# Nursing: Thoughts on Nursing Service and Identification of the Service Offered—II

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### Signs contributing to the identification of the nursing process

One can distinguish among three kinds of signs contributing to the identification and recognition of nursing care, bearing in mind the basic difference between routine and habitual care—care for the maintenance of life—and care actions aimed at cure.

These distinguishing signs are the same as those one finds for every job or profession offering a service to society.

—knowledge;

—the technology utilized;

—the beliefs and the values on which the profession bases its service.

### Knowledge

One saying has it: "Tell me what you read and I will tell you who you are." One could turn this to say: "Tell me what knowledge you utilize in providing care, and how you use it, and I will tell you what care you give."

Two points should be looked at in relation to knowledge; the sources of the knowledge utilized; and how it is utilized; that is, the organization of knowledge.

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### Sources of knowledge

If the nursing process begins with the action of determining the vital needs of the patient and the search for a response to these, there is a need to call upon knowledge of various kinds and from different sources to perceive the signs of the health-illness process and to understand its significance; that is, to decode these signs by searching for their meaning in relation to the person concerned, within the context of his life and activities.

Two examples given by Claudine Herzlich in her book entitled **Health and Illness** illustrate the importance of bearing in mind how the patient feels about the illness in relation to his life context. One person, asked what "being ill" meant to her, replied: "Illness is anything which makes it impossible for a person to live normally.... if one has a cold, for example, one can continue one's life normally....except if one is a singer; in this case one can no longer work and therefore one is ill."

Health, and illness, reflect the life of the individual. If the care process, the nursing process, does not bear this in mind, then it is unrealistic.

In perceiving needs two points should be kept in mind. One needs to discover the nature of the person and observe what the person expresses other than through a systematic and sterotyped series of questions which are aimed more at placing people in categories rather than trying to understand what they are saying in relation to their lives. One then needs to decipher what people or groups are trying to say by measuring their statements against sources of knowledge which put us on the road to identification.

The first source of knowledge is the person or group which expresses a problem; for example, a group of women discussing contraception. This seems self-evident, but it is a way of proceeding which is the opposite of what has been ingrained through education. Nurses have been taught to tell people, to explain to people, before having discovered and understood what people are trying to tell them. Or else nurses use what people say to place them in a category of illness, or to classify them as "cases".

### Need to renew knowledge and for different kinds of knowledge

To understand what is said, one needs to compare it against knowledge which can explain and clarify the situation. But what sources of information do nurses use? Does nursing borrow its knowledge from old and outdated sources, inadapted to social and economic evolution; does nursing use cliches and well established routines? Does nursing rely on a single and unique source of explanation of illness and its manifestations; that is, on medicine, or is nursing care based on a body of knowledge providing information about the life of people, their beliefs, their daily habits—within the family, at school, at work, in groups, in institutions?

The health-illness process, the life-death process, cannot be viewed differently if we continue to rely on a single medical source and if we attribute ill-

ness to a single factor or cause, and eliminate or reject different cultural, social and economic factors.

### Example

One example is the increasing number of children who do not speak or who have not learned the basics of language at the age of three or beyond. The number of children with this deficiency is estimated at 10% in certain poor urban zones; they can also be found in rural areas. When these children are seen by health personnel and this deficiency is "identified" by using medical knowledge, health and social personnel undertake further research into the child's condition. These children are sent back and forth between various services and clinics. When it has been determined that there is no apparent physical reason for the child's deficiency, one finds marked in the child's record "nothing of note". Parents are reassured: "The problem will take care of itself, don't worry"....If it continues, special lessons are considered. Time passes... and some of these children begin school and the problem increases, others remain at home as long as possible because of this problem.

No further investigations are carried out and no further explanations are sought in order to understand this phenomenon, for the medical response is satisfactory and health personnel no longer feel themselves

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concerned with the problem. But is this not a very serious problem in life, and therefore of health? It is a problem which will have lasting consequences, and will have an indelible effect on the life of the person concerned.

