is important to establish that both methods of assignment, as suggested by their names, involved some sort of a team approach. Newcomb, for example, looked at the team plan as '*an effort to have a group of people work so well together that they seem to function as one person*' (Perkins, 1952a, p. 185), and Leino who took part in the initial study mentioned by Lambertsen defined a nursing team as '*a group of persons working together toward a common goal*' (Leino, 1951, p. 665). Already, in these first definitions of the team approach, one of the major differences between the team plan and team nursing came to the fore. This is borne out by the way in which the respective team concepts were subsequently connected with the provision of nursing care. In Newcomb's view, for example, the team plan amounted to a new division of authority (Newcomb, 1953a, p. 17):

> *'The team plan is a decentralization of authority. It permits the head nurse to delegate responsibility for patient care to a staff nurse who is called a team leader. The role of the team leader is in the process of evolution. It is a role which appeals to nurses who do not want to leave the bedside but who also want the prestige which goes with having responsibility. It might be compared in some respects with the role of the assistant head nurse, except that the leader functions in a limited area; she performs no clerical duties and she continues to dive some bedside care. Another difference is that she may share the evening assignment with other team leaders. Although the team plan creates a new role in nursing administration, the key person in the situation is still the head nurse. Her philosophy and managerial ability are the determining factors in its successful operation. It is she who assigns and supervises the leaders, plans the composition of the teams, sets up the time schedule, shares in ward teaching, and evaluates the patient care.'*

This somewhat administrative outlook on the team approach was in sharp contrast with the professionally-inspired view of team nursing (Leino, 1951, p. 665):

> *'A nursing service team is a group of professional and nonprofessional nursing service personnel working together in planning, giving, and evaluating patient-centered nursing care to a group of patients. The individual patient's nursing problems are the point of departure. Within the team organization, each worker functions according to his abilities and preparation, and each contributes his share to the team's job. The professional nurse functions as the team leader, democratic principles are inherent in the concept, and the contribution of each member is important to the achievement of individualized nursing care, which is the team's goal.'*

So, whereas Newcomb emphasised the authority of the head nurse, team nursing implied that '*The real authority of the situation is the patient and his nursing needs*' (Lambertsen, 1953, p. 13). The patient was thus attributed a totally different position in the two patterns of organisation. In the latter, the patient stood at the top, whilst in the former he was placed at the bottom of the organisational structure. In other words, whereas the team plan started with the organisation of the nursing service, team nursing's point of departure was the patient. To grasp the consequences of the opposing positions outlined so far, it is necessary to analyse both the team plan and team nursing in more detail.

21.2.2. The team plan

Fortunately, Newcomb has made no secret of the ideas underlying her view of the team plan, thereby also demonstrating to what extent its rationale differed from the one given for the nursing team. This, for example, was how she started her book on the team plan (Newcomb, 1953a, p. 1):

> *'While many nursing leaders and educators are proclaiming a new era in nursing, those of us facing the daily problems of providing good nursing care with limited resources are not so sure whether we are witnessing the emergence of a new era, or simply struggling in the decline of an old one.'*

From this statement, it can be inferred that Newcomb identified herself with the practitioners of nursing whose outlook on the situation in which nursing found itself was at variance with that of the nursing leaders and educators at the time. This clash of opinions between practitioners and educators covered a wider range of issues than just the obvious differences between nursing practice and nursing education (Newcomb, 1953a, p. 6):

> *'We have reached the point in nursing where we cannot see the forest for the trees. We are silently condemning ourselves because we cannot give the luxury care of the past while at the same time planning curricula that will prepare nurses to meet the nursing needs (physical, mental, and spiritual) of the whole person, the community, the nation, and the world!*
> *In* A Program for the Nursing Profession *the following statement appears: "Only a radical break with the past, which would relieve nursing of its romantic heritage and its service for education and place it on a comparable social and economic footing with other professions, holds promise of solving the major difficulties which now confront it." In the light of our present so-called* nurse shortage *and with 88 per cent of our schools still hospital-controlled, it is frightening to think of what would happen to our patients if we should make a radical break with the past. It is typical of human nature when in difficulty to choose a completely new course of action. Things seem so bad that there appears to be nothing to salvage. The tendency is to want to make a clean break, get off to a fresh start. Inevitably, however, we must come back to the fact that only as we build on the past can we go forward in the future. There is something in our romantic heritage and its service for education that might well be retained.'*

Rationale. In fact, the points on which Newcomb took issue with nursing leaders and educators were related to the concepts of nursing, nursing education and professional nursing underlying the evolving model of patient-centred nursing. The fact that she used a quote taken from the Ginzberg Report was, moreover, most indicative as to which nursing leaders and educators she had in mind when writing these lines, viz. the staff at Teachers College and all those who subscribed to the ideas developed there. This is not, however, to say that Newcomb's views were more at home with the model of comprehensive nursing, for this was definitely not the case. In fact, given the opinions expressed by her, one might be forgiven for thinking that she belonged to the group of conservatives so frequently referred to by Stewart.

Newcomb first of all accused nursing educators of teaching students a concept of individualised nursing care that, in the light of the daily problems caused by the nursing shortage, should be considered a luxury of the past (Newcomb, 1953a, p. 3):

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> *'Nursing educators with vision are advocating treating the patient as an individual, considering the whole person, and planning comprehensive nursing care. The student absorbs these ideals and concepts readily but soon finds that they are impossible of attainment. Finally, coming as a graduate into the ward she finds her contribution little more effective than that of the students and the auxiliary workers, in spite of her long and thorough preparation. She joins an assembly line so far as assignment of patient care is concerned. There is little planned continuity so that she loses interest in individual patients.'*

Instead of emphasising professional preparation for comprehensive nursing practice, Newcomb argued that it was impossible to have a good educational programme and satisfied nurses unless the ward situation was '*intelligently managed by a person who has a deep-seated conviction that nursing is caring for people*' (Newcomb, 1953a, p. 4). In other words, the objective of professional education for nurses had to be subordinated to the somewhat vague objective of 'caring *for people*.'

The second issue touched upon by Newcomb centred on the differences between the system of '*service for education*' and the system of '*education for service*.' As to this issue, she saw no need for nursing education to move to institutions for higher learning if only the educational potential of the ward environment could be more fully utilised (Newcomb, 1953a, p. 7):

> *'We would not of course want to go back to the long hours, the drudgery, and the scant preparation of the early days of nursing education. But have we considered what could be accomplished if the ward environment were deliberately organized to promote learning? The fact that students give service is*

incidental and irrelevant when practice is designed to reinforce learning and develop skills. And yet very little emphasis has been put on this obvious fact.'

According to Newcomb, the concepts of nursing and nursing education advanced by nursing educators were aimed at achieving professional status for nurses. Against this strategy, she argued that (Newcomb, 1953a, p. 1):

'Professional status for nurses may evolve more naturally through the demonstration of changing attitudes on the part of nurses themselves than in any radical change in the pattern of nursing education.'

