

A Contemporary Perspective on Florence Nightingale's Writings in *Notes on Nursing* and *Florence Nightingale to her Nurses*

Some Personal Reflections By Felicity Stockwell

BACKGROUND

Florence Nightingale was the younger daughter of a 'landed gentleman' whose father had set up a lead factory and a weaving factory on their land. Born in 1820, she grew up as an upper middle-class woman in Victorian England. Her father was a very well-educated man and determinedly shared his knowledge with his daughters. Florence cooperated willingly and, in addition, took great interest in the running of the estate and the factories. Her parents were keen socialisers, with a large circle of friends and with their extensive family.

At that time, industrial developments had led to a large influx of labouring families into the towns and cities on the one hand and to the growth of the new affluent middle-class on the other. The Christian ethos of the times encouraged philanthropy and good works, but middle-class women were expected to find their fulfilment as wives and mothers.

Florence became extremely frustrated by the 'natural order', dictated by the moral and social code, which insisted that the only role for women was in the domestic sphere. With plenty of servants, 'middle class women were starved of mental and spiritual nourishment, and condemned to spend their days in a meaningless round of trivial occupations'. There was no employment for women, so Florence used her wide circle of family and friends to search for a meaningful life. She turned her attention towards the conditions in hospitals and became determined to learn how to nurse.

Health care in Victorian England

At the beginning of the nineteenth century most of the ill and injured were cared for in their own homes, either by the domestic staff or by self-appointed unmarried women and widows of variable quality. There were some institutions that provided care for the impoverished sick and these were usually religious houses run by nuns and there were also some municipal workhouse infirmaries.

Medicine and surgery were very basic and nursing even more so, but soon there would be a wide expansion of knowledge and skill. This led to the twin pressures of medical professionalism, which needed a supply of patients for teaching medical students, and the increased population in towns and cities throughout the country, which led to the building of many hospitals. Some of these were an extension of the religious provision and the municipal infirmaries and others were initiated by charitable donations.

The best of these hospitals attracted some remarkable women who were appointed as 'matrons', with the task of the domestic organisation and the staffing of the wards. They would be expected to be 'good Christian women' and the hospitals were built with chapels at

their centre. However, in the early days, it was difficult to recruit the right calibre of nurses. This was because looking after the sick and needy, beyond the provision in convents, had a very low priority for funding and conditions were poor, so doctors and carers had to be desperate to work there for the very poor wages. As this led to a deplorable image of 'nursing', it is not surprising that Florence's determination to learn to nurse met with opposition.

Florence's experience in the Crimea and her return to England

When she was 30 her parents sent her on a European tour and she managed to organise visits to various hospitals, including Kaiserworth Hospital, to learn about nursing and, probably more importantly, to study at a hospital run by Catholic Sisters in Paris. Here she was also introduced to medical reports and statistics from all over Europe, which she found fascinating and which raised all sorts of questions.

On her return to England, her parents were unable to prevent her accepting a post of Superintendent of an establishment for invalid gentlewomen. She employed a woman to be the 'housekeeper' (the name given to the women who ran the hospitals who became the 'matrons') and together they made successful changes.

Not long after her appointment, news of the war in the Crimea and the terrible conditions there prompted Florence to persuade the War Office to let her take a group of nurses to provide care for the wounded. The nurses' duties were mainly washing, sewing and cooking, and comforting the soldiers. Florence realised that appalling sanitary conditions and severely disorganised administration were causing unnecessary suffering and deaths, which the nurses could do little to ameliorate. Despite much resistance from the army and the War Office, her determination and the knowledge she had accumulated overcame the many hurdles that were put in her way, and led to the improvement in the conditions which resulted in her being feted as 'the soldiers' saviour' on her return to England.

Florence Nightingale returned from the Crimea with a pioneering zeal to improve the conditions in all the military hospitals. However, in 1856, 'a grateful nation' had raised a large sum of money (£2,000,000 in present day money) that was put in a trust for her use. She persuaded the trustees that she should be allowed full control of the money, but she had no idea as to how she would use it.

