The essence of nursing

In the first of two articles, Alison Kitson outlines the fundamental elements of nursing, and how they should be protected and communicated. She argues that having the ability to care for the patient as a whole person is the essence of good nursing practice, in which a range of environmental and organisational conditions prevail, and over which the nurse must be in control. Similarly, basic observation and practical skills in traditional nursing must be evident before nurses can be assured they have met basic needs. She considers the effect of health care and other changes on nursing, along with strategies for ensuring that the essence of nursing is protected. The second article will appear next week.

As the clock ticks on towards the inevitability of the millennium, more and more emphasis will be placed upon the meaning of the event. Imagine the world’s population engaged in collective reflection on the purpose of life, the meaning of suffering, the quest for wealth, the eradication of poverty and disease and the desire for happiness.

Whether we like it or not, whether we personally wish to engage in these collective reflections or not, we will be caught up in a period of analysis. Add to this the surreal knowledge that the world’s computers might not make the move from the 20th to the 21st century and we have a quite fantastic plot for a science fiction story.

The reality is, however, that in a world becoming more standardised, where more and more people can access far-flung corners through travel and technology, increasingly more individuals are feeling alienated. We are living longer than at any point in human history but universally, we seem less able to cope with frailty and death. With the rise of modern medicine, we expect to be fitter, younger, sexier and healthier than ever before. We expect science to work miracles for us. The idea of manufacturing a sheep from its own cell would have seemed ridiculous ten years ago and we hardly notice when news bulletins report on the first arm and hand transplant. Similarly, when researchers implant microchips deep into the brain cells of two quadriplegic patients and report that they can use their own thoughts to work a word processor, we hardly know how to respond to the significance of the event.

The triumphs of science and technology seem to diminish the importance of other experiences. We forget that it was a mere 50 years ago that the first sulphonamides were used to treat pneumonia and with that breakthrough, a whole therapeutic industry was born. As our technical knowledge grows exponentially we are forced to adapt our cultural, social, political and ethical frameworks in the wake of such profound changes.

It is in this context of global change, both frightening and exhilarating, that contemporary nursing finds itself. Weathered by history and tradition, professional nursing as a social phenomenon is a relative latecomer to the human stage. Although every society has its own methods and traditions around caring for the sick and dying, it is only within the last 100 years that an organised approach to nursing has appeared.

What the building blocks for nursing were and whether they remain today, forms part of the debate in this article. Indeed, the search for the essence of nursing takes on millennium-type proportions, challenging us to consider what we should be cherishing as we move into a new century.

Like all quests, communicating the essence of nursing will be familiar yet at times unrecognisable, riddled with paradox, sublimely simple, yet deeply complex, frustrating and at the same time satisfying. While history and personal experience will inform the journey, I will attempt to offer sound arguments and research evidence to defend my perspective.

What is important is to be able to distil out those essential elements and to safeguard them over time, transmitting them through generations by word and deed. In doing so, those parts of stereotypes that are authentic can remain intact and other less helpful parts can be discarded. Similarly, in the wake of wider social and political change, decisions can be made around the appropriate statutory and legal frameworks,
educational preparation and organisational
structures needed to support the essential
practice of nursing.

The essence of nursing

Perhaps the two most influential thinkers of
modern nursing have been Florence Nightingale
and Virginia Henderson. Nightingale’s widely
quoted book Notes on Nursing (1969) reflects her
then contemporary understanding of theories of
health and sickness. The need for proper hygiene
and the control of the patient’s immediate
environment were central to effective nursing, as
was the collection of factual information on
which to base individual patient and
organisational decisions.

Her insistence on a proper moral education for
nurses, as well as tutelage in the natural and
medical sciences, set up the framework for
modern nursing. The classic stereotypes of
nursing also come from this era, the ministering
angel, the matriarch or mother surrogate.

Probably the most widely used definition of
nursing came in 1969 from Virginia Henderson:
‘The unique function of the nurse is to assist the
individual, sick or well, in the performance of
those activities contributing to health or its
recovery (or to peaceful death) that he would
perform unaided if he had the necessary strength,
will or knowledge. And to do this in such a way
as to help gain independence as rapidly as
possible.’

Nursing’s focus has moved to the individual,
rather than controlling the environment to enable
the individual to be healed. This may be the result
of better healthcare environments, which enable
nurses to concentrate more on their
interpersonal, supportive role.

A similar metaphor, used by Campbell (1984), is
that of the nurse as a ‘skilled companion’.
Companionship focuses on nurses’ ability to ‘be
with the patient’ as well as ‘doing things for
them’. It also focuses on the patient-centred
nature of the relationship, explicit in Henderson’s
definitions but implied through Nightingale’s
insistence on the need for dedication and altruism
in caring for the sick.