Time should not be wasted and other cases should be explored at the same time as the medical investigation is conducted. For example, everything related to the mother's way of expressing herself with her child or children needs to be studied, bearing in mind the isolation of some mothers, their lack of possibilities for social exchange, for meeting others, and their impossibility of expressing themselves, which leads to a severe limitation of their vocabulary, and in the use of language, neglect of the spoken words and therefore a lack in the relationship with the child. Some mothers, deprived in today's society of the company of others which they formerly would have had with their mothers, mothers-in-law, and neighbours, really believe that the child will begin to speak all by himself one day. They know nothing about the process of imitation and reinforcement of experience. In this example we are confronted with a process of desocialisation. Isolation, poverty of the environment, lack of exchanges and of social relationships, simplification of the gestures of daily life which become more and more uniform, isolated from meeting others, from celebrations, from the rhythm of the seasons, these mothers themselves no longer speak, or else use a "baby" language (Dolto).

When faced with this type of problem, if one does not make educated guesses which go beyond the boundaries of medicine, one is faced with an impasse and an aggravation of individual situations which become life-long handicaps.

Moreover, when the roots of cultural and social problems are found, the response cannot be limited only to that case. Consideration must be given to measures which can be taken to recreate social bonds among people in certain buildings and in certain neighbourhoods. One is truly faced in such cases with the need for community action —action which can modify the conditions of life of the families concerned by such a problem. This example is more common that one might imagine. In rural areas, it is linked to a social process, which takes different forms for different reasons; for example, the decreasing population in rural areas.

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### What knowledge?

It is no longer possible to envisage nursing care without referring to very diffrent sources of information and knowledge relating to nurses and the life of individuals; such as:

—the body, and not as anatomical sections and physiological mechanisms; but for example, the image of the body, of the being, the means of expression of the body and the relationship between body and spirit (which we continue to want in dissociate);

—ways of life, conditions of work, family life, different styles of being;

—the diversity of beliefs and cultures, the variety of things which are considered "good" for one group and "bad" for another family or another group;

—factors which characterize a population and groups within the population;

—institutions in relation to social organization.

Knowledge breaks the uniform and conformist way of approaching health-illness problems, and health and social problems. This knowledge is to be found in areas as varied as:

—biology, which is quite different from the pathology on which nursing education programmes are built, whether this be general nursing or psychiatric nursing (Jacob, Laborit);

—demography, the study of populations, their distribution within a neighbourhood, a sector or a hospital by sex, age, socio-professional categories, and the study of migration;

—cultural anthropology and social psychology, in order to discover different cultures, relationships with time and space and their different symbolic meanings;

—sociology, in order to understand the impact of institutions on styles of living;

—economics, and particularly economics re-thought in relation to delving further into the idea of energy, utilisation of energy and sources of energy.

### How to find knowledge?

This knowledge must be gained through education and in the course of professional practice. This cannot be done only through courses of fragmented teaching. This knowledge, in order to be utilized and significant, must be based on teaching which goes to the sources of life surrounding us in its different aspects and manifestations. It is an open mind to the world and the capacity to delve into the sources of information of all kinds which can make the utilization of information real.

These sources of information pass through ourselves first. When will we allow free circulation of knowledge between our personal lives and our professional lives? Why must we, in our professional lives continually lose sight of the basic good sense which every mother has in relation to her child, or every person in relation to a friend?

Why must we continue to separate from professional practice everything which is based on thinking about personal experiences? Why are we not conscious of the fact that even by pushing these reactions into the background, by denying them, they affect our way of being, of acting, and of reacting?

We should also be utilizing everything which brings us information in daily life:

—films, which relate and analyse all kinds of events and which are impregnated with cultural and social models;

—books which speak about life —novels, biographies;

—group activities.

—group activities.

All these means will considerably broaden our way of viewing life, of defining ourselves, and will help us to better understand the problems of life which individuals must face, which create health needs as well as the process of deterioration, destruction, and maladaptation, as they appear in illness or accident. This presupposes that these sources of life can be considered in institutions, schools and services, in different forms: study groups, exchanges based on examples. This also presupposes that we use them to enrich the nursing care given.

### Organization and utilization of knowledge

In the last few years much emphasis has been placed on awareness, but awareness is a useless burden if one does not see how to use it, if one does not discover the significance of what is expressed by people, of what they want or do not want to say. Language often reflects the ambivalence of a desire or non-desire; these crisscross and present different facets which on the surface are in opposition, but in reality which co-exist.

Discernment grows out of the contrast of varied knowledge. But, in order for knowledge to be usable, it must be integrated within a process of analysis and synthesis. Every job, every profession develops only if it utilizes this process; otherwise it remains at the level of carrying out functions, of applying without questioning knowledge which is readymade and taken for granted.

