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The Calling of Nursing

Rae M. Huegli Lecture, Oct. 9, 2009, 4:00 pm

College of Nursing, Valparaiso University

by

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Ladies and Gentlemen!

Honored Guests, Alumni, and Students!

Baffled by the broad variety and diversity of nursing and unable to discover one single common thread of thought and discussion in the literature, I got desperate and finally turned to Dean Brown for help, hoping to get some viable direction. And, indeed, I did, yet of course not the way I expected. When I asked her if she would be so kind as to name me the standard instruction textbook used for nursing education and practice, she unhesitatingly replied: “There isn’t one. Because there are so many content areas in nursing, there is no one text that is considered the ultimate one that must be used by all.” And when further asked about the “reference work for the history of nursing in the US” her reply was: “I don’t think there is one most reliable source.” So there I was, my puzzlement now confirmed by a knowledgeable authority. And Dean Brown does know her subject really well, indeed she does. Her reply is fully in line with a comprehensive study by the American Nursing Association (ANA) which showed that nursing practices in the U.S. vary to a confusing degree. Nursing practices not only reflect the various job perceptions by individual nurses, their educational, social, and ethnic background. They reflect also the broad variety of the different hospital types across the nation, the economic standing of the institutions served, and the attitude of respective state legislatures.¹

Realizing this situation I wondered if the various nursing professions do actually have anything in common at all. Would it not be more appropriate to speak of nursing professions instead of just nursing? As early as 1949 the *American Journal of Nursing* published a letter whose author,

after stating that “nurses worry about the practical nurse, the bedside nurse, the R.N., and the professional nurse,” suggested that “professional nurses should be differentiated from ‘nurses’ by changing her [!] title.”² Although this suggestion did not get the expected approval, it highlighted an issue haunting the profession. In addition, advances in medical treatment and intervention entailing corresponding specialization in, for instance, nephrology, gastroenterology, and gerontology added to and accelerated professional diversification. To make things more confusing, changes in hospital and health-care-plans administration, management, and financing have had—and continue to have—their impact on nursing too, as do the overall health-care politics of the individual states and the nation at large.³ It is certainly true that nurses nowadays work in a very “volatile environment” requiring permanent readjustments, especially here in the U.S.⁴

Such dazzling proliferation of the profession prompted me to carefully search its wilderness for what has stimulated this astonishing variety and diversity, which as you can imagine took quite some time. But finally I did find something, a new kind of species, unknown to the scientific world so far, at least to my knowledge. I did discover the species *procomea acujat*. *Procomea acujat*? Well, that is the professionally competent, medically educated, and always cheerfully understanding Jack (or: Jennie) of all trades, or: *nurse* for short. Such description of the species is less farfetched than you might think. Gillian Rose in her autobiographical memoir reflecting her time in the hospital as a cancer patient in 1997 sketches the nurse in this way: “A multiple female beast, with millions of eyes and heads ... and good intentions ... ‘Nurse’ ... is a supernatural being. She executes endless good works and she offers her soul as well as her skill.”⁵

The discovery of the *procomea acujat* was quite eye-opening, believe me. While it certainly was somewhat amusing, it was at the same time very disturbing in many ways. It also made me aware of the actual limitations of whatever may be said here and now since the broad diversification of the profession today does not allow for making sweeping simplifying generalizations nor does it tolerate a one-size-fits-all approach.⁶ It makes a world of difference if one holds a diploma, an associate degree (ASD) or the BSN. There are noticeable differences in the work, responsibilities and, of course, the pay of Registered Nurses (RN), Licensed Practical Nurses (LPN; or Licensed Vocational Nurses, as they are called in Texas and California), and the hosts of Nurse Aides (NA)⁷ and Unlicensed Assistive Personnel (UAP).⁸ This clearly reflects the ever broadening professional diversification. Fields of caring have grown considerably over time and the ever in-

creasing need for nursing personnel has led to a variety of supply mechanisms at various levels of qualification, sometimes putting a heavy strain on existing professional relationships.⁹ Besides, consider the varieties of tasks a community, a parish, or family visiting nurse has to shoulder. Think of hospital nurses specialized in pediatric or nephrology nursing, oncology or critical care nursing, just to mention a few. There are nurse practitioners (NP)¹⁰, nurse anesthetists, and nurse midwives, too, and, not to forget the vast field of mental health care, geriatric, and hospice nursing. Nurses work on Reservations and in rehabilitation centers, in homes for the insane, in military hospitals and Veterans' Administration facilities. Nurses pursue research and have taken on executive functions in hospital administration, insurance companies, and in managed health-care systems. The U.S. Nurse Association Directory lists more than sixty different professional nursing groups presently, all of which have well established national networks; other sources show even more entries.¹¹

So, here we are at a college of nursing, one of these fertile seedbeds and greenhouses for further growth of the profession. Yet a college of nursing does not produce specialists. It only prepares for potential specialization later on by laying a stable and solid enough foundation—it is hoped—on which to build careers afterwards. This, however, implies that there must be at least *some* common ground to be found despite the mushrooming variety of the profession. But: what is it?

To explore this answer is the opportunity a special occasion such as this one today provides. It invites us to step outside the ordinary, to take a step back and pause—at least for a while—in order to reflect upon “The Calling of Nursing.” To an audience as educated, skilled, and conversant with the issues of the nursing profession as this one, such a plain lecture-title might sound somewhat ridiculously naïve, doesn't it? Yet, the plain need not necessarily be trivial or irrelevant. The plain, rather, is oftentimes not wanted, because it disarms the professional hide-and-seek strategy which precisely tilts toward *not* facing the actual challenge, an attitude I do not want to foster. What I would like to facilitate instead is a refocusing of the vision which once—I would guess—drew many of you into nursing in the first place. It is important to regain this vision for finding a motivation strong enough to sustain you in the important and demanding work you are doing or will be called to do in the near future. Let us now look first into the

history of nursing for a while before attempting in a second step a phenomenological analysis of the profession.

I –Nursing: A historical approach

The advent of professional nursing is a fairly recent phenomenon in the history of humankind. However, unlike many other phenomena, this one represents a remarkable achievement in human civilization since it defies natural instinct. It is perfectly natural to care for one's own kin in times of sickness and when they are or become too frail to care for themselves due to age, physical or mental challenges. It is anything *but* natural to do so for members outside one's very own family and clan. What is natural instead is to instinctively shun suffering and wailing. It is also only natural to dissociate oneself from failing life, from dying, and death, as is so powerfully expressed by Velma Wallis in her novel *Two Old Women*.¹² The debate on altruism in animals by socio-biologists and in evolutionary biology has yet to prove that there really is such a quality. What we know about unselfish behavior so far relates to comparatively small cohorts only and to relatively close-knit kinship relations in human and non-human animals.¹³ The altruism we have become familiar with in our health-care system whenever we visit a doctor's office or a hospital or when we decide to join "the largest of the health-care professions"¹⁴ by becoming a nurse is—again—anything *but* normal. And, honestly, who can really want always to face the massive wretchedness and misery of human life in hospitals and nursing homes, in insane asylums and hospices, in neglected family homes and struggling communities? Who can really want to stand these conditions at the expense of constantly suppressing one's own feelings and emotions? I think it is important for all persons in the profession—as it is for all of society—consciously to acknowledge this. Otherwise a proper understanding of the particular challenge of nursing will not be gained.¹⁵

Moreover, today's occupational prestige of nursing is also of very recent origin. To assist strangers too sick to manage their private daily routines themselves—eating, drinking, and bodily cleanliness—and to keep them company has always required robust personalities. It asks for people strong nerved enough to handle the sometimes quite disgusting care of wounds and to attend to the hygiene of the private parts.¹⁶ Until about a century ago nursing happened in private homes only. Families unable to provide care for their sick hired personnel somehow skilled in

nursing and compensated for these services in kind with food, drink, lodging, and—only occasionally—cash. The nursing appointment often lasted only days or weeks, but also could be extended provided the means for remuneration were there. One frequently asked-for nursing service was, of course, the care for pregnant and nursing women. But once the child was born and the mother strong and well again, once the patient recovered or died, the nurse's employment and income ceased until she was called for assistance elsewhere.¹⁷ The nursing attendants of old, thus, depended heavily on neighborhood and physicians' referrals. Both their reputation and their income were determined by success and public acceptance.

