Table 1—*Reasons why students chose St Mary's. Values are numbers (percentages) of students giving reason for choice, fractions showing that more than one reason was given*

	1971–82			1983–94		
Reason	**Men (n=144)**	**Women (n=114)**	**Both (n=258)**	**Men (n=200)**	**Women (n=187)**	**Both (n=387)**
Friendly	70.5 (49)	63 (55)	133.5 (52)	128 (64)	144 (77)	272 (70)
Adviser	38.5 (27)	36.5 (32)	75 (29)	17.5 (9)	6 (3)	23.5 (6)
Academic	3.5 (2)	1.5 (1)	5 (2)	13.5 (7)	12 (6)	25.5 (7)
Not academic	0.3		0.3	0.5	1 (1)	2 (1)
Sport	9.5 (7)	1.5 (1)	11 (4)	14 (7)	5 (3)	19 (5)
Music		0.3	0.3	3 (2)	5 (3)	8 (2)
Prospects	9.5 (7)	8.5 (7)	18 (7)	5 (3)	3 (2)	8 (2)
Location	5 (2)	2.5 (2)	7.5 (3)	4 (3)	3 (2)	7 (2)
Low grades	5 (3)	0.5	5.5 (2)	6.5 (3)	4 (2)	10.5 (3)
Miscellaneous	2.5 (2)		2.5 (1)	8 (3)	5 (3)	13 (3)

residential accommodation, and acceptability of mature students. One had been a patient, and another was impressed by royal patients. One chose randomly, another because of its Welsh connection, one by the sixth form conference, one by the television programme *Doctor to Be,* and one appreciated the bar and the beer.

Comment

Advice from older people is no longer important. St Mary's is increasingly chosen because it is regarded as small and friendly. By the end of the 1990s, 12 London medical schools will have been (sub)merged into four multifaculty colleges of London University, Imperial (Charing Cross, St Mary's, Westminster), King's (Guy's, King's, St Thomas's), Queen Mary's Westfield (St Bartholomew's, the Royal London), and University College (Middlesex, Royal Free, University College Hospital), leaving St George's standing alone. It will be interesting to see what criteria applicants will choose in deciding whether to apply for these medical schools.

Funding: None.
Conflict of interest: Formerly consultant physician and subdean at St Mary's.

1 McManus IC, Richards P. Audit of admission to medical school. I. Acceptances and rejects. *BMJ* 1984;**289**:1201-4.
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Does nursing have a future?

Alison L Kitson

This article is adapted from the Distinguished Nursing Lecturer delivered at the John Hopkins Hospital, Baltimore, Maryland, USA, on 7 May 1996.

> The history of nursing is rarely one of triumph in the face of adversity but of struggle and compromise and often defeat.
>
> A M RAFFERTY, 1995[1]

Starting a paper on the future of nursing with such a quote may be rather melancholic, but I am troubled for the profession of which I am a devoted and committed member. We, together with the rest of our health care colleagues—in every continent, it seems—are experiencing change unprecedented in its nature and scale. The turbulence is disorientating and almost prohibits us from seeing the things that matter. My purpose here, therefore, is to refocus on those essential elements that give nursing its structure, its character, its presence, and its strength in a turbulent environment. I want to explore the issues facing us, how we are tackling them, and to finish by considering what the future holds for us.

Nurses as agents of control

Some will recognise the description in the box (p 1648) as coming from one of Kurt Vonnegut's short stories, *Welcome to the Monkey House.*[2] What interested me was the caricatures he used to portray the hostesses. These were manipulative, seductive, coercive individuals, trained in the techniques of caring but programmed to carry out definite tasks. They were plausible, socially skilled, and they upheld the values of the ruling party. There were no scientists or doctors in this story; the world government was in control, whose president, by the way, was an ex-suicide hostess. The great evils—illness, aging, suffering—seemed to have been overcome, but the world was without purpose or spirit.

Perhaps this is one future scenario for nursing that we need to consider. If technology comes up with all its promises and delivers us from suffering and death what need will there be for nursing? Will we become agents of control, using our interpersonal and caring skills to encourage people to comply? Or do we find this imagery offensive and unrepresentative of the essence and purpose of nursing? What stereotypes of nursing was Vonnegut using when he wrote this story, and should it count as something we should respond to?