The kind of change that was needed involved the acceptance of nonprofessional nursing personnel by the professional nurse (Newcomb, 1953a, pp. 11-12):

'If nurses are to have the kind of working conditions enjoyed by other workers in other fields, and at the same time retain their professional standing in society by assuring that society of the kind of care to which it is entitled, they must be willing to make sacrifices. They must recognize that they can no longer be a law unto themselves. They need help and they must extend to that help the kind of responsibility and the prestige which has made them strong. ... If we invite into our midst people who will make it possible for us to achieve the so-called good working conditions for which we are striving, we cannot withhold our approval of them. Are we ready to recognize the worker as an individual, rather than as a person in a category? Are we willing to break down the barriers separating the professional from the nonprofessional person? Unless we can answer both of these questions in the affirmative, we have not recognized the need for the team plan.'

This stance was in line with Brown giving a higher priority to the interests of society than to the vested interest of nursing.

The nature of the team plan. Whereas, in order to enhance the professional status of the nurse, nursing educators could be seen to advocate radical changes in nursing education, Newcomb's main concern was how the variously prepared groups of workers could be welded together into a closely knit team. It was at this point where, in Newcomb's opinion, the team plan came into play because the team concept (Newcomb, 1953a, pp. 1-2):

'... breaks down and forever dissipates the importance of position. A title becomes only a mark of identification, a symbol of the kind of contribution the individual is making in the care of the patient. What a well-motivated and well-trained aide can do for the comfort of the patient is more important than what the director of nursing service can do. And yet the aide and the director of nursing service have the same basic needs to satisfy in their daily living: belonging, approval, security, and all the rest. Under the old hierarchy the nurse had only a meager gratification for her labors. Her professional and emotional growth was stultified beneath a so-called professional attitude. There was a constant projection of: "All's well," when all was not well. With the team concept in nursing the individual functions freely according to her ability in an atmosphere which recognizes her personal worth and tends to promote her development.'

The team plan thus required a change of attitudes on the part of nurses themselves for it implied that, beneath the position of head nurse, every one was equal and not some (professional nurses) more equal than others (practical nurses). Only to the degree that this ideal of democracy - '*the "we" feeling*' (Perkins, 1952a, p. 165) - was achieved, was the team able to '*work so well together that they seem to function as one person*.' This conception of the team approach was in line with the team concept which was articulated by Brown during the National Nursing Planning Conference at Battle Creek (Phillips, 1949, p. 504):

'Previously we have thought in terms of levels of hierarchy, but the team concept implies a supplementing *of each other's efforts. Every member of the group is indispensable.'*

However, it is, as will be shown later, highly debatable whether Brown would have agreed with the role which Newcomb attributed to the professional nurse, in that she was to focus her attention on the nursing team rather than the provision of comprehensive nursing care. What all this added up to was that the team plan was characterised by a preoccupation with the coordination of duties rather than the provision of total nursing care, or better still, with team management rather than case management.

21.2.3. Team nursing

The development of team nursing at Teachers College originated in the recommendations made by the Ginzberg Report, viz. that (Lambertsen, 1958, p. 74):

- the nursing function be subdivided among two groups of personnel - professional and practical nurses,
- relationships be clarified and improved between the nurse and other members of the medical and health team,
- suitable relationships be developed among the various groups of nursing personnel who together comprise the nursing team,
- the professional nurse complete a four-year course in a college or university affiliated school of nursing.

Newcomb's assessment of the position taken by the nursing educators at Teachers College was thus essentially correct.

Rationale. The recommendations made by the Ginzberg Report rested upon the assumption that, in spite of the increased use of nonprofessional nursing personnel, it should be possible to hold fast to the ideal of individualised or patient-centred nursing care. According to the Ginzberg Report, there were basically three ways to achieve this objective, viz. by '*differentiating the work of the practical and professional nurses in terms of the class of patients, the types of functions, or through the adoption of a "team approach"* (Ginzberg, 1948, p. 37). On balance, the team approach was considered to be the chosen method (Ginzberg, 1948, pp. 38-39):

> *'The third approach, which of late has been receiving increasing consideration, does not deny the possibilities inherent in differentiations based on the class of patients or on the type of functions, but places its major reliance on the performance of the total nursing mission by a group of nurses in which the essential element is the supervisory relationship between the registered or professional. nurse and the practical nurse. This so-called team approach starts from the premise that there is a nursing function to be performed and recognizes that various individuals with different skills can participate in its discharge. Since the specific problems of individual patients are taken as the point of departure, the establishment of a nursing plan is of paramount importance. Implementation of the plan will depend largely on the welding together of a group of professional and practical nurses. The effectiveness with which the team works will be determined largely by the quality of the supervisory leadership.'*

In the team approach, as conceived in the Ginzberg Report, the management of the team was subordinated to the management of the nursing care of the individual patient, for his problems were regarded as the point of departure whilst team management only came into play at the implementation of the nursing care plan. The responsibility for both types of management was, moreover, placed with the professional nurse rather than the team as a whole (Oinzbero, 1948, p. 40):

> *'The "team approach" places full responsibility for the planning of the nursing function and the primary responsibility for its proper execution on the most mature and competently trained individual, the professional nurse, and leaves to her the assignment of specific duties among other less competently trained. This allocation of duties is the beginning, not the end, of the relationship between the professional nurse and her associates; as head of the team she provides professional counsel and retains supervisory responsibility.'*

Given the expanded function of the professional nurse, it was thought necessary to provide her with a good academic education and a thorough background of clinical nursing. For this purpose, the traditional system of '*service for education*' had to be replaced with the system of '*education for service*'. All in all, these changes

were indeed expected to enhance the professional status of the nurse. This conclusion is corroborated by the evolution of team nursing at Teachers College in the first half of the 1950s.

The nature of team nursing. In contrast with the team plan, team nursing represented '*a philosophy of nursing and patient care as well as a method of organization*' (Lambertsen, 1953, p. 12). In other words, team nursing should not be taken to imply a new version of the functional method of assignment with the professional nurse rather than the head nurse as team leader. On the contrary, the first consideration in team nursing was that the function of nursing was unique because of its close and individualised service to the patient and this objective was considered incompatible with the use of the functional method of assignment. The acceptance of an increasing number of nonprofessional nurses, however, made it impossible to use the case method of assignment as the over-all pattern of organisation of the nursing service. Apart from that, this method of assignment was expected to give rise to a division of labour based primarily on the physical needs of the patients and to result in technical and routine rather than total nursing care. Consequently, a new method had to be found for the division of labour between the variously prepared members of the nursing team. This method rested upon the assumption that there existed, within the scope of nursing, a differentiation of function (Columbia University, 1950, p. 54):

> *'The function of nursing may be conceived of as being of a spectrum range. Many functions involye the performance of skills and technics varying in difficulty and complexity and extending on a continuum, from the simplest performed by the mother and others, and easily picked up without training, to the most complex function demanding a very high degree of skill and expertness that can be developed only with considerable training. Many functions also demand judgment ranging from that based upon common knowledge to judgment that can be arrived at only by bringing to bear upon professional problems pertinent knowledge from an extensive reservoir of scientific information derived from many fields of study. The functions at one extreme of the range of the spectrum, those demanding a high degree of skill and judgment, must be the responsibility of nurses whose educational preparation has been of a professional type. Nurses who perform these functions can be assumed to need and to possess the breadth of scientific information with which to do reflective thinking and to have developed their higher intellectual powers and habits of reasoning, Judging, and drawing inferences about nursing problems.'*

This so-called McManus assumption amounted to three different functions (Lambertsen, 1953, p. 17):

- assisting functions; involving skills readily learned on the job and also entailing hygienic and homemaking functions,
- semiprofessional or technical functions: involving skills required in the physical care of patients and in carrying out medical orders of the physician as well as the exercise of judgement in nursing situations which are repetitive under the supervision of a professional nurse or physician,
- professional functions: involving skills and the exercise of judgement both requiring '*an ability for the application of scientific principles to problem solving in planning, providing, and evaluating nursing care*.'