Undoubtedly, literary characters, for instance, Ms. Sarah Gamp and Ms. Betsey Prig in Charles Dickens' 1844 novel *Martin Chuzzlewit*,¹⁸ represent average nurses in the pre-Nightingale days quite faithfully. In a preface to the novel written years later and obviously responding to particular criticisms, Dickens explicitly remarked: "I have taken every available opportunity of showing the want of sanitary improvements in the neglected dwellings of the poor. Mrs. Sarah Gamp was ... a fair representation of the hired attendant on the poor in sickness. ... Mrs. Betsey Prig was a fair specimen of a Hospital Nurse."¹⁹ It is highly instructive to note that even after groundbreaking changes in nursing and nursing education had taken place mid-century, the heralds of these changes used—yes—the image of Ms. Gamp as the stereotype to illustrate the disgusting and dark past of a profession which by then had become somewhat reputable due to concern for cleanliness and nobility, as one of the very first issues of the British *Nursing Record* prominently stated.²⁰

What brought the change about? First of all, it was the Deaconess movement. It formed in 1836 in Kaiserswerth (near Düsseldorf, Germany) under the leadership of Pastor Theodor Fliedner (1800-1864) and his wife Friederike (1800-1842). The Fliedners ran an educational institution for training young women as "Protestant attendants" for deserving poor, orphaned children, and for attending the sick. These women were soon called "Deaconesses"²¹ indicating Fliedner's conscious attempt to revive an ancient Christian ministry of solidarity with the needy and poor in order to cope with the enormous social challenges of his day caused by the industrial revolution while at the same time helping unmarried women find a respectable career. To do so, the Deaconesses, who all lived in celibacy, wore the dress and bonnet of married women of the day, the bonnet which later became the nurse's cap.²²

The Deaconesses lived in a “Motherhouse,” an order-like community with a spiritual regimen, and were supervised by an aristocratic spinster. The students received basic education in the arts and sciences as well as in housekeeping and also in medicine, the latter being taught by a licensed physician. Once consecrated “Deaconesses” they went out to work in hospitals, families, and in parishes but continued to live in the “Motherhouse” which not only guided their work and provided them with a nominal allowance, but also fostered their lifelong spiritual discipline and devotion.²³ All these elements together – decorum, education, medical training, spiritual nurture, frugal lifestyle, personal commitment, and competent leadership by people of high social standing – were instrumental in raising the occupational prestige of the profession; and since Kaiserswerth Deaconesses were also taking up work in other parts of the world, mainly the Near East²⁴ and the U.S.,²⁵ the idea spread beyond local confines. Florence Nightingale visited Kaiserswerth twice²⁶; the second time she participated in a three month educational course, as she did later also in Paris (1853) with the Sisters of Charity. While she held Kaiserswerth in high esteem as her “spiritual home” she judged that the nursing of the sick there was not on par with like institutions of the day in London or Paris.²⁷ How could it be!

It was Florence Nightingale’s (1820-1910) ability for keen observation, her talent to see matters in context, her systematic approach to nursing by painstaking record keeping, besides her commitment to practical nursing itself and her tireless advocacy in both writing and student formation for skilled nursing work which made her the foundress of professional nursing.²⁸ In her *Notes on Nursing* she programmatically turned the task of attending the sick from a charitable, well-intended waiting upon suffering people into a pro-active initiative to ease pain and respond to the immediate needs of the ill. In addition to practicing these skills, she wanted nurses to create an atmosphere conducive to regaining health by paying attention to overall environment details, such as ventilation of the room, its cleanliness, lighting, and quiet.²⁹ And she was plain spoken, too. Her *Notes on Hospitals* opens with the blunt and pointed remark: “It may seem a strange principle to enunciate as the very first requirement in a Hospital [!] that it should do the sick no harm.” So Florence Nightingale in 1863³⁰, a sentence still valid today, albeit for different reasons.³¹

Her “Nurses Training School” founded at St. Thomas Hospital, London, in 1860—though not the first of its kind³²—served as the model for numerous like institutions around the world, finally

reaching the U.S. in 1873 when three such institutions opened in rapid succession: the first at Bellevue Hospital in New York, the second as the independent Connecticut Training School in New Haven, and, finally, the Boston Training School for Nurses in Boston.³³ The training the students received in these schools, which by the turn of the twentieth century numbered not less than 432,³⁴ was akin to that offered at Kaiserswerth, because the nursing students were initially trained not just for work in hospitals but also for work in families, with the poor, and as teachers for youngsters.

Still, the occupational prestige of nursing, which had to do not only with competence and skill in actual nursing but also—and much the more so—with the social background of the average nurses, was poor. “Let it cease to be a disgrace to be called a nurse;” the English physician and advocate for quality nursing Edward Henry Sieveking (1816-1904) wrote in 1852, “let the terms of nurse and gin-drinker no longer be convertible; let us banish the Mrs. Gamps to the utmost of our power; and substitute for them clean, intelligent, well-spoken, Christian attendants upon the sick.”³⁵ Efforts to raise public prestige were also pursued on the American continent. The influential editor of the then very popular *Godey’s Lady’s Book*, Sarah J. Hale (1788-1879) of Philadelphia, in 1871 published an article in her periodical entitled “Lady Nurses.”³⁶ A champion of women’s education, Ms. Hale opened her article in a very telling way: “Much has been ... said of the benefits that would follow if the calling of sick nurse were elevated to a profession which an educated lady might adopt without a sense of degradation, either on her own part or in the estimation of others”; and further: “The ‘graduate nurse’ would in general estimation be as much above the ordinary nurse of the present day as the professional surgeon ... is above the barber-surgeon of the last century.”³⁷ However, the struggle for proper recognition and prestige of the profession was far from over, despite the fact that around those years the public image of nursing received a powerful boost from a very different quarter. In this time of armed conflict and war, nursing wounded soldiers became a patriotic virtue: “Become a nurse: Your country needs you!”

It is well known that Florence Nightingale demonstrated the significant improvement of skilled nursing in the barracks hospitals on the battlefields of the Crimean war (1853-1856). And years before the first formal training schools were opened in the U.S., numerous volunteers—both male and female—served as nurses in the Civil War (1861-1865).³⁸ Henry Dunant (1828-1910)

founded the Red Cross in 1863, partly because of his traumatizing witness of the carnage of the battle of Solferino (1859); the new organization counted the senior Swiss army general Henri Dufour (1787-1875) among its five constitutive committee members.³⁹ The two big wars of the twentieth century (World War I, 1914-1918; World War II 1939-1945) and multiple other armed conflicts occurring thereafter—Korea (1950-1953), Vietnam (1959-1975) and the Gulf (1990-1991) —added their part in shaping the profession.⁴⁰

As much as armed conflicts increased the reputation of nursing services for obvious reasons, they also left their mark on nursing itself in, for instance, the uniforms, the hierarchical structure, and the organization of practical nursing, especially in hospitals, and, of course, in the very annoying way in which nurses—and physicians alike—have the patients under their command.⁴¹ The impact of war and armed conflict on nursing was so crucial that it could be said that “Nursing is warfare, and the nurses are soldiers”⁴² and also: “War is the father of modern nursing.”⁴³ While this might sound too much of a stretch to many, today’s text books on nursing confirm that “wars ... have brought advances in how care is provided” because “nurses have ... expanded the role of nursing, and created new nursing techniques.”⁴⁴

As to the occupational prestige of the nursing profession nowadays, a Harris poll of “Most Prestigious Occupations” conducted in August this year (2009) is highly instructive. It yielded that nurses rank fourth (after firefighters, scientists, and medical doctors) with a 56% approval rate in the public eye. This ranking placed nurses above teachers (51 %, rank sixth), clergy (41%, rank 8), members of congress (28%, rank 12), and well ahead of bankers whose profession ranked 19th (in a list of 23) and scored a public approval rate of only 16%!⁴⁵ However, regarding actual job satisfaction things look somewhat different. According to a study of two-hundred professions based on current data from the U.S. Bureau of Labor Statistics, the Census Bureau, and materials from trade associations regarding job satisfaction by Les Krantz and reported in the *Wall Street Journal* in January this year (2009), Registered Nurses (RNs) hold place 149, while their licensed practical colleagues (LPNs) come in on rank 184 only; at least they both are still within the “Top 200 Jobs” this country has to offer.⁴⁶

A lot has changed, indeed, since the days of Mrs. Sarah Gamp and the early days of professional nursing. These changes affected not only nurses’ attire as noticeable in the vanishing of the once famous cap; one simply need to compare the frontispiece of the first edition of Kalisch & Kalisch

The Advance of American Nursing of 1978 with that of the third edition of 1995, almost twenty-five years later! Likewise telling is the poster of this year's "Nursing Week" since it shows that what once was the responsibility of an identifiable individual is now handled by team of highly specialized professionals.⁴⁷