Images, metaphors, and rituals

Our impressions of other groups, nations, and races generally emerge from a collection of images and assumptions we hold. Such stereotypes help to classify and give meaning to ever increasing arrays of information bombarding us. Images are difficult to shift in the public domain, particularly those images which are falling from grace. For example, an increasing phenomenon in Western civilisation is the lack of faith in medical technology. Aiken quotes recent surveys where two out of three Americans are losing faith in doctors,[3] and where they see health care services as slightly better than automotive repair shops and less good than supermarkets and airlines.[4]

Nursing, however, continues to be held in positive regard,[5] and most people say they are willing to receive more health care from nurses. So why, if there is public support for role expansion, does this not happen? Part

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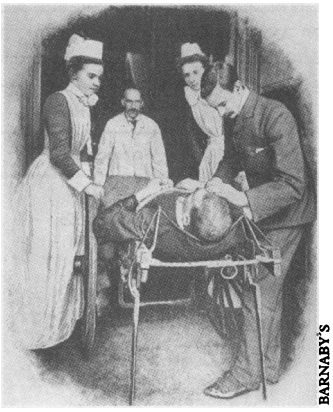
BMJ 1996;**313**:1647–51


NATIONAL PORTRAIT GALLERY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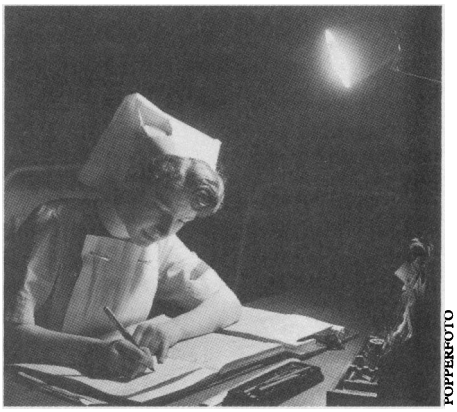

POPPERFOTO

After Florence Nightingale struggled to create a new workforce the enduring imagery was of nurses as doctors' handmaidens and as guardian angels

of the puzzle may lie in the ambiguous images the public and other professions hold about nursing. This ambiguity can be traced back to the beginning of professional nursing and I believe it is something which continues to thwart our ability to deliver on a number of broader health policy issues.

NURSING'S ROOTS

None of us should underestimate the social turbulence of the latter part of the 19th century, from which professional nursing emerged.[6] This was a period of major scientific advancement and controversy as well as of social reform. The laissez faire approach to social issues was challenged by reformers in social policy, health, and prison reform. Changes in the social structure also became evident: the role of women, the function of the extended family, educational opportunities, and increasing prosperity. Florence Nightingale faced a considerable challenge in introducing a new workforce comprising middle class women who hitherto had not been expected to have a role outside the home. The new rules and codes of conduct for nursing had to ensure the moral welfare of vulnerable women as well as protecting them from the dangers of contact with other social classes—not to mention naked bodies.

The emerging imagery of this period—the nurse as guardian angel and doctors' handmaiden—embodies the complex interplay of the many new roles and expectations put on nursing. The ministering angel metaphor communicated the value base of nursing, firmly grounded in the Judaeo-Christian ethic of *agape* and *charitas*,[7] the selfless devotion and compassion required to nurse. The image of doctors' handmaiden was also necessary: women had yet to obtain the vote, their family structures were paternal; doctors became of necessity the substitute fathers, husbands, and brothers. Medicine also represented the growing use of scientific knowledge, which was at that time seen as a male preserve.[8]

While these two images of nurses were necessary at that time it is interesting to consider the impact they have had on subsequent generations of nurses and on the public and other professionals working with nurses. Those parts of Nightingale's vision of nursing which were not idealised related to her reforming zeal in public health and her belief that all women should be trained in the art of nursing. These wider public health and health promotion roles were only partially addressed in the early days of nursing and certainly were not idealised. The focus tended to be on building up the profession within hospitals.

