THE NATURE OF NURSING

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EDITORS’ NOTE

At a time when the profession was struggling to define itself apart from medicine, Virginia Henderson provided a clear definition of nursing that delineated an independent dimension. It provided the language for nurses to articulate what was uniquely nursing, including its role in health and illness, recovering and dying.

It is self-evident that an occupation, and especially a profession whose services affect human life, must define its function. Nursing’s attempt to do so has a long, and still unfinished, history. Inevitably, we go back to Florence Nightingale. In her Notes on Nursing: What It Is and What It Is Not, she says, in essence, that what nursing has to do is to “... put the patient in the best condition for nature to act upon him.”1 There is no doubt that Miss Nightingale’s concept influenced the development of modern nursing more than any other. Some nurses still cite this as the definition they find most helpful.

But with the passage of the nurse registration act in England and state nurse practice acts in the United States around the turn of the century, it became necessary to describe nursing in such a way as to protect the public and the nurse. The definitions at this time were necessarily concerned with what the nurse was legally empowered to do and, as most nurses were then working as private practitioners in homes and hospitals, most of the legal definitions implied that the nurse operated under the supervision of a physician. They failed to identify that aspect of her work that was independent or self-directed.

The idea of the nurse as merely the physician’s assistant, however, has never been satisfying to the occupation as a whole or to many of its individual members. For example, in 1933 and 1934, Effie J. Taylor defined nursing as “adapting prescribed therapy and preventive treatment to the specific physical and psychic needs of the individual.”2,3 She also added, “the real depths of nursing can only be made known through ideals, love, sympathy, knowledge, and culture, expressed through the practice of artistic procedures and relationships.” In these statements, made 30 years ago, Miss Taylor anticipated some of the current emphasis on patient-centered care and a liberal education for the nurse.

Immediately after World War II, the rumblings of dissatisfaction with the ambiguous position of nursing heard during the first half of the century, developed into a major explosion of discontent. In 1946, the American Nurses’ Association asked certain nursing leaders to formulate their definitions of nursing and devoted a session at that year’s convention to the subject.4

About this time, Esther Lucile Brown was asked by the National Nursing Council to study the needs of society for nursing. Included in her report is a definition of nursing developed by a group of nurse experts—an excellent statement, but so general any health worker might claim it also applies to his field.5
Three regional conferences were also held in connection with Miss Brown’s study. At one of these a small committee, of which I was a member, developed a definition that was much more specific than the one previously referred to; it represented, in fact, my point of view modified by the thinking of others in the group. Although this statement was included in the report of the regional conferences, it has never been cited directly.6

Another approach to defining nursing was the American Nurses’ Association’s five-year investigation of the nurse’s function. Studies were made in 17 different states, and the results summarized in Twenty Thousand Nurses Tell Their Story.7 And, following this, the various ANA sections developed statements on the functions, standards, and qualifications for practice in the fields of nursing represented.

Whether or not these research efforts give us a satisfying description of the nursing function is open to question, but certainly they throw considerable light on what nurses were actually doing in the 1950s, and on what they consider their proper functions.

Now, just as at the turn of the century, the necessity for a legal definition of nursing practice remains. The most recent official statement (1962) on the subject, was designed for inclusion in nurse practice acts.8 This statement, although still very general and inclusive, suggests that the nurse can observe, care for, and counsel the patient and can supervise other health personnel without herself being supervised by the physician. It implies a more independent function for the nurse than did previous official statements.9

While the official statements on nursing may serve the purpose for which they are intended, there is abundant evidence that they have not satisfied everyone. And, in recent years, with the development of varying types and grades of nursing personnel, the difficulty of defining function has been compounded. Probably the effort of organized nursing to formulate a statement of its function will always be unfinished business since conditions change from one era to the next and with the culture or nature of a society. But so long as available definitions are unsatisfying to nurses, or too general to guide practice, research, and education, individuals will continue to search for statements that fulfill their needs.