She was still very involved with the War Office and, although she had an idea at the back of her mind to take the poorest and least organised hospital and put herself there for some time to learn how best the money could be used to improve conditions for nursing throughout the country, she was too busy to do it. In 1859 she eventually decided to use the money to provide nursing training for the women who were staffing hospital wards and doing the home nursing at that time.

St Thomas' Hospital and *Notes on Nursing*

St Thomas' Hospital was in the process of planning a new building on a new site and Florence Nightingale was advising on its construction. There she met the 'matron', Mrs Wardroper, who was worried about the difficulty in finding nurses and improving

conditions. So the two of them cooperated in devising a scheme for training nurses and they made certain that the new building would not only meet Florence's sanitary requirements, but that it would also meet their needs for a nurse training school. For example, nurses' homes and accommodation for ward sisters were included.

Notes on Nursing was written and published in 1859, while St. Thomas's was still at the Southwark site and where what came to be called The Nightingale Training School was started in 1860. It moved with the new hospital to Lambeth in 1862, so the book was written as much for the planners as for the nurses but concentrates on the importance of the nurses role in attending to the 'sanitary' aspects of combating and preventing disease. She does say in the conclusion, 'Let no one think that because *sanitary* nursing is the subject of these notes, therefore, what may be termed *the handicraft of nursing* is to be undervalued'.

THE DEVELOPMENT OF FLORENCE'S NURSING PHILOSOPHY

Florence Nightingale had strong views about the nature of disease and what was needed to help recovery. The prevailing view at that time was that disease was caused by a miasma that arose from dirt and decay (it was to be some years before micro-organisms were discovered) and the reality of this was brought home to her with her experience in the Crimea. She learned, from being ill herself (possibly with brucellosis) and with caring for ill people at home, that the conditions in which people were looked after and the way in which the care was given made all the difference to recovery.

It was also understood that the human body had inherent processes that could overcome disease and promote healing, and she knew that skilled nursing care could offer the best support for these 'reparative processes of nature' to take effect. She also observed that medical and surgical interventions were of no avail unless the patients were well nursed.

Her vision for the future was to recruit suitable ward sisters who would be trained to become the skilled carers of patients, who she saw as 'temples of the Holy Spirit', and the teachers and role models for the students. The students and sisters would be resident in specially-provided homes. The most important sister post was to be the Home Sister, who was charged with the physical and moral care of the students and with doing some teaching. When the students were deemed to be suitable and proficient they were encouraged to go to other hospitals or to do home nursing, and act as ambassadors/emissaries for high quality, dedicated nursing. Eventually some of the experienced ward sisters would be sent as matrons to hospitals all over the country to share the excellent standards.

Spreading the word

By the turn of the century, trained 'Nightingale Nurses' were sent to hospitals all over the country to set up training schools and spread Florence's ideas. They would soon introduce new ideas and practices to keep up with medical improvements and social changes. In addition, a very important innovation was the setting up of Preliminary Training Schools. The first of these was set up at the London Hospital, then at Guy's Hospital and St Thomas's Hospital set up theirs in 1910. These provided ten weeks of theoretical and practical tuition, with a day a week spent in the wards. Some time afterwards, study periods of some weeks'

duration were included in the training, and were run by specially-trained Sister Tutors. Lectures were also given by medical staff and some specialists.

Nursing defined

Florence saw nursing as being made of two parts: 'sanitary nursing', which was care of the environment, and 'nursing as a handicraft'.

Sanitary nursing

This is the aspect of nursing concerned with ensuring that the environment in which the patient is cared for is health giving and in no way harmful. Provision of efficient ventilation, light, warmth, clean water and efficient drainage are beyond the nurses' remit, but it is their duty to ensure that the patients' needs for fresh air, light, warmth, and cleanliness are met.

Nursing as a handicraft

This is what we would call 'basic nursing care' these days, and it meant ensuring that the patients had their needs for fresh air, nutrition, fluids, hygiene and elimination monitored and met. In addition, it was essential to ensure the patients' safety and comfort and to prevent any worries or anxiety. This would be achieved to the highest standards by the manner in which the nurses conducted themselves, the way in which they carried out their tasks and their kindness and impartiality in interacting with the patients and their relatives. She recognised that the skills and understandings could only be learnt thoroughly in the wards of a hospital. She was certain that, with a wise and skilled ward sister in charge of the ward, the students would become well versed in the art and skills of nursing, and that they did not need wider education or lectures from the doctors.