Meleis (1985) analysed the key shifts in nursing
thinking between 1950-1980. She identified
three trends – the needs-based approach to
defining nursing built upon medical science,
developmental and behavioural psychology – and
championed an objective, rational, problem-
based approach to nursing, for example Abdellah
et al (1973), Henderson (1966), Orem (1980), and

Emerging from the psychotherapeutic move-
ment, particularly in the 1950s, came nursing
theories that concentrated on the interpersonal
relationship between nurse and patient, for
example, in the work of King (1981), Travelbee
(1971), and Wiedenbach (1964). These perspectives
were eclipsed by what Meleis called outcome or
holistic theories which focus more on patients in
context of their social, physical and emotional
environment, shown by, for example, Johnson
(1980) and Rogers (1980).

Implicit in each of these phases have been
accompanying descriptions of how nurses should
engage or form a relationship with patients.
Kitson (1993) described three complementary
phases that link each phase with a particular way
of thinking about the nurse/patient relationship.
Thus, with needs-based theories, nurse-patient
relationships were constructed within the
traditional imagery of dedication, altruism,
unquestioning obedience and discipline. As
treatment began to depend more upon the
therapeutic relationship with patients, so
interpersonal links between nurses and patients
needed to be redefined. The work of Carl Rogers
(1976) influenced many nurses, helping them to
shift from a caring-as-duty-bound approach, to
one that attempted to form a therapeutic
relationship with patients.

More recently, attempts to explicate dimensions
of the nurse-patient relationship in the context of
outcome or holistic theories of nursing have
focused on a range of post-modern theories and
ideologies, such as in the work of Benner (1984).
What this means is that nurses are increasingly
being encouraged to find out what patients need
from them, how they want to respond to their
particular situation, how they want to draw
meaning from it and how the nurse can help them
experience something positive.

At their most extreme, such descriptions are both
narcissistic and unrealistic, given the reality of most
nursing encounters. Considering the logical
consequences of each phase of developing
theories, however, one is struck by the constants:
the recognition of protecting personhood,
whether it be through traditional Judeo-
Christian values, or psychotherapy or humanistic
existentialism. The interesting question is whether
any one of these approaches is more effective (safe
or morally superior) than any other, and whether
the context in which nursing takes place namely,
increasingly ‘hi-tech’, high patient turnover, means
that a patient-centred, holistic approach to nursing
is increasingly a relic of the past.

The importance of the person

Enshrined in nursing’s practical and intellectual
history has been the centrality of personhood.
Modern nursing emerged in a period of great
social reform spurred on by the evangelical
fervour of such people as Wilberforce, Rathbone
and Nightingale. The type of Christianity that
mixed fear of God with Kantian ethics and the
quest for scientific knowledge enabled a social
infrastructure to be set up around nursing. As we
have seen, the traditional Christian values of duty,
altruism and dedication ensured that such
entrants into the profession knew how to care.

The effect of secularisation on nursing as
Bradshaw (1994) has described elsewhere, was to shift theories of personhood from the religious and metaphysical, to more contemporary theories of existentialism, relativism and post-modernism. The individual patient was still supremely important, but less as a passive recipient of care and more as an active determinator of self-fulfilment. The nurse too had individual wants and needs, all of which had to be negotiated in some complex process at every nurse-patient encounter.

Thus, we find ourselves facing a number of dilemmas around this central notion of patient-centred care. On the one hand, every nursing textbook and theory advocated the central importance of this approach. On the other, the practical descriptors of how we actually initiate and sustain it, philosophically, morally, interpersonally and practically, were becoming more abstract, shifting from practical activity to more interpersonal encounters.

Also moving on from patient-centred care, variously termed ‘caring for the whole person’ or ‘holistic care’, one needs to consider the similarities across the range of nursing theories that have emerged to plot those essential elements, and those aspects of nursing practice that need to be sustained – no matter how the external environment changes.

The first essence or essential element in nursing is the philosophical and moral recognition of nursing as a person-centred activity. With this acknowledgement comes a set of beliefs and values – whether they are overtly Christian, humanistic or existential is not important here – about the uniqueness of the individual, his or her needs and how he or she should be treated. Also comes along a set of attitudes and behaviours required for the nurse to operate in a person-centred way.

Techniques include paying attention to detail, uncovering meaning in everyday situations, being attentive and available, reliable and true to promises, understanding the importance of each person’s own particular biography and how he or she is seeking to gain an understanding of what is happening to him or her (Kitson 1998, MacIntyre 1985).