In contrast with the team plan, team nursing thus implied different groups of workers partaking in the function of nursing with an emphasis upon the role of the professional nurse. The latter was reflected in the role of the professional nurse being compared with that of the physician (see table 19). With the benefit of hindsight, it can be said that the McManus assumption was instrumental in emphasising the professional nature of nursing.

Within a few years time, the differentiation of functions was taken a decisive step further, in that the total function of nursing came to be regarded as the exclusive domain of practice of the professional nurse. As for the involvement of other workers in the nursing service, it was added that (Lambertsen, 1958, p. 82):

> *'The accomplishment of these functions involves certain tasks which may be delegated by the professional practitioners to other workers who assist the professional. Functions of a profession can never be delegated, merely tasks.'*

As a result, the nature of team nursing changed dramatically. Whereas, formerly, team nursing was characterised by teamwork towards a common goal, it now became more and more preoccupied with professional nursing service to the patient (case management) to be provided by the professional nurse whilst leadership of the

nursing team (team management) was regarded as just one of the many responsibilities of the professional nurse. As for this professional function, Leino outlined the following steps in planning, directing, giving, and evaluating patientcentred nursing care (Leino, 1951):

1. *Identify the patient's problem,*
2. *Interpret nursing problems to co-workers and seek their cooperation in planning,*
3. *Formulate and record the nursing care plan,*
4. *Differentiate and delegate all aspects of nursing care,*
5. *Direct the programme of nursing care,*
6. *Evaluate and record the results of nursing care.*

21.2.4. The professional nurse

The analysis of the team approach so far has shown it to be one thing to distinguish between two classes of nurses, but quite a different thing to weld these two groups of nurses into a closely knit team, and even more so because of the persisting objective of treating the patient as an individual in spite of the shortage of professional nurses and the use of nonprofessional workers. The main problem was not so much the incorporation of the practical nurse into the nursing team as to decide upon what should be the role of the professional nurse. This problem was complicated by the fact that, as far as bedside nursing care was concerned, the practical nurse proved able to do virtually the same job as the professional nurse. This problem was, incidentally, also noted by Newcomb (Newcomb, 1953a, pp. E60):

> *'That the place of the professional nurse is undergoing a change is recognized, but a good deal of uncertainty obtains as to the direction this change will take. We are beginning to question the attempt to classify groups on the basis of functions. We find that, except for the administration of medicines and the teaching of patients, the practical nurse and auxiliary workers, properly prepared and supervised, appear to be able to take care of most patients as well as the professional nurse. One of the reasons for this may be the fact that many of these workers reach a certain point in their development and remain at that level. AlSo, as a group they do not seem to move around as much as professional nurses. The result is that they remain in one situation and by repetition become quite gmgrt in their work. The greatest need seems to be to find a means of utilizing this potential force to the fullest, and, in doing so, to strengthen the position of the professional nurse. Only as we are able to do this can we assure society of nursing care which is safe as well as acceptable.'*

This observation made by Newcomb goes a long way to show how difficult it was, at the time, to identify the role of the professional nurse. Notwithstanding that, it was generally conceded that, within the framework of both the team plan and team nursing, the professional nurse had to play a pivotal role. This raises the question of whether, and to what extent, the models of nursing discussed in these chapters have determined the nature of the team plan and team nursing, and even more so because these models have been shown to build on the earlier model of individualised nursing by adding a well-articulated concept of professional nursing. Generally speaking, Newcomb was hard pressed to distinguish the role of the professional nurse from that of the other members of the nursing team for, in terms of the ability to give bedside nursing care, there was little difference between the two groups, except for the fact that practical nurses and auxiliary workers needed proper supervision to be able to take care of the patients. Because the head nurse could no longer provide this supervision, it seemed only logical to attribute this function to the professional nurse but this fell far short of professional nursing as conceived by Brown (Newcomb, 1953a, p. 25):

> *'The nursing care team is concerned with comprehensive nursing care only to a point. As this role is being created, it seems wise to limit the responsibility of the team leader to bedside nursing care. The more efficient the leader, the more she will contribute to the comprehensive nursing care of the patient. The stronger the line of communication in both directions between the head nurse and the team leader, the more assured the patient will be of receiving comprehensive care. But it is still the function of the*

head nurse to interpret patient's needs to doctors, hospital administrators, social service workers, dieticians, physiotherapists and others.

This does not mean that the team leader closes her eyes to problems which involve the help of other groups. It is, in fact, one of the strengths of the team plan that such awareness increases in all workers. The point is that the team leader should not be expected to obtain that help except through the head nurse.'

Within the framework of the team plam, the professional nurse was thus expected to analyse the nursing needs of the patients being cared for by her team and to see to it that those needs were met by the team. Only to the degree that she demonstrated effective leadership in bedside nursing, was she expected to go beyond that, not to mention her relationships with other professional health workers. This was in sharp contrast with the idea advanced by Brown that comprehensive nursing implied bedside nursing being effectively handed over to the nonprofessional workers, so that the professional nurse could focus her attention upon the provision of comprehensive nursing care.

In contrast with the team plan, the primary objective of team nursing was individualised nursing care. As a result of connecting individualised nursing with the role of the professional nurse, the evolution of team nursing gave a new meaning altogether to comprehensive nursing (Lambertsen, 1958, p. 90):

'Comprehensive nursing is a systematic process of problem diagnosis, problem analysis, development of a plan of care and continuous assessment of the evolving plan of care; it is not and cannot be considered a conglomeration of routine and isolated tasks or activities. It is an indvidualized plan based upon scientific principles and concepts in the form of understandings on the part of the nurse and the utilization of specialized skills and technics. The problems of the client are unique and to solve these problems the nurse must draw upon certain basic principles rather than depend upon routine procedures. The basic principles required for comprehensive nursing care determine the areas of learning of the curriculum.'