Nursing and Christianity

Florence's lifelong belief in the importance of Christian ideals as informing every area of everyone's lives is evidenced in all her relationships and in all her writings. Her sincere hope was that Christian beliefs should inform all the nurses' care and that the patients would gain an understanding of the power of Christianity and come to know that, whatever their station, they were filled with the Holy Spirit and worthy of that care. However, Florence was not unduly pious and was in touch with the realities of other peoples lives, and there are touches of humour in her writings.

Florence's religious convictions guided every aspect of her life and, for her, nursing was the application of all the Christian 'womanly' virtues to the tasks of ensuring the patients' safety and well-being. Alongside this was the religious imperative of 'loving ones neighbour as oneself' and serving others 'for the glory of God', and not seeking further reward.

Within the religious language of her writings there are all the prescriptions for how to ensure a safe and health promoting environment, how to allay patient anxiety in the way the nurses conduct themselves and way in which they carry out all the necessary tasks, and how to do all the nursing tasks for the maximum comfort and safety of the patients.

Nursing as offering a role for women

Florence saw that, with the right initiation, nursing could offer women a meaningful life, which would provide them with a channel for their Christian virtues, their motherly nature and their natural intellect. She looked for women who were honest, kind, obedient and temperate, and who had enough intelligence to both learn and understand what would be required of them. She also wanted the hospital to look after the welfare of the staff, with comfortable board and lodging and with sitting rooms to encourage companionship. It was these two aspects that led to nursing offering a vocational life for spinster women.

Florence's writing

Florence Nightingale was a prolific writer throughout her life. She wrote books, papers, reports and thousands of letters, all of them imbued with her analytical understandings, her wisdom and her knowledge, and all offered with love and generosity, although they had to be tempered with criticism sometimes. The books that I will be focusing on are *Notes on Nursing: what it is and what it is not*, which was first published in 1859, and *Florence Nightingale to her Nurses*, which was published in 1914 by Macmillan and Co., which is a selection from Miss Nightingale's addresses to her probationers and nurses of The Nightingale School at St. Thomas's Hospital. I trained as a nurse at St Thomas in the 1950s and when I was asked if I would like to contribute a contemporary perspective on *Notes on Nursing* I realised, on re-reading it, that it gives a very limited account of Florence Nightingale's precepts and understandings. We were imbued with much of her wisdom during our training and I was given a copy of *Florence Nightingale to her Nurses*, as a treasured possession, by a retired Home Sister. This book is a selection taken from the annual letters that Florence Nightingale sent to the nurses at The Nightingale School, between 1872 and 1900 and gives a much better account of her philosophy.

Notes on Nursing was written for the ward sisters and it is not surprising that the admitted emphasis was placed on 'sanitary nursing', because she had seen the lethal damage done in the Crimea by lack of attention to the environmental conditions. Because new hospitals were being built, she had to liaise with architects and builders and to spell out in detail how to ensure good ventilation, warmth, light and cleanliness in the new wards.

As well as giving thought to the establishment of the training schools that would be included in the new hospitals, she also felt that she had to make her ideas available to the many women nursing in less suitable places. She knew she would be preparing many of the students to nurse people in their homes and would have to give them instructions on how to make the best of the unsanitary conditions that they might find there. However, the addresses in the book are not meant to 'teach nursing'; rather they are exhortations to the students and trained staff to always strive for improvement, and be aware of failings that can creep in.

Florence was brought up to be a God-fearing Christian and in Victorian England she would assume that the people she is addressing have been brought up within the Christian context of morality and love for one's fellows. If they had not had a Christian upbringing, then she saw it as her duty to use nurse training to lead them into those ways. With that in mind, she places great emphasis on the students developing personal virtues as well as learning the many skills needed. An example of what she repeatedly says is 'What we can do

depends so much upon *what we are*. To be a *good Nurse* one must be a *good woman*; or one is truly nothing but a tinkling bell’.

