Conceptual Bases of Professional Nursing

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To the memories of two people whose beliefs and values helped to shape my professional identity: my father, Dr. Bert B. Kun, and my baccalaureate program chairperson at Skidmore College, Miss Agnes Gelinas

S.L.

To Janis H. David, a mentor who taught me the essence of professional nursing, helped me develop as a nurse educator, demonstrated what it means to be an advocate for patients, served as a guide throughout my professional growth, and remains a friend

J.M.P.

Preface

In the last quarter century, nursing has moved decisively toward becoming a scientific discipline. It has begun to develop and test its own theoretical bases, to promote scholarly development of its professional practitioners, and to apply its own theory to its practice. Although progress in attaining control of its own practice has been slow and is still not completely accomplished, a clearer picture of the special service offered to society by the profession is emerging. As the autonomous body of knowledge that is called nursing is developed and disseminated, and as the profession assumes accountability to the public it services by requiring excellence in the education of its practitioners and the delivery of its services, control of its practice is more likely to be completely accomplished. Acknowledging the absolute necessity for the profession to practice from its own body of knowledge, we have recognized the need to emphasize the conceptual bases from which professional nursing is practiced.

Conceptual Bases of Professional Nursing represents our efforts to present an overview and synthesis of professional concepts that we believe to be basic to the development of professional practitioners. This book was originally conceived to assist the registered nurse engaged in baccalaureate nursing education to become resocialized into the full professional role. In the process of writing, however, it seemed to us that the contents of this book could serve as a useful resource to all professional nursing education programs; to facilitate resocialization in "second step" programs, to serve as a resource at multiple points in the educational development of students in first professional degree programs, and to provide a professional review with a consistent framework in the early part of the education of graduate students from diverse baccalaureate nursing programs.

The book is organized into four sections. Section 1 addresses the nature of the profession through exploration of historical influences, philosophical perspectives, factors that influence socialization into the profession, and the development of a professional self concept by the practitioner. Section 2 focuses on theoretical bases of professional nursing, with separate chapters related to scientific thought and theory development, the research process, theories applicable to nursing, and models of nursing. Section 3 addresses concepts relevant to the delivery of professional nursing, the health process, the health care delivery system, and accountability. Finally, in Section 4 the components and roles of professional nursing are consid-

ered. These include nursing process; communication and helping relationships; leadership; and the roles of change agent, client advocate, and contributor to the profession. Future perspectives are then projected briefly.

The book has been written as an integrated text with a common framework and liberal use of cross references; however, each chapter can "stand alone," and thus the content can be read in any order. If the contents are assigned in a different sequence from that presented, however, we would encourage an early review of our conceptual framework for nursing, which is found at the end of Chapter 2.

We have been fortunate to have received feedback from a number of our professional colleagues. Special appreciation is expressed to Sharron Humenick, Donea Shane, Roanne Dahlen, Carolyn Lansberry, Hanna Jacobson, and Carol Lofstedt, who all critiqued parts of the manuscript; however, we take full responsibility for the philosophical and conceptual views expressed.

We could not have completed this book without the support and tangible assistance provided by Ed and Carol, to whom we express our heartfelt appreciation and love.

The contents of this book reflect the current synthesis of ideas, knowledge, and values that we began to articulate seven years ago, as we struggled with the development of a new curriculum. Our conceptions are continuing to evolve. We eagerly anticipate the debate and dialogue we hope this book will engender, in order to further the development and refinement of nursing science.

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Nurse, nourish, and nurture are all words that are derived from the same Latin source. These words have been so closely associated through the years that some people have labeled any caregiver as a nurse. Thus, some historians have identified the roots of modern nursing in the care given to the sick by military camp followers or religious sisters, or even the nurturance of children by their mothers. The assumption that nursing is an art possessed automatically by any female has hindered the development of a concept of nursing as a profession with an organized body of knowledge and specialized skills of its own.

Nursing as an organized occupation began in the United States in 1873 with the formation of educational programs based on the British Florence Nightingale model. However, because of enormous social and technologic changes taking place at that time in history, nursing was rapidly manipulated for the profit and advantage of other groups. Given the dependent position of women in Victorian society, and the lack of a conceptual base for practice, nursing education was vulnerable to control by hospital administrators and physicians. These same forces have continued to influence the development of nursing so that it is only now, after more than 110

years, that modern nursing is finally emerging into professional status. This chapter presents a historical perspective on the forces that are currently influencing the growth and development of the nursing profession.