DEVELOPMENT OF A CONCEPT

My interpretation of the nurse’s function is the synthesis of many influences, some positive and some negative. Before discussing it, however, and identifying the most significant experiences leading to its formulation, I should first make clear that I do not expect everyone to agree with me. Rather, I would urge every nurse to develop her own concept; otherwise, she is merely imitating others or acting under authority. In my own case I felt as though I was steering an uncharted course until I resolved certain doubts about my true function as a nurse.

My basic training was largely in a general hospital where, for the nurse, technical competence, speed of performance, and a “professional” (actually an impersonal) manner were stressed. We were introduced to nursing as a series of almost unrelated procedures, beginning with making an unoccupied bed and progressing to, say, aspiration of body cavities. In this era, ability to catheterize a patient seemed to qualify a student for “night duty” where, without any previous experience in the administration of a service, she might have the entire care of 30 sick souls and bodies.
An authoritarian type of medicine and nursing were practiced in this hospital. Teaching was based on the textbook. Not even lip service was given “patient-centered care,” “family health service,” “comprehensive care” or “rehabilitation.”

But there was, for me, an influence in these early student days that tended to negate this mechanistic approach to patient care. Annie W. Goodrich was dean of my school, the Army School of Nursing, and whenever she visited our unit she lifted our sights above techniques and routines. She saw nursing as a “world-wide social activity,” a creative and constructive force in society, and, having a powerful intellect and boundless compassion for humanity, she never failed to infect us with “the ethical significance of nursing.” It is to her that I attribute my early discontent with the regimentalized patient care in which I participated and the concept of nursing as merely ancillary to medicine. But while Miss Goodrich presented us with the highest aim for nursing she left us to translate it into concrete acts. I needed someone to “show me”—as Liza Doolittle sang, when words had ceased to be enough for her. I seldom, if ever, saw graduate nurses practice nursing; never my teachers. Their teaching was in a classroom.

A positive nursing experience, however, was a summer spent, when I was still a student with the Henry Street Visiting Nurse Agency. Here I began to discard the formal approach to patients approved in the general hospital. In fact, I acquired a skepticism of medical care in hospitals that remains with me. Seeing the sick return to their homes following hospitalization, I began to realize that the seemingly successful institutional regimen nevertheless often failed to change the factors in the patient’s way of living that had hospitalized him in the first place. Even today I question whether our traditional hospital routines and practices can really prepare a patient for a return to health. Nowhere during my entire student experience, it seems to me, did I have the opportunity to see or practice individualized care—to acquire the human relations skills that I needed. My psychiatric nursing affiliation concentrated on disease entities and their treatment, not on how the nurse might help the individual patient. And although, during my pediatric nursing affiliation, I first experienced the satisfaction—and saw the superiority—of a “case” as opposed to a “functional” assignment, the care was too mechanistic to teach me the true value of patient-centered care.

With this background and after a year of visiting nurse work I became the only full-time instructor in a school of nursing. Here I was forced to learn as I taught. I at least sensed the need for more knowledge and clarification of my ideas and, fortunately for all concerned, I went back to school.

Except for a brief period of clinical supervision and teaching at the Strong Memorial Hospital, I remained at Teachers College, Columbia University—as student and teacher—for some 2 years, and during this time my concept of nursing was not so much changed as clarified. It is impossible to identify all the persons and experiences that brought this about, but a few stand out.

Caroline Stackpole based her teaching of physiology on Claude Bernard’s dictum that health depends upon keeping the lymph constant around the cell. This emphasis on the unit structure taught me relationships in what were, up to that time, unrelated laws of health. Miss Stackpole was a master teacher who was never satisfied until the student answered his own question. Jean Broadhurst, a microbiologist, had this same concept of teaching. Primarily from those two, I acquired an analytic approach to all aspects of care and treatment.
Now, as I read reports of malnutrition from therapeutic diets, emotional and physiological crises from endocrine therapy, drug-induced skin lesions, and the varied complications from cortisone administration, I think to myself: “the constancy of the intercellular fluids has been dangerously reduced.” Ever since I grasped this danger I have believed that a definition of nursing should imply an appreciation of the principle of physiological balance. It makes so vivid the importance of forcing fluids, of feeding the comatose, or of relieving oxygen want.