Both nurses' education and their social standing have changed dramatically as have their places of work. Formal nursing training in the U.S. was established in the second half of the nineteenth century as a hospital-based education. Surprisingly though, until well into the twentieth century, only a fraction of trained nurses actually worked in hospitals later on. Lynaugh and Brush point out "Three-quarters of all graduate nurses in the 1920s and early 1930s were concentrated in the private duty market, working either in patients' homes or as 'specials' for patients requiring hospitalization. These graduate nurses were paid by the patients they cared for, usually on a daily or weekly basis. It was student nurses who were the mainstay workforce for hospitals; graduate nurses' work was not intrinsically linked to the hospital ward until the 1940s."⁴⁸ However, private graduate nurses were, up until the late 1960s, especially contracted to care for hospital patients needing unusual attention or post-operative supervision. But with the Medicare /Medicaid legislation of 1965, hospitals became *the* all defining focus for most graduate nurses, too, who under the Regional Medical Programs received government funded special training for intensive or critical-care units which opened in significant numbers of hospitals at that time, thus offering specialized nursing careers which have increased ever since.⁴⁹

1965 also marks the beginning of a new kind of nursing education emerging alongside hospital run nursing schools scattered all over the country.⁵⁰ With the introduction of the Medicare/Medicaid programs paid for by public funds, health-care and hospital access were opened to the elderly (i.e., those over 65) and the poor, leading to a heightened demand for nurses. To meet this need the federal government supported two initiatives which caused a drift away from classical training sites⁵¹: associate degree programs through community colleges (in existence since 1952 but now more emphasized⁵²) and new incentives toward obtaining a baccalaureate degree in four year colleges. Valparaiso's College of Nursing, founded in 1968, is a very fine example of this trend⁵³, a trend which also strives to meet ever rising mental and intellectual challenges of nursing work in the complex reality of the hospital world today where the demands of patients and their families have to be reconciled to the demands of evidence based case management and the

expectations and interests of other stakeholders in the health-care delivery system, be they medical institutions or professional organizations, licensing bodies watching over professional conduct or hospital corporations trying to break even or to make profits by keeping costs down.⁵⁴

According to a survey of the Registered Nurses' Population by the Department of Health and Human Services based on a national sample taken in 2004, the number of Registered Nurses employed in nursing more than doubled from 1,272,851 in 1980 to 2,915,309 in 2004.⁵⁵ The number of nurses qualified by diploma programs declined markedly during this period that is by 56.5% (from 903,000 to 510,000), while simultaneously the percentage of associate, baccalaureate, masters, and doctoral degree holders increased markedly (associate degree + 332.5 % from 295,000 to 981,000; baccalaureate + 270% from 368,000 to 994,000; masters/doctor degree + 438.4 % from 86,000 to 377,000).⁵⁶ 1,361,000 Registered Nurses worked in hospitals, 360,000 in Public or Community Health Programs, 278,000 in Ambulatory Care and 153,000 in nursing homes, while 63,000 worked in nursing education and 156,000 in so called "Other" fields of work such as health insurance companies, politics, correctional facilities, etc.⁵⁷ However, a certain trend toward change can be detected when one looks at the percentage increase over several years in the number of Registered Nurses employed in various settings: in the hospital 62.8 %, the public or community health-care sector 128.8 %, ambulatory care 169.5 %, nursing home and extended care 51.3 %, and, finally in nursing education 21.9 %. These figures indicate a growing tendency of relocating nursing work away from the hospital and venturing into new ways of health-care delivery. They also reflect the change in the overall health-care policy.⁵⁸

With all this achieved and being mindful of the impressive changes and the remarkable developments having taken place over time within the nursing profession, one wonders why insiders still keep on stressing the need to consciously enhance the image of nursing as, for instance, Carol Huston does in her book *Professional Issues in Nursing* published as recently as 2006. Huston states that "[m]ore efforts must be made to improve the public's image of nursing" because the nursing profession, she asserts, has been "unable to effectively change public perceptions regarding professional nursing roles and behaviors."⁵⁹ The recent Harris poll referred to before tells otherwise. However, Huston's call clearly indicates an insider's perception struggling with the all too common discrepancy of claim and reality. Other contemporary authors

address the appalling shortage of qualified personnel also in places other than hospitals, such as nursing homes and rehabilitation centers and bemoan the “historic failure” of the profession “to ensure quality nurses for the sick outside the hospital.”⁶⁰

Great things have been achieved and great strides have been made, indeed. And yet there remains this uneasiness regarding the reputation of nursing, its professional role, and the education leading to its practice. Why? In an attempt to find an answer I suggest approaching the work of nursing now from a different perspective, one which has been called “phenomenological.” Might be that this approach will hold the answers to both questions raised: What is the core common to all of the nursing professions? And second: Why is there this continuous worrying about the professional image?

II – Nursing: A phenomenological approach

A phenomenological approach is a conscious analysis of actual real life-world situations informed by a particular philosophy. While it was introduced into nursing research more than thirty years ago⁶¹ it is only now receiving the attention it deserves since—as nursing scholars have noticed—phenomenology “provides a[n] ... approach that is consistent with the art, philosophy and practice of nursing ...”⁶² Moreover, because “nursing is predominantly a social act” they expect that “the phenomenological approach” will “enable nurses to better understand” their work.⁶³

The phenomenological approach is a “qualitative” one, meaning: it does not focus on collecting data by questionnaires to be analyzed for testing a hypothesis with randomly selected subjects as is typical of “quantitative” approaches. Instead, the methodology employed by phenomenology is engaged participant observation which, in the case of nursing, looks at the way in which care for the sick is actually carried out, or—to express this more pointedly in the respective technical terminology—phenomenology looks at how nursing as social interaction presents itself and gets enacted. What actually distinguishes the phenomenon of nursing from any other phenomenon of human interaction? What are the specifics of nursing?

This leads us straight into the common core in all of nursing to which every nursing student gets exposed. That core is the bedside nursing situation as a personal encounter between non equals,

where one person, the patient, is in critical, vital need of the support which the other person, the nurse, is expected to provide, trusting that such help will be rendered faithfully. This – and *just* this – is at the core of all of nursing. This person to person encounter in caring which has also been termed the “nursing” or “caring moment”⁶⁴ requires of nursing personnel to really dare to care⁶⁵ and be present with mind and heart whenever attending upon needy others.⁶⁶ Every other activity now part and parcel of the professional nursing baggage is only secondary in nature and importance. The nursing act is thus straightforward, plain, and obvious which, of course, is not to say that nursing work is easy and simple and does not require special skills. However, since nursing books are replete with technical, managerial, and legal details, one can get lost much too easily in taking these details for the subject matter itself. Establishing evidence—based benchmarks and developing error-proof systems of documentation in the best interest for patient safety and a speedy recovery have to be critically weighted against the nursing moment nonetheless. They have not to dominate it. They have to serve it.

The nursing moment or nursing situation is constituted by at least three elements which qualify it as such. These are the presence of sick individuals in critical need of vital help, the presence of people with the capacity to render this help professionally, and the confident trust that such life sustaining help will be faithfully provided. Unlike physicians who are mainly concerned with diagnosis and treatment of diseases and who confine their assistance for the sick to operations, therapeutic directives, and short visits during their rounds, it is nurses who are expected to assist in the daily struggle of the patients entrusted to their care by watching diligently over them and monitoring their vital signs and their compliance with the therapy. Beyond this work, however, nurses also are expected to assist patients in managing the challenges posed by disease or infirmity in regaining self-control over the very basics of their bodily existence like eating and drinking, digesting, excreting, and cleansing, breathing, sleeping, and moving. These are not just the basic functions of life. This *is* the actually lived life of patients which nurses are called to assist in. Nurses are called to care for the well-being of people too sick and old, too impaired and frail to do so for themselves. Their professional designation is—not quite arbitrarily—derived from the responsibility to “provide nurture”.⁶⁷ This is also at the same time a powerful, constant reminder for the profession of what should be its focus. Nurses have to care for life and have to nurse well-being! That is their specific calling and vocation.

