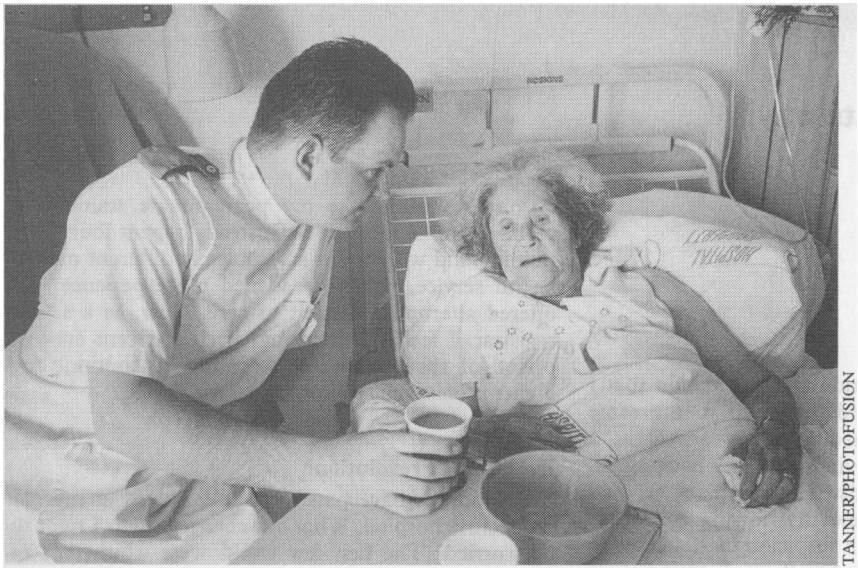

TANNER/PHOTOFUSION

Nurses may lose their role of helping patients with activities of daily living

private tasks helps to build the therapeutic relationship on which assessments of mental state are accurately based.

Clinical teaching placements can no longer offer these practical skills, as the senior nursing colleagues from whom nurses previously learnt so much have been caught up in the tide of health service reforms and in many cases no longer have any contact with patients with acute conditions. With the move to community care, others are now working as primary therapists in the community. The role models of the specialist skills needed for acute, inpatient care have gone. The nursing profession in general has never properly recognised, or rewarded, those clinical nurses who chose to stay at "ward level." They are regarded either as lacking in direction and initiative or as being too rigid and unable to adapt to the new progressive thinking. Perhaps that explains my defection.

At least as a doctor I am able to maintain my contact with patients, and perhaps also take up the role of advocate, by encouraging junior nursing colleagues to see patients in a more holistic light and not to dismiss the medical model. We must address this imbalance. The right of our patients to have the best multidisciplinary care depends on it.

Nursing and medicine: cooperation or conflict?

Ann Bradshaw

Two years ago a newspaper's foreign correspondent in Russia described her observations of health care in post-communist Moscow. Through her visits to a sick friend in hospital and conversations with her taxi driver, whose mother was in hospital, the correspondent came to see a system of health care based on contractual, material rewards: flowers, chocolates, and perfume for the nurses; crates of whisky for the doctors. Sitting on her friend's bed (for which the patient had to provide her own linen and pillows), the correspondent watched in horror as nurses provided the expected "tender loving care" to some patients—changing bedclothes, taking temperatures, and giving tea—but ignored other patients completely, even if their sheets were horribly soiled and they were crying out for a glass of water. These patients, or their relatives, had failed to give the nurses any presents: no presents, no nursing. The correspondent concluded that we should be thankful for our own NHS.[1]

But I wonder if the correspondent's horror at the cold hearted contractual nursing she witnessed was the result of her own assumed and inherited expectations that nurses are inducted into a tradition of "tender loving care"? Does she still taste the fruit of a tree which is now almost cut down? British nursing, under the powerful influence of North American sociological, psychological, and educational nursing theory, has undergone a rapid transformation since the 1970s, which makes such assumptions questionable. Indeed the past 20 years have seen a revision of nursing history and a rejection of the traditional nursing ethos. Contemporary British nursing theorists have vigorously sought to challenge both the "biomedical" view of care and the moral values that underpinned it and, most particularly, the concept of nursing as altruistic, self effacing service—dare I say, vocation. The new nursing values of autonomy and empowerment, rejecting what is mistakenly and simplistically perceived to be the past nursing values of submission and obedience, have deconstructed the sense of continuity with the past and led to a loss of authority in the present.[2-4]

The break with tradition

These axioms have led to a new orthodoxy, which has brought fragmentation to the nursing profession as each nurse is taught to become a wholly autonomous practitioner; hence, the ward sister no longer inducts her charges into a tradition but rather takes on the role of a detached business manager. It has also brought alienation of the nursing profession from the medical profession because doctors, particularly male doctors, are seen as the perpetrators of past nursing oppression still intent on holding nurses in subservience. No doubt both ward sisters and doctors bear some responsibility for this sense of alienation, perhaps by exercising authority in the form of power rather than as authority vested in a shared moral tradition of fairness, justice, and care. But this overreaction has resulted in an often implicit sense of rejection of doctors as unfeeling technologists and, sadly, in a sundering of the science and art of care. At the same time the concept of care is now very problematic for nursing theorists, and the loss of continuity with the past means that the notion of care has become the subject of academic inquiry and empirical research, predominantly derived from the social sciences. Indeed, as the consultant orthopaedic surgeon Robert Hay has recently noted with sadness, the value of bedside nursing care is devalued in favour of what he believes is the pursuit of a "pseudo-intellectualisation" and an attendant "pseudo-managerial gibberish."[5]