From this new interpretation of comprehensive nursing it can be inferred that team nursing was instrumental not only in putting the model of comprehensive nursing into practice but also in developing the model of patient-centred nursing care. The driving force behind the transition from one model of nursing to the other was the increasing emphasis placed upon the role of the professional nurse in providing a unique and professional service to the patient. Within the framework of team nursing, the role of the professional nurse entailed not so much that she supervised the nursing team as that she was the person who made the nursing diagnosis and decided upon what course of action to take. This was considered a professional function that could not be delegated to nonprofessional workers (McManus, 19a). By virtue of this role, as well as her professional education, the professional nurse function was differentiated from the tasks to be delegated to and performed by the other members of the nursing team. This differentiation amounted to the distinction between nursing as a profession and an occupation to the effect that nursing as a profession encompassed '*the aims the profession is committed to accomplish through services to clients*,' whilst nursing as an occupation was made up of '*the multiplicity of numerous routine or technical tasks or activities*' which gave rise to occupational subgroups within a profession (Lambertsen, 1958, pp. 81˙82).

As far as the physician-nurse relationshijo was concerned, the unique and professional role of the professional nurse caMe to the fore in the emphasis placed upon her independent functions. As to her dependent functions, it was moreover stressed that '*A dependent area of function, in a professional relationship, is a collaborative relationship and in no way can negate the independent function of nursing*' (Lambertsen, 1958, p. 82). What all this added up to was that it was up to the nursing profession, with the exclusion of all others, to define the unique and professional functions of nursing. As a result, team nursing not only enabled nurses to hold fast to the ideal of individualised nursing care but also helped to clarify the nature of professional nursing.

22.
THE MEANING OF
COMPREHENSIVE NURSING AND PATIENT-CENTRED NURSING

The point of departure of the conceptual development of nursing after the Second World War was the shortage of nurses and the three reports dealing with this problem (Brown, 1948; Ginzberg, 1948; Murdock et al, 1948b). The impetus for each of these reports was admittedly rather different, viz. the need for educational reform (Brown Report), the curriculum revision at Teachers College (Ginzberg Report), and, the nursing crisis in the hospitals (Murdock Report). But in all three reports, the shortage of nurses was very much in evidence. More importantly, there was considerable consensus as to the need for both professional and nonprofessional nursing personnel to work together in a nursing team. However sensible this solution for the shortage of nurses may have seemed at the time, it also created a new problem, viz. what was the function of the professional nurse going to be?

The formal introduction of nonprofessional workers, notably the practical nurse, was initially perceived as a threat to the established position of the registered nurse. In addition; to the extent that practical nurses were genuinely accepted and recognised as members of the nursing team, professional nurses were obliged to identify and articulate their unique contribution to the nursing care of the patient. Their role within the nursing team apart, professional nurses also had to find a niche of their own within the health team. As a result, they were compelled to identify and articulate,their unique contribution to the health of the patient as well. These factors, between them, gave rise to the growing concern about the nature of professional nursing, both in relation to practical nursing and the other health professions.

The process of identifying and articulating the nature of professional nursing was reflected in the models of comprehensive nursing and patient-centred nursing. In spite of the similarities between these models of nursing and the model of individualised nursing, each model as a whole was new because of the increasing emphasis placed upon the nature of professional nursing. As a result, the postwar period heralded a new era in the conceptual development of nursing, if only because concern about the nature of professional nursing was substituted for the traditional preoccupation with nursing education. As a result of this change, the conceptual development of nursing affected not only nursing education but also, albeit to a far lesser degree, the practice of nursing.

The period following the Second World War was, moreover, characterised by a gradual shift from the model of comprehensive nursing to the model of patient-centred nursing which was reflected in the evolution of the team approach in nursing. This shift had to do with the different origins of the models of nursing concerned. Whereas the former model originated in the Brown Report, which represented the interests of society, the latter resulted from the the Ginzberg Report and the follow-up given to this report at Teachers College both of which reflected concerted efforts to enhance professionalism in nursing. The fact that, in the long term, the model of patient centred nursing proved the most viable model, incidentally, suggests that, as in the prewar period, the major impetus for the conceptual development of nursing came from nursing educators rather than the practitioners of nursing.

In this chapter, the outcomes of the comparative analysis of the models of comprehensive and patient-centred nursing will be summarised and discussed in order to illustrate the shift from one model of nursing to the other, and to compare both these models with the model of individualised nursing.

22.1. From comprehensive nursing toward patient-centred nursing

The two models of nursing analysed in the preceding chapters have been shown to rest upon a concept of nursing rather similar to the concept of nursing underlying the earlier model of individualised nursing. Whereas comprehensive nursing was focused upon the social and health needs of the whole patient, patient-centred nursing drew attention to the covert needs of the patient as opposed to his overt needs. As far as the concepts of nursing were concerned, one could thus be forgiven for thinking that both the models of comprehensive nursing and patient-centred nursing represented more or less updated versions of the model of individualised nursing.

This impression, incidentally, led many nurses to believe the meaning of comprehensive nursing and patient-centred nursing to be so identical that these designating adjectives could be interchangeably used.

However, when it comes to the respective models' concepts of professional nursing, major differences arise. At the source of these differences was the fact that comprehensive nursing and patient-centred nursing were in contrast with the narrower concepts of nursing designated by bedside nursing and the disease and procedure approach respectively. These latter concepts of nursing were instrumental in distinguishing nursing on a professional level from nursing on a vocational or technical level in two different ways, resulting in two equally different concepts of professional nursing and nursing education. These differences were also reflected in the evolution of the team approach in nursing.

22.1.1. Nursing

The models of comprehensive nursing and patient-centred nursing had common ground in that their concepts of nursing centred on the whole patient or the patient as a person. In this respect, it is contended here, both Brown and Abdellah would feel very much at home with the concept of nursing underlying the model of individualised nursing as opposed to the concept of functional nursing:

	functional nursing	**individualised nursing**
	deals with	deals with
person	the body	the total individual, psychological as well as physical
	in relation to	in relation to
environment	its physical environment	his natural environment, social as well as physical
	and is aimed at	and is aimed at
health	treating disease	attaining and maintaining health
	by means of	by means of
nursing	the manual activities required in the routine physical care of the sick	the activities required to meet all the nursing needs of the individual, sick or well

This should not, however, be taken to imply that Brown's and Abdellah's concepts of nursing were identical to this concept of individualised nursing, for these concepts emerged within a totally different context which added a new dimension altogether to the meaning of individualised nursing.

Comprehensive nursing. During the NLNE-convention in 1951, Marion Sheahan, the director of programmes of the NCINS, mentioned the following changes which affected nursing in the postwar period (AJN, 1951c, p. 433):

- changes in the purposes of medical education,
- increasing acceptance of the hospital as a community health agency,
- changes in the whole meaning of public health, and
- changes in the concept of society's responsibility for individuals and groups.

These were precisely the changes which were reflected in Brown's adaptation of the concept of individualised nursing. First, Brown called attention to the growing body of opinion within the medical profession which argued for the maintenance of health as the motivation, for operating a medical school, rather than organic disease. This shift from a predominantly curative to a preventive and positive approach in medicine was said to be reflected in:

- the emphasis upon the normal person, and sickness as a deviation from the normal,
- an understanding of the emotional factors which are a component if not the cause of disease (psychosomatic medicine),
- the responsibility of the health professions in aiding Persons, individually and groupwise, to maintain health.