THE INFLUENCE OF THE ROLE OF WOMEN

During the mid-19th century women led very circumscribed lives. Legally, a woman was considered a ward of her father or husband. She had no independent rights, since common law stated, "the husband and wife are one, and that one is the husband" (Kalisch and Kalisch, 1978, p. 71).

The "Victorian age" also produced an exaggerated chivalry and etiquette. The "lady" was considered fragile and physically weak. "Smaller and weaker than man, she was obviously mentally and physically inferior as well" (Kalisch and Kalisch, 1978, p. 49). The American woman was expected to be modest, humble, pious, and chaste. The "cultured, educated and 'womanly woman' intuitively discovered and appreciated her limitations and did not venture beyond them" (Kalisch and Kalisch, 1978, p. 184).

The woman's role was in the home. Her prime duty was fulfilled in motherhood. It was not considered proper for respectable women to have careers or even to be educated. In fact, there was some concern that education would interfere with childbearing by focusing energy on the brain instead of the reproductive organs! Even working as a governess in a socially acceptable home was suspect. Few women ever went beyond grammer school, although a few exceptions may have attended a "finishing school" where they learned social graces and the art of piano playing and singing.

Thus, in the 1870s women who had to work were in a very difficult position. The choices for untrained lower-class women outside of the home were "virtually limited to retail clerking, factory labor, domestic service or prostitution" (Bullough and Bullough, 1978, p. 118), since teaching or even office work required some education. For these reasons, nursing training seemed to be a reasonable alternative for women of modest means who wanted or needed a career.

However, until that time nursing had been considered an inferior, undesirable occupation. Much of the care of the sick in hospitals was provided by women paupers from the workhouses who had neither the experience nor the desire to be good "nurses." In New York, female criminals who had been arrested for drunkenness or vagrancy were required to work in Bellevue Hospital for 10 days instead of serving a jail term. Sairey Gamp and Betsy Prig, both sloppy, careless, and slovenly old women, were immortalized by Dickens (1910) in *Martin Chuzzlewit* as a "fair representation of the hired attendant on the poor in sickness." Certainly no respectable woman would have stooped to hospital "nursing" had it not been for the example of Florence Nightingale.

The example of Florence Nightingale during the Crimean War began the change in the public's image of nursing. "She made public opinion perceive, and act upon the perception, that nursing was an art, and must be raised to the status of a trained profession" (Kjervik and Martinson, 1979, p. 22). As a product of an upper-class English Victorian upbringing, Florence Nightingale saw nursing as being closely related to mothering, since both used the "natural feminine characteristics of nurturance, compassion, and submissiveness" (Kjervik and Martinson, 1979, p. 38). Although she developed a theoretical model for nursing (in which the environment influenced health outcomes), she believed that the nurses' role should be

to follow protocol rather than use independent decision-making. She thus believed that the emphasis of nurses' training should be on the carrying out of orders. This belief set a crucial precedent in defining nurses as subordinate to physicians, even in giving basic nursing care, an area in which physicians lacked any semblance of expertise.

Florence Nightingale's determination to improve the dismal reputation of nursing led her to propose stringent policies that were appropriate at that time, but were perpetuated to the detriment of the professional development of nursing. Good character was emphasized in the selection of student applicants, but intellectual characteristics were ignored. The nursing "residence" was installed to protect and monitor morality, but it also promoted the dependence and isolation of the students, and gave the hospital control over all aspects of their lives. The strict nursing service hierarchy, which was installed to maintain discipline, promoted an emphasis in nursing on deference to authority rather than on the development of an individual's leadership qualities. But, because of Florence Nightingale's example, the popular image of the nurse became the "lady with the lamp" with saintlike qualities of selfless compassion and endless toiling to ease suffering. Almost singlehandedly, Florence Nightingale had made nursing respectable, and women were attracted in droves.

In the United States the nurse training system was instituted at the very time that college education was becoming available for upper-class women. By the end of the 1870s, most of the state universities were admitting women. Vassar opened in 1865, and both Smith (1871) and Wellesley (1875) were established in the 1870s. Since these colleges were just in the process of establishing themselves, they did not want to be associated with an occupation of questionable reputation. They were also financially out of reach for the lower-class women who were attracted to nursing as a way to improve their status. It remains an irony of time that at the same time that medical education moved into the postgraduate university, nursing education became established as apprenticeship training under the control of physicians and hospitals.