SCHISM AND FRAGMENTATION

Other interpretations of the guardian angel, doctors' handmaiden image include the schism between the technological and scientific basis of nursing and its nurturing or caring role. Nightingale believed very strongly that good nurses were the product of moral rectitude, maturity, and a deep understanding of the character traits needed to care for sick and vulnerable people. While she acknowledged scientific training, she was concerned that science alone would not produce good nurses. The second wave of reforms in nursing led by Bedford Fenwick[1], and including the American nurse pioneers (Hampton, Dock, and Nutting),[9] chose a medical model for professional nursing which emphasised education in the sciences.

Meanwhile, images of nursing were beginning to fragment. It is difficult to be a ministering angel, and as social reforms began to change women's roles in society so nurses began to be seen as surrogate mothers, battleaxes, sexual teases, body experts, or body minders.[10] The image that remained more constant was their subordinate role to medicine. This may have been due to the then unquestioning belief in the power of medical technology.

But first a story...

Imagine the situation. Earth has a population of 17 billion and the world government, whose headquarters are in the Taj Mahal, has a two pronged attack on overpopulation. One is ethical suicide, which means going to the nearest suicide parlour and asking a hostess to kill you painlessly. The other is compulsory ethical birth control: the only legal form of birth control. The pills, taken three times a day, do not interfere with a person's ability to reproduce, which would be immoral: all they do is take every bit of pleasure out of sex.

Hostesses enforce the rules. They look after the suicide parlours with meticulous precision and work with the sheriffs to ensure that everyone takes their ethical birth control pills. Hostesses are carefully selected. They have to hold advanced degrees in psychology and nursing. They are invariably tall, handsome, and expert at judo and karate. The art of every hostess is to see that volunteers to the suicide parlours don't leave—to coax, wheedle, and flatter them patiently every step of the way.

Hostesses and sheriffs were lucky: everything else was automated. The average citizen moped around home watching government TV, taking her anti-aging pills twice a year so that everyone looked 22. What could be better—eternal youth, health, painless death? The climax of the story comes when Billy the Poet, the Nothinghead who refuses to take his ethical birth control pills, challenges Nancy, one of the hostesses, about the value of her life. He wrote her a poem and she became a Nothinghead too.

What is interesting is that whereas nursing over the years has tended to devote the major part of its intellectual energy to developing a scientific base—note that the early nursing theories of Abdellah,[11] Orem,[12] Roy,[13] and Henderson[14] were based in the biological sciences—the public's image revolves round nurses' caring role. So Vonnegut will caricature nurses as manipulative sirens and agents of control, and Nurse Ratched (the "big nurse") in Ken Kesey's novel *One Flew over the Cuckoo's Nest*[15] provides an extreme but none the less telling example of mothering as tyrannical control. Similarly, suggestions that nurses wear short skirts and black stockings to make patients feel better[16] is another illustration of the confused imagery the public and other professions use to understand nursing.

What this seems to do is to relegate the contribution of nursing to levels of absurdity. As one respondent said, "You have to work hard not to be typecast as a nurse, to make clear that you are a serious person across a broader range of topics."[1] And another, "I'd wrestle as a practising nurse with the undervaluing of nursing." What are the macro issues that structure that perception?[1]

Dangerous route

Yet possibly the most dangerous tactic that nursing could choose would be to try to win recognition and respect through the route of nursing as science alone. Consider the recent position of the American Nurses Association on President Clinton's US heath care reforms.[17] The nursing argument was based on the cost effectiveness of using advanced practice nurses to deliver health care on the cusp of the medical-nursing boundary. Despite the moral high ground of campaigning for universal health care coverage, more effective cost containment, and greater concentration on primary health care, long term care, and health promotion, nursing lost the battle. As Rafferty comments, nursing was also seen to fail along with the Clinton taskforce.[1] Nursing had not succeeded in "knocking down the door in formulating the tenets of health reform and had not convinced others that nursing was taken seriously as an important source of ideas or intellectual force early on."[1]

By taking what critics called an elitist nursing agenda towards advanced nursing practice reform, nurse leaders effectively alienated the majority of nurses who give care. In most of the world most nurses are not trained at graduate level nor do they have advanced practice skills. The old schism between graduate, educated nurses and "vocational" nurses is not going to be put to rest unless nursing itself tackles the problem.[18]

KOBAL COLLECTION

Later images became more complex: from the Carry On films come nurses as battle-axes or sexual teases, while Nurse Ratched from "One Flew over the Cuckoo's Nest" embodies tyrannical mothering

And the seriousness of the problem cannot be underestimated. Note the language used to describe associate or, in the UK, diplomate students—"vocational." With that term we are catapulted into the confused imagery of nurse as angel, harlot, mother figure, battle-axe. The intelligentsia of the profession does not seem to have fully grasped the extent of this problem.