Dr. Edward Thorndike’s work in psychology, also at Teachers College, provided some parallel generalizations, or fixed points, in the psychosocial realm. His study of the fundamental needs of man made me realize that illness all too often places a person in a setting where shelter from the elements is almost the only fundamental need that is fully met. In most hospitals the patient cannot eat as he wishes, his freedom of movement is curtailed, his privacy is invaded; he is put to bed in strange nightclothes, making him feel as unattractive as a punished child; he is separated from the objects of his affection; he is deprived of almost every diversion and of his work, and is reduced to dependence on persons who are often younger than he is, and sometimes less intelligent and courteous.

From the time I saw hospitalization in this light I have questioned every nursing routine or restriction that is in conflict with the individual’s fundamental need for shelter, food, communication with others, and the company of those he loves; for opportunity to win approval, to dominate and be dominated, to learn, to work, to worship, and to play. In other words, I have since conceived it to be the aim of nursing to keep the individual’s day as normal as possible—to keep him in “the stream of life” to the extent that it is consistent with the physician’s therapeutic plan.

Soon after this enlightenment I saw the work of Dr. George G. Deaver and the physical therapists associated with him at the Institute for the Crippled and Disabled in New York City. It seemed to me that in their work I was witnessing the implementation of many ideas I had been accumulating. And I saw that much of the effort of rehabilitation went into building the patient’s independence—the independence of which hospital personnel had unwittingly deprived him or had, at least, failed to encourage. Nothing has made my concept of nursing more concrete than the insistence of these workers on individualized programs with constant evaluation of the patient’s needs and progress toward the goal of independence.

My participation in preparing the 1937 Curriculum Guide, in the work of the NLNE’s special committee on postgraduate clinical courses, and in the regional conferences associated with Miss Brown’s study, all forced me to express in writing these evolving concepts of nursing. It was not until the 1940s, however, that I could test my ideas in actual practice, when we developed at Teachers College a unique—at least, for that time—type of advanced study in medical-surgical nursing.

This course was unique because it was organized around nursing problems rather than medical diagnoses and diseases of body systems. The associated field experience gave the graduate nurse student an opportunity, for example, to increase her competence in helping a patient to cope with such problems as long-term illness, impending surgery, the relative isolation necessitated by a communicable disease, or the depression following the loss of an arm or a leg. It was one of the first advanced clinical courses where students actually nursed patients and conducted nursing clinics and interdisciplinary conferences around the care of the patients they nursed.
The Nursing Profession

Exchanging views with the able nurses associated with me in planning or teaching this course, and with the students, who were often experienced and expert, was of immeasurable benefit to me in clarifying my ideas. Therefore, in the 1955 revision of Harmer and Henderson’s *The Principles and Practice of Nursing*, I was able to present what seemed to me a tested and specific definition of nursing.12

Since that time the writings of psychiatric nurses, particularly those of Gwen Tudor (Will) and Ida Orlando (Pelletier) have made me realize how easily the nurse can act on misconceptions of the patient’s needs if she does not check her interpretation of them with him.13,14 The continuing work of faculty and students at the Yale University School of Nursing has reinforced Miss Orlando’s conclusions, and further convinced me, that the most effective nursing involves a continuous analysis and validation of the nurse’s interpretation of the patients’ needs.

**UNIQUE FUNCTION**

In 1958 the nursing service committee of the International Council of Nurses asked me to describe my concept of basic nursing. The resulting statement published in pamphlet form by the ICN in 1961, was an adaptation of the definition of nursing in Harmer and Henderson and represented the final crystallization of my ideas on the subject.15

It is my contention that the nurse is, and should be legally, an independent practitioner, so long as she is not diagnosing or treating disease or making a prognosis, for these functions fall in the physician’s realm. But the nurse is the authority on basic nursing care. And, by basic nursing care, I mean helping the patient with the following activities or providing conditions under which he can perform them unaided:

1. Breathe normally
2. Eat and drink adequately
3. Eliminate body wastes
4. Move and maintain desirable posture
5. Sleep and rest
6. Select suitable clothes—dress and undress
7. Maintain body temperature within normal range by adjusting clothing and modifying the environment
8. Keep the body clean and well groomed and protect the integument
9. Avoid dangers in the environment and avoid injuring others
10. Communicate with others in expressing emotions, needs, fears, et cetera
11. Worship according to one’s faith
12. Work in such a way that there is a sense of accomplishment
13. Play, or participate in various forms of recreation
14. Learn, discover, or satisfy the curiosity that leads to “normal” development and health and use the available health facilities.
In helping the patient with these activities the nurse has infinite need for knowledge of the biological and social sciences and of the skills based on them. There are few more complex arts than that of keeping a patient well nourished and his mouth healthy during a long comatose period; or of helping the depressed, mute psychotic re-establish normal human relations. There is no worker but the nurse who can and will devote herself so consistently day and night to these ends.

This unique function of the nurse I see as a complex service. But, in emphasizing this basic function, I do not mean to disregard the nurse’s therapeutic role. She is in most situations the patient’s prime helper in carrying out the physician’s prescriptions.

If we put total medical care in the form of a pie graph we might assign wedges of different sizes to members of what we now refer to as “the team.” The wedge must differ in size for each member according to the problem facing the patient; in some situations certain members of the team have no part of the pie at all. The patient always has a slice, although that of the newborn infant or the unconscious adult is only a sliver; his very life depends on others, but most particularly on the nurse.

In contrast, where an otherwise healthy adult is suffering from a skin condition such as acne, he and his physician compose the team and they can divide the whole pie between them. If the problem is an orthopedic disability, the largest slice may go to the physical therapist; when a sick child is cared for at home by the mother, then the latter’s share may be by far the largest. But of all the members of the team, excepting the patient and the physician, the nurse has most often a piece of the pie and, next to theirs, hers is usually the largest share.

In talking about nursing we tend to stress promotion of health and prevention and cure of disease; we rarely speak of the inevitable end of life. Critics of our culture say we are prone to shrink from the thought and sight of old age and death. The nurse, however, cannot do this if she is to fulfill her unique function as I see it. There is a great deal that the nurse can do to keep the environment in which death occurs an esthetic one, and to relieve the patient’s discomfort with nursing measures. Even more important, in my concept of nursing, is the nurse’s effort to assist the patient toward a “peaceful death” by facing it with him honestly and courageously, thus lending it dignity and even an awesome beauty.

In essence, then, I see nursing as primarily complementing the patient by supplying what he needs in knowledge, will, or strength to perform his daily activities and also to carry out the treatment prescribed for him by the physician. What are the implications of such a concept for nursing practice, research, and education?

**NURSING PRACTICE**

The nurse who sees herself as reinforcing the patient where he lacks will, knowledge, or strength must make an effort to know him, to understand him, to “get inside his skin,” as we have said. She will listen to him, his family, and his friends with interest. She will be especially aware of her relation with the patient and will try to make it a constructive, or therapeutic one realizing that this demands self-understanding. Finally, and most important, she will give of herself to the patient.

She will be willing, even anxious, to help the patient perform the functions we have just enumerated. In cooperation with the patient, his family, and other members of the health team,
and according to the situation, she will make some sort of individualized plan, or a daily regimen that meets the whole range of human needs. She will not be satisfied to provide merely shelter, sanitary facilities, three meals a day, and the treatments prescribed by the physician.

But just as the nurse seeks to meet the patient’s needs during a period of dependency, so she also tries to shorten this period. Before she commits any act for the patient, she asks herself what part of it he could himself perform. If he is unable to act at all, she identifies what he lacks and she helps to supply this lack as rapidly as she can. She evaluates her success with each patient according to the degree to which he establishes independence in all the activities that make up for him, a normal day. The rehabilitation of all patients, in the hands of such a nurse, begins with her first service to them.

This primary function of the practicing nurse must, of course, be performed in such a way that it promotes the physician’s therapeutic plan. That means helping the patient carry out prescribed treatments or administering the treatment herself. Again, she will consider herself more successful if she assists the patient than if she acts for him.