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It is not enough to have courses taught on very different subjects. One must learn to analyze situations. One must be able to recognize and to regroup signs of what remains of health and of what appears as illness; of what is still a possibility for life and what is damaged. One must seek the significance of these signs in relation to the factors which create and which influence the situation. One must also develop working hypotheses. All this constitutes the sum of a process of elucidation with the object of determining not only the nature of the problems posed, but also the way to respond to them. This analysis takes place within the dynamics of time.

The health-illness process is not static; it is continually moving forward. The process of life and death takes place within an irreversible context of time.

From various situations one can learn to seek and to utilize knowledge to explain and verify phenomena and understand their significance in relation to care.

### Organizing knowledge for specific situations

Based on certain situations having common elements one can constitute areas of knowledge which one will come across frequently.

It is in this way that one can progressively develop theories which can be adapted and utilized in situations where there are common elements; in relation to age, the degree of illness or handicap, the nature of the crisis linked to a specific event in life and in relation to social and economic factors.

In spite of what is commonly thought, it is not the knowledge utilized which is specific, but rather the utilization which one makes of it which can be spefic; that is, adapted to particular cases or specific situations. A particular variable may be found over and over again.

In order for the organization of knowledge to be significant, it must be relative, changing and dynamic. It cannot be enclosed in rigid systems. Categories can serve as points of identification, but should not place the problem in a vacuum.

The organization of knowledge must take into account the meanderings and fluctuations in the process of life and death. It is a series of trial and error, calling into question certain so-called scientific truths. It is a continual state of seeking and becoming, and it respects the irrational.

This organization of knowledge, to be meaningful, must be integrated; that is, it must not remain outside ourselves, but must become a part of ourselves. This knowledge cannot be utilized and be a source of development unless it is based on real experience in order to give it meaning and permit it to be regenerated and re-created.

It must re recognized that for a very long time nurses were afraid of knowledge, for the whole concept of care and a whole social system kept

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them away from it, because of their belonging to a feminine and religious profession. In their capacities as women and as members of religious orders, then as nurses, they were kept away from sources of knowledge, Nurses were caught in the trap of cultural structures.

These cultural factors have left a deep impression on the profession, on the public and on the concept that the medical profession has of the nursing profession.

Every new piece of knowledge calls into question the pre-established moral order and the related social order. Knowledge modifies one's ways of being, of understanding the world and of reacting to it, and at first this can be frightening. But not to use this knowledge means that one accepts what happens and that one falls behind on the road of life. Life itself is a projection towards the future and it continues without us.

It is so important to encourage free access to and free circulation of knowledge right from the beginning of nursing education, and in all services. Access to knowledge should not depend upon rising in the pyramidal structure of the profession, for in that case the basic work will always remain underdeveloped, and those who provide care, like those who receive it, will only become poorer.

Finally, the knowledge utilized by a profession must constitute its heritage and must engender other knowledge and serve as a permanent foundation for all professional evolution. This heritage can only be constituted if there is written work which serves as a guarantee, as a reference and as the impulsion for evolution. Without written work, all is lost and needs to be begun again. There is no continuity and still less development and creativity.

"The competencies which characterise a profession flow from an ensemble of organized knowledge... The acquisition of professional competence requires previous or parallel mastery of the theoretical bases of this competence" (Bitensky).

**Technology**

Technology means the total of the tools utilized for providing a service, and the techniques associated with these tools: that is, the way in which one uses them.

Every job, every profession can be practised only by utilizing tools. These tools determine the professional practice which they orient and which they contribute toward identifying. If we take the example of the job of baker, this job is determined both by the product produced—bread, and by what serves to make it—the oven, as well as all the tools which are needed in making bread. Bread will be termed "good" or "bad" according to how the dough is kneaded, the oven used and the way of using it. (A wood oven and an electric oven give different qualities of bread).

By the tool utilized (the oven) and the way of using it, the baker will be described as a good or poor baker... Care, and nursing care, have had recourse to various technologies, of which the main ones were, for thousands of years, all those which helped to maintain life: common hygiene, nutrition, and relaxation. This care was always accompanied by a relationship which could not be dissociated from the act of providing care. Then came tools and curative techniques which were more and more complex, to which could be added the technologies of information. In relation to the utilization of technologies in providing nursing care, we can refer again to the old expression: "Tell me what tools you use rarely, frequently, almost always, never, in providing care... and I will tell you what care you give."

