Nursing Education in the Social Perspective

by

Prof. S.K. Ramachandra Rao

Professor of Psychology, Callison College and National Institute of Social Sciences, Bangalore ; Visiting Professor, College of Nursing, Bangalore.

NURSING has for long been recognised as an important aspect of medical care in the community. Although in the professional stratification, the placement of a nurse is secondary, her acknowledged role is impressive enough. And the recognition over years that the nurse is required not only to assist the physician or surgeon in carrying out the routine checks, in administering medications and in interpreting the doctor's prescriptions to the patient, but also in caring for the patient and encouraging his participation in the treatment programme has highlighted the need for effective nursing education. In fact a trained nurse has now a more significant role to play in the therapeutic team than in the years that have gone by. The realisation that while the doctor treats a case the nurse is confronted by a person, and that while the doctor cures the patient the nurse cares for him has vastly altered the traditional role of a nurse. One can now no longer function as a nurse merely on the basis of compassion, not because solely of the need for some employment, nor yet as a result of some snappy training provided by the medical staff within an hospital set-up. Training of a nurse has naturally and justifiably become elaborate and self-contained and has risen to high academic standards. Nursing education has become a speciality, because nurses can and do function in their own right.

The old world values that the nurse must be kind and friendly, cheerful and dedicated, and so on emphasised aptitude and inspiration rather than knowledge and technical competence. Even when hospitals were no longer charitable institutions, that they were in the middle ages, the 'tender loving care' of a nurse continued to be played up. The emergence of the professional nurse distinguished by the corpus of technical knowledge and with a pride in her craft has been a recent event, still incomplete and ongoing. The talk of the 'milk of human kindness' has given place to ideas of specialised technical skills. With the more recent transformation of the hospital into a kind of factory, (as George Rosen has pointed out) or into a kind of garage where "human cars" are brought for repair (as Hans O. Maunksch has observed), the emphasis on routinization and automation has further robbed the institutional nurse of what angelic values that still lingered : she is a partner in a healing business and naturally has her eyes on the responsibilities and the associated privileges.

I hasten to add that this change is no way an abnormal development, but, is in perfect accord with the general changes that we see taking place elesewhere in society. The hospital is after all a social system, and class dynamics is an unavoidable feature in any social organization. It is small wonder, therefore, if nurses are drawn into an ethnocentric involvement. Nursing is now a profession, a vocation, an employment opportunity. It fulfils a felt need in the institutions meant for medical care and cure ; and such institutions employ other functionaries who are not required either by the administration or by the public to show the same 'tender loving care' that is expected of nurses. And the job of the nurse is getting sharply defined and formalised as regards the work-load as well as hours of work. She is caught up in a routine, and has necessarily to perform most of her work rather mechanically. Scope for exercising her compassion is limited indeed, as limited as in the case of foreman or a labour welfare officer in a factory. The prevailing view that the patient is hospitalized not much to be looked after as to be cured of an ailment and relieved of a distress condition has determined the nature of the hospital organization which is becoming increasingly client-oriented. More than the philosophy of nursing, it is the function of nursing that has become important. And rightly so, for nursing is not merely a role, but a career. The world has changed considerably since the days of Florence Nightingale.

II

The social changes which brought about this transformation of nursing from a disposition to a profession also extended the academic horizons related to nursing. When the nurse was a mere 'handmaiden' to the doctor, implementing his directives and helping him in his healing procedures, what little training she needed was given by the doctor himself. But when in due course she was no longer the doctor's 'handmaiden', but a participant member of the health team her training began to be considered at the University level. It was the Columbia University Teachers' College that recognised as early as 1899 the nurse's need for higher education, and it was the University of Minnesota that organised in 1910 the first basic school for nursing. Since then nursing education has made rapid strides both in the curriculum content and in the methods of preparing the nurses.

(*Contd.*)

It is usual to recognise three phases in the development of nursing education. The first phase commencing from the Goldmark Report of 1923, continued the legacy of the earlier emphasis on the physical aspects and on the medical care. The nurse was still largely the doctor's assistant, and her world was filled with only medical jargon, signs and symptoms, a few manipulative techniques (like pulse, temperature and respiration) and the custodial care of the patient. Her training was restricted to this gamut. Neither the society nor the doctor considered the role of a nurse as essential. The person with a disease went to the doctor, and the doctor busied himself with the disease and not with the person who had it ; the patient for him was only a 'symptom-vehicle'. Neither the social sciences nor the biological sciences (including medicine) had at that time developed sufficiently to tell the society as well as the doctor that in any treatment procedure the person was more important than the disease he had, and that the cure of a disease necessarily involved the consideration of the person.

