Shifting the paradigm

by Alison J Tierney (FRCN 1995)

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In a stirring editorial in 2018 to launch the global Nursing Now campaign, its executive director Barbara Stilwell and colleague Jane Salvage incited us to seize the opportunity to tell 'a new story of nursing' (Salvage and Stilwell 2018). 'This is the moment', they said, 'to shift the paradigm'.

Paradigm is not a word in nursing's everyday vocabulary, but it is a relevant concept for any discipline. Kuhn (1962) defines a paradigm as referring to the practices that define a scientific discipline and encapsulate the patterns, theories, standards and methods distinctive of that discipline at any particular time. This distinct identity unifies its members and binds the body of knowledge that underpins their professional practice. Through research and scholarship, that body of knowledge is continuously clarified and refined. As a result, from time to time, one paradigm loses influence and another ascends.

Various paradigm shifts have redirected the focus and ethos of health policy and health services over time: for example, the 'managerialism' that drove the health service reforms of the 1980s (Griffiths 1983); the 'evidence-based healthcare movement' of the 1990s that demanded clinical decision-making be underpinned by research (Muir Gray 1997); and, more recently, the shift from the overly narrow millennium development goals to more inclusive sustainable development goals (SDGs) for global health in the 21st century (Benton and Shaffer 2016).

Now, for nursing worldwide, the SDGs are driving the agenda mapped out in the recently published State of the World's Nursing report (World Health Organization) 2020).

All paradigm shifts in health care impinge on nursing and they also can be shaped from within nursing itself. Arguably the work of America's early nurse theorists from the 1950s onwards took nursing into a new paradigm. Henderson, Johnson, Rogers, Orem, King, Neuman, Roy and Watson are among the best known. Although with varying emphases, their conceptual frameworks, otherwise called nursing models, all promoted the detachment of nursing from the traditional medical model towards a person-centred focus of care. The first nursing model in the UK was produced by Roper, Logan and Tierney, first published in 1980 in The Elements of Nursing.

Despite interest in this model, the British nursing profession at large did not warm to the notion of models and theories and as the 1980s gave way to the 1990s the criticisms became more vociferous and more polarised. A paper by Reed in 1995 helped me to understand better the arguments and forced me to think hard about whether nursing models had any continuing role. In turn, I published a paper in 1998 in the Journal of Advanced Nursing under the title 'Nursing models: extant or extinct?'. It is this paper that I chose to revisit for my contribution to this collection of articles by RCN Fellows.

Nursing models: extant or extinct?

Abstract
Although nursing models have always had their sceptics, they are now subjected to more sustained criticism. Critiques have tended to focus mostly on the value of models for nursing practice but, increasingly, their place in nursing science is also being questioned. Reed believes that the growing disparagement of nursing models is symptomatic of the tensions between modernist and postmodernist perspectives on nursing.

Drawing its title from Reed's discussion, this paper – from the opposite side of the Atlantic – reflects on the original purpose of nursing models and critically examines their relevance now, using the first and best-known British nursing model (the Roper-Logan-Tierney model for nursing) as the particular example for scrutiny.

Although the popularity of this model is acknowledged, concern has been expressed that it has not been tested. Can, and should, models be tested? This question is addressed in view of its apparent importance to the debate about whether or not nursing models have any continuing, legitimate role in theory or in practice.

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Introduction and background

In my 1998 JAN paper, I rehearsed the arguments in defence of nursing models and addressed some of the dogged questions.

On the question of 'testing', I still fall back on the assertion that a conceptual model is not a theory and, therefore, cannot be empirically tested, at least not in its entirety, but instead that the 'goodness' of a model hinges on the notion of credibility (Fawcett and Downs 1986).

And I still find helpful Reilly's (1975) explanation of the original purpose behind nursing models: 'We all have a private image (concept) of nursing practice which influences our interpretation of data, our decisions, and our actions. But can a discipline continue to develop when its members hold so many private images? The proponents of conceptual models of practice are seeking to make us aware of these private images, so that we can begin to identify commonalities in our perceptions of the nature of practice'.

Fawcett (1984) identified these 'commonalities' as 'person', 'health', 'environment' and 'nursing' and, together, these four concepts provide an overarching paradigm – a metaparadigm – for nursing.

Indeed, those very concepts were at the heart of the first-ever articulation of 'the nature of nursing' by Florence Nightingale in her Notes on Nursing: What it is, and what it is not' (Nightingale 1860).

Nightingale did not see her 'Notes' as a definitive account: indeed, she described its content as 'hints'. In the Introduction she wrote: 'It has been said and written scores of times, that every woman makes a good nurse. I believe, on the contrary, that the very elements of nursing are all but unknown'.

A century was to pass before Nightingale's portrayal of nursing was further developed by Virginia Henderson (Harmer and Henderson 1955, Henderson 1960) and her definition of nursing was promoted widely by the International Council of Nurses in a little booklet titled Basic Principles of Nursing Care. I still have my copy. It sits side by side with my Notes on Nursing. Both were compulsory reading when I was an early undergraduate student (1966-71) in the Department of Nursing Studies at The University of Edinburgh.

That was how I met Winifred Logan – she was one of my lecturers. I met Nancy Roper when I later returned to Nursing Studies to do a PhD under a Nursing Research Training Fellowship and she was there doing an MPhil. Her study (Roper 1976) exposed the fragmentation of clinical experience in registration-level nursing education at the time, and Nancy postulated that a nursing model might help to unify that disparate learning. She invited Win Logan to work with her to develop that idea and, to include a youngster in the team, they invited me. The outcome of our work together was the 'Model for Nursing based on a Model of Living' that provided the framework for our textbook, The Elements of Nursing (1980).