MARRYING SCIENCE AND CARING

There have been past attempts to marry the scientific with the nurturing role. We see this in the shift in nursing theories in the 1950s and 1960s, when the principles and practices of humanistic and existentialist psychology[19-21] greatly influenced the thinking and work of such nurse theorists as Peplau,[22] Travelbee,[23] and Paterson and Zderad.[24] The emergent image of nurse as therapist came some way to reconciling the need for a scientific approach with a human response to caring. However, as Hall has suggested, a further problem to emerge from this is that as nurses become more psychologically minded, their own analyses of nursing can convey the message that mere care is second best.[25] They are at risk of selling their caring birthright for a mess of psychological pottage.

What is care and do we value it?

One of the architects of the Oregon health plan, Ralph Crawshaw, wrote recently, "That everyone cannot have everything is a commonplace of our world, yet as any government leader knows, this reality turns to political poison when applied to the delivery of health care."[26] In his reflections on what is happening to British health care he identifies several tensions:

- The growing preoccupation with quantitative considerations of economy over qualitative issues of caring.
- The worst case scenario where unlimited medical technology continues to be provided to a few, while other groups (who in the main need care) are denied the right to treatment and care.[17]
- The growing marginalisation of professional care through the "reskilling," re-engineering, or downsizing of the nursing profession and nurses' replacement with technicians and care assistants.

He concludes by reflecting on whether we can afford civilisation any longer, civilisation meaning a sense of community and corporate responsibility for each other, particularly for the most vulnerable and needy. He considers what it would take to have governments, insurance companies, and hospitals to count in the cost of caring as much as the cost of medical supplies. Unfortunately, it is a rhetorical question and one which he does not answer.

But who should be answering it? And why are we in a situation where the most sophisticated health delivery systems in the world have not explicitly acknowledged the need to build in care to health costs? Care may be built in implicitly but it needs to be explicit. If I can come across situations where night nurses are waking confused elderly patients at 0500 to give them their morning wash because there will not be sufficient nursing staff on day duty to get through the work, then all that can be assumed is that nursing is either very badly managed or not appreciated as a vital service to patients and thus not properly funded.

Nurse as companion

What happens between nurses and patients is rarely articulated in the public or professional domain.[27] Research indicates that patients value the nurse as a person: her personal qualities, attitude, manner, personality, and her presence—her being with the patient and being readily available.[28] The encounter between nurse and patient carries with it the rituals

around having to deal with vulnerability, dependency, fear, suffering, insecurity, and possible death. The patient needs to be able to trust, perhaps more than any other health care professional, the intentions of the nurse, her attitude to her patient's vulnerable position. Campbell, a theologian and philosopher, has characterised the nurse's role as one of skilled companion and in so doing attempts to bring together the science and moral basis of nursing practice.[10]

In companionship there is closeness that is not sexually stereotyped; it implies movement and change and requires commitment and mutuality. The skills of companionship are in being able to sense the need of the other person and accommodate oneself to the other's idiosyncrasies, to help the person onward by enabling them to see how the journey can be accomplished, and to guard against the imposition of routines which make the patient feel trapped. The price is high for nurses because the care involves "being with" as well as "doing to." Nurses also need to know whether they can risk involvement with demanding and apparently ungrateful patients. Nursing is costly on individuals; it requires a constant presence and involvement, not merely the episodic encounter. But it is doable because it offers limited companionship. When the patients are ready to move on they say farewell.

Nurse as companion may be the emerging metaphor or image for public consumption. A recent slogan from the American Nurses Association said, "Every patient deserves a nurse." A more central slogan combining the technical with the nurturing role might be "We'll be there for you." But how do we communicate the central message of nursing, which is about being there, in a climate that is cost driven, technology bound, and committed to keeping prevailing powerful alliances intact?