The Brown Report of 1948 marked the beginning of the second phase in nursing education. The biological and social sciences had by then made great strides and the knowledge of man and of his environment (both physical and social) was considerably advanced. Man as a person and disease as an entity were both in clearer prespective, and their import for social welfare was also underlined. Disease was no longer considered a purely medical problem, to be tackled solely by the doctor. The social aspects of disease and impairment were stressed in Sociology and the cultural variations in disease patterns were highlighted in cultural anthropology. Psychology, of course, came into the picture in a big way. The person, therefore, had to be treated as more than a mere disease-bearer ; his social background and efficiency, cultural stresses and provisions, psychological reserves and defences had necessarily to be taken into account.

And the hospital organization was also getting elaborate and intricate ; with an increase in the incidence of disease, in the variety of disease, and in the awareness among people of the improved medical facilities, the hospitals found it expedient to provide stylised assistance to the doctor. Instead of the doctor alone approaching the patient there was now a health team of which, however, the doctor was naturally the leader. But the team was structured on the basis of roles. And the inclusion of nurse in the team not only specified her role but emphasised that role. The idea that was gaining ground was that the care of the patient had to be comprehensive, that the patient had to be treated as a 'whole person' and not merely as a 'case' of a disease.

Within the health team, the doctor's speciality being exclusively medical, the responsibility for comprehensive or total patient care was laid on the nurse. There was thus a major shift in the nurse's role ; it now included work not only 'for' the patient (custodial care) and 'to' the patient (technical care) but also 'with' the patient (professional care). This aspect matured in the third phase, which is still on. Apart from the traditional duties a nurse continues to perform today (i.e. recognising symtoms and reporting deviations to the doctor), she is expected to assume a supportive and counselling role, encourage the patient to have self-direction, teach him not only about his ailment but about life-problems surrounding that ailment, and work with the patient and his family towards adequate rehabilitation and so on. The list of expectations is long and impressive ; the new role that the nurse is to assume no doubt is welcome but difficult in the extreme.

III

The third phase has naturally presented numerous problems. The nurse has emerged in this phase as a significant member of the health team, not only in the hospital setup but in homes and health agencies of several types. Her role now is complicated and no longer confined to making the patients physically comfortable and assisting the doctor in a therapeutic programme. Her education, therefore, has become the chief problem. It is well-known that there is no such thing as a 'nursing science', although the National League for Nursing Education (June 1957) in New York employed this expression. We do not have a well-defined scientific body of knowledge which is uniquely suited for nurses. Besides the subjects which are medical and paramedical, (which continue to constitute the major load in the nursing curriculum), social sciences (primarily Psychology, Sociology and Social Pathology, Anthropology and Education) and Philosophy (including Axiology and religions) are relevant to the nurse's new role. Many of the Nursing Schools have indeed included most of these subjects in their curricula.

But aspects of these disciplines that are relevant to the theory and practice of nursing need to be coordinated and integrated to provide a consistent academic framework for the nursing student. It is unsound and wasteful to leave the many and unconnected subjects in the curriculum as such, leaving to the doubtful ability of the students the task of integrating them for themselves. Purposeful education involves a readily recongsiable and meaningful pattern of subjects taught in the class-room. In view of the changed role of the nurse in the community today, her education needs to be broadbased in structure and inter-disciplinary in character. For her field of work is now wider and communications more expandded.

It is important to recognise that a nurse today is something of a technologist, and she is being prepared to be a kind of "human engineer" in the health set-up. Her work is essentially with human beings—human beings in distress, with painful problems, needing urgent help and advice, eager for care and reassurance, and anxious for knowledge and understanding. Health is one, but disease is manifold. Medico-Social problems

(*Contd.*)

occur in infinite shades and brands; the only common feature in all of them is that human beings are involved. A nurse is called upon to minister, to observe, to teach and to communicate. There is an increasing demand for nurses with specialized technical skills. Dean Reiter has contrasted professional nursing with technical nursing, underlining the increased need for the former ! (Quality of Nursing Care, 1963). Of the three types of direct nursing cares, viz. custodial, technical and professional, the emphasis now is on the third. And this emphasis has altered the nursing perspectives. The education and preparation of a nurse are, therefore, both academic and professional.