THE INFLUENCE OF THE HEALTH CARE DELIVERY SYSTEM

The Home as a Setting for Care

Nurses were first trained in the United States in the 1870s. At that time medical care was provided in the home for paying patients, with nursing care provided primarily by females of the patient's family. As nurses began to graduate from the training schools, they were hired to provide nursing care in the home, under the supervision of the physician.

The only alternative for those too poor to afford a physician and nurse in the home was to go to a hospital, with "care" provided by untrained medical students and slovenly attendants. It was not until 1886 that the first organized district nursing organizations were formed in Boston and Philadelphia, to provide care to all who were sick regardless of ability to pay. Nurses followed the physician's orders, gave treatments, recorded temperature and pulse, and taught hygiene to the patient and his family (Moore, 1900, pp. 18–20).

Lillian Wald and Mary Brewster opened the Henry Street Settlement House in New York in 1893, and used the term "public health nurse" for the first time to

describe their trained nurses. By 1900 there were 20 district nursing organizations in the country that employed 200 nurses (Roberts, 1954, p. 14).

> Some of the basic principles of public health nursing were becoming apparent. It was increasingly evident that nursing should be available to all who were sick, regardless of ability to pay or religious affiliation; a definite distinction was being made between nursing and almsgiving; nurses were beginning to recognize the importance of keeping records; professional relationships between the doctor and nurse were carefully guarded and maintained; and the importance of cooperation with other groups in the community was being stressed in order to provide the best care to the patient. It was recognized that district nurses needed more preparation than they received in hospital programs. (Tinkham and Voorhies, 1972, p. 22)

Public health nursing continued to prosper from 1900 until the time of World War I. Social consciousness was widespread, and social and legislative reform were encouraged. Voluntary agencies developed rapidly in this climate. The National Organization for Public Health Nursing was established in 1912, with membership open to public health nurses, public health agencies, and interested citizens. At this time (1910), the Department of Nursing and Health was established at Teachers College in New York, the first nursing department in a college. Post-basic nursing courses for the preparation of teachers, administrators, and public health nurses were offered.

As hospitals and the medical profession developed, the home lessened in importance as the setting for care. Hospitals became respected institutions in the community for all classes of patients. However, trained nurses were not employed in hospitals in any significant numbers until the early 1930s. Until then, care by trained private duty nurses and public health nurses continued to be provided in patients' homes.

The Hospital as Employer

At the beginning of the last quarter of the 19th century when nursing education in the United States began, hospitals were institutions for the "accomodation of strangers and the sick poor" (Kalisch and Kalisch, 1978, p. 24). Most hospitals were dirty, unventilated, and contaminated by infection. The causes for infectious diseases such as typhoid fever, cholera, and diptheria would not be discovered for another 10 years. Rubber gloves for use in surgical operations were not invented until 1891. Even the thermometer and the hypodermic syringe were not commonly used until the 1880s. The major treatment for most illnesses was bloodletting, which certainly killed more patients than it helped.

Hospital conditions were so miserable that people began to demand reform. During the Crimean War in Europe 20 years earlier (1854–1856), Florence Nightingale and her small group of self-proclaimed nurses had reduced mortality in one army hospital from 42% to just over 2% (Goodnow, 1938, pp. 95 and 97). Several years later, during the American Civil War (1861–1865), women volunteers demonstrated their ability to handle the hard work and improve the conditions in military hospitals. Thus, after the war, the movement to establish nurse training schools was seen as a way to bring an improvement in hospital conditions while, at the same time, provide a respectable occupation for women.

Hospital growth was promoted by the tremendous scientific discoveries and so-

cial change that occurred during the last quarter of the 19th century. The discovery of radiography, anesthetics, and the value of aseptic procedure, led to the development of aseptic surgery, requiring specialized equipment that could seldom be found outside of the hospital. Because of the industrial revolution there was an influx of people to the cities, thus increasing the demand for medical care. Previously, physicians had cared for paying patients at home, and only those too poor to pay for a private physician went to a hospital. The improving conditions in hospitals, combined with the need to centralize medical care led to rapid growth of hospitals. From 1873 to 1923, the number of hospitals in the United States grew from 149 to 6,762 (Bullough and Bullough, 1978, p. 132); many were under the proprietary ownership of physicians. That enormous growth could not have taken place without the cheap, efficient service provided by nursing students in the hospital training schools.

The hospital training school remained the primary educational source of nurses until the 1960s when associate degree programs began their spectacular growth (Table 1-1). Since hospitals have also been the primary employer of nurses since the 1940s, they continue to exert an important influence on nursing practice today.