"Also tell me if you are clear about the final objective in utilizing such and such a technology, in relation to what is important in the life of a person

or family, and you will tell me what care you give..." Study of the technologies utilized in nursing care seems to the author to be a domain which totally needs to be explored.

If we carried out research in hospital wards and in outpatient services on the tools and the techniques that we utilize in providing care and on those that we never use, we would have a very clear image of the kind of care offered, of the predominance of curative care over daily and habitual care mobilizing life forces, including in those sectors where one has no need of super technology—or only exceptionally—as in domiciliary care. Moreover, one could evaluate the pre-dominance of "paper technology."

Certain paths could be followed in determining the kind and the quality of care.

One could, for example, ask oneself:

— What are the technologies utilized by nursing?

— What is the significance and the impact of the technologies utilized in providing nursing care?

— Does the nursing profession have tools and techniques which are unique to it?

**The body, first "tool" of care**

The body itself was the first tool used by a person providing care, and remains still the principal tool of nursing, in the sense that it is the vehicle of care. It is through the use of the body that one can give care to someone else.

First of all is the sense of touch, the major sense in providing care, first by the mother, then by the hands of all those who provide care.

What nursing care do the hands provide? Are they utilized only to handle, manipulate, carry, lift, press, inject, bandage? Are they still used to feel, calm, massage, relax, caress? One could do a whole analysis of the kinds of nursing care provided in a service by searching out everything that hands do in providing care by regrouping all the verbs which reveal actions carried out by the hands in the process of care, in relation to each situation, and by observing the importance given to some actions in relation to others and by noting those which have disappeared.

Our sense of hearing transmits a message and is the vehicle of listening. Hearing picks up the unusual silences, the almost imperceptible noises, crying, laughter, and identifies those who remain silent. Hearing tolerates aggression because it can find the reasons for it. Hearing seeks to understand the symbolism of words.

Sight situates people in their environment, discovers a face, deciphers a message sent by the whole body, according to whether it is bent, curled, nervous, anguished, unmoving, waiting...or open, expressive and relaxed.

But to speak of the body as the first privileged instrument of care is not only to evoke the senses, it is also to rediscover sensitivity.

The impersonalization of the body can only lead to impersonal and depersonalized care. To rediscover the body is also to ask how the body lives and how to seek out the conditions which can facilitate the life of the body. After the body, the main vehicle of care, the following need to be taken into account:

— the technologies linked to daily and routine care for the maintenance of life,

— the technologies for cure,

— the technologies of information.

**Technologies for maintenance of life**

There are an infinite variety of technologies for the maintenance of life and they should always be the object of imagination and creativity. These are all the technologies and all the tools linked to everyday life, but which require discernment about daily habits, whether in relation to washing, eating, the importance of clothes, the way of moving, and the organization of the space within the room, the home. Related to these technologies are those which are not common in France—either in hospitals or outpatient services—which compensate for functional handicaps; all those tools and gadgets which give total or partial autonomy to patients, and which ease the burdens of families and care-givers.

These are tools as simple and as practical as those to pick up things, and gadgets which allow the patient to feed himself. There are also all the instruments compensating for posture difficulties: seats which can be raised or lowered, cushions for the head, book stands. These are not used frequently for reasons which vary greatly, from fear of using them to fear of losing our own sense of usefulness.

To know about these tools, to use them, to offer advice about them, to help people learn to use them, is an intrinsic part of nursing care.

**Technologies for cure**

As already mentioned, the technologies of cure, as well as technologies for investigating the causes of illness, have progressively invaded the nursing care field. These range from the simplest instruments to the most complex machines and pose the problem of the limits of their utilization. This question is made more difficult by the fact that the utilization of these instruments and tech-

niques belongs more to medical care, prescribed by doctors and carried out by nursing personnel. Nursing care is therefore confronted with a multiplication and an inflation of cure technologies at the expense of other technologies, and also the exclusion of simple cure measures or care based on still unexplained knowledge but which is nonetheless real; e.g., elements of Oriental medicine and traditional medicine.