Now, in certain situations, the nurse may find it necessary to assume the role of a physician—in hospitals with no resident physician, for instance, or in emergency conditions. First aid, which has elements of diagnosis and therapy, is expected of all informed citizens under certain circumstances. As long as nurses are better prepared than any other member of the health team to act as a physician surrogate they will be tempted, in the interests of the patient, to assume this role. But it is not, in my judgment, their true role. In assuming it they not only practice skills in which they are ill prepared but rob themselves of the time needed for the performance of their primary role. Inevitably it forces nurses to delegate their primary function to inadequately prepared personnel. In my opinion, the social pressures that have called for a phenomenal increase in nurses has also demanded a proportionate increase in doctors.

This brings us to the question of the coordinating, managerial, and teaching functions that now consume so much of the professional nurse’s time. Nurses must, of course, administer nursing services and teach nursing, but whether they should coordinate the services of the entire medical team is questionable. I, for one, applaud the investigations on non-nursing coordinators and administrators of clinical units. I am impressed, too, with the emphasis that Dorothy Smith has recently placed on developing a system in which the nurse can function as effectively as she knows how.

The nurse who sees her primary function as a direct service to the patient will find an immediate reward in his progress toward independence through this service. To the extent that her practice offers this reward, it will be satisfying; to the extent that the situation deprives her of it, she will be dissatisfied. And she will use whatever influence she possesses to foster conditions that make the social rewards for practice at least commensurate with those for teaching and administration.

**NURSING RESEARCH**

When a nurse operates under a definition of nursing that specifies an area in which she is pre-eminently qualified, she automatically imposes on herself the responsibility for designing the methods she uses in her area of expertness. Studies of nursing functions have shown that, of the hundreds of specific acts performed by nurses, many are non-nursing in nature.
and could be assigned to other personnel; others are medically prescribed procedures for
the design of which the physician is partially responsible. But if the nurse carries out the
latter procedures and is liable, in the legal sense, for harmful effects on the patient, then she
must share the responsibility for the design of the procedure with the physician.

The activities with which I am mainly concerned, however, are those having to do
with nursing care itself. Most of these procedures—in fact, most aspects of basic nursing,
including the nurse’s approach to the patient and what she may and may not say or do for
him—are based on tradition or authority, learned by imitation, and taught with little, if any
scientific backing. It is my contention that methods in this all-important area will remain
static and invalidated if the nurse fails to study them.

In a survey and assessment of nursing research, Leo W. Simmons and I have pointed
out the preponderance of education and occupational studies over clinical investigations. We
tried to identify the conditions that discouraged patient-centered research and found:
that the major energies of the occupation have gone into improving preparation for nursing
and into learning how to recruit and hold sufficient numbers of workers in the occupation;
that the demand for administrators and teachers almost exhausts the supply of degree hold-
ers, with the result that nurses with a university background tend to study administrative
and educational problems; and that those few nurse practitioners prepared to study nursing
practice often fail to get the support they need from hospital administrators, nursing service
administrators, and physicians.

But if, by definition, nursing has an area of independent professional practice, is not
clinical nursing research as necessary, if not more so, than research into other professional
problems? Do we not deny our function when we fail to investigate it?

The Surgeon General’s Consultant Group on Nursing says, “Nursing research must
be stimulated. Research in nursing has just begun to yield the body of knowledge needed
as a basis or the improvement of nursing care. . . . Much greater support is required for
patient-oriented studies in line with the changing patterns of nursing care.”

It is not only in this country that the need for research in nursing practice is recognized.
Margaret Jackson, a British physician, has expressed some of these ideas simply and directly:

Research into nursing methods and appliances possibly began with Eve. Miss
Nightingale and the generation of nurses trained under her aegis took it, of course,
immeasurably further; but since their day it seems to have come to a dead end of
evolution, like the frog. The basic techniques of bed-making, blanket-bathing, giv-
ing an enema, administering medicines, and the like, seems hardly to have changed
within the memory of woman; and few nurses seem to pause and ask themselves
whether their methods and equipment are the best possible, or whether in fact they
might be better.