To be called a “nurse” means to consciously stand in for solidarity with those who are easily despised by folks who shun the needy other and wonder: Why care at all? Is caring—especially for the old and feeble—not a waste of resources, of talent and capacity? And members of the profession have seriously asked: Why should we as nurses burden ourselves with the care for people from whom the rest of society turns away? Why associate with folks at the margin of society except for the sake of earning money and embarking on a professional career? Will this not adversely affect the reputation of the profession?⁶⁸ Being called a “nurse”—registered or not—means being called to challenge such kind of thinking and to protest against it *in action*. The nobility of the profession rests in its committed caring for—and into—life. It rests in the virtue of heeding the call of wounded, vulnerable strangers needing help by people who are vulnerable and anxious human beings themselves but who cannot do otherwise than to respond to this call with all their acquired professional skill. Such genuine personal concern for the afflicted is but critical to the success of nursing as respective studies have shown.⁶⁹ It is here where the nursing moment comes into its fullest as Hildegard Peplau (1909-1999) has shown.⁷⁰

Further in-depth analysis of the nursing moment reveals that their caring bedside presence exposes nurses to very particular challenges from which medical experts are more or less shielded on account of their absence from the sick room. These challenges arise from patients’ peculiar personal habits and traits, internalized since childhood and formed within a particular cultural setting. These behaviors come to the fore most powerfully once life suffers impairment and people become confined to a sick-room, a wheel-chair, or the bedstead. Not just patients, but nurses, too, have than to cope with whatever might surface on this level during hospitalization and convalescence.⁷¹ Likewise, nurses are exposed to patients’ rejection of their dependent situation and possibly their resistance to treatment. The simple fact that all patients are compelled to give up much of their autonomy and are willy-nilly asked to adjust to a daily routine governed by principles not their own is most troublesome for many; just consider the localities they have suddenly been moved into and the time schedule they are subjected to, in addition to the oftentimes confusing language used to communicate with them and the boot-camp style tone of command.⁷²

Sir William Osler (1849-1919) when addressing the 1897 graduating class of nurses at Johns Hopkins then still in its nascent stage asked—with a twinkle in his eye—: “Is [the nurse] an

added blessing or an added horror in our beginning civilization?” And he continued: “Speaking from the point of view of a sick man, I take my stand firmly on the latter view, for several reasons. No man with any self-respect cares to be taken off-guard. ... Sickness dims the eye ... and makes a man a scarecrow, not fit to be seen by his wife, to say nothing of a strange woman all in white or blue or gray” who “will take ... unwarrantable liberties with a fellow, particularly if she catches him with fever; ... she will stop at nothing, and between baths and sponging and feeding and temperature-taking you are ready to cry with Job the cry of every sick man—“*Cease then, and let me alone. ... [But] this the trained nurse has, alas, made impossible. ... You are*” so Osler to the nurses “intruders, innovators, and usurpers, dislocating ... from their tenderest [!] and most loving duties ... mothers, wives and sisters. ... The handing over to a stranger the care of a life precious beyond all computation may be one of the greatest earthly trials. Not a little of all that is most sacred is sacrificed to your greater skill and methodical ways.”⁷³

The point Osler tried to convey is as valid today as it was back then, because any nursing activity no matter how kindly, skilled, and well-intending cannot adequately compensate for the loss of personal autonomy a patient suffers nor can nurses avoid encroaching upon the private lives of strangers who have happened to become dependent on their care. Consideration of and sensibility for such heightened vulnerability of a patient’s personality, as well as the intrusive character of any nursing activity, ought to be the principal points of concern for professional patient assessment so as to avoid humiliation as much as possible and to warrant the integrity and dignity of individual patients with their very own biographies and life stories. However, since it is Registered Nurses who are entrusted with the task of patients’ nursing assessment, diagnosis, and case management, it is somewhat disturbing to find that Registered Nurses become more and more removed from their time at the bedside because of their increasing administrative and documentary responsibilities dictated by a profusion of regulations—mainly to avoid litigation—and by an always insufficient staffing situation.⁷⁴ Thus essential nursing tasks have come to be delegated to assistants.

A recent study claiming to be “the first hospital environmental study to quantify how nurses spend their time” showed that “more than three-quarters” of salaried nursing time is spent “on nursing practice-related activities” and only “less than one-fifth on activities defined as patient care activities” which in the end boils down to about five minutes—or even less—per patient.⁷⁵

Given this situation, how do nurses actually live up to the claim that they really *care* for “their patients” and are their “advocates”⁷⁶ when they actually spend most of their time away from them? How can nurses—as is expected of them—meaningfully intervene in critical situations in the best interest of “their patients” without having cultivated a genuine personal concern for them? How to reconcile claim and reality in actual nursing practice and education?

It is disturbingly revealing, too, I think, that the manual on *Registered Professional Nurses and Unlicensed Assistive Personnel* published by the American Nurses Association (ANA) advises that direct patient-care activities like “feeding, drinking, ambulating, grooming, toileting, dressing, performing dependent activities of daily living” be delegated to unlicensed assistants.⁷⁷ Since caring for vital matters of life was once considered central to nursing,⁷⁸ how shall we understand such advice? Is it to show how best to avoid patient contact since—as already noted—such behaviors go against our very instincts? Is it to encourage well educated white-collar nurses to escape the call to the bedside?⁷⁹ As embarrassingly unacceptable as these reflections might sound at first hearing, they are by far *not* besides the point: how else understand the alarming decline of Registered Nurses in nursing homes by 25% since the year 2000?⁸⁰ Is such work *not* nursing work? Or is it just not “attractive” enough for well educated professionals? Or is it just too poorly remunerated? And likewise: What about the strange attitude toward the profession of certain feminists who criticize it for perpetuating “negative female stereotypes,”⁸¹ that is, for staying content with working in a field predominantly left to women instead of contesting the situation?⁸²

Carol Huston holds that “nursing cannot afford to value the art of nursing over the science. Both are critical to making sure that patients receive the highest quality of care possible.”⁸³ This is a laudable concern, indeed. But on closer scrutiny it does become obvious that the noble cause is much less directed toward the actual plight of suffering humans. It is, rather, stimulated by concern for the utmost practical and economic efficiency⁸⁴ as well as fueled by liability threats and—last, not least—by a styled professionalism courting science. Why weigh up the “art of nursing” with the “science of nursing”? Why try to balance them out at all? Do not such alternatives distort the focus of professionals by insinuating that nurses, at least Registered Nurses, have all to become scientists—kind of—and that nursing has to be done scientifically? In surveying respective studies Herman Finer in 1961 concluded that because quality nursing care

is “nonmeasurable” [!] as he expressed it, “the nursing profession must face the fact that” its caring work is “not susceptible of precise or statistical measurement and statement.”⁸⁵ Professional nursing, therefore, has to be extremely cautious that its concern for evidence-based practice, as necessary as it is given the overall professional circumstances of today’s health-care system,⁸⁶ does not blind it to what is really needed here and now in the actual nursing moment of caring.⁸⁷ The demand for increased qualification in response to the growing complexities of the working environment can in the end turn against the very core of nursing, because it drives nurses away from the bedside of patients. Since all attempts toward raising occupational prestige and since all efforts for higher qualification thus appear to have the tendency to become counterproductive to genuine nursing by widening the chasm between patient care and care-related activities, between nursing proper and nursing management, the question has to be asked: how best to assure that the concern for providing the best care possible does not become an end in itself at the expense of patients?

This is by no means a moot point. This question has to be raised for the sake of the profession, for there is no other way of regaining a vision except by honestly struggling with the obvious contradictions at hand, contradictions which have emerged as unsought byproducts of the explicit concern: to deliver the best care available. It is time to realize the full impact of the truly paradoxical situation in which nursing as a profession is caught up today.⁸⁸ This being torn between conflicting loyalties might, in the end, well explain the insiders’ persistent worry about the image of the profession.

Conclusion

We may ask in conclusion if there is anything like a “calling” in nursing at all. Doesn’t such phrasing camouflage the wishful thinking which would endow the profession with an inestimable, even religious dignity for the sake of attracting and retaining a sufficient number of people? Nursing is, after all, a job for making a living like any other, isn’t it, albeit one with somewhat assured employment even in trying times.⁸⁹ Living in a society with increasing life expectancies and, consequently, with increasing ailments⁹⁰ the demand for nursing can actually never be sufficiently supplied⁹¹ nor can it be adequately paid for.⁹² Be it as it is, at least, there will always be plenty of work for nurses. Besides, nursing—as just seen—has turned into a

profession capable of satisfying all kinds of contemporary career ambitions.⁹³ So what is gained by speaking of the “calling of nursing”?

Phenomenological analysis has shown that there *is* a call voiced by those who suffer the breaking-in of human frailty. But not everyone listens to it and heeds it since it is not attractive and goes against selfish nature. However, some *have* listened to the plight of these others and provided help to the best of their knowledge and abilities. In the course of times such heeding has prompted the development of the nursing profession. As the history of nursing and especially that of Christian caring records, those who responded do so in obedience to a higher calling, being convinced that whatever *is done* to—or *withheld from*—one of the least of God’s children in this regard is *done*—or *not done*—unto God self.⁹⁴ Answering *this* call has not so much to do with studying books, listening to lectures and passing exams. *This* answer can be given only in living, in simply *doing* the obvious work called for. Only *in so doing*—not in arguing about or delegating it—one comes to understand more fully what nursing is really all about.

The great lady of professional nursing, Florence Nightingale, who after addressing the then popular debate on the appropriateness or inappropriateness of nursing for women in her *Notes on Nursing* concluded the book with a sigh and this charge: “Oh, leave these jargons, and go your way straight to God's work, in simplicity and singleness of heart.”⁹⁵ Devoted caring for the sick in simplicity of mind and singleness of heart does more than rid nursing from the doom of desperate image building. Such an attitude helps to keep the profession properly focused. And to foster these virtues in the minds and hearts of aspiring nurses is a most desirable and appropriate task for a College of Nursing in the 21st century, I am sure.