### Technologies of information

In the process of providing care, nurses use instruments and techniques of transmission of information. Many of these techniques, conceived more in relation to the organization of tasks than to the intent of the care provided, are of little significance and interfere considerably with nursing care. One finds them utilized to a large extent—as if by compensation—in services which do not use heavy technologies. For example, school health services have been invaded by a "paper technology" of no significance.

The techniques of information and their supports of all kinds can invade nursing care in the hospital and destroy its coherence. Whether in the hospital or in community services the technologies of information take up a great deal of time: multiplication of questioning, documents for filing the information, slips and papers to fill out without there being, in the majority of instances, a coherent link to the objective; that is, to assist each care-giver to understand and comprehend the whole situation of a person or a family. This fractioning of information

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isolates each aspect of a situation and leads to measures being taken one after the other, certain of which can even be harmful to the person and those around him because they bear no relationship to what is important to him.

The utilization of a set of technologies for nursing care poses the problem of the use which is made of them.

### Significance and impact of technologies utilized for nursing care

In looking at the effect and the sense of the technologies utilized in care settings, we are looking at their value in use. Are they "appropriate"; that is, are they appropriate to life? What life? How do they satisfy the total life needs? Or do they only fulfil an isolated need in the course of the life of a person or family, or social group?

The kind of nursing care that we offer to patients will be better identified if we determine the appropriateness of the tools that we use, and how we use them.

On the basis of what thinking do we choose to use or to eliminate such and such a tool? Or such and such a technique? On what basis do we feel obliged to discuss with others—doctors, physiotherapists—the use of such and such a technique in relation to what the patient expresses about his needs?

How do we analyze the importance to be accorded to technologies which contribute to meeting common needs in relation to indispensable curative technologies? On what basis are priorities evaluated?

One can also ask: how and by what means do these technologies affect the independence or dependency of the patients in our care? How do they assist us to go beyond the simple compensation of illness to be concerned with the totality of the person within his environment? How do they affect our means of communication and relationships with others—patients, other health personnel, families? How do they contribute to smothering or developing our discernment of human problems? How do they limit us to carrying out specific tasks emptied of their meaning? How do they contribute to monopolising or sharing knowledge?

### Integration of the technological procedure and the relationship process

The significance and the impact of the technologies utilized depends also to a great extent on the link between the technology used and the relationship that goes with it. To help someone live, to facilitate someone's life, the utilization of tools and of care techniques requires a closely linked supportive relationship. Care has its full meaning only if utilization of techniques remains integrated in the relationship process.

When the mother bathes her child, she contributes to his whole psycho-motor development because she associates the bath with a whole set of

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tactile, verbal and non-verbal relationships which make the bath a game which stimulates the child and is a source of awakening and development.

This integration of technological procedures and the relationship process is found also at the level of curative care, whether from the medicinal point of view—herbal infusions, potions, backrubs; or other forms—covering with blankets, bandaging. With the changes brought about through technological development at the end of the 19th century, other forms of work organization appeared

and the rhythm of life accelerated. Little by little, tasks were divided and subdivided.

This work in little bits or crumbs progressively impregnated the whole process of care: first of all by separating maintenance care and curative care from the emotional support system; then by stripping them of a large part of their significance. Care became a series of isolated, stereotyped acts. There was a gradual impoverishment of care, and this had repercussions both for clients and for care-givers. Care became more and more separated from the relationship process which is a part of it. This impoverishment did not affect nursing only, but the whole field of care, including the oldest forms of care: maternal health and family health. More numerous than one would imagine are the mothers for whom the bath and care of the child are only carried out for hygienic reasons. Some of them cannot even imagine that these acts could have more meaning. (Anthropological and sociological studies have shown the superiority of the psychomotor development of children in African societies up to the age of weaning, because of all the forms of bodily, emotional and social relationships which they have—relations which accompany all on-going care).

In the health services, the organization of tasks has little by little become more important than their significance, while tasks isolated from the context of the relationship have been built on the growing complexity of technologies, to the point that they serve as a scale of measurement for the economic and social value of care, and of nursing personnel.

It is, therefore, necessary to reconsider the utilization of the tools and techniques of care in relation to the dimension of relationships, for that is what gives care meaning. As long as there are technologies and technicians (created by and modeled for technologies), and on the other hand relationships so dissociated from care that they are handed over more and more frequently to specialists, the care process will be illegitimate, impoverishing, and will miss its objective, at the same time creating frustrations and guilt feelings on the part of care-providers.

