

# Historical development of nursing

[Health & Medicine](#), [Nursing](#)



Historical Development of Nursing Timeline Create a 700- to 1,050-word timeline paper of the historical development of nursing science, starting with Florence Nightingale and continuing to the present. Format the timeline however you wish, but the word count and assignment requirements must be met. Include the following in your timeline:

- Explain the historical development of nursing science by citing specific years, theories, theorists, and events in the history of nursing. Explain the relationship between nursing science and the profession.
- Include the influences on nursing science of other disciplines, such as philosophy, religion, education, anthropology, the social sciences, and psychology. Prepare to discuss your timeline with your Learning Team or in class. Format all references consistent with APA guidelines.

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Nursing Theories. The Base for Professional Nursing Practice, Sixth Edition Chapter 2: Nursing Theory and Clinical Practice ISBN: 9780135135839 Author: Julia B. George RN, PhD copyright © 2011 Pearson Education

Florence Nightingale believed that the force for healing resides within the human being and that, if the environment is appropriately supportive, humans will seek to heal themselves. Her 13 canons indicate the areas of environment of concern to nursing.

These are ventilation and warming, health of houses (pure air, pure water, efficient drainage, cleanliness, and light), petty management (today known as continuity of care), noise, variety, taking food, what food, bed and

bedding, light, cleanliness of rooms and walls, personal cleanliness, chattering hopes and advices, and observation of the sick. Hildegard E. Peplau focused on the interpersonal relationship between the nurse and the patient. The three phases of this relationship are orientation, working, and termination.

The relationship is initiated by the patient's felt need and termination occurs when the need is met. Both the nurse and the patient grow as a result of their interaction. Virginia Henderson first defined nursing as doing for others what they lack the strength, will, or knowledge to do for themselves and then identified 14 components of care. These components provide a guide to identifying areas in which a person may lack the strength, will, or knowledge to meet personal needs.

They include breathing, eating and drinking, eliminating, moving, sleeping and resting, dressing and undressing appropriately, maintaining body temperature, keeping clean and protecting the skin, avoiding dangers and injury to others, communicating, worshiping, working, playing, and learning. Dorothea E. Orem identified three theories of self-care, self-care deficit, and nursing systems. The ability of the person to meet daily requirements is known as self-care, and carrying out those activities is self-care agency.

Parents serve as dependent care agents for their children. The ability to provide self-care is influenced by basic conditioning factors including but not limited to age, gender, and developmental state. Self-care needs are partially determined by the self-care requisites, which are categorized as universal (air, water, food, elimination, activity and rest, solitude and social interaction, hazard prevention, function within social groups),

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developmental, and health deviation (needs arising from injury or illness and from efforts to treat the injury or illness).

The total demands created by the self-care requisites are identified as therapeutic self-care demand. When the therapeutic self-care demand exceeds self-care agency, a self-care deficit exists, and nursing is needed. Based on the needs, the nurse designs nursing systems that are wholly compensatory (the nurse provides all needed care), partly compensatory (the nurse and the patient provide care together), or supportive-educative (the nurse provides needed support and education for the patient to exercise self-care). Dorothy E.

Johnson stated that nursing's area of concern is the behavioral system that consists of seven subsystems. The subsystems are attachment or affiliative, dependency, ingestive, eliminative, sexual, aggressive, and achievement. The behaviors for each of the subsystems occur as a result of the drive, set, choices, and goal of the subsystem. The purpose of the behaviors is to reduce tensions and keep the behavioral system in balance. Ida Jean Orlando described a disciplined nursing process. Her process is initiated by the patient's behavior.

This behavior engenders a reaction in the nurse, described as an automatic perception, thought, or feeling. The nurse shares the reaction with the patient, identifying it as the nurse's perception, thought, or feeling, and seeking validation of the accuracy of the reaction. Once the nurse and the patient have agreed on the immediate need that led to the patient's behavior and to the action to be taken by the nurse to meet that need, the nurse carries out a deliberative action. Any action taken by the nurse for

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reasons other than meeting the patient's immediate need is an automatic action.

Lydia E. Hall believed that persons over the age of 16 who were past the acute stage of illness required a different focus for their care than during the acute stage. She described the circles of care, core, and cure. Activities in the care circle belong solely to nursing and involve bodily care and comfort. Activities in the core circle are shared with all members of the health care team and involve the person and therapeutic use of self. Hall believed the drive to recovery must come from within the person.