Influence and impact

Did the Roper-Logan-Tierney (RLT) model for nursing have an influence? Did it make an impact? I think it is fair to say that it did.

Our model was never intended primarily as a contribution to nursing theory or as a tool for practice. Its purpose was to provide an overarching conceptual framework for introducing nursing students to nursing in a way that shifted the focus from the persisting medical model of health care – centred on disease and treatment – towards a focus on the individualisation of nursing on the basis of a partnership relationship with patients.

Our model placed nurses in an interdependent relationship with doctors rather than in a dependent and subservient role. Those ambitions were somewhat at odds with the primacy of medicine at the time, but

they were in keeping with – and a necessary response to – the societal changes and scientific advances that throughout the 1970s had been gathering pace.

One of the criticisms of our model was that it was little more than a re-jig of Henderson's (1960) definition of nursing. Yes, there was overlap. Just as Henderson built on Nightingale, we built on both. We all stand on the shoulders of giants. The 'RLT model' was not reinventing nursing, but it did contain new concepts and new emphases. Henderson's construct had centred on 'helping (the) patient' with 14 'components of basic nursing care'.

Our 12 Activities of Living (ALs) was not a list of nursing activities. It was a prompt for systematic assessment of how the individual's activities (of living) – each with a range of possible complexities, often inter-related – were or could be affected by their change in health status. This was a radical shift, even if that's hard to believe now, from the routinised and standardised role of nurses that was dictated by the patient's medically diagnosed disease condition and its medical treatment. The pity was that our model was often reduced to a list of the 12 ALs and the all-important more complex conceptualisation of the model as a whole could only be appreciated by studying the book.

The book – The Elements of Nursing – became a core text in many first-level nursing programmes in the UK. With more than a dozen translations it also was used in schools of nursing around the world. So, our model did become very widely known. It was the model most often used in hospital wards, if a model was used at all, and especially by nurses trying to 'implement' the then-new Nursing Process because we had integrated its steps – assessment, planning, implementing, evaluating – into the RLT model. This systematic approach is taken for granted in today's evidence-based approach to practice but, back then, 'the process' was resisted by nurses and ridiculed by doctors (Mitchell 1984, Tierney 1984).

Does the fact that the RLT model became well known mean that it influenced the development of nursing? That it made an impact on the mindset of a generation of nurses? That it changed day-to-day practice? Impossible to say. All I would claim is that our model was timely, even prescient, and arguably that it (along with other models) did play a part in the sea change – the paradigm shift – that radically changed British nursing though the eighties and nineties.

Current and future relevance

So, do nursing models – an invention of last century – have any continuing relevance for 21st century nursing? That was essentially the question behind my 1998 JAN paper 'Nursing models: extinct or extant?'. I think now that I rather fudged the answer or, at least, hid behind the conclusion drawn by Reed (1995) that our 'systems of knowledge' in nursing must always be seen as 'open and alterable, and always evolving'.

We could have continued to evolve the RLT model but Nancy, Win and I already had decided not to produce a further edition of The Elements of Nursing (Roper, Logan and Tierney 1980, 1985, 1990, 1996). Not because we believed the model was entirely redundant, indeed its core concepts were rooted in values and ideals that still had real relevance, but because updating a large generic textbook was becoming an impossible task with research now burgeoning. Instead, we published a millennial monograph (Roper, Logan, Tierney 2000) to document our development of the model and its refinement over time, and to bring to a close our work together, leaving others to build on it if they so wished.

As the new millennium has progressed, there definitely has been a continued decline of interest in nursing models and Shi-FanHan et al's (2017) bibliometric analysis shows that related publications have been steadily decreasing. However, they also point out that a diminishing literature does not necessarily signal redundancy of a subject but, instead, could reflect a process of maturation and assimilation. It is the case, in all disciplines, that ideas which were novel, sometimes disruptive, do become accepted and assimilated to consolidate the paradigm shift. That, I suggest, is what has happened with at least some of the conceptualisation that was central – and novel – to models of nursing.

Models certainly get no mention in the State of the World's Nursing report (WHO 2020). However, I can discern in its summarisation of what nursing encompasses (para. 20) and in its description of nursing roles in 21st-century health systems (paras. 23-28) that many of the concepts which nursing models promoted are embedded in current thinking about nursing and its future directions.

We may no longer want models, but we still need to be articulating and documenting our evolving thinking about nursing. My sense is that the nursing profession still recoils from theoretical writing and debate. However, there

are important reasons for continuing to reflect on our disciplinary development.

We need to be clear about the core and the boundaries of nursing in order to focus and prioritise our research endeavours, and to understand and negotiate our inter- and multi-disciplinary interactions. That was much simpler in the past when health systems were still hospital-dominated and staffed primarily by doctors and nurses. In contrast, there is nowadays a huge range and diversity of health services and healthcare teams, in and across hospital and community settings, and at the interface of health and social care. The world of health care in the 21st century is a very complex web indeed. And the challenges are huge.

If our profession really is to play a pivotal role in tackling these challenges, the 'new story for nursing' requires a bigger paradigm shift than ever before. One in which nursing looks outwards rather than inwards, working together with other health professions and the public to co-construct the broader story that could take us closer to achieving that compelling global aspiration of 'health for all'.

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