Contemporary theorists such as Benner (1984), Ersser et al (1995) and Titchen (1998), have used a variety of approaches to explain how nurses can provide patient-centred care. They have shown that the tools central to patient-centred care include a demonstration of the nurse’s ability to hold an ‘unconditional positive regard’ (Rogers 1976) for the other person, otherwise known as ‘mutuality’. In addition, the skills of being able to focus in on significant events, conditions or situations, enable the nurse to help each person feel intact. Sensing the importance of certain events, helping to put them into context, discovering deeper meaning or merely being there while the person does this him- or herself, is part of the nurse’s sensing and intuitive role.

Equally, there must be a shared experience, one of reciprocal giving and taking where the essence of being human ensures that two people sharing a situation, recognise each other’s contributions.

That such complex and profound descriptions of human interaction can be expected to happen between strangers, between men and women, dying and healthy, in chaos, amid anger and stress, without them being reduced to pathos, reflects the true mystery of nursing. Knowing when to spend more time with a patient, knowing when only a smile or the soft touch of a hand is all that is needed, reflects the deeper sensitivity needed to work as a nurse.

And while nursing must start and finish with this philosophy, it also requires a set of practical skills. Those essential elements making up patient-centred care include:

- Essential care
- Technological care
- Psychosocial/emotional care
- Information and education
- Continuity and co-ordination

The selection of these elements comes from my own personal observations and experiences and is informed by familiarity with key nursing theories, described and used over the years, together with findings from discrete empirical studies. The list is very practical, almost task-bound, yet paradoxically it would seem that excellence in nursing care only comes about when we have mastered the multiple practical tasks that come together to make up patient-centred care.

The complexity of nursing is not necessarily about the challenge of discrete tasks, rather it is the requirement of nurses to be able to undertake a whole range of practical duties in such a way that protects the humanity and the individuality of the person for whom they are caring. Thus, to carry around in one’s head a simple framework outlining the range of tasks to be undertaken, would seem sensible because it is the interpretation and synthesis of these activities into a personalised package of care that requires the most energy.

The ordering is deliberate. Like Nightingale, I believe that the most important job of the nurse is to put the patient in the right environment to ensure optimal recovery. Then comes the finely honed monitoring and observation skills that require a deep understanding of underlying pathology, treatments, side-effects and potential hazards. Next, interpersonal skills supported by the ability to communicate, inform and educate patients, relatives and their carers. Finally, there is the need for the nurse to know how to provide a continuous uninterrupted package of care, co-ordinated across geographical and service boundaries as well as between members of the healthcare team and the patient’s own family.

Such elements are fundamental to patient-centred care. They are necessary in every specialism in nursing, are transcultural and, if internalised, would enable every practising nurse
to provide care that is more patient-centred. In order to organise care, the nurse needs to ask the following questions:

- How can I ensure that the immediate environment is conducive to optimal care?
- How stable and predictable are the patient’s physiological functions?
- How stable and predictable are the patient’s psychosocial and emotional states?
- What does the patient need to know and learn about his or her condition/situation?
- How can I ensure that the patient experiences care that is uninterrupted and co-ordinated?

**Essential care**

Recently, some writers have criticised nursing in the popular press (Lawson 1996, Marrin 1998). They have described the disintegration of basic hygiene standards, inedible food and lack of basic equipment such as beds, linen and clothing, blaming such lapses in standards on so-called ‘academic nursing’. What most commentators fail to realise is that hospitals in the UK no longer enable nurses to be in control of their immediate work environment.

Despite Nightingale’s warnings, nurses no longer are in control of the immediate environment in which patients are nursed, less perhaps in residential and nursing homes, and least of all in the community where nurses are ingenious in creating the right environment. Gone are the days when heating, lighting, ventilation, the control of noise and ensuring proper rest times for patients were the domain of the ward sister. Equally, ensuring the sufficient number of beds, chairs, linen and other materials has been taken out of nurses’ hands. Similarly, food and drink have become the responsibility of other departments.

While the need for a reorganisation of work is undoubtedly both a function of the complexity of delivering and maintaining the discrete service, as well as a recognition of the growing complexity of nurses’ jobs, it is manifestly inefficient if such consequences result in more fragmented patient services.

To provide essential nursing care – feeding, washing, toileting, sleep and rest, ensuring dignity and privacy – is a highly complex task relying on the effective co-ordination of numerous essential services over which the nurse must be in control. Evidence for such claims comes from a variety of sources, notably the ‘Magnet hospital’ work (Kramer 1990) and Aiken et al (1994), and subsequent studies. In the UK, the RCN’s recent ward leadership project (1997) reinforced this message by demonstrating that when nurses were more in control, patient care improved.