Every aspect of nursing care is considered, always within the context of her Christian commitment and always concentrating on the patient’s experience. She gives reminders of ideal care and the harm poor care can do, in relation to the patient’s needs for fresh air, nutrition, fluids, hygiene and elimination. There are many tips on the best ways in which to do such things as feeding and bathing patients, very often with reference to Christian principles and God’s concern as guide and reward, but always with the main emphasis being on the patient’s safety and wellbeing. However, this emphasis on caring ‘for’ the patient does not exclude the importance of the patient’s own contribution to their recovery. She also recognises that although they may be dependent on the nurses while ill, the patients are the nurse’s equal in the sight of God.

Because of my interest in ‘unpopular patients’, I was surprised and pleased to see, on page 21, the heading ‘Tiresome Patients’ in *Florence Nightingale to her Nurses*, and I reproduce what she writes here because it typifies the style of the rest of her letters.

Lastly, it is charity to nurse sick bodies well; it is greater charity to nurse well and patiently sick minds, tiresome sufferers. But there is a greater charity even than these: to do good to those who are not good to us, to behave well to those who behave ill to us, to serve with love those who do not even receive our service with good temper, to forgive on the instance any slight which we may have received, or may have fancied we have received.

If we cannot ‘do good’ to those who ‘persecute’ us – for we are not ‘persecuted’: if we cannot pray “Father forgive them for they know not what they do”: how much more must we try to serve with patience and love any who use us spitefully, to nurse with all our hearts any thankless peevish patients!

When my book *The Unpopular Patient* was published, half the nurses in the country said they had never met any unpopular patients, while the other half said it was a common problem and therefore a waste of money doing research on it. The ‘nursing prescription’ at handovers was usually ‘to ignore them’ – which is the opposite of what Florence describes and only exacerbates the problem. I had wanted to include, in contemporary language, the advice that Florence gives in my study but, because there was no ‘proof’ that it was effective, it had to be left out. However, there are still many nurses, especially in mental health nursing who have not taken this precept on board.

Key quotations

One is spoilt for choice, but these are a few key quotes from Florence’s writings that are pertinent to present times.

Every patient in this ‘house’ shall be treated as an honoured guest.

From a pamphlet for new patients

It may seem a strange principle to enunciate as the very first requirement in a hospital, is that it should do the sick no harm...

Notes on Hospitals (1863)

The art of cultivating good health is as important as the art of sick-nursing – stress on prevention rather than cure – nursing proactive rather than reactive. Also note, it is nursing the sick, and not nursing sickness. Nature attempts to cure and nursing must put the patients in the best possible conditions for nature to restore health.

Article for the International Nursing Congress (1893)

PERSONAL REFLECTIONS AND A CONTEMPORARY PERSPECTIVE ON FLORENCE'S WRITINGS

My background

Because this year (2010) is the centenary of Florence Nightingale's death, I have been asked to share some personal reflections on her writings and on the early state of professional nursing, and then relate them to the situation that exists nowadays. My credentials for agreeing to this somewhat daunting task are as follows.

I started my nursing career in 1951 with orthopaedic nurse training so this gives me the long view. I did my general nurse training at St Thomas' Hospital, qualifying in 1957, and this introduced me to Florence Nightingale's work and influence. Doing my mental nurse training (I qualified in 1960) led me to become involved with nursing politics. I did my training at a very forward-looking hospital, one of about six, where mental illnesses were viewed as being, in large part, caused by, or resulting in, social incapacity, and I was happy to accept that their purposeful and enabling care was the norm. Then I became a GNC Examiner, visiting hospitals around the country, and I discovered this was far from the case. I joined the Royal College of Nursing in 1957 and was persuaded to attend the monthly local branch meetings in south-west London. At that time, those meetings were attended by the 'movers and shakers' of the profession and I was the only staff nurse, but I was made welcome and involved. I continued to participate actively while I did my mental nurse training and thereafter, until I left London in 1969. Finally, being appointed as a research assistant on 'The Study of Nursing Care' project and contributing my study *The Unpopular Patient* gave me, among other things, a wide overview of 'the state of nursing'.