Fragmenting moral values

Nursing, however, is not independent of the mores of society. Does the change in the identity of nursing merely reflect the moral state of society and health care within it? Alasdair MacIntyre's *After Virtue* offers us an illuminating template.[6] Drawing on Max Weber's thesis of bureaucratisation and rationalisation, MacIntyre argues that the destruction of the inherited moral tradition has resulted in an emotivist culture dominated by three types of attitude exemplified in the characters of the aesthete, the therapist, and the manager. Their emotivist concerns are no longer those of the truth discernible through moral debate; rather they are the values of efficiency and measurable effectiveness derived from the imputed skill and knowledge of the so called "expert." Values are utilitarian; ends are given and are outside the scope of

debate. The aesthete, the manager, and the therapist are therefore in different but complementary ways concerned only with technique, skill, profit, and effectiveness. They are uncontested figures who engage only in the kind of discourse in which rational agreement is possible—the realms of fact, means, and measurable effectiveness.

"For all of us, whether doctors or nurses, genuine compassion must be the foundation for care."

And here we see the link with current nursing attitudes towards patient care, which sacrifice the traditional metaphysical principles of truth (and hence the moral and scientific principles derived from it) for aesthetics, therapeutics, and managerialism. The aesthetic nursing attitude seeks to provide "holistic and spiritual" care directed at contemplation of beauty and the arts; the therapeutic nursing attitude seeks to transform "maladjusted" patients through psychological and emotional techniques of counselling and complementary therapy; and the managerial nursing attitude seeks to manipulate human beings into compliant patterns of behaviour to achieve purportedly measurable standards of quality.

Yet we are forced to ask whether this discourse, which replaces ultimate moral principles with techniques of productive and psychological effectiveness, offers a possible or desirable method for producing nurses who can give patients "tender loving care" and can offer medical and other colleagues partnership, team loyalty, and mutuality? Can the morality of this contractual nursing, derived from the cult of autonomy, engender in a nurse a warmth and freedom of the heart that is independent of either material rewards or competition for status? Traditional nursing depended on an ethic of service derived from the moral principles of *caritas* or *agape*. This ethic was the basis of the nursing tradition revived by Nightingale, handed down to generations of nurses by Evelyn Pearce,[7] and affirmed by the eminent surgeon Lord Webb-Johnson.[8]

Genuine compassion: the foundation for patient care

The same ethic, as Lord Walton argued in his 1990 Harveian oration to the Royal College of Physicians, formed the basis for the humane practice of medicine by humanising the Hippocratic tradition and so extended medical care to all and even to those with incurable disease.[9] Indeed this same moral tradition was responsible for the foundation of the modern hospice movement and thus palliative care of terminally ill and dying patients.[10] So it is not surprising that the chief medical officer, Kenneth Calman, should acknowledge that quality in health care is related to human values.[11] But these values need not only coherent articulation, as Calman suggests, but also incarnation. The story of care in post-communist Russia surely demonstrates how easily the values of genuine compassion can be lost and our hearts harden. And for all of us, whether doctors or nurses, genuine compassion must be the foundation for care.

No better illustration of this can be found than in Sir Archie Cochrane's autobiography. He relates an incident during the second world war when a dying Soviet prisoner was dumped in his ward. The patient was moribund and screaming. Sir Archie examined him, believed the cause of the pain was a severe pleural rub, and, having no morphine gave him aspirin. But the prisoner still screamed, and Sir Archie took him in his arms. The screaming stopped at once. "It was not the pleurisy that caused the screaming but loneliness."[12]

I suggest that if we are not to lose the humanity of caring for vulnerable members of society (and the medical basis for this caring), all of us involved in health care need to examine the roots of our tradition of dedicated service. Perhaps then we will be able to build quality and cooperation in health care in the future and keep alive the founding values of the NHS.

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Towards an ethos of interdisciplinary practice

Mike Nolan

Anyone browsing through the nursing journals over the past few months will have noticed that the profession seems to be undergoing sustained and quite unprecedented change. While change characterises the health care environment in general, several factors seem to have impinged on nursing and exacerbated an already fraught situation.

On the one hand there are dire warnings of the potential impact of "multiskilling," whereby unqualified and minimally trained personnel are undertaking activities previously deemed to be the province of nurses. Indeed in the United States such workers seem to be already moving into quasi-medical territory and are suturing wounds, injecting intravenous drugs, and inserting catheters.[1] Paradoxically, in Britain there are concurrent accounts of the potential benefits, particularly for junior doctors, of nurse practitioners completing a similar range of tasks.[2]

Although some experts feel that the development of the nurse practitioner will also benefit nursing, there are those who argue that such an initiative is of questionable value and does little but reinforce the traditional "handmaiden" relationship, with the nurse now cast in the role of "technical functionary."[3] In considering alternatives, others assert that nursing's future lies outside acute care, in such domains as health promotion, which is seen to offer "truly infinite scope" for professional growth and development.[4]

Against this backcloth Castledine suggested that nursing is currently in the throes of an identity crisis, initiated and sustained by the scale and pace of technological, economic, and scientific change in the NHS.[5] To consider the likely impact of such factors on the delivery of health and social care and the role of the nurse in the next century the chief nursing officers for England, Northern Ireland, Scotland, and Wales convened a group of nursing leaders and other professional colleagues in May 1993. The report of their deliberations outlined several potential scenarios based on the premise that there is, and will continue to be, a shift in the balance of health care away from institutional provision and towards community care,