It is my belief that on every clinical service of a hospital a medical research committee
and a nursing research committee are needed—both devoted to the ultimate and common
goal of improving patient care. The medical research committee would study those prob-
lems lying wholly in the realm of medical practice; the nursing research committee would
investigate procedures or problems that lie wholly within the realm of nursing practice.
But still another committee—a joint one which would include not only doctors and nurses
but other specialists as indicated—is also needed to study such treatments or diagnostic
tests as are prescribed by the physician and carried out entirely or partially by the nurse.
In this era, research is the name we attach to the most reliable type of analysis. It is based on the full use of scientific findings and is the most reasonable approach man has invented to the solution of his problems. No profession, occupation, or industry can, in this age, adequately evaluate or improve its practice without research. Nursing, if it is truly to represent an area of independent practice, must therefore assume responsibility for validating and improving the methods it uses.

NURSING EDUCATION

A definition staking out an area of health and human welfare in which the nurse is the expert and an independent practitioner calls for education rather than training: a liberalizing education, a grounding in the physical, biological, and social sciences, and the ability to use analytic processes. The curriculum must be organized around the nurse’s major function rather than that of the physician, as it has been in the past.

Early emphasis must be given to fundamental human needs, to patients’ daily activities, and to the development of the nurse’s ability to assess them properly and help the person meet them. In the next stage of the professional curriculum the student might then be introduced to the modifications in nursing care demanded by chronological and intellectual age, sex, emotional balance, state of consciousness, nutritional balance, and other conditions common to all patients and found on any clinical service. This content might constitute the core of the clinical curriculum. Finally, the student would be helped to study the particular needs of each patient, both in relation to these more general conditions and to those stemming from his specific disease, handicap, or condition.

Since the turn of the century, prominent American nurses—conspicuous among them, Miss Goodrich and Miss Watting—and physicians have said that nursing schools should be developed within the educational system—not within the service institutions—of this country. But it is not only in this country that this need has been recognized. Informed physicians and educators throughout the world expressed this opinion.

A revision of established patterns of nursing education calls for strong leadership. At a meeting 20 years ago when someone was bemoaning the fact that there were no leaders in nursing coming along to take the place of our great women of the past, Miss Goodrich rose to protest. She said that the conditions were passing that demanded the militant personalities of earlier years; the idea—not the individual—should lead, she said. She believed firmly that what she called “the complete nurse”—the woman with social experience and a thorough education—had proved her worth, not only as administrator and teacher but more particularly as a practitioner. Therefore she saw as inevitable, rather than as something we must fight for, the preparation of nurses, within the colleges and universities.

I think that the professional quality of nursing service and the appropriateness of a professional preparation have been grasped in many countries, but the means by which these ideas can be implemented are slow in developing. It is up to us who share this faith in the social value of nursing to speed this process.
SUMMARY

The function we believe the nurse performs is primarily an independent one—that of acting for the patient where he lacks knowledge, physical strength, or the will to act for himself. We see this function as complex and creative, as offering unlimited opportunity for the application of the physical, biological, and social sciences, and the development of skills based on them. We believe society wants and expects this service from the nurse and no other worker is as able, or willing, to give it.

If a nurse believes that she is preeminent in an area of health practice, she will try to develop a working milieu in which she can realize her potential value to the person served. She will also recognize her responsibility for the validation and improvement of methods she uses, or for clinical nursing research.

In order to practice as an expert in her own right and to use the scientific approach to the improvement of practice, the nurse needs the kind of education that, in our society, is available only in colleges and universities. Educational programs operated on funds pinched from the budgets of service agencies cannot provide the preparation she needs. Her work demands self-understanding and a universal sympathy for and understanding of, diverse human beings. The “liberalizing” effect of a general education must be recognized, for the personality of the nurse is possibly the most important intangible in measuring the effect of nursing care. As Clare Dennison herself once said, “Finally and fundamentally the quality of nursing care depends upon the quality of those giving care.”22

NOTES