"Being there" for you

Most success stories in business or industry describe the dramatic turnaround of tired, bureaucratic, wasteful organisations that have lost sight of their primary function. By refocusing on what they ought to be doing they become outstandingly successful. Examples—even from the UK—abound. Recently, British Airways succeeded in turning around its whole enterprise by refocusing on customers, giving them a more attentive service, and publicising that change to the public. Research in nursing and health care shows that attentive nursing care makes patients feel better and get better more quickly.[29-32] Organisations that value the nursing contribution recruit and retain their nurses. Implicitly, the message of skilled companionship and being there seems to work. So why does such a relatively straightforward and simple idea not seem to spread? There may be several reasons.

- In the broad church that makes up nursing we have not united on the central image of nursing which we want to communicate to the public and our professional colleagues.
- Our core values, which implicitly continue to be social justice, equality, and respect for individuals, are not recognised because of the inherent tensions within our profession.
- Such tensions reflect our past and our present. They include the tension between autonomous practitioner versus subservient employee; our quest for legitimacy from scientific pursuits versus our need to explain the mystery of professional care; the tension between our quest for health reform and greater access for disadvantaged groups and our focus on individuals and their care; the tension between our heterogeneity as a professional group accepting a diversity of people from different socioeconomic, ethnic, and religious groups and our desire to be seen as a bone fide profession; and, lastly, our strategy of promoting the contemporary image of the nurse as an advanced practitioner in order to gain some political leverage without considering the knock on effect on the majority of nurses who are not, never will be, and don't need to be advanced practitioners.

Are any of these tensions creative? Or do they lead to chaos? Why have we not succeeded in dealing with them more successfully? That the tensions are equally visible on both sides of the Atlantic demonstrates that it is not the prevailing health systems that have created the problems. I suggest that nursing's persistent inability to grasp the nettle of reconciling our technical skills with our caring skills is at the heart of the matter. And I believe we are facing a time when these two core ingredients might be wrenched apart. This will not happen through any malevolent plan but more probably through ineptitude and lack of appreciating what matters to us. In particular, it may happen through our having to work in a wider context which still fails to appreciate the central value and importance of caring.

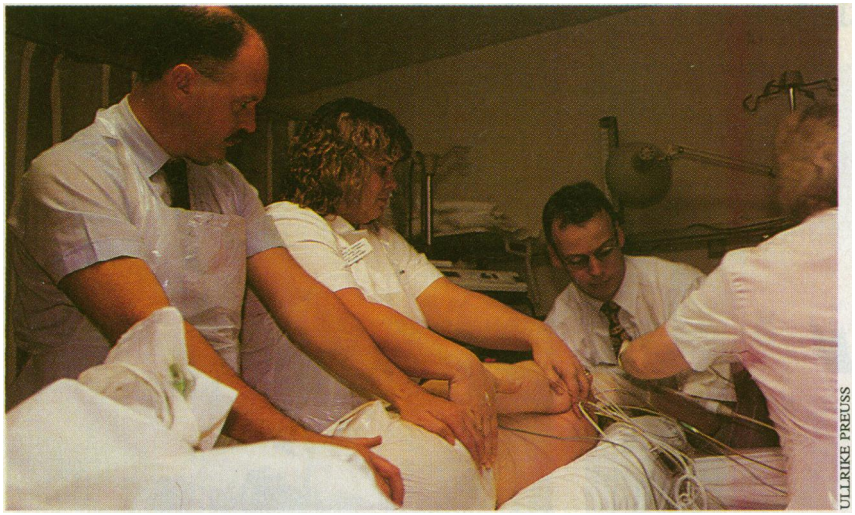
Revisiting professionalism

The pragmatic response of the cost containers is already evident in reskilling programmes and the naive assumptions that nurses can be replaced by trained care technicians.[33] Inadvertently the advanced practice nurses may be playing right into the hands of those who can see a cost effective and simple solution to rising costs in reducing the numbers of trained nurses. Our defence is not only to show how advanced practice nurses can be both cost and clinically effective, but also to argue very strongly for the protection of caring as a skilled and moral force in society.