Thank you for your kind attention.

NOTES:

¹ See Everett C. Hughes, Helen McGill and Irwin Deutscher, *Twenty Thousand Nurses Tell Their Story: A report on studies of nursing functions sponsored by the ANAI*, Philadelphia, J. B. Lippincott, 1958. – Even though this publication is somewhat dated now, the findings are by no means obsolete because the situation of the profession has changed in such a way that it has become even more complex and diversified than before.

² *American Journal of Nursing*, *Letters pro and Con*, Dec. 1949, p.6, as quoted in J. E. Lynaugh, B. L. Brush, *American Nursing: From Hospitals to Health Systems*, Cambridge, MA, Blackwell, 1996, p.18. Lynaugh and Brush remark that after World War II a “shift in the meaning of the word ‘nurse’” had taken place, because after that war “a ‘nurse’ could be a student, graduate or practical nurse, an aide, an orderly. Consequently, the definition of ‘nurse’s work’ became increasingly blurred.” (Ibid., p. 23) The ANA publication *Registered Nurses & Unlicensed Assistive Personnel*, of 1997 speaks of the assistive personnel as “non-nurse[s]”. (p. 13)

³ See *Nursing in Transition: The Growth of the Health Care Industry*, in: P. A. Kalisch, B. J. Kalisch, *The Advance of American Nursing*, Philadelphia, J. B. Lippincott, 1995, pp. 445-472; Lynaugh/Brush, *American Nursing*, pp. 63-69; Janice R. Ellis, Celia L. Hartley, *Nursing in Today’s World: Trends, Issues, and Management*, 9th ed., Philadelphia, Kluwer / Lippincott Williams & Wilkins 2008, pp. 1-57.

⁴ Kalisch & Kalisch, *The Advance of American Nursing*, p. viii.

⁵ *Love’s Work: a Reckoning with Life*, London, Schocken 1997, pp.74-75. - The *Final Report* of the Secretary of the Department of Health and Human Services’ Commission on Nursing of 1988 stated: “that nurses [are or have become] ... all-purpose employees” in hospitals, at least in quite a number of these. See: The [Department of Health and Human Services] Secretary’s Commission on Nursing, *Final Report* (Washington, DC: US Department of Health and Human Services, 1988), as quoted in Lynaugh/Brush, *American Nursing*, p. 60. See also Janice R. Ellis, Celia L. Hartley, *Nursing in Today’s World*, 9th ed., Philadelphia, Wolters Kluwer / Lippincott Williams & Wilkins 2008, pp. 509-531.

⁶ It is quite telling, I think, that one book on nursing is titled: *The Nursing Profession: Views through the Mist*, Norma L. Chaska, ed., New York, McGraw-Hill 1978.

⁷ “Ancillary nursing personnel, nursing support personnel, assistive personnel, nurse extenders, unlicensed nursing personnel, multicompetent workers, nurse assistants, or aides are all generic terms used to refer to the various clinical and nonclinical jobs that augment nursing care. This group of employees includes an array of support nursing personnel including certified nurse assistants, orderlies, operating room technicians, home health aides, and others. They assist the licensed nurse by performing routine duties in caring for patients under the supervision of an RN or an LPN. Although Congress defined “nurse” for the purposes of this study [i.e. *Nursing Staff in Hospitals and Nursing Homes*] to include RN, LPN, and NA, it has not been possible at all times to disaggregate information on NAs from the remaining support personnel because national statistics are often collected and/or tabulated for the group as a whole. For example, the American Hospital Association does not separate information on nurse assistants from that on other “ancillary nursing personnel.” Throughout this report [i. e. *Nursing Staff in Hospitals and Nursing Homes*], the term ancillary nursing personnel will be used for this group of staff when nurse assistants cannot be disaggregated.” (*Nursing Staff in Hospitals and Nursing Homes: Is it adequate?*, Institute of Medicine, IOM, Gooloo S. Wunderlich, Frank Sloan, Carolyne K. Davis, eds., The National Academic Press, Washington DC, 1996, p.2, note 3).

⁸ “In fact, UAP are represented by almost 65 different job titles.” (Carol J. Huston, *Professional Issues in Nursing: Challenges & Opportunities*, Philadelphia, Lippincott Williams & Wilkins 2006, p. 148) For regulations of the relationship of RNs to UAPs see the ANA paper *Registered Professional Nurses & Unlicensed Assistive Personnel*, 2nd ed., American Nurses Association, Washington DC, 1997.

⁹ A good survey of respective problems is provided by Carol J. Huston, *Unlicensed Assistive Personnel and the Registered Nurse*, in: Carol J. Huston, *Professional Issues*, p. 147-165, esp. p. 156. See also Hughes, McGill and Deutscher, *Twenty thousand Nurses*, p. 139, which mentions the jurisdictional disputes emerging.

¹⁰ The monthly *The Nurse Practitioner: The American Journal of Primary Health Care* (in print since 1975) is one of the leading professional print media for advanced practice nurses. Professional associations for NPs are the Ame-

ican Academy of Nurse Practitioners, formed in 1985 (<http://www.aanp.org>) and the American College for Nurse Practitioners, Washington D.C., formed in 1993, (<http://www.acnpweb.org>).

¹¹ The directory is accessible on the internet at the URL <http://www.nursetogether.com>. The actual number of associations as on Sept. 12, 2009 was 64. Yet some of these are devoted to special interests and concerns and are not reflecting a specialized branch of the profession like the *American Assembly for Men in Nursing*, the *American Association of Nigerian Nurses*, and the *American Association for the History of Nursing*. Carol J. Huston (*Professional Issues in Nursing*, pp. 484-486) lists 117 different professional nursing organizations working on a national or international level.

¹² *An Alaska Legend of Betrayal, Courage and Survival*, Seattle, WA, Epicenter Press 1993. Another novel, this time set within the context of Japanese culture is Gail Tsukiyama's *The Samurai's Garden*, New York, NY, St. Martin's Griffin 1996. For the Japanese cultural attitude toward sickness, especially Leprosy see A. H. Ninomiya, *Japanese Attitudes Towards Disabled People – Religious Aspect*, in: *The Japanese Christian Quarterly*, vol. 52 (1986), no. 4, pp. 202-206; H. Sato, M. Narita, *Politics of leprosy segregation in Japan: the emergence, transformation and abolition of the patient segregation policy*, in: *Social Science and Medicine*, 2003, June, vol. 56 (12), pp. 2529-2539.

¹³ For some of the more recent topic related literature in English see Dugatkin, L.A., *The Altruism Equation*, Princeton, Princeton University Press, 2006; Fletcher, J.A., Doebeli, M., *How Altruism Evolves: Assortment and Synergy*, in: *Journal of Evolutionary Biology*, 2006, 19, pp. 1389-1393; Lehmann, L., Keller, L., *The Evolution of Cooperation and Altruism. A General Framework and Classification of Models*, in: *Journal of Evolutionary Biology*, 2006, 19, pp. 1365-1376; Okasha, S., *Altruism, Group Selection and Correlated Interaction*, in: *British Journal for the Philosophy of Science*, 56 (2005), pp. 703-724; Rosenberg, A., *Altruism: Theoretical Contexts*, in: *Keywords in Evolutionary Biology*, E.F. Keller, E.A. Lloyd, eds., Cambridge MA, Harvard University Press 1992, pp. 19-28; Wilson, D.S., Dugatkin, L. A., *Altruism: Contemporary Debates*, in: *Keywords in Evolutionary Biology*, *ibid.*, pp. 29-33; Uyenoyama, M.K., Feldman, M.W., *Altruism: Some Theoretical Ambiguities*, *ibid.*, pp. 34-40.

¹⁴ Lynaugh/Brush, *American Nursing*, p. 73.

¹⁵ Canadian born Sir William Osler (1849-1919), the first professor of medicine at the newly established Johns Hopkins Hospital (1889) and later Regius Professor of Medicine at Oxford, UK, when addressing the 1891 graduating class of nurses at Johns Hopkins made a similar observation saying: "Nursing as an art to be cultivated, as a profession to be followed, is modern; nursing as a practice originated in the dim past, when some mother among the cave-dwellers cooled the forehead of her sick child with water from the brook, or first yielded to the prompting to leave a well-covered bone and a handful of meal by the side of a wounded man left in the hurried flight before an enemy." (*Doctor and Nurse*, in: W. Osler, *Aequanimitas with other Addresses to Medical Students, Nurses and Practitioners of Medicine*, 3rd ed., Philadelphia, P. Blackstone Son & Co., 1932, p. 156.)