Nursing in the 1960s

In the 1960s there was an implicit understanding that nursing was in good shape, that the 'true' nurses were those who remained at the bedside, and that the rating of hospitals by

patients and the community was dependent on the status and standard of 'nursing'. However, there had been many social, demographic and political changes through the years, as well as great advances in medical and nursing techniques, which were causing worries and challenges. The two main concerns were:

- how to improve the status of nursing, within the NHS and in society;
- how to raise the academic level in the preparation for nursing and also generate a fulfilling career structure.

I participated in many formal and informal discussions among senior nurses, and the main concern was how to organise a degree-level education that was integrated with a 'registration' level of clinical skills and experience, and which would encompass the several branches and many settings of nursing. Many people were very afraid that academic studies would diminish the students' desire to do clinical nursing. However, several of the 'senior nurses' taking part in these discussions had already obtained degrees before starting nursing, and they said this was nonsense and they pointed out that doctors combined clinical and academic input throughout their careers.

There were some pilot studies set up that linked a university department with a hospital, each with a different program and qualifications. (I do not know the outcome of these studies, but I read later on that most of the students in a follow-up study were found to be working in clinical areas.)

There were other concerns such as those about the apprenticeship scheme of training and task assignment, and how to engage the patient's participation and understanding in their care and in health education. Encouragement was given to men to undertake general nursing and second level nurses were given a two-year training for enrolment.

The Salmon Report (1966)

The first major change came when Lord Salmon was invited to chair a committee charged with devising a scheme that would provide a career structure for senior nurses and his report was published in 1966. I attended the launch of the report and there was great consternation among the assembled nurses. This was because the proposed structure was entirely concerned with 'management', which was to be disengaged from any 'clinical' nursing concerns. I quote a paragraph from the report on 'Senior Nursing Staff Structure', p. 7, para.13

A need that was often expressed (by senior nurses) was a desire to remain "close to the patient". This attitude, while wholly admirable and indicative of the professional sense of service, is also a contributory cause of some of the defects in the working of the present structure. Senior nurses tend to interfere in ward matters more than they ought to, and, however laudable it might seem for the administrative nurse to "roll up her sleeves" in the wards, it is often really a satisfying of her own needs and not a service to patients or ward sisters. If the senior managerial positions are clearly seen to be of greater importance, in the service to more patients rather than 'to the patient', these positions become desirable to the nurse with a developed sense of vocation.

[The following paragraph recommends a senior Nursing Officer (grade 7) post for skilled clinical nurses to be in control of nursing in units or areas, but this was not put into effect.]

Recognition that the Salmon Committee had completely misunderstood the role of matrons and their assistants did nothing to lead to anything of a reappraisal or review of the report. The nurses' demand for pilot studies to be carried out led to three being set up, but the report was fully implemented before they were complete.

In practice, at the time, the matrons and their assistants certainly had an administration and a management role, but the task they set themselves, of visiting the wards everyday, served a very important additional function. The sisters were appointed by the matron and her role was to set the standards and the 'ethos', which was then maintained by being a wise guide, counsellor and friend to the sisters when she did her rounds. Matron's rounds also reinforced the patients' trust and hope. This contributed much to the high level of morale in well-run hospitals.

However, when 'nursing officers' were introduced, as a result of the implementation of *The Salmon Report*, they were required to undertake management courses that took no account of the psychological aspect of their former role. Instead, in many situations, the ward sisters experienced criticism and direction from nursing officers when they visited the ward, and they missed the friendly approval of a matron. Of course, there were many situations where the previous enabling role was maintained, but it set up a pattern that, through the years, has become exacerbated by other social and political changes.

Development since the 1960s

The Salmon Report of 1966 was the first response to the nursing profession's plea for a reorganisation that would offer a preparation for nurses that would include higher education and advanced management skills, and that would be closely linked to clinical practice and research at all levels. It took nearly 30 years for the next major change to be introduced, which was when Project 2000 was launched, and nurse education moved into the universities. These two factors, as well as many social, demographic and political changes, have certainly changed the face of nursing since *Notes on Nursing* was published.