Has the nursing profession developed tools and techniques which are unique to it?

If one of the basic determinants of a profession is the tools and techniques utilized in professional practice, one can very well ask whether nursing personnel have specific tools of their profession. Have we conceived, forged and developed tools in the practice of nursing? Or are the tools which we utilize all borrowed from other professions, particularly the medical profession?

**"In the health services, the organization of tasks has little by little become more important than their significance."**

Why are we conditioned to prefer without hesitation the almost exclusive use of certain techniques borrowed from the medical field, neglecting the utilization of techniques from other fields and other arts? We should be searching to incorporate in nursing care techniques as varied as the techniques of corporal expression: esthetics, relaxation, mime, dance, dramatic arts, music, painting, as this is beginning to be done in certain psychiatric therapies. Nursing should delve into all sorts of various technologies and recreate them, re-think them, adapt them, in view of care practices. The same is true for the utilization of the technologies of information.

### Simple technologies

There are simple technologies of daily care, primary care. The technologies utilized at this first level of care prevent any aggravation of the condition and therefore limit considerably the need for curative care when people have been able to benefit from it in time by having access to it near their homes and at suitable hours. There is an infinite number of tools and varied and simple techniques, adapted to people, and which can be utilized by patients themselves, as WHO has stated in recommending that research be carried out in this field: "To provide basic care, elementary technology is needed which can be easily understood by the population and easily practised by non-specialists. To identify and develop this technology is part of the health revolution of people and groups" (WHO July 1977).

These technologies should be given priority: "Too many resources are spent on spectacular hospital treatment of acute illnesses, and too little on the primary health care needed by large segments of the population, as well as continuing health care for those persons suffering from chronic physical or mental illnesses and the handicapped" (WHO January 1977).

### Beliefs and values

Nursing is marked by and therefore identifiable by the concepts, beliefs and values to which both the consumers and the providers of care are attached. Both groups are under the influence of predominant values promoted by the social system which localize their action in relation to the diversity of cultures of groups, class cultures, geographic, climatic, rural or urban cultures.

If the author has mentioned last the beliefs and values on which the action of care is based, it is because they are closely interdependent with the knowledge and technology of a period. One can distinguish

several currents of beliefs and values influencing and even determining the orientation of nursing care.

### Traditional beliefs and values

Nursing practice is based on ancient empirical knowledge and therefore the values in nursing are related more to dogmatic ideologies, linked to traditional morals.

These values had, for so long, such an influence on the concept of care that they prevented new knowledge from being accepted and based nursing practice on noble motivations and blind devotion. This slowed down considerably the evolution of nursing and prevented the growth of nursing science.

These values are less distinguishable at the present time, but they still relate to a whole concept of nursing practice in more disguised forms. They are still very present and continue to influence nursing education and practice.

They are based both on everything which has separated the body from the spirit, on everything which has made of the body and in particular the female body an instrument of evil and of sin, and they are based on all the social values born from the concept of the place of men and women in society, values on which are based the whole concept of family and institutions. They are still based on a whole acceptance of wealth and poverty linked to social classes (Bertaux).

### Beliefs and values based on the supremacy of technology

Beliefs and values based on the supremacy of technology have appeared more recently, with the development and the invasion of the care field by investigative and curative technologies. We have sought to promote nursing practice and especially to promote the nurse by mastering more and more complex tools and techniques, thereby imitating physicians and trying in this way to be more highly considered and to gain more social recognition.

These beliefs, based on the appreciation of technologies, could only develop within the hospital sector, relegating practice outside the hospital to the category of an illegitimate branch of care or a non-professional one. (Many nurses who leave the hospital setting feel that they have left their profession, or no longer know anything about it. This is very true if one takes into account that they have learned nothing of what their profession could be outside the hospital setting).

Even within the hospital setting, this acceptance of technologies took place without any analysis of their contribution to nursing care responding to the needs of individuals and of groups. It took place under the influence of medical orientations —organic or psychiatric medicine—and choices of economic models which placed value on certain services.