Secondly, Brown envisaged administrative and fiscal changes in the health services to the effect that the hospital would increasingly be viewed in relationship to other community health agencies within a coordinated system of health agencies aimed at meeting the social and health needs of society.

Thirdly, Brown expected a shift of emphasis within the public health services from problems related to disease and mortality to problems related to positive health, or as Winslow put it, to health in its old Anglo-Saxon meaning of '*wholeness*.'

What all these changes added up to was a shift of emphasis from the physical to the social as well as from the disease to the health aspects of health care, thereby also implying that health care was a concern not so much of the individual as of society as a whole. Accordingly, health care came to be viewed as a service to society, and because of that, all health care professions were expected to subordinate their professional interests to the common good of a healthy society.

As for nursing, these changes indicated the need for a concept of nursing along the lines of the definition of nursing set down by Sister M. Olivia (Brown, 1948, pp. 74-75):

> *'Nursing in its broadest sense may be defined as an art and a science which involves the whole patient - body, mind, and spirit; promotes his spiritual, mental, and physical health by teaching and by example; stresses health education and health preservation, as well as ministration to the sick; involves the care of the patient's environment - social and spiritual as well as physical; and gives health service to the family and community as well as to the individual.'*

In so far as this concept of nursing stressed the mental as well as the physical and social aspects of nursing, it very much resembled the concept of nursing underlying the curriculum guide. This concept, it will be recalled, was inspired by the mental hygiene concept (adjustment).

In addition, Brown's concept of nursing, based upon a '*philosophy of the essentials of patient care*,' was contrasted with the narrower concept of nursing as '*physical care*,' and this contrast indeed paralleled the earlier debate between functional nursing and individualised nursing, or between nursing narrowly and broadly conceived.

What was new, though, was that Brown's concept of nursing was interpreted against the background of the responsibility of the nursing profession to meet the social and health needs of society, thereby giving rise to a new distinction, viz. between comprehensive nursing and bedside nursing. Given the future functions of nursing within the health services, on the one hand, and the shortage of nurses, on the other, Brown argued, nurses could not be expected to provide comprehensive nursing care unless they were prepared to delegate part of their work load, i.e. bedside nursing care, to practical nurses. This distinction, however, did not parallel the debate between functional nursing and individualised nursing, for bedside nursing was thought to be an integrated part of comprehensive nursing, even though this function of nursing was delegated to a group of less well prepared nursing personnel.

Patient-centred nursing. In contrast with Brown, who sought to differentitate between the functions of nursing resulting in the distinction between comprehensive nursing and bedside nursing, Abdellah focused her attention upon the function of nursing itself. In other words, she was not so much interested in '*what'* different groups of nurses did as in '*why'* they did the things they did. Furthermore, Abdellah's concept of nursing should not be interpreted against the background of future changes in the health services, but the gap between the acclaimed purpose of the health services and the services actually provided to the patient.

These factors, between them, led Abdellah to distinguish two concepts of nursing. One was the so-called disease and procedure approach geared to the service needs of the hospital, the other the patient-centred approach geared to the needs of the patient. In Abdellah's opinion, it was, moreover, not the hospital but the patient's needs which should determine the kind of nursing care he received. Consequently, nursing care had to be tailored to the needs of the patient. This was, in fact, her main criticism of Brown's concept of nursing, namely that this concept, in spite of its emphasis upon the whole patient, had not succeeded in putting an end to the functional approach to nursing. In other words, the kind of nursing care received by the patient continued to be determined by the system, i.e. the differentiation of functions within the nursing service, rather than by the patient's needs. To counterbalance this undesirable effect, Abdellah articulated the unique function of nursing in relation to the needs of the patient. As a result, the patient and his problems became the core of nursing which

she defined as a problem-solving process related to health. These characteristic features of Abdellah's concept of nursing gave a new meaning to nursing insofar as they called attention to the unique function of nursing rather than making this function dependent upon what physicians, hospital administrators, and society for that matter, thought nursing to be.

Another distinguishing feature of Abdellah's concept of nursing was that nursing was not so much concerned with the health needs as with the personal needs of the patient affecting his health. In this respect, Abdellah's concept of nursing was strongly ' reminiscent of the adjustment aim in individualised nursing. More importantly, the shift of emphasis noted here was also instrumental in identifying the unique function of nursing, because it gave rise to a shift of emphasis from the dependent to the independent functions of nursing.

Finally, Abdellah's distinction between the disease and procedure approach to nursing, on the one hand, and patient-centred approaches to nursing, on the other, paralleled the contrast between functional nursing and individualised nursing. This is not to say that she considered the technical competence needed to meet the overt needs of the patient to be irrelevant. On the contrary, but she also drew attention to the professional competence needed to meet the covert needs of the patient. Because both this technical and professional competence were required to meet the needs of the patient, both were regarded as essential parts of the unique function of nursing not to be delegated to others.

Summary. The comparative analysis of the concepts of nursing underlying the models of comprehensive nursing and patient-centred nursing can be summarised as follows:

	comprehensive nursing	**patient-centred nursing**
	deals with	deals with
person	the whole patient	the patient and his problems
	in relation to	in relation to
environment	his natural environment	his natural environment
	and is aimed at	and is aimed at
health	meeting the social and health needs	meeting the overt and covert needs
	of the patient	of the patient
	by means of	by means of
nursing	a differentiation of the fundtions of nursing	a problem-solving process related to health

22.1.2. Professional nursing

When it comes to the concepts of professional nursing underlying the models of nursing under comparison here, it is important to remember that the model of comprehensive nursing served to substantiate the need for professional education, whilst the model of patient-centred nursing was aimed at identifying the unique function of nursing. This made all the difference as far as the role of the professional nurse was concerned.

Comprehensive nursing. The professional nurse emerging from the Brown Report was, so to speak, caught between the nursing team and the health team. On the one hand, she was expected to delegate bedside nursing to nonprofessional workers in order to be able to provide comprehensive nursing care, and to supervise the nursing team, thereby implying that she was expected to play a predominantly supervisory and administrative role. On the other hand, the professional nurse was also expected to act as the physician's assistant and as a minister to the healing arts, or to become a specialist in clinical nursing, thereby implying that the medical care plan was the determining factor for the function of nursing. Neither of these implications were conducive to the development of the independent functions of the professional nurse implicit in the concept of comprehensive nursing. Instead, the professional nurse became, more than anything else, the mediator between the health team and the nursing team. This conclusion is borne out by the way personalised nursing and total nursing were defined at the time. In both cases, the function of nursing was determined from an administrative and medical rather than a nursing point of view.

It would be quite beside the point to blame Brown for this, as her concept of comprehensive nursing pointed in rather different directions. However, the postwar period was dominated by the scarcity of nurses. As a result,

it became imperative to utilise nurses as efficiently and economically as possible. This situation was further complicated by the increasing use of practical nurses and auxiliary workers who needed supervision and training on the job. Yet another factor was the nurse's job satisfaction which was expected to increase if she was given more responsible work to do. Given these circumstances, it is quite understandable that the functions forced upon the professional nurse had not so much to do with comprehensive nursing as with the need to keep the nursing services going.