The inclusion of behavioural sciences (like Psychology and Sociology) has now become an accepted policy in nursing education. As early as 1937, the *Curriculum Guide for Schools of Nursing* (National League for Nursing Education, New York) made an attempt to correlate the biological sciences with the social from the nursing point of view. Since then, however, the social sciences have themselves developed so significantly that their import for social work (including nursing) has become all the more relevant. Consider, for instance, what has been decided by an expert body as basic in the education of all health workers :

"1. Normal growth and development including aging processes ;
2. Dynamics of group behaviour and interpersonal relationships ;
3. Psychological, sociological and economic concepts that are used to interpret individual behaviour;
4. Principles of learning and teaching ;
5. Concepts of prevention and rehabilitation ; and
6. Basic communication skills"

This list, given by the sub-committee of the National League for Nursing headed by Faye Abdellah, for developing meaningful clinical record (Patient-Centered Approaches to Nursing, 1960, p. 23) indicates the importance of Psychology, Sociology and Communication Science in nursing education. Especially important are the problems like socialization, supportive counselling, role-assumption, sociosomatic and psychosomatic processes, principles and expression of social pathology, attitude-formation, stereotypes and group dynamics. There is much in these topics that would directly concern a nurse and help her to take her enlarged role with an awareness of its involvements. There was a time when nursing education was primarily empirical ; there is now a distinct shift to its being scientific.

IV

Greater emphasis on the attitudes rather than on the tasks seems to be indicated by this new outlook. There is already a protest in nursing circles against over-specialization by clinical sub-divisions. Edith Lentz and Robert Michaels undertook to compare medical nurses with surgical nurses, and found that training makes a big difference in the attitudes of a nurse. (*Nursing Research*. 1959, 8, pp. 192-197). When the disease groups and the physical needs of the patients in those groups determine the training in nursing specialialities, we can only expect the attitudes that are likely to develop to be narrow and disease-orinted. But the present-day stress is on comprehensive care and patient-orientation ; and there is undoubtedly a demand today for specialist nurses. The problem before the nursing educators, therefore, is how to reconcile these conflicting trends. The way-out seems to be to provide a layered programme of instruction devoted to the attitude-oriented general comprehensive preparation at the initial levels, and task-oriented specilization at the terminal levels.

The need for attitude-oriented preparation on the part of a nurse is being increasingly felt in countries where the ideas of extended care, progressive patient care (PPC) and personalized care have been accepted. The Social Security Amendment of 1965 which focussed attention on extended nursing care indicated that the nurse was the chief therapeutic agent in this framework ; she was the final 'effector' in providing inter-related patient care. The 'nursing homes' where restorative service and rehabilitative attention are provided illustrate how effective the new extended care role of the nurse can be. The progressive patient care is distinguished by its self-care aspect which is a sort of a half-way house for the patient between the hospital and his home. In this as well as in the other four aspects (intensive care, intermediate care, long-term care and extension of hospital services), the role of the nurse is all too important because of her attitude-oriented preparation. The rehabilitation is achieved by the patient, which he plans with the nurse.

The worst thing that can happen and also the most usual thing to happen to a patient who is hospitalized is to get depersonalized. An anxious bundle of symptoms, his interests are also morbidly constricted ; away from home, thrown into a strange surrounding and subjected to an unfamiliar routine, he quickly loses his identity in that set-up, and when individualized attention is also lacking his 'sense of psychological desertion' becomes complete. Ignorance about his illness and dread concerning the treatment can easily aggravate his condition. The sick person is proverbially ego-centric, and this makes matters worse. The hospital becomes a traumatic situation, whatever the severity of the impairment. The patient's helplessness adds to his discomfiture. Although he is the one who is most directly concerned with the treatment, his role is altogether passive ; he is only at the receiving end, and often he is not even taken into confidence, nor is he always properly motivated. Personalized nursing care concept is designed to remedy this anomaly. Patient participation in the treatment procedure has to be made active and positive ; the patient should be helped to define for himself his own situation.

Virginia Henderson described as the unique function of a nurse "to assist the individual sick or well, in the performance of those activities contributing to health or its recovery that he would perform unaided if he had the necessary

(*Cont. on page 342*)