### Health for its own sake

Other beliefs are based on the concept of health. Here again, points of view are very different according to whether health is defined through a stereotyped definition, based on out-dated ideologies, such as "a state of complete well-being." There is no health without life and life is constant movement, it takes place within a constant dynamic. It is the opposite of a "state" and it is incompatible with "total well-being", for there is no life without struggle and conflict at the biological level as well as cultural, social and economic levels. Based on this overestimated idea of health, one can conceive a whole system of care which is alienating, as much for the receivers of care as for the providers of care. On this concept of health, isolated from the illness process, we have erected a whole system of preventive care based on changing behaviours and on surveillance and control; a system which separates the well from the ill.

The three sources of belief and values mentioned abov are mutually dependent ar are found in many situations various forms, marked by re titive ideologies. "The pat is most important"; "The he of people is most importar but there is rarely an analys of these themes.

### Beliefs and values based on analysis of the life-death proc

Another way is open to nurs ing to clarify the concept c care and to renew its belie which always run the risk o hardening and becoming dog mas. This way is to analyz everything that affects the pro cess of life and death, as experienced by man as different manifestations of life. It is an analysis of everything that contributes to birth, to develop the life of the individual, and what can hinder it.

It is a discovery or re-discovery of the different fundamental aspects of life, by restituting them in relation to the socio-cultural and socio-economic experience of individuals and groups, bearing in mind the social group, work, and resources.

Therefore, ideas need to be explored concerning energy (there is no life without energy); space (there is no life without a setting in space); the idea of territory; dimensional space; relational space in respect of people and objects; and the comprehension of space in relation to cultures—the symbolism of space, and various aspects which relate to it—the outline of the body, the image of the body; time (the present, the length of time, frequency, rhythm of time, the comprehension of time at different ages

nd different stages of life). inked to the idea of time are leas of identity and of change nd transformation within the rocess of adaptation and in- laptation.

Another idea for study is that threshold. Life takes place ween a minimum and a maxi- n threshold, linked to an y of stimulation and acti- s. There are differences ese thresholds in relation tures and individuals. To re related phenomena of s, crises, and loss (deaths).

ne idea of information and ramming also needs study, ding biological informa- (the genetic haritage), cul- information (the cultural age which inscribes its mo- as different experiences are rbed); and information and titutions.

relation to all these as- ts, we need to discover or ediscover the importance of he different fundamental ele- ments of life, bearing in mind age and cultures—water, air, earth, fire, light. The health-illness process is a whole indissociable from the life-death process of which it is a manifestation.

Nurses should be aware of this and nursing should evolve only on the basis of an analysis of the contradictory and indissociable forces of life and of death.

Knowledge, technologies, values and beliefs are identifiable points which allow us to define better the kind of nursing care offered to the population: habitual and daily care for the maintenance of life, and curative care. Besides these basic characteristics, and in relation to them, one more thing needs to be taken into account: the social and economic dimension of nursing care.

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*(Article to be continued in next issue)*

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# STUDY VISITS IN THE UNITED KINGDOM FOR THE OVERSEAS NURSES 1981

The Royal College of Nursing, London invites the members of the Trained Nurses Association of dia to United Kingdom for professional observational visits under the ICN Nursing Abroad Programme Scheme. The study visits will be arranged as per schedule given below:—

| | |
|---|---|
| April 6th-10th | 60 places |
| November 9th-13th | 60 places |
| November 23rd-27th | 60 places |

Applications for the above visits will be accepted by the Rcn International Department only rough the Trained Nurses Association of India. Those who are interested may apply to the Secary, TNAI, L-17, Green Park, New Delhi-110 016, with the following information a **minimum** of **three nth** before the date of your visit.

1. A resume' of your professional experience and curriculum vitae.
2. A brief description of the aims of your visit and your particular areas of professional interest.
3. The exact dates of your arrival in and departure from the U.K.
4. Dates which you would like to be left free during the professional programme for private or family visits or sightseeing.
5. Your address in the United Kingdom (the Rcn has no facilities to arrange accommodation and you are advised to ask your own travel agent for an accommodation and travel package).

The above information is necessary to fit in with your particular needs and interests.

Participants will be responsible for financing their own travel to and from London, in addition accommodation and meals, and any transport which may be required by you during the programs, as some host hospitals are not in Central London. There will be a non-refundable charge in the ion of £15.00 to cover expenses on administration and planning. This fee is to be paid by partici- nt in sterling on the first day of the programme.

SECRETARY, TNAI.