¹⁶ For further study of this topic see Holmes, D., Perron, A., O'Byrne, P., *Understanding Disgust in Nursing: abjection, self, and the other*, in: *Research and Theory for Nursing Practice*, 2006, Winter, vol. 20,4, pp. 305-315; Alavi, C., *Breaking-in bodies: teaching, nursing, initiations or what's love got to do with it?*, in: *Contemporary Nurse*, vol. 18, no.3 (April-June 2005), pp. 292-299; Susan B. Miller, *Disgust: the gatekeeper emotion*, The Analytic Press, Hillsdale, NJ, 2004.

¹⁷ See S. Reverby, *A Caring Dilemma: Womanhood and Nursing in Historical Perspective*, in: *Nursing Research*, 36, 1987, pp. 5-11.

¹⁸ Charles Dickens, *The Life and Adventures of Martin Chuzzlewit*, Oxford, Oxford University Press 1987. Special reference to Ms. Gump are found mainly in chapters 19, 26, 46, 48, 49.

¹⁹ *Ibid.*, p. XV. The 'Preface' was written five years later, i. e. in 1849. See also: Nancy A. Metz, *The Companion to Martin Chuzzlewit*, Westport, CT, Greenwood Press 2001, pp. 268-283; Anne Summers, 'The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and her Detractors, c. 1830-1860', in: *Victorian Studies*, 32 (1989), pp. 366-386.

²⁰ On this publication see Maria Lorentzon, *Nursing Record/British Journal of Nursing archives, 1888-1956*, in: *British Journal of Nursing*, vol. 13, 5 (11. Mar 2004), pp. 280 – 284. On the comparison in question see A. Summers, *Mysterious Demise*, pp. 382-386.

²¹ Pastor Fliedner did not name the trainees ‘Deaconesses’ at first due to a charge by the then Prussian King Friedrich Wilhelm III (1770-1840) who objected that women were to become bearers of a title of a Church ministry who do work in non-Church ministries. (Martin Greschat, *Die Vorgeschichte der Inneren Mission*, in: *Die Macht der Nächstenliebe – Einhundertfünfzig Jahre Innere Mission und Diakonie 1848-1998*, im Auftrag des Deutschen Historischen Museums und des Diakonischen Werkes der Evangelischen Kirche in Deutschland, U. Röper, ed., Berlin 1998, pp. 46-57).

²² For the history of nurses uniforms and the caps see Josephine A. Dolan, *History of Nursing*, 12th ed., Philadelphia, W. B. Saunders, 1968, pp. 264-265; Ellis / Hartley, *Nursing in Today's World*, pp.155-156; Kalisch & Kalisch, *The Advance*, pp. 79-84. However, the legend to the photograph in the left column on p. 82 mistakenly explains: “The nurse’s cap was originally designed to cover the long hair styles of the late 19th century.” This is true only in so far, as it refers to the long hair being worn in a bun around which the cap got fixed.

²³ For the impact of the Deaconess movement on the British Isles in those days see Mary Stanley, *Hospitals and Sisterhoods*, London, John Murray, 1854 (re-published 2008 by Kessinger Publishing); Mark Bostridge, *Florence Nightingale: The Woman and Her Legend*, London, Viking Press, 2008, pp. 96-103.

²⁴ Kaiserswerth Deaconesses began working in Jerusalem, Palestine in 1851, in Smyrna (Izmir), in then the Osman Empire, now Turkey in 1853, in Constantinople and Alexandria, Egypt, in 1857 and in Beirut, Lebanon in 1860.

²⁵ Deaconesses took up work in Pittsburgh, Pennsylvania, in 1849. Pastor Fliedner himself accompanied the first group of four to their new place of work among the immigrants.

²⁶ The visits took place in 1850/1851 according to the archive at Kaiserswerth. The years conflict, however, with the statement by Patricia Donahue (*Nursing: The finest Art. An Illustrated History*, St. Louis, C. V. Mosby, 2nd ed. 1996) p. 200, where 1847 is given as the year of these visits; see now also Bostridge, *Florence Nightingale*, pp. 142-160.

²⁷ Donahue, *Nursing*, pp. 200. - Florence Nightingale published her observations in *The Institution of Kaiserswerth on the Rhine for the Practical Training of Deaconesses under the direction of Rev. Pastor Fliedner, embracing the support and care of a Hospital, Infant and Industrial Schools, and a Female Penitentiary*. Printed by the Inmates of the London Ragged Colonial Training School, 1851, see Bostridge, *Florence Nightingale*, pp. 145-146

²⁸ The telling title of the 1999 report of the ‘Joint Commission on Accreditation of Healthcare Organizations’ reads: *Florence Nightingale: Measuring Hospital Outcomes*, Oakbrook Terrace, IL, 1999.

²⁹ *Notes on Nursing: What it is and what it is not*, London, Harrison & Sons 1859/60; first American ed., New York, D. Appleton & Co. 1860. As for the publication date see *Florence Nightingale on Public Health Care*, Collected Works of Florence Nightingale, vol. 6, Lynn McDonald, ed., Waterloo, Ontario, Canada, Wilfrid Laurier University Press 2004, pp. 17-19.

³⁰ Preface to the 3rd ed., London, Longmans, Green and Co. 1863, p. iii. This edition is an almost completely rewritten version of the 1st ed. 1859, John W. Parker and Sons.

³¹ See for instance Ivan Illich, *Medical Nemesis: The expropriation of health*, New York, Pantheon 1982 (1st ed. 1974); *Hospital Infections*, John V. Bennett, Philip S. Brachman, eds., Philadelphia, PA, Lippincott-Raven 1989.

³² The St. John’s House in London was founded in 1840. And the Quaker Elizabeth G. Fry (1780-1845) not only was engaged in campaigning for prison reforms but also founded the Institute for Nursing Sisters (Society of Protestant Sisters of Charity), who received nursing training in St. John’s House; see A. Summers, *Mysterious Demise*, pp.372-373; Donahue, *Nursing*, pp. 187-191; M. Bostridge, *Florence Nightingale*, pp. 97-99.

³³ See MBostridge, *Florence Nightingale*. For the history of early schools for nursing in the US and Canada see Kalisch & Kalisch, *The Advance*, chapter 3, *The Founding of Early Schools of Nursing in America*, ibid. pp. 57-84.

³⁴ Donahue, *Nursing*, pp. 273-280; quote p. 324.

³⁵ *The Englishwoman’s Magazine*, 7, 1852, 294, as quoted in A. Summers, *Mysterious Demise*, p. 365. Sieveking also published among his several books on medical topics *The Training Institutions for Nurses and the Workhouses* in 1849.

³⁶ Rogers Sherbrooke, *Sarah Josepha Hale: A New England Pioneer 1788-1879*, Grantham. NH, Tompson & Rutter 1985.

³⁷ *Godey's Lady's Book and Magazine*, vol. 82, 1871, pp. 188-189.

³⁸ Famous names to be mentioned here are Dorothea Lynde Dix, Clara Barton, Louisa May Alcott, Mother Bickerdyke (Mary Ann Ball) Harriet Tubman, Sojourner Truth, and Walt Whitman, the poet and outstanding male nurse of those days. For a list with more details of some of these names see Ellis/Hartley, *Nursing*, p.136; for a more extensive treatment see Donahue, *Nursing*, pp. 242-264; Kalisch & Kalisch, *The Advance*, pp. 38-56.

³⁹ See Pierre Boissier, *History of the International Committee of the Red Cross. Volume I: From Solferino to Tsushima*, Henry Dunant Institute, Geneva 1985; Caroline Moorehead, *Dunant's dream: War, Switzerland and the history of the Red Cross*, London HarperCollins, 1998. – Dunant himself did give account of his experience of the Solferino battle which left nearly six thousand troops dead and twenty-five thousand wounded in his *A Memory of Solferino*. ICRC, Geneva 1986 (first ed. Un Souvenir de Solferino, 1862)

⁴⁰ For a list of wars in the 20th and 21st centuries see H. Mückler, *The Wars of the 21st Century*, in: *International Revue of the Red Cross*, no. 849, 2003, pp. 7-22. Updates at http://www.historyguy.com/21st_century_wars.html.

⁴¹ On the military influence on nursing see Ellis/Hartley, *Nursing*, pp. 134-140.

⁴² Quoted in Susan G. Malka, *Daring to Care: American Nursing and Second-Wave Feminism*, Urbana, University of Illinois Press 2007, p. 13.