Patient-centred nursing. By comparison, the professional nurse emerging within the framework of patient-centred nursing was much more of a professional person in her own right, because the nature of professional nursing was determined by what came to be regarded as unique to nursing, i.e. the typologies of nursing problems and nursing treatments. These typologies were based upon the following assumption, expressed at a conference at Teachers College by McManus (in: Lambertsen, 1958, pp. 84-85):

> *'Until a scientific basis for the professional service has replaced the empirical basis and until a systematic plan for continuing research in these services has been established by a group, the profession remains on an immature level.'*

By means of such a scientific basis and ongoing research into the practice of nursing, it was hoped that the scientific principles of control which are unique to nursing could be identified. More importantly, this body of knowledge was expected to identify and articulate the role of the professional in relation to both the health team and the nursing team.

As for the nurse's role within the health team, the independent functions of the professional nurse were given a much higher priority than her dependent functions, notably with regard to her professional right to diagnose the nursing needs of the patient and to decide upon the course of action to meet these needs. This is borne out by the fact that, within the framework of patient-centred nursing, personalised nursing and total nursing were given a new meaning, in that these concepts of nursing were connected with the needs of the patient rather than the dependent functions of the nurse.

As for the professional nurse's role within the nursing team, it was emphasised that the first responsibility of the nurse was the patient and not the nursing team. Accordingly, it was argued, the division of labour within the nursing team should be based on, firstly, the individual patient's needs, and, secondly, the nursing skills required to meet these needs. This concept of professional nursing thus subordinated the team approach to the case method in nursing. More importantly, it was established that a patient-centred approach to nursing amounted to a professional activity that could not be delegated to nonprofessional workers. This was in sharp contrast with the differentiation of functions advocated by Brown.

Summary. The concepts of professional nursing underlying the models of comprehensive nursing and patient-centred nursing have been shown to be rather different. Whereas the former concept was inspired by society's increasing demand for nursing care, the latter concept rested upon what was conceived as the unique function of professional nursing.

What this difference adds up to is that the former concept was heteronomously determined and the latter autonomously. Due to the shift from comprehensive nursing to patient-centred nursing, it was firmly established that, in the final analysis, it is up to the nursing profession itself to decide upon its unique function. The identification of this unique function was, moreover, expected to enhance the professional stature of nursing within society.

22.1.3. Nursing education

The differences noted so far were also reflected in the accessory concepts of nursing education. Generally speaking, the model of comprehensive nursing implied a student-centred approach which was reminiscent of the curriculum guide's concept of '*education as adjustment*,' to the effect that the aim of nursing education was to enhance the social effectiveness of the nurse who was functioning in a rapidly changing society. This was in sharp contrast with the patient-centred approach, in which it was not so much the professional competence of the nurse as the use of scientific principles of control constituting professional nursing practice that was emphasised.

This explains why Brown recommended that more attention should be paid to the general or academic education of the nurse, whilst Abdellah focused her attention on problem-solving methods as the preparation for professional nursing practice. Both these characteristics once again illustrate the contrast between the models of comprehensive nursing and patient-centred nursing. In the case of the former model, the student-centred approach and academic education were aimed at improving the utilisation of the nurse's administrative capacity rather than the nursing care provided by her. In the latter model, on the other hand, the patient-centred approach and the use of problem-solving methods were explicitly aimed at raising the quality of nursing to a professional level.

22.1.4. The team approach

The practical application of both models of nursing tends to confirm the shift from comprehensive nursing to patient-centred nursing. Both the models of nursing concerned had common ground in advocating the use of the team approach in nursing. But, within the framework of comprehensive nursing, the management of the nursing team was given a higher priority than the provision of individualised nursing care, and understandably so, given the imbalance between the demand for and the supply of nursing care at the time. Over the years, however, there was a gradual shift to a more patient-centred approach, resulting in the reversal of priorities with the effect that the patient came to be seen as the first and highest responsibility of the nurse, rather than the supervision of the nursing team.

This shift of emphasis was paralleled by the process of clarification of the functions of the professional nurse and the practical nurse. In this respect, the ANA-definitions of professional nursing and practical nursing (AjN, 1955b) were a significant turning point. These definitions not only stressed the independent function of the professional nurse but also established that the practice of professional nursing required 'substantial specialized judgment and skill' and was based on '*knowledge and application of principles of biological, physical, and social science.*' As a result, it was argued (McManus, 1958, p. 88):

> *'The professional function of the nurse is distinctive to nursing and is exclusively the province of the professional in contrast to other types of nursing personnel.'*

It can therefore be concluded that the evolution of the team approach in nursing reflected the transition from comprehensive nursing to patient-centred nursing.

22.2. Individualised nursing revisited

Finally, it remains to be seen to what extent the models of comprehensive nursing and patient-centered nursing were similar to, or different from the model of individualised nursing.

The concepts of nursing underlying these models of nursing focused either on the whole patient, or the patient as a person, or the patient as an individual. This would suggest that the adjectives '*individualised*,' '*comprehensive'* and '*patient-centred*,' when used in connection with nursing, have virtually the same meaning to the effect that they can be interchangeably used to designate one and the same meaning of nursing.

On the other hand, given the different historical contexts from which these models of nursing emerged, as well as the different concepts of nursing education and professional nursing involved, it would appear that the models of nursing concerned are not so similar after all. Taking into account all the presuppositions and implications of these models of nursing, it would, in fact, appear more appropriate to use the adjectives concerned as technical terms, which should only be used to designate the meaning of nursing as it was conceived at different times in the conceptual history of modern nursing. Consequently, '*individualised nursing*' should only be used to designate the meaning of nursing as it was conceived in the 1920s and the 1930s, whilst '*comprehensive nursing*' and '*patient-centred nursing*' stand for the meaning of nursing which was expressed by Brown and Abdellah respectively.

Yet another way of reaching a conclusion on this issue is to look into the behavioural consequences of the models of nursing concerned. This approach rests upon the pragmatist assumption that, if two apparently different ideas or beliefs give rise to identical practical consequences, then these ideas or beliefs can be said to

have the same meaning. Comparing the practical applications of the models of nursing concerned, it can be argued that the model of comprehensive nursing is the odd one out, mainly because of its emphasis on team management rather than case management. The models of individualised nursing and patient-centred nursing, on the other hand, can be said to have the same meaning insofar as both models put such great emphasis upon the use of the case method in nursing.

CONCLUSION

> *'Last but not least, the method must provide the means to identify the practical bearings of the similarities and differences between 'individualised nursing,' 'comprehensive nursing' and 'patient-centred nursing,' and so on, for nursing science, nursing research and the nursing profession as a whole.'*

This study originated in the variety of adjectives currently in use to denote the meaning of nursing, and was aimed at identifying what each of these adjectives adds to the meaning of nursing in terms of opinions, beliefs and values as to what nursing stands for and what it does not.