Activities in the cure circle also are shared with other members of the health care team and may include the patient's family. The cure circle focuses on the disease and the medical care. Faye G. Abdellah sought to change the focus of care from the disease to the patient and thus proposed patient-centered approaches to care. She identified 21 nursing problems, or areas vital to the growth and functioning of humans that require support from nurses when persons are for some reason limited in carrying out the activities needed to provide such growth.

These areas are hygiene and comfort, activity (including exercise, rest, and sleep), safety, body mechanics, oxygen, nutrition, elimination, fluid and electrolyte balance, recognition of physiological responses to disease, regulatory mechanisms, sensory functions, emotions, interrelatedness of emotions and illness, communication, interpersonal relationships, spiritual goals, therapeutic environment, individuality, optimal goals, use of community resources, and role of society.

Ernestine Wiedenbach proposed a prescriptive theory that involves the nurse's central purpose, prescription to fulfill that purpose, and the realities that influence the ability to fulfill the central purpose (the nurse, the patient, the goal, the means, and the framework or environment). Nursing involves the identification of the patient's need for help, the ministrations of help, and validation that the efforts made were indeed helpful.

Her principles of helping indicate the nurse should look for patient behaviors that are not consistent with what is expected, should continue helping efforts in spite of encountering difficulties, and should recognize personal limitations and seek help from others as needed. Nursing actions may be reflex or spontaneous and based on sensations, conditioned or automatic and based on perceptions, impulsive and based on assumptions, or deliberate or responsible and based on realization, insight, design, and decision that involves discussion and joint planning with the patient.

Joyce Travelbee was concerned with the interpersonal process between the professional nurse and that nurse's client, whether an individual, family, or community. The functions of the nurse-client, or human-to-human, relationship are to prevent or cope with illness or suffering and to find meaning in illness or suffering. This relationship requires a disciplined, intellectual approach, with the nurse employing a therapeutic use of self. The five phases of the human-to-human relationship are encounter, identities, empathy, sympathy, and rapport.

Myra Estrin Levine described adaptation as the process by which conservation is achieved, with the purpose of conservation being integrity, or preservation of the whole of the person. Adaptation is based on past

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experiences of effective responses (historicity), the use of responses specific to the demands being made (specificity), and more than one level of response (redundancy). Adaptation seeks the best fit between the person and the environment. The principles of conservation deal with conservation of energy, structural integrity, personal integrity, and social integrity of the individual. Imogene M.

King presented both a systems-based conceptual framework of personal, interpersonal, and social systems and a theory of goal attainment. The concepts of the theory of goal attainment are interaction, perception, communication, transaction, self, role, stress, growth and development, time, and personal space. The nurse and the client usually meet as strangers. Each brings to this meeting perceptions and judgments about the situation and the other; each acts and then reacts to the other's action. The reactions lead to interaction, which, when effective, leads to transaction or movement toward mutually agreed-on goals.

She emphasizes that both the nurse and the patient bring important knowledge and information to this goal-attainment process. Martha E. Rogers identified the basic science of nursing as the Science of Unitary Human Beings. The human being is a whole, not a collection of parts. She presented the human being and the environment as energy fields that are integral with each other. The human being does not have an energy field but is an energy field. These fields can be identified by their pattern, described as a distinguishing characteristic that is perceived as a single wave.

These patterns occur in a pandimensional world. Rogers's principles are resonancy, or continuous change to higher frequency; helicy, or

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unpredictable movement toward increasing diversity; and integrality, or the continuous mutual process of the human field and the environmental field. Sister Callista Roy proposed the Roy Adaptation Model. The person or group responds to stimuli from the internal or external environment through control processes or coping mechanisms identified as the regulator and cognator (stabilizer and innovator for the group) subsystems.

The regulator processes are essentially automatic, while the cognator processes involve perception, learning, judgment, and emotion. The results of the processing by these coping mechanisms are behaviors in one of four modes. These modes are the physiological-physical mode (oxygenation; nutrition; elimination; activity and rest; protection; senses; fluid, electrolyte, and acid-base balance; and endocrine function for individuals and resource adequacy for groups), self-concept-group identity mode, role function mode, and interdependence mode.

These behaviors may be either adaptive (promoting the integrity of the human system) or ineffective (not promoting such integrity). The nurse assesses the behaviors in each of the modes and identifies those adaptive behaviors that need support and those ineffective behaviors that require intervention. For each of these behaviors, the nurse then seeks to identify the associated stimuli. The stimulus most directly associated with the behavior is the focal stimulus; all other stimuli that are verified as influencing the behavior are contextual stimuli.