**Psychosocial and emotional care**

Having strategies to help patients cope with anxiety, stress, pain, fear, despair, discomfort, anger, isolation, abandonment, confusion, rejection, and depression, requires maturity, experience and a working knowledge of underlying theories of human behaviour. Yet recent research (RCN 1997, Titchen 1998) has shown that time to build up the relationship is the most important element to making it effective. This appears to be the least available commodity, in conjunction with faster throughput of patients in the hospital sector and less direct contact with community nursing staff. Forming a relationship with a particular nurse, whether a key-worker, primary nurse or team leader, also requires a time-frame, context and particular set of sensitivities and skills to enable the nurse to empathise with the patient.

In mental health, where the nature of the relationship between the nurse and patient is a key therapeutic intervention in itself, pacing and protecting the encounter may be easier to achieve. Increasingly in acute and community care, however, nurses complain of having less time to talk to patients and this denies such patients the reassurance and support many of them need to cope with their illness.

Others argue that because essential care has been delegated to healthcare assistants, the time nurses once spent talking to patients, assessing and addressing many of the psychosocial and emotional issues ‘behind the scenes’, has all but disappeared. And because systems have been separated out around the patient, there is no way

**REFERENCES**


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of integrating basic care with technical care and psychosocial care.

A typical patient in a busy hospital ward may, therefore, be helped to wash by one person, served breakfast by another, dressed by someone else, have his or her observations recorded by another and then asked how he or she is feeling by the nurse in charge. Typical casualties are older people who find themselves in acute medical and surgical wards. Disoriented, dislocated, dejected, often confused, they suffer in inappropriate surroundings and from aggressive routines and care regimes that do not give them sufficient time to orientate themselves to what is happening. That nurses have a contribution to make to the patient's psychological well-being is unquestionable; whether they carry it out effectively is still to be proven.

Information and patient education

Research shows the importance of information to patients to help them cope with illness and treatment options. Indeed, Cullum (1997) found that the effect of patient education by nurses was the most frequently studied area of direct nursing interventions. Nurses have been found to be more effective in communicating with patients than other groups, for example, in studies looking at the role of specialist nurses (Read and Shawen 1998) and particularly nurse practitioners (Richardson and Maynard 1995). Information via the telephone has also been shown to be more effectively delivered by nurses than doctors (Lattimer et al 1998).

Thus, the evidence is quite categorical in terms of the singular importance of nurses' information-giving and educative role with patients, assisting them in a better understanding of what is wrong with them, what treatment options they should be considering and how they can best manage their situation.

The link with other carers and the shared understanding of illness, coping with it and treatment regimes, needs to be explored more fully. Nurses must be sensitive to their role in communicating directly to patients and ensure they have the appropriate skills and conditions to allow effective communication to take place.

Continuity and co-ordination

Nursing is often described as the ‘cement’ in the structure that keeps the different parts of healthcare delivery together. Despite their continuous presence, nurses need more than sheer physical proximity with patients to guarantee a co-ordinated, continuous service.

Typically, patient-centred nursing requires systems and structures that enable nurses to work across departments, agencies, geographical boundaries and specialisms. Nurses need to be able to make decisions about where and how patients should be nursed: do they need a more supportive environment, a more tranquil and secure environment? Can their information and education needs be met adequately in a busy ‘hi-tech’ area or can they spend time recovering in a sub-acute area?

The need for nurses to have greater control over managing the nursing contribution to care has resulted in nursing-led services (Pearson et al 1992) and nursing development units (Ersser et al 1995) being established. In such situations, nurses are responsible for admitting and discharging patients from areas of care which require more or less active nursing support. Equally, the provision of care to patients in their own homes requires that nurses consider not only the direct medical support needed, but also the range of environment, physiological, psychosocial and information needs of patients and their carers.

Understanding the support network around patients, their ability to cope and their carers' capacity to cope both in the short- and long-term, are dimensions of care that need to be considered within the remit of continuity of care.

Whether such approaches are now called care programmes, care pathway approach or managed care, hardly matters. The important fact to acknowledge is that someone needs to co-ordinate the patient experience to ensure an integrated experience. Traditionally – and legally – it has been the GP and/or the medical consultant who have taken responsibility for the patient's experience. However, there is evidence to show that while the medical profession deals with the medical condition, it requires a different set of skills actually to manage the process of care effectively. Much of the ‘turf war’ between doctors and nurses in the recent past has been to try to identify how nursing can legitimately take on this role without being seen to undermine medical responsibility to patients (Read and Shawen 1998, Richardson and Maynard 1995).

In the second article, I will compare the essential elements of nursing described here, with how nursing appears in practice.