At an early stage, it was decided to investigate the meaning of nursing within the framework of a theory of meaning rather than a theory of reference. In other words, the study was to result, for each of the adjectives under investigation, in the reconstruction of:

- its mental representation,
- its presuppositions and implications,
- the domain(s) of interpretation within which each adjective is meaningful,
- the meaning of nursing.

To achieve this objective, required a method geared to the generation of hypotheses concerning these domains of interpretations, i.e. the generation of theory. The comparative analysis of Grounded Theory and Practice Theory showed that the former was the chosen method for a study such as this. The main reason was that, whereas the latter method of generating theory is ultimately aimed at practical action in order to transform a problematic situations in nursing practice into a resolved situation, the former is primarily aimed at discovering meaning in order to transform an indeterminate or meaningless situation into a determinate or meaningful situation. The latter objective is achieved by means of the constant comparative analysis of the data systematically obtained and analysed from social research, resulting in the discovery of:

- categories,
- concepts,
- hypotheses,
- an integrated theory.

In short, according to Practice Theory, a nursing theory has thus to be put to the test to see if it works, whilst, in Grounded Theory, a theory is held to be true as long as it can be seen to be grounded in the data.

As for this study, the data were obtained by means of an extensive study of the literature which was selected on the basis of theoretical purpose and relevance. On coding and analysing the data, extracted from utterances concerning nursing found in the literature, it indeed proved possible for each of the adjectives under investigation (when used in connection with nursing) to isolate categories, concepts and hypotheses which, between them, add up to an integrated theory concerning a specific meaning of nursing. By using the constant comparative analysis, it moreover emerged that the adjectives under investigation (when used in connection with nursing) add up to a conceptual history of modern nursing in the United States.

At the end of the study, it would seem appropriate to return to its point of departure, viz. its practical bearings for:

- nursing science,
- nursing research, and
- the profession as a whole.

1. Nursing science

Looking back upon the foregoing analysis of the meaning of nursing, it can be concluded that, over the years, the meaning of nursing has changed dramatically. Consequently, the question can be raised as to what nursing scientists are, so to speak, talking about when discussing models of nursing.

1.1. The changing meaning of nursing

That the meaning of nursing has changed is demonstrated by the fact that the presuppositions and implications of the various models of nursing have been shown not to be the same. For each of the models of nursing identified in this study it was possible to reconstruct concepts of nursing, nursing education, and professional nursing which are, in fact, markedly different.

For a start, the various models of nursing can be divided into two groups, viz. the Nightingalian model as opposed to the other models, chiefly because of the idiosyncratic meaning of the former model if compared with the models which emerged in the United States. These latter models of nursing have moreover been shown to have so many features in common that, between them, they add up to a conceptual history of modern nursing in the United States. The continuity manifested by these common features should not, however, be taken to imply that these models add up to one and the same meaning of nursing for, given the different presuppositions and implications, they definitely do not.

Secondly, it would appear that the present emphasis upon the nature of man in nursing science is relatively new, in that nursing's unique perspective, at least in the earlier models of nursing, was either the influence of the environment upon man's mode of being (Nightingale), or the adjustment of the individual to his natural environment (individualised nursing), or the social and health needs of the patient (comprehensive nursing), or the overt and covert needs of the patient (patient-centred nursing). The unique perspective of nursing science is thus not as timeless as it might seem, for it, too, is susceptible to change. On the other hand, the models of nursing identified in this study can be said to have prepared the ground for the nature of man to become the unique perspective in nursing science.

Thirdly, the various models of nursing have been shown to give rise to different, practical consequences in terms of the nurse's behaviour. The Nightingalian model of nursing, for example, gave rise to what Ten Have (1983) called a '*sociological'* approach, whilst the models of nursing emerging in the United States reflected a so-called '*biological'* approach (see also pp. 189-190). On the other hand, these American models differed from each other, in that individualised nursing and patient-centred nursing had common ground in advocating the use of the case method, whilst, in comprehensive nursing, the case method was subordinated to the team approach in nursing.

1.2. Metatheoretical implications

Given the constantly changing meaning of nursing, it is rather questionable whether '*individualised nursing*,' or '*comprehensive nursing*,' or '*patient-centred nursing*' should be taken to refer to nursing as it is known to exist in the world of nursing practice. And even more so, because experience shows that the actual implementation of these models of nursing left much to be desired. In other words, most of the time, these particular models of nursing were lacking a referent in the 'real' world which could be pointed at when asked what the meaning of the models concerned was.

What the models of nursing identified in this study, however, do refer to is nursing as it was conceptualised at the time. This should not be taken to imply that these models of nursing were, therefore, unreal or imaginary, for, as shown by this study, it is perfectly possible to reconstruct these models of nursing by collecting, coding and analysing utterances about nursing. What it does imply, however, is that these models of nursing are meaningful to the degree that they refer to a cognitive reality rather than the real world of nursing.

This cognitive reality consists of the domains of interpretation (encompassing mental representations, presuppositions and implications) in which each model of nursing (encompassing categories, concepts and hypotheses concerning nursing) makes sense. It simplifies matters if models of nursing are seen as semantic representations of the cognitive reality encompassing the domains of interpretation in which the models concerned make sense.

Furthermore, the various models of nursing identified in this study have been shown to be essentially different, in that each model refers to its own domain of interpretation. An important corollary of this observation is that it supports pluralism in nursing science. In fact, it justifies such pluralism to the degrre that each individual nurse is free to develop her own, meaningful model of nursing.

The next question to deal with is whether such models of nursing can be said to be true or not, given that each nurse can develop her personal model of nursing. As for this question, the place to look for an answer is, once again, not the world of nursing but the domain of interpretation concerned. Categories, concepts and hypotheses which do not make any sense in, for example, the domain of interpretation of individualised nursing, are devoid of meaning for that particular model of nursing and, therefore, lack a truth-value. In other words, it cannot be decided whether they are true or not. If, on the other hand, these categories, concepts and hypotheses can be interpreted within the domain of interpretation concerned, they are meaningful, and it can subsequently be decided whether (within that domain of interpretation) they are true or not.

This is not, however, to say that these categories, concepts and hypotheses will also hold true in the real world of nursing, for that is an entirely different question. In that case, the question is namely whether nursing as it exists answers to the descriptions, explanations and predictions offered by the model. To decisively answer this question, the nursing scientist has indeed to turn not to the cognitive domain of interpretation but to the world of nursing as his model's domain of verification.

What all these metatheoretical implications add up to is the distinction between the language in which the meaning of nursing is expressed, and the cognitive reality it denotes. On the basis of this distinction, it is perfectly justifiable to construct a model of nursing (i.e. a semantic representation of nursing) which can be both meaningful and true, even though nursing as it exists does not answer to the descriptions, explanations and predictions offered by the model. The main condition to be met by such a model of nursing is that it is 'grounded' in an identifiable domain of interpretation (i.e. a cognitive representation of nursing).

Incidentally, to clarify the full meaning of nursing, it would be moreover advisable to extend the notion of '*model of nursing*' so that it entails more than just a concept of nursing comprising the four key elements of person, environment, health and nursing. To make the meaning of a particular model of nursing perfectly clear, it is contended here, the nursing scientist has also to take into account the model's presuppositions and implications with regard to nursing education and professional nursing.