Any stimuli that may be influencing the behavior but that have not been verified as doing so are residual stimuli. Once the stimuli are identified, the nurse, in cooperation with the patient, plans and carries out interventions to

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alter stimuli and support adaptive behaviors. The effectiveness of the actions taken is evaluated. Betty Neuman developed the Neuman Systems Model. Systems have three environments—the internal, the external, and the created environment. Each system, whether an individual or a group, has several structures. The basic structure or core is where the energy resources reside.

This core is protected by lines of resistance that in turn are surrounded by the normal line of defense and finally the flexible line of defense. Each of the structures consists of the five variables of physiological, psychological, sociocultural, developmental, and spiritual characteristics. Each variable is influenced by intrapersonal, interpersonal, and extrapersonal factors. The system seeks a state of equilibrium that may be disrupted by stressors. Stressors, either existing or potential, first encounter the flexible line of defense.

If the flexible line of defense cannot counteract the stressor, then the normal line of defense is activated. If the normal line of defense is breached, the stressor enters the system and leads to a reaction, associated with the lines of resistance. This reaction is what is usually termed symptoms. If the lines of resistance allow the stressor to reach the core, depletion of energy resources and death are threatened. In the Neuman Systems Model, there are three levels of prevention. Primary prevention occurs before a stressor enters the system and causes a reaction.

Secondary prevention occurs in response to the symptoms, and tertiary prevention seeks to support maintenance of stability and to prevent future occurrences. Kathryn E. Barnard's focus is on the circumstances that

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enhance the development of the young child. In her Child Health Assessment Interaction Model, the key components are the child, the caregiver, the environment, and the interactions between child and caregiver. Contributions made by the child include temperament and ability to regulate and by the caregiver physical health, mental health, coping, and level of education.

The environment includes both animate and inanimate resources. In assessing interaction, the parent is assessed in relation to sensibility to cues, fostering emotional growth, and fostering cognitive growth. The infant is assessed in relation to clarity of cue given and responsiveness to parent. Josephine E. Paterson and Loretta T. Zderad presented humanistic nursing. Humans are seen as becoming through choices, and health is a personal value of more-being and well-being. Humanistic nursing involves dialogue, community, and phenomenologic nursing.

Dialogue occurs through meeting the other, relating with the other, being in presence together, and sharing through call and response. Community is the sense of “ we. ” Phenomenologic nursing involves the nurse preparing to know another, having intuitive responses to another, learning about the other scientifically, synthesizing information about the other with information already known, and developing a truth that is both uniquely personal and generally applicable. Madeleine M. Leininger provided a guide to the inclusion of culture as a vital aspect of nursing practice.

Her Sunrise Model posits that important dimensions of culture and social structure are technology, religion, philosophy, kinship and other related social factors, cultural values and lifeways, politics, law, economics, and education

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within the context of language and environment. All of these influence care patterns and expressions that impact the health or well-being of individuals, families, groups, and institutions. The diverse health systems include the folk care systems and the professional care systems that are linked by nursing.

To provide culture congruent care, nursing decisions and actions should seek to provide culture care preservation or maintenance, culture care accommodation or negotiation, or culture care repatterning or restructuring. Margaret Newman described health as expanding consciousness. Important concepts are consciousness (the information capacity of the system), pattern (movement, diversity, and rhythm of the whole), pattern recognition (identification within the observer of the whole of another), and transformation (change). Health and disease are seen as reflections of the larger whole rather than as different entities.

She proposed (with Sime and Corcoran-Perry) the unitary-transformative paradigm in which human beings are viewed as unitary phenomenon. These phenomenon are identified by pattern, and change is unpredictable, toward diversity, and transformative. Stages of disorganization, or choice points, lead to change, and health is the evolving pattern of the whole as the system moves to higher levels of consciousness. The nurse enters into process with a client and does not serve as a problem solver. Jean Watson described nursing as human science and human care.