Development of the Medical Profession

The current status of medical education and the medical profession seems incredible when compared with the situation just after the American Civil War. In the United States as a rule, a medical school conferred a degree on completion of "annual courses of four months' duration over a two year period. Both first and second year students attended the same lectures each year" (Kalisch and Kalisch, 1978, p. 25). It was hoped that in between the two courses of lectures the students would spend some time observing patients with a physician preceptor, but there was no systematic hospital teaching.

Medical schools of that period were proprietary schools, not associated with a university or a hospital. The best medical schools finally began to strengthen their links with hospitals in the 1870s and 1880s. Regular attendance at classes was not required and examinations generally were cursory. Admissions standards varied

TABLE 1-1. Graduations From Baccalaureate, Associate Degree, and Diploma Programs of Nursing

Year	Baccalaureate (No.)	Baccalaureate (% of total)	Associate Degree (No.)	Associate Degree (% of total)	Diploma (No.)	Diploma (%)	Total (No.)
1960–1961	4031	13	917	3	25071	84	30019
1965–1966	5488	16	3349	10	26072	74	34909
1970–1971	9856	21	14534	31	22065	48	46455
1975–1976	22579	29	34625	45	19861	26	77065
1981–1982	24523	33	38770	52	11682	15	74975

(Data modified from Nursing Data Book, pp. 39, 56. New York, National League for Nursing, 1982, and Vaughn J: Educational preparation for nursing—1982. Nurs Health Care, October 1983)

from some high school to college graduation. A common saying of the time was that "a boy who is unfit for anything else must become a doctor" (Kalisch and Kalisch, 1978, p. 25).

During the last quarter of the 19th century and the beginning of the 20th century, the focus of medical education reform was on upgrading the standards of entry, "to level the whole profession above a recognized base rather than create an educational elite" (Stevens, 1971, p. 38). (As we will see later that is exactly the emphasis in nursing education 100 years later!) The reforms at Harvard in the 1870s that led to a graded curriculum, lengthening of the curriculum to 3 years, administration of regular examinations, and the requirement of a college degree for entry, marked the beginning of a new movement toward a genuine university medical education (Stevens, 1971, p. 41). Between 1900 and 1926 the number of medical schools decreased from 160 to 79 and the number of yearly graduates from 5,214 to 3,962 (Burgess, 1928, p. 35). The rapid increase in the knowledge base for medical practice mandated an increase in standards for admission and graduation and an increased emphasis on quality.

Thus, through a coincidence of history, the late 1800s were a crossroads for both nursing and medicine. The establishment of hospital-based nurse training programs provided nursing students with constant access to patients. This was threatening to physicians, most of whom had little practical training. All efforts to increase the education in nurse training was resisted strenuously by physicians and organized medicine. Domination effectively prevented competition. At the same time the exploding scientific and technologic revolution as well as rapid urbanization and immigration "sparked the development of hospitals and medicine" (Stevens, 1971, p. 34). Medical education moved into the postgraduate university, which led to true professional education. Nursing education remained apprenticeship training that maintained the subservient relationship with hospitals and physicians.

Why didn't nurses break out of the apprenticeship mold? Why didn't nursing education move into the university as had medical education? The simple answer is that nursing was comprised almost solely by women. And in the 19th century United States, women had very limited opportunities. In the absence of nursing theory to provide a power base separate from medicine, nursing was easily controlled by hospitals and physicians.

Growth of the "Nursing Team"

By the time the United States entered World War II, graduate registered nurses had become accepted as part of the hospital staff. Many hospitals had closed their schools of nursing when they discovered that they could hire graduate nurses more cheaply than the cost of staffing with students. Thus, when large numbers of graduate registered nurses joined the armed forces, a serious shortage of nurses developed in civilian hospitals. Nursing schools received federal monies to increase student nurse enrollment, and, at the request of the Office for Civilian Defense, trained volunteer nurses' aides who were hired to assist nurses. In addition, certificate holders from the Red Cross home nursing classes first volunteered for nonprofessional duties and later were paid as auxillary workers.

Early federal concern for production of adequate numbers of nurses led to the Nurse Training Act of 1964 (P.L. 88-581). "Adding Title VIII to the Public Health Service Act, it authorized (1) grants to assist in the construction of teaching facilities, (2) grants to defray the costs of special projects to strengthen nurse edu-