On the other hand, it can be argued that such a model of nursing is only relevant to the degree that it is generated to be used, or to be put to the test. Otherwise, the resulting model would amount to mere theoretical speculation or, worse still, a Utopian model of nursing. This leads us to the relationship between the models of nursing identified in this study, and the real world of nursing.

2. Nursing research

Each of the models of nursing identified in this study has been shown to reflect a strong body of opinions, beliefs and values as to what nursing stands for and what it does not, noticeably with regard to nursing, nursing education and professional nursing. Between them, these opinions, beliefs and values gave rise to a particular approach in the practice of nursing. These observations are relevant to the ongoing debate about the need for a qualitative approach in nursing research, as opposed to the merely quantitative approach.

2.1. Facts versus values in nursing

The Nightingalian model of nursing was based on outspoken religious opinions, beliefs and values concerning health and disease. A similar conclusion holds for the American models of nursing for, in the United States, nursing gradually came to be seen as a social institution which was deliberately created in order to meet the nursing needs of the individual, sick or well. As a result, the conceptual history of modern nursing in the United States reflects, more than anything else, the evolving opinions, beliefs and values of American society with regard to health and disease, as well as nursing.

In addition, these opinions, beliefs and values have been shown to refer to nursing as it was conceptualised rather than nursing as it was practised at the time. So much so, that it appears advisable that the adjectives '*individualised*,' '*comprehensive*,' and '*patient-centred*' should only be used to denote these particular conceptualisations of nursing, and another adjective should be coined to designate the meaning of nursing at present.

As for nursing research, these observations add up to the question of what kind of facts constitute facts relevant to nursing research.

2.2. Methodological implications

As mentioned earlier, to test whether nursing as it is practised answers to the descriptions, explanations, and predictions offered by a particular model of nursing, the researcher has to put the model in question to the test. In so doing, he must indeed turn to the real world of nursing as his domain of verification.

Looked at it superficially, this verification would be concerned with the bare, value-free facts of nursing. Correspondingly, the outcome of nursing research would amount to a picture-like representation of reality which is objectively true to the degree that the researcher can demonstrate that there exists a more or less rectilinear relationship between the model of nursing (i.e. the semantic representation of nursing) and the reality of nursing (i.e. the domain of verification) which is similar to the geometrical projection of surface A (language) on surface B (reality).

However, underlying this approach to nursing research is the assumption that there exists something like the eternal and timeless nature of nursing. This assumption is in sharp contrast with the outcome of this study which points to the ever-changing and ever-developing opinions, beliefs and values with regard to nursing, nursing education and professional nursing. It can, therefore, be argued that nursing facts relevant to nursing research are value-laden rather than value-free, and, therefore, entail value judgements rather than bare facts.

Another way of putting it would be this. A model of nursing is a linguistic sign which shows itself to the researcher and shows something else to him as well, viz. the opinions, beliefs and values underlying the model concerned, or better still, the meaning of nursing. And the meaning of nursing, as mentioned earlier, denotes the cognitive domain of interpretation rather than the real world of nursing.

Testing a model of nursing in order to see whether it corresponds with the real world of nursing, therefore, amounts to testing whether its domain of interpretation (which comprises, amongst other things, certain opinions, beliefs and values with regard to nursing) corresponds with some domain of verification in the world of nursing. As long as the research method used is not capable of dealing with the opinions, beliefs and values which come to the fore in the model under investigation, and the quantitative method of research isn't, the researcher is bound to fail in his objective to test the model in nursing practice.

What these methodological implications add up to is the recommendation that nursing researchers should stop looking for facts referred to by propositions about the nature of nursing, for there is no such thing as the eternal and timeless nature of nursing. Instead, they should look for facts which are concerned with the meaning of nursing. In other words, the quantitative method of research in nursing is in urgent need of being complemented by qualitative approaches to nursing research.

3. The nursing profession

Finally, as for the nursing profession, this study has shown that the meaning of nursing reflects the ever-changing and ever-developing relationship between nurses and the nursing environment. This relationship is determined by the development of the forces which operate to make nursing what it is today - the force of medical advance, of public health, of mental hygiene, of hospital administration, of general education, of societal changes, and so on. But, at the end of the day, as Leone put it, '*nursing does not emerge as the creature of these forces, rather it is a force in itself, impelled to growth in accordance with its ever-expanding function in society realistically interacting with other forces*' (in: Roberts, 1954, p. vi).

Given this dynamic evolution, it does not make sense to dwell upon the supposedly timeless nature of nursing. Instead, nurses should rather attempt, time and again, to articulate the meaning of nursing. Also, it would appear advisable that the methods used in nursing research should be adapted to the purpose of finding out more about the meaning of opinions, beliefs and values concerning nursing for the practice of nursing. Last, but by no means least, nurses should complement, to use the words of Dickoff and James, these theoretical and technical judgements with a political judgement which enables them to realise what they conceive to be the meaning of nursing. If the shoe fits, wear it.

The outcomes of this study go a long way to show that the individualisation of nursing care is one of the most persistent trends in the conceptual development of modern nursing in the United States. For, in the long run, it is this individualising trend, originating in the 1920s and 1930s and enriched by the concept of professional nursing underlying the model of patient-centered nursing, which has given rise to the concepts of nursing emerging in

more recent years. Consequently, because of its emphasis upon the the team method rather than the case method of assignment, the model of comprehensive nursing should be seen as a transitional model of nursing between the model of individualised nursing and the model of patient-centered nursing.

Also, this study has shown that the conceptual history of modern nursing in the United States has a history of its own rather than that it represents the Nightingalian model of nursing taken to its logical conclusion. In fact, whereas the latter model of nursing stood for a sanitary approach to nursing, American nursing was characterised by a persistent trend toward the individualisation of nursing. Apart from that, the Nightingalian model of nursing also rested upon religious beliefs American nurses were not familiar with.

In spite of these incompatibilities, Nightingale's ideas, notably on health nursing and on the question of how to run a school of nursing, have not failed to influence the thinking of American nurses but devoid of their religious and sanitary connotations.

Finally, the comparative analysis undertaken in this study points to the individualisation of nursing care as the most persistent trend in the conceptual history of modern nursing in the United States. This should however not be taken to imply that the different adjectives used to designate each model of nursing can be interchangeably used as each adjective has been shown to derive its meaning from the wider context of the accessory model of nursing. Consequently, it would be advisable to use the adjectives 'individualised,' 'comprehensive' and 'patient-centered' only in their technical meaning, so to speak, in order to denote the respective models of nursing.

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AJN American Journal of Nursing
ANA American Nurses' Association
NLNE National League of Nursing Education
PHN the Public Health Nurse (from 1931: Public Health Nursing

Whenever reference is made to a news item or an editorial comment published in one of the journals of nursing, which is unattributable to a particular author, the journal concerned is referred to as the author in this bibliography (e.g. American Journal of Nursing, Nursing Outlook, Public Health Nursing).

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