Her clinical caritas processes include practicing loving-kindness and equanimity within a context of caring consciousness; being authentically present and enabling and sustaining the deep belief system and subjective life world of self and one-being-cared-for; cultivating one's own spiritual

practice and transpersonal self, developing and sustaining helping-trusting in an authentic caring relationship; being present to and supportive of the expression of positive and negative feelings as a connection with the deeper spirit of self and the one-being-cared-for; creatively using self and all ways of knowing as a part of the caring process to engage in artistry of caring-healing practices; engaging in a genuine teaching-learning experience that attends to unity of being and meaning while attempting to stay within other's frame of reference; creating healing environments at all levels, physical as well as nonphysical, within a subtle environment of energy and consciousness, whereby the potentials of wholeness, beauty, comfort, dignity, and peace are enhanced; assisting with basic needs, with an intentional caring consciousness, to potentiate alignment of mind/body/spirit, wholeness, and unity of being in all aspects of care; tending to both embodied spirit and evolving spiritual emergence; opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; and soul care for self and the one-being-cared-for. These *caritas* processes occur within a transpersonal caring relationship and a caring occasion and caring moment as the nurse and other come together and share with each other. The transpersonal caring relationship seeks to provide mental and spiritual growth for both participants while seeking to restore or improve the harmony and unity within the personhood of the other.

Rosemarie Rizzo Parse developed the theory of Humanbecoming within the simultaneity paradigm that views human beings as developing meaning through freedom to choose and as more than and different from a sum of parts. Her practice methodology has three dimensions, each with a related

process. The first is illuminating meaning, or explicating, or making clear through talking about it, what was, is, and will be. The second is synchronizing rhythms, or dwelling with or being immersed with the process of connecting and separating within the rhythms of the exchange between the human and the universe. The third is mobilizing transcendence, or moving beyond or moving toward what is envisioned, the moment to what has not yet occurred.

In the theory of Humanbecoming, the nurse is an interpersonal guide, with the responsibility for decision making (or making of choices) residing in the client. The nurse provides support but not counseling. However, the traditional role of teaching does fall within illuminating meaning, and serving as a change agent is congruent with mobilizing transcendence. Helen C. Erickson, Evelyn M. Tomlin, and Mary Ann P. Swain presented the theory of Modeling and Role-Modeling. Both modeling and role-modeling involve an art and a science. Modeling requires the nurse to seek an understanding of the client's view of the world. The art of modeling involves the use of empathy in developing this understanding.

The science of modeling involves the use of the nurse's knowledge in analyzing the information collected to create the model. Role-modeling seeks to facilitate health. The art of role-modeling lies in individualizing the facilitations, while the science lies in the use of the nurse's theoretical knowledge base to plan and implement care. The aims of intervention are to build trust, promote the client's positive orientation of self, promote the client's perception of being in control, promote the client's strengths, and set mutual health-directed goals. The client has self-care knowledge about what

his needs are and self-care resources to help meet these needs and takes self-care action to use the resources to meet the needs.

In addition, a major motivation for human behavior is the drive for affiliated individuation, or having a personal identity while being connected to others. The individual's ability to mobilize resources is identified as adaptive potential. Adaptive potential may be identified as adaptive equilibrium (a nonstress state in which resources are utilized appropriately), maladaptive equilibrium (a nonstress state in which resource utilization is placing one or more subsystems in jeopardy), arousal (a stress state in which the client is having difficulty mobilizing resources), or impoverishment (a stress state in which resources are diminished or depleted).

Interventions differ according to the adaptive potential. Those in adaptive equilibrium can be encouraged to continue and may require only facilitation of their self-care actions. Those in maladaptive equilibrium present the challenge of seeing no reason to change since they are in equilibrium. Here motivation strategies to seek to change are needed. Those in arousal are best supported by actions that facilitate change and support individuation; these are likely to include teaching, guidance, direction, and other assistance. Those in impoverishment have strong affiliation needs, need their internal strengths promoted, and need to have resources provided.

Nola J.

Pender developed the Health Promotion Model (revised) with the goal of achieving outcomes of health-promoting behavior. Areas identified to help understand personal choices made in relation to health-promoting behavior include perceived benefits of action, perceived barriers to action, perceived

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self-efficacy (or ability to carry out the action), activity-related affect, interpersonal influences, situation influences, commitment to a plan of action, and immediate competing demands and preferences. Patricia Benner described expert nursing practice and identified five stages of skill acquisition as novice, advanced beginner, competent, proficient, and expert.