⁴³ In a statement on *Krankenschwestern und Dienstbarkeit: Über die Allianz von Pflegen und Töten in der (Kriegs-) Geschichte* [Nurses and Servility: The alliance of caring and killing in (war-)history] by Christa Nickels on occasion of the 5th Congress for the Prevention of Nuclear War, organized by International Physicians for the Prevention of Nuclear War (IPPNW) at Mainz, Germany, Nov. 1985, as published in T. Bastian, ed., *Wir warnen vor dem Atomkrieg* [We warn against nuclear war], Neckarsulm, Jungjohann Verlagsgesellschaft 1985. Christa Nickels who is a critical-care nurse herself served the German government in the capacity of Secretary of Parliament in Healthcare during the years 1998-2001.

⁴⁴ Ellis/Hartley, *Nursing*, p. 134.

⁴⁵ See *The Harris Poll* at http://harrisinteractive.com/harris_poll/index.asp?PID=739.

⁴⁶ Sarah E. Needleman, *The Best and Worst Jobs in the U.S.*, in: *The Wall Street Journal*, Jan. 26, 2009. For the research instrument and methodology see http://www.careercast.com/jobs/content/JobsRated_Methodology. As to the main criteria for their determination the researchers say: "To quantify the many facets of the 200 jobs included in our report, we determined and reviewed various critical aspects of all the jobs, categorizing them into five "Core Criteria;" that is, the general categories that inherent to every job: Environment, Income, Outlook, Stress and Physical Demands."

⁴⁷ For the image of the nurse in movies see Philip A. Kalisch, Betrice J. Kalisch, *The Changing Image of the Nurse*, Menlo Park, CA, Addison-Wesley Publishing Company 1987.

⁴⁸ Lynaugh/Brush, *American Nursing*, p. 1. See also Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*, New York, Basic Books 1987; Diana E. Long, Janet Golden, eds., *The American General Hospital: Communities and Social Contexts*, Ithaca / London, Cornell University press 1989.

⁴⁹ By 1969 at least 50% of general hospitals in the U.S. had some kind of such a unit. (Lynaugh/Brush, *American Nursing*, p. 35) See also pp. 3, 41, 52ff. But until about that time the general rule was: "If a patient was critically ill, the family would try to hire a private duty nurse if they could find and afford one." (ibid., p. 33)

⁵⁰ There were a total of 1,100 of these according to Lynaugh/Brush, *American Nursing*, p. 11.

⁵¹ See Kalisch & Kalisch, *The Advance*, pp. 432-434, 446-452; Lynaugh/Brush, *American Nursing*, pp. 12-14; 42-46.

⁵² “By the 1970 the associate-degree movement was booming.” (Lynaugh/Brush, *American Nursing*, p. 49) A collection of papers related to this issue is found in Carrie Lenburg, ed., *Open Learning and Career Mobility in Nursing*, St. Louis, C. V. Mosby, 1975.

⁵³ Brief remarks regarding the founding of the college of Nursing are to be found in Richard Baepler, *Flame of Faith, Lamp of Learning: A history of Valparaiso University*, St. Louis, Concordia Publishing House 2001, esp. pp. 285, 395-396.

⁵⁴ The “rapid escalation in the complexity of hospital nursing work ... made high-volume, low cost nurse training more and more inadequate.” (Lynaugh/Brush, *American Nursing*, p.73.)

⁵⁵ *The Registered Nurse Population: Findings from the March 2004 National Sample survey of Registered Nurses*, U.S. Department of Health and Human Services, Health Resources and Services Administration, Washington D.C., 2009, p. 7.

⁵⁶ *Ibid.*, p. 12.

⁵⁷ *Ibid.*, p. 9. As to the 600,000 not accounted for RNs see p. 8 of the report.

⁵⁸ *Ibid.*, pp. IX-X; 66-69.

⁵⁹ *Ibid.*, p. 99.

⁶⁰ *Ibid.*, p. 71.

⁶¹ See for instance Anne J. Davis, *The Phenomenological Approach in Nursing Research*, in: Norma L. Chaska, ed., *The Nursing Profession*, pp. 186-197; Carol A. Soares, *Low Verbal Usage and Status Maintenance Among Intensive Care Nurses*, in: *ibid.*, pp. 198-204.

⁶² Tanya McCane, Sonya Mcilpatrick, *Phenomenology*, in: R. Watson, H. McKenna, S. Cowman, and J. Keady, eds., *Nursing Research: Designs and Methods*, Philadelphia, PA., Churchill Livingstone Elsevier 2008, pp. 231-241, quote p. 231; see also: Lopez K.A., Willis, D. G., *Descriptive versus interpretative phenomenology: their contributions to nursing knowledge*, in: *Qualitative Health Research*, 14 (2006), pp. 726-735; P. Balls, *Phenomenology in Nursing Research: Methodology, Interviewing and Transcribing*, in: *Nursing Times*, Aug. 18-31, 105 (2009), issues 32/33, pp. 30-33; B. Chamberlain, J. Buelow, *Using Research to advance Nursing Practice: Phenomenology: A Qualitative Method*, in: *Clinical Nurse Specialist*, 23 (2009), 2, pp. 52-53, and the extensive bibliography in Patricia L. Munhall, *Revisioning Phenomenology: Nursing and Health Science Report*, New York, NY, National League for Nursing 1994, pp. 311-319. A very brief treatment of phenomenology is also found in Janice M. Brencick. Glenn A. Webster, *Philosophy of Nursing: A new vision for health care.*, Albany, NY, State University of New York Press 2000, pp. 124-125 and 145-156.

⁶³ Anne J. Davis, *The Phenomenological Approach*, p. 186.

⁶⁴ See Donahue, *Nursing: The finest Art*, p. 473; P. Hawley, *The Nursing Moment*, at <http://www.phenomenologyonline.com/articles/hawley.html> (accessed Sept. 26, 2009). For the terminology of “caring moment” see C. L. Montgomery, *The Spiritual Connection: Nurses’ Perceptions of the Experience of Caring*, in: D. Gaut, ed., *The Presence of Caring in Nursing*, New York, National League for Nursing 1992, pp. 36-52.

⁶⁵ So the title of Susan G. Malka’s book (see note 42).

⁶⁶ The literature on the topic of “presence” in nursing is impressive. Just see m. E. Doona, L. A. Haggerty, S. K. Chase, *Nursing Presence: An Existential Exploration of the Concept*, in: *Scholarly Inquiry for Nursing Practice*, 11, 1997, no. 1, pp. 3-20; D. Finfgeld-Connett, *Qualitative Comparison and Synthesis of Nursing Presence and Caring*, in: *International Journal of Nursing Terminologies and Classifications*, 19, 2008, no. 3, 111-119; H. Covington, *Caring Presence-Delineation of a Concept for Holistic Nursing*, in: *Journal of Holistic Nursing*, 21, 2003, no. 3, pp. 301-317.

⁶⁷ See *Oxford English Dictionary*, Oxford University Press 1971; *Webster’s Third New International Dictionary*, Chicago, Encyclopaedia Britannica 1986, p. 1551.

⁶⁸ See the Editorial *Caring-Uncaring* by L.L.Harrison in: *Journal of Advanced Nursing*, 15, 1990, pp. 125-127.

⁶⁹ See for instance S. Halldorsdottir, E. Hamrin, *Caring and Uncaring Encounters Within Nursing and Health Care from the Cancer Patient's Perspective.*, in: *Cancer Nursing*, 20, 1997, no. 2, pp. 120-128.

⁷⁰ *Interpersonal Relations in Nursing*, New York, G. P. Putnam & Sons 1952; revised and enlarged: *Interpersonal Relations in Nursing: A conceptual framework of reference for psychodynamic nursing*, New York, Springer 1991. About H. Peplau: Barbara J. Callaway, *Hildegard Peplau: Psychiatric Nurse of the Century*, New York, Springer 2002.

⁷¹ For further analysis of the situation yet from a somewhat different perspective see M. Van Manen, *Modalities of Body Experience in Illness and Health*, in: *Qualitative health Research*, 8, 1998, no. 1, pp. 7-24.

⁷² For an analysis of the low verbal usage among nurses on an intensive care unit see Carol A. Soares, *Low Verbal Usage*; for respective observations in an ER see E. Wiman, K. Wikblad, *Caring and Uncaring Encounters in Nursing in an Emergency Department*, in: *Journal of Clinical Nursing*, 13, 2004, no. 4, pp. 422-429.

⁷³ Sir William Osler, *Aequanimitas*, pp. 149-150; original emphasis.