If we are successful then we need to revisit our notion of a profession. We cannot cling to an idea that, to be taken seriously we must espouse the characteristics of traditional professional groups. Do we not recognise along with Freidson[34] that the prevailing qualities of professionalism are the ability to control and regulate entry into an occupational group rather than necessarily safeguarding public wellbeing? On this criterion nursing can hardly be seen to be successful, and this is because at the heart of nursing, and what makes it nursing, is the giving out and giving away of one's knowledge, skill, and energies. Thus, when Nightingale wrote in 1860 that she wished the principles of nursing to be taught to every woman[35] she combined a profound understanding of the central necessity of such knowledge to improve the health of ordinary people with an expectation of how professional nurses should work—namely, as community leaders and educators equipping ordinary people with basic self care skills.

Such vestiges of vision still appear in nursing but they have been compromised by our inadequately thought through position on professional status. Instead of one legally binding term we need several descriptors identifying to the public what sort of a nurse we are and how advanced our technical and caring skills are. If we choose to explore this then of course the legislative and educational challenges will be considerable. But the current situation in both North America and the UK is unacceptable.

In both countries confusion exists over the level of training required to register individuals as nurses; public demand is growing for direct access to nursing care and for nurses to prescribe certain drugs with the consequent need for new legislation; although nurse education has moved into higher education in the UK, there is still confusion and controversy over what sort of nurses it will produce. In the USA there is no national requirement to regulate nurse education; in the UK the nursing profession has chosen not to be as involved as it could have been with the training and preparation of health



The nurses of the future need new images to reconcile their technological skills with core values of caring and companionship

care assistants; and nursing shortages and skill mix problems continue to exercise leaders in both countries.

What is clear is that size does not mean power and influence. Nursing leaders around the world are doing their best to ensure that the nursing voice is heard. But perhaps in these reflections we are beginning to realise that the nursing voice is in need of tuning. The rhetoric does not always match the reality, and the courage to tackle some of the central schisms seems to be thwarted.

What does the future hold for us?

So what does the future hold for us? As isolated units we can espouse a tradition of exemplary care without defining it and follow the path of adding to the scientific base of nursing practice. We can build up systems of expert practice and of patient centred care—only to see them being wiped away because of a change in financial remuneration or the loss of a clinical contract.

As we approach the millennium I believe we are in a similar state of social and political turmoil to that which was responsible for the emergence of nursing. A century on we still have not reconciled the tension between the scientific base of nursing and its moral base of care. We believe our salvation is in advancing our technological skills, while the rest of the world thinks of us in terms of ministering angels, six foot hostesses, surrogate mothers, and, just possibly, skilled companions. Perhaps this realisation explains Rafferty's quote, that our struggle, compromise, and defeat are not because our causes aren't worthy but because, like a cracked vessel, we sink before we have reached our destination.[1]

The future could hold the reconciliation of our two sides. It could herald the dawn of health care systems around the world committed to promoting health and wellbeing instead of systems that treat illness.[36] The future could hold the possibility of advanced practice nurses running community health programmes in every country, supported by doctors, nurses, lay carers, family members, and members of the wider community and instituting better ways of living. But, as Dubos points out, living wisely is a much more difficult job than being fixed up by doctors.[37]

Perhaps we need the general public to realise that there are no magic cures, that, as Vonnegut graphically illustrated in *Welcome to the Monkey House*, eternal youth and painless death do not lead to fulfilled, meaningful lives. What will always be required are people to be there for you, not the duplicitous hostess type of presence but one that is skilled and authentic.

To be skilled and authentic in the future nursing needs to recognise those images and metaphors associated with it, those which influence its perception and acceptance in the wider political context. Nurses need to understand the impact of wider social, political and cultural factors on how nursing is perceived. Nursing needs to be clear about the messages it sends regarding its implicit and explicit value base; nursing needs to be more than simply being dedicated to education and practice.[38] Nursing needs to be clear about the value and cost of caring: if you don't cost it in, then you've counted it out.

New metaphors

Nursing needs new metaphors and new images to communicate its essence. "We will be there for you" needs to be dissected and its implications explained in terms of legislative, educational, and health care reform. Nursing needs to demonstrate its commitment through innovative schemes that bring together its essential ingredients—empowering, enabling, and educating people to take control of their lives.

Nursing's strategy for this must be built on a unity of purpose and a vision that is shared not just among nurses themselves but also with medical colleagues, chief executives, politicians, and the public. Nursing in future needs to be seen as part of the solution rather than contributing to the problem.

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