She discusses a number of concepts in relation to these stages, including agency, assumptions, expectations and set, background meaning, caring, clinical forethought, clinical judgment, clinical knowledge, clinical reasoning, clinical transitions, common meanings, concern, coping, skill acquisition, domains of practice, embodied intelligence, embodied knowledge, emotions, ethical judgment, experience, graded qualitative distinctions, intuition, knowing the patient, maxims, paradigm cases and personal knowledge, reasoning-in-transition, social embeddedness, stress, temporality, thinking-in-action, and unplanned practices. Juliet Corbin and Anselm L. Strauss developed the Chronic Illness Trajectory Framework, in which they describe the course of illness and the actions taken to shape that course. The phases of the framework are pretrajectory, trajectory onset, stable, unstable, acute, crisis, comeback, downward, and dying.

A trajectory projection is one's personal vision of the illness, and a trajectory scheme is the plan of actions to shape the course of the illness, control associated symptoms, and handle disability. Important also are one's biography or life story and one's everyday life activities (similar to activities of daily living). Anne Boykin and Savina Schoenhofer present nursing as caring in a grand theory that may be used in combination with other theories. Persons are caring by virtue of being human; are caring, moment to

moment; are whole and complete in the moment; and are already complete while growing in completeness. Personhood is the process of living grounded in caring and is enhanced through nurturing relationships.

Nursing as a discipline is a being, knowing, living, and valuing response to a social call. As a profession, nursing is based on a social call and uses a body of knowledge to respond to that call. The focus of nursing is nurturing persons living in caring and growing in caring. This nurturing occurs in the nursing situation, or the lived experience shared between the nurse and the nursed, in which personhood is enhanced. The call for nursing is not based on a need or a deficit and thus focuses on helping the other celebrate the fullness of being rather than seeking to fix something. Boykin and Schoenhofer encourage the use of storytelling to make evident the service of nursing.

Katharine Kolcaba developed a comfort theory in which she describes comfort, comfort care, comfort measures, and comfort needs as well as health-seeking behavior, institutional integrity, and intervening variables. She speaks of comfort as physical, psychospiritual, environmental, and sociocultural and describes technical comfort measures, coaching for comfort, and comfort food for the soul. Ramona Mercer describes the process of becoming a mother in the four stages of commitment, attachment, and preparation; acquaintance, learning, and physical restoration; moving toward a new normal; and achievement of the maternal identity. The stages occur with the three nested living environments of family and friends, community, and society at large.



Afaf Meleis, in her theory of transitions, identifies four types of transitions: developmental, situational, health-illness, and organizational. Properties of the transition experience include awareness, engagement, change and difference, time p, critical points, and events. Personal conditions include meanings, cultural beliefs and attitudes, socioeconomic status, and preparation and knowledge. Community conditions include family support, information available, health care resources, and role models. Process indicators are feeling connected, interacting, location, and being situated and developing confidence and coping. Outcome indicators include mastery and fluid integrative processes. Merle H.

Mishel describes uncertainty in illness with the three major themes of antecedents of uncertainty, appraisal of uncertainty, and coping with uncertainty. Antecedents of uncertainty are the stimuli frame, including symptom pattern, event familiarity, and event congruence; cognitive capacity or informational processing ability; and structure providers, such as education, social support, and credible authorities. Appraisal of uncertainty includes both inference (use of past experience to evaluate an event) and illusion (creating beliefs from uncertainty with a positive outlook). Coping with uncertainty includes danger, opportunity, coping, and adaptation.

The Reconceptualized Uncertainty in Illness Theory adds self-organization and probabilistic thinking and changes the goal from return to previous level of functioning to growth to a new value system. Each of these models or theories will be applied to clinical practice with the following case study: May Allenski, an 84-year-old White female, had emergency femoral-popliteal bypass surgery two days ago. She has severe peripheral vascular disease,

and a clot blocked 90% of the circulation to her right leg one week ago. The grafts were taken from her left leg, so there are long incisions in each leg. She lives in a small town about 75 miles from the medical center. The initial clotting occurred late on Friday night; she did not see a doctor until Monday.

The first physician referred her to a vascular specialist, who then referred her to the medical center. Her 90-year-old husband drove her to the medical center on Tuesday. You anticipate she will be discharged to home on the fourth postoperative day, as is standard procedure. She is learning to transfer to and from bed and toilet to wheelchair. Table 2-1 shows examples of application in clinical practice that are not complete but are intended to provide only a partial example for each. Study of these examples can provide ideas or suggestions for use in clinical practice. Readers are encouraged to develop further detail as appropriate to their practice.