⁷⁴ In the hospitals around the middle of the twentieth century, 30 % of patient care was provided by professional nurses. "A government-sponsored study in 1954 reported that nursing time with patient totaled less than one hour per day. For each patient ... registered nurses spent 12 minutes, nursing students 18 minutes and licensed practical nurses 18 minutes actually in direct contact in any one day." (Lynaugh/Brush, *American Nursing*, p. 29)

⁷⁵ A. Hendrich, M. Chow, B. Skierczynski, and Zhenqiang Lu, *A 36-Hospital Time and Motion Study: How Do Medical-Surgical Nurses Spend Their Time?*, in: *The Permanente Journal*, Summer 2008, vol. 12, no.3, pp. 25-34; quote p. 31. The calculation is based on the 81 minutes identified in the study as 'Patient Care Activities' of a ten hours' shift divided by an assumed patient population of only 15; but wards are actually easily double the size. In the case of just fifteen patients it would be exact 5.4 minutes.

⁷⁶ See for instance Huston, *Professional Issues*, pp. 300-307; Ellis/Hartley, *Nursing in Today's World*, pp. 359, 510; *Clinical Research Nurses: Dedicated Advocates for Patients on Clinical Trials*, in: *Focus on Care*, Spring 2008, pp. 2-3.

⁷⁷ *Ibid.*, p. 21. See also Huston, *Professional Issues*, pp. 147-181.

⁷⁸ So at least according to Florence Nightingale's *Notes on Nursing*. See Marie Mantey, *The Practice of Primary Nursing*, 2nd ed., Minneapolis, MN, The Creative Health-Care Management, 2002; Lynne M. Hektor Dunphy, Jill E. Winland-Brown, Brian O., Porter, Debra J. Thomas, eds., *Primary Care: The Art and Science of Advanced Practice Nursing*, 2nd ed., Philadelphia, F. A. Davis Co. 2007; see also the discussion on the "Primary Nursing" concept Lynaugh/Brush, *American Nursing*, pp. 28, 37-38, 72.

⁷⁹ On the discussion of care, caring, and committed care as central for nursing see for instance J. Watson, *New Dimensions of Human Caring Theory*, in: *Nursing Science Quarterly*, 1, 1985, no. 4, pp. 175-188; W. Addison, *Setting Standards of Compassion*, in: *Nursing Standard*, 18, 1990, no. 4, 22-24; M. Roach, *The Human Act of Caring: A Blueprint for Health Professions*, Ottawa, OT, Canadian Hospital Association Press 1992; Focht Dagi T., *Compassion, Consensus and Conflict: Should Care Givers Needs influence the Ethical Dialectic?*, in: *The Journal of Clinical Ethics*, 3, 1992, pp. 214-218; C. Bohny, *Compassion Part of RN Role in Long Term Care*, in: *American Nurse*, 25, 1993, no. 7, pp. 24-25; J. Koerner, *The Essence of Nursing—Creative Compassion*, in: *Journal of Professional Nursing*, 11, 1995, no. 6, pp. 317 & 366; M. L. Schantz, *Compassion: A Concept Analysis*, in: *Nursing Forum*, 42, 2007, no. 2, 48-55.

⁸⁰ Harrington, C., *Nurse Staffing in Nursing Homes in the United States*, Part 1, in: *Journal of Gerontology Nursing*, 31, 2004, no. 2, pp. 18-22; see also by the same author *RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents*, in: *American Journal of Nursing*, 105, 2005, no. 11, pp. 58-70; Lynaugh/Brush, *American Nursing*, pp. 28, 66, 71f.

⁸¹ Lynaugh/Brush, *American Nursing*, p. 50. See also the various contributions in: *Caring and Nursing: Explorations in Feminist Perspectives*, Ruth M. Neil, Robin Watts, eds., New York, National League for Nursing 1991, p. 77.

⁸² See Huston, *Professional Issues*, pp. 374-375; see also *ibid.* p. 66, 448. – The female/male ratio in the U.S. is 96% / 4 % according to *The Registered Nurse Population*, (2004 Sample Survey), HRSA, Appendix A, table 1.

⁸³ Huston, *Professional Issues*, p. 61.

⁸⁴ A good example for this is the introduction of the “Progressive Patient Care” concept in nursing which was adopted from the industrial assembly-line model; see *Progressive Patient Care: An Anthology*, Lewis E. Weeks, John R. Griffith, eds., Ann Arbor, MI, University of Michigan Press, 1964; Lynaugh/Brush, *American Nursing*, pp. 14-15, 34.

⁸⁵ H. Finer, *Administration and the Nursing Services*, New York, McMillan 1961, as quoted in Lynaugh/Brush, *American Nursing*, p.21.

⁸⁶ Evidence-based practice has been adopted from the medical profession by nursing in the late 1990s (see Ellis/Hartley, *Nursing in Today's World*, p. 224-236). It was first defined by D. L. Sackett, W. S. Richardson, W. M. C. Rosenberg, R. B. Hayes, eds., in *Evidence-based medicine: How to practice and teach EBM*. Edinburgh: Churchill Livingstone 1997, p.5, as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." For the most recent developments as far as nursing is concerned see <http://www.evidence-based-nursing.com>.

⁸⁷ An interesting case study is given by Patricia Hawley, *The Nursing Moment*; see also Carol A. Soares, *Low Verbal Usage*.

⁸⁸ It is telling that Daniel J. Pescut entitled his contribution to the voluminous *The Nursing Profession Tomorrow and Beyond*, Norma L. Chaska, ed., Thousand Oaks, CA, Sage Publications 2001, as *Healing into the Future: Re-creating the profession of nursing through inner work*, pp. 853-863.

⁸⁹ This got impressively corroborated by a recent article entitled *Unemployment Nation* written by Joshua C. Ramo, published in *Time Magazine*, Sept. 21, 2009, pp. 26-30 (for references to nursing see *ibid.* pp. 31-32). The entire issue of *Time Magazine* is entitled *Out of Work in America – Why double-digit unemployment may be here to stay—and how to live with it*.

⁹⁰ For the most recent census data (of 2000) see http://www.census.gov/hhes/ageandrace/c2kbr01-02/chart_age.html. The projection as to the expected development for the age-group 65+, which will double in the span 2000 to 2030, namely from 35 million to 70 million, see Wan He, Manisha Sengupta, Victoria A. Velkoff, and Kimberly A. DeBarros, U.S. Census Bureau, Current Population Reports, P23-209, *65+ in the United States: 2005*, U.S. Government Printing Office, Washington, DC, 2005.

⁹¹ The discussion of a perceived crisis in nursing due to a shortage in more or less qualified personnel is a perpetual one, it seems. In Post World War II America the call for increasing the number of nurses (RNs, LPNs, and NAs) was raised by Eli Ginzberg, *A Program for the Nursing Profession by the Committee on the Function of Nursing*, New York, Macmillan, 1948, and the American Medical Association's (AMA) *Report of the Committee on Nursing Problems*, in: *Journal of the American Medical Association*, July, 1948, pp. 872-889. The demand increased dramatically after the Medicare / Medicaid legislation in 1965, see: *Report of the National Advisory Commission on Health Manpower*, Washington DC, US Government Printing Office, 1967; Robert Flint, Karen Spensley, *Recent Issues in Nursing Manpower: A Review*, in: *Nursing Research*, 18, June 1969, pp. 217-229. In the seventieth the issue was also addressed at a nursing conference at Columbia University, New York, see: Michael Millman, ed., *Nursing Personnel and the Changing Health Care System*, Cambridge, MA, Ballinger, 1978. Ten years later in the Secretary's Commission's *Report on Nursing* (see note 7 above) the prevailing shortage of nurses was again addressed, and with the present (Obama) Administration's plan for basic health-care for all Americans it will remain so in years to come. As nurses were the first group to fully support the Medicare / Medicaid legislation in 1965 (see Lynaugh/Brush, *American Nursing*, p. 82, note 100) so they do so with the current initiative, too (see *America's Registered Nurses to Obama*, Wed. Sept. 9, 2009, at <http://www.reuters.com/article/pressRelease/idUS37689+10-Sep-2009+PRN20090910>).

⁹² See the discussion at the web-site of *United American Nurses, AFL-CIO (UAN)* at <http://www.uannurse.org> or of the *United Nurses of America* at <http://www.afscme.org/workers/68.cfm>. For the actual figures of salaries across the

nation see the statistics at <http://www.allied-physicians.com/salary-surveys/nursing>. Historical information on the issue of nurses' salaries are given by Lynaugh, Brush, *American Nursing*, p. 8, 24.

⁹³ See for instance Sacks, Terence J., *Careers in Nursing*, 2nd ed., New York, McGraw-Hill, 2003; Keville, Frederickson, *Opportunities in Nursing Careers*, 2nd ed., New York, McGraw-Hill, 2003; Novotny, Jeanne M., Lippman, Doris D., Sanders, Nicole K., and Fitzpatrick, Joyce J., eds., *101 Careers in Nursing*, Springer, New York 2003.

⁹⁴ See Gospel according to Matthew, chap. 25, 31-46.

⁹⁵ *Notes on Nursing*, 1860, p. 136.