

GUEST EDITORIAL - NANCY ROPER

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REFLECTIONS ON NURSING

When asked to contribute this Guest Editorial I realised that after 65 years in the profession I still spend time reflecting on that age-old, apparently simple question 'what is nursing?'.

In the first 80 years of the last century the main perception of nursing held by lay people, particularly those intending to make a career in nursing, was 'hospital' nursing. Transfer of nursing into tertiary education in the latter part of the last century highlighted the fact that students were still eager 'to get to the wards'.

But much earlier, that is in 1859, Florence Nightingale's 'Notes on Nursing' was published. She wrote that the laws of health were the same as those of nursing and almost 150 years later the World Health Organisation considers that nurses are in the best position to encourage nursing patients in the community rather than in hospitals as well as encouraging health and preventing ill health.

No wonder that at the end of the 20th century - Marriner Tomey and Alligood consider Florence Nightingale to be the first 'Nursing Theorist'.

At 18 years of age I left school to begin a three-year apprenticeship training to become a State Registered Children's Nurse (1936-1939) at the end of which, World War II was declared. I proceeded to a similar type of training to become a State Registered Nurse (1940-1943). In both these trainings I disliked being moved to various wards supposedly to gain experience in different 'sorts' of nursing. Later, as a teacher, I realised that all these moves were demanded by the registration council and were essential for completion of entry forms for state examinations. However, I was of the opinion that there were more commonalities than differences in the nursing experience available in those various wards.

The writing part of my career began while I was teaching and after 15 years it became evident that I had to choose between the two. So, in 1964, I became a self-employed writer, the first British nurse to do so. When I was not writing new editions of my books (which included a nurses' dictionary and a pocket medical dictionary) I spent time thinking about commonalities and differences. I started from the premise that if it were valid to accept categories such as gynaecological nursing, psychiatric nursing and so on, then the commonality was 'nursing' and it should be identifiable. I collected data about the patients in all the clinical areas used for allocation of students in one college of nursing. The data revealed that the common

core related to patients' everyday living activities, consequently my research monograph contained the Roper model of nursing based on a model of living (Roper 1976).

In 1980 these models were superseded by the Roper-Logan-Tierney models, which were published in 'The Elements of Nursing' (1980, 1985, 1990, 1996). The fourth edition in 1996 is our last. The final version of our models is contained in a monograph, which was published in 2000. It was reprinted in 2001 and is being translated into Japanese, German and Portuguese.

The literature review for my research revealed the history of nursing models. It started around the 1950's when head nurses in the USA were resigning in large numbers and this phenomenon was called 'flight from the bedside'. Investigation revealed that they were dissatisfied that nursing was increasingly being predicted by the patients' medical diagnosis. The time was ripe for differentiating doctoring from nursing. By 1965, a small group of American nurses recognised the absence of an organising framework for nursing knowledge. They formed a Nursing Model Committee at the Nursing Faculty of the Catholic University of America, Washington. In 1968 it became the Nursing Development Conference Group and in 1973 it published the result of its work and the book was called 'Concept Formalization in Nursing: Process and Product'.

Over the years there followed publication of various models and in 1994 30 were collected as one book (Marriner Tomey, Alligood 1994). Roper-Logan-Tierney were the only other non-American 'Nursing theorists' to be included. Reflecting on the pros and cons of this era, readers are referred to Tierney's discussion 'Nursing Models: Extant or Extinct?' (Tierney 1998).

We stated that our model captured the core of nursing and that patients/persons enacting their relevant activities of living (ALs) were central to that core. Using a tree as a metaphor, the roots need to continually receive adequate nutrition from education, practice, management and research to constantly nourish the ever-changing trunk - the core of nursing. Trunks give off innumerable branches - each one bearing the name of an adjectival form of nursing and each needs the developmental support of education, practice, management and research as well as continual nourishment from the trunk/core of nursing. These adjectival forms of nursing are often called specialties and the Royal College of Nursing UK has 40 forums to support members working in these different specialties. The journals publish reports from an

increasing number of nurse specialists and their area of work seems to be more technical and dependent on medical diagnosis. Have we come full circle? Or is it due to a shortage of doctors? A shortage of nurses is frequently acknowledged in the journals! Or is it thought that publishing the technical specialty is adding to 'nursing's' body of knowledge. In a Nursing Theory Conference in Stockholm in May 2000 Jacqueline Fawcett voiced her anxiety about nursing surviving as a discipline if its research is conducted without the context of a conceptual model of nursing.

What is nursing? What is the meaning of a baccalaureate, masters, doctoral degree in nursing in the context of a conceptual model of nursing? As yet, no country's health service is carried out only by graduates who are also registered by the country's statutory body. Non-registered personnel, whatever their title, contribute to the nursing service. They may be nationally prepared at first, second or third level according to the length of the program, and they may gain a nationally relevant certificate. Other institutions use an in-house program and may award a certificate, which is not recognised nationally or even by other similar institutions. So what is the commonality of all these differently prepared personnel? Again I find a metaphor useful, this time a microscope at the end of which there is a slide of a conceptual model of nursing. Level one health care assistants look at it through a weak lens and learn about the model in a simple way. Level two assistants need a stronger lens and a less simple learning program, and so on, until doctoral students are

studying at an advanced level. It would mean that all contributors to the nursing service conceptualised the patient/person enacting relevant ALs as the core/trunk of their work from which the branches/specialties grow. Implicit in a conceptual model is the invisible contribution to the patient/person. A list of tasks can never define the work/role of any contributor to the patient/person's welfare and in this fast changing world, the role and conceptual models need to be broad and flexible to accommodate change. This is the exciting challenge of the 21st century - to confidently state our unity and acknowledge diversity.

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