As one of the six nurse participants in 'The Study of Nursing Care Project' we visited practically every hospital in and around London of the 1960s. We found it was possible to recognise that some hospitals were 'better' than others and that nursing skills occasionally were not up to standard, but our impression was that, overall, all the patients were safe and well cared for. However, about ten years ago, not long after I retired, I was a regular visitor to a friend who had major abdominal surgery, which was considered to be successful, but he contracted an MRSA infection that caused complications. This led to prolonged hospitalisation, with a further two MRSA infections, and eventually led to his death 11 months after his admission. Project 2000 had been implemented since I retired and I expected the nursing care to be better, if anything, but I was sadly disappointed. I shared my observations of poor standards of care with the heads of the hospital Trust and the local university nursing department. Then I set myself the task of trying to understand what had gone wrong. This is not the place to go into details, but it led me to understand that there are many factors that put a great strain on the nursing profession as a whole and on all the individuals doing nursing.

Since I sat alongside my friend, there have of course been considerable improvements, thanks most often to the efforts of the directors of nursing services in various trusts – the people who would have been matrons of Florence Nightingale's day. Also, as we observed in the 1960s, there will be a range of standards of nursing care throughout the NHS, but it is particularly upsetting that there have been some instances where standards have been very poor and have been widely publicised. I am certain that no nurse gets up in the morning planning to do a poor job, and I am equally certain that every nurse determines to the best job, but circumstances can sometimes make it very difficult and the nursing profession has

to be proud of the many who manage to work effectively and often beyond the call of duty.

I continue to have many informants, both nurses and patients, who keep me up to date with what is going on and, as I share my understandings about Florence's views about nursing in relation to nursing at the present time, they are based on my personal interpretation of the facts as I see them.

My appraisal of the contemporary state of nursing

In sharing my perspective on the state of present-day nursing, in the light of a reappraisal of Florence Nightingale's publications, I am tempted to imagine her reactions to finding herself as a patient on a contemporary ward. I will take it that she has some idea of the huge changes in the world at large and is just focussing on 'being nursed'. She might be:

- Embarrassed by the proximity of the other three patients in the four-bed bay, which does not afford as much privacy as the Nightingale wards, and disturbed that she cannot see the whereabouts of the nurses from her bed. Especially the ward sister, who doesn't seem to do a round of the patients.
- Disturbed by the lack of formality of the nursing staff – horrified at being called Florence.
- Having difficulty knowing who was responsible for what among the nurses, and horrified at having to ask for a bedpan, rather than being offered one.
- Disturbed by the constant bustle and the number of people coming and going with a variety of duties in the ward, including non-nurses being responsible for the food and drink.
- Grateful for care assistants who come to the bedside and answer her questions and give her a smile.
- Bemused that student nurses receive half their 'education' at the local university.
- Bemused that ward cleaning is 'contracted out' and beyond the ward sister's control. (In Florence's time the ward maid came to be a highly valued member of the ward teams).
- Most of all she would be distressed by the noise, the chatter and the bustle throughout the day, and sometimes at night.

What has changed in the last 100 years?

So we now consider nursing practice, one hundred years after Florence's death. The changes in the world at large have accelerated at an unprecedented rate, and have necessitated and contributed many changes to the organisation and practice of nursing. However, fundamental human nature does not change and when people become dependent on others through illness or accident, they will always need the safety and skills of well-prepared nurses.

Some of the changes that influence the direct delivery of nursing care arise from the increased complexity and diversity of medical and surgical interventions and the extra nursing skills that these require. Understanding about infection and sterilisation, and the discovery of antibiotic drugs, is possibly the most significant change to influence nursing practice, but Florence's hunch that cleanliness and hand washing would prevent the 'miasma' causing disease anticipated later knowledge about cross infection.

Other changes concern the politics in the setting up of the NHS and managing the services provided, including the Salmon Report and, more recently, the change to 'a market economy' process for administering the service areas. There are also the many social and demographic changes that influence the people who come forward to be nurses and influence their lives in and around nursing. Also there are the momentous changes in transport and communications, which include computing and the internet. It is impossible to guess how Florence would react to all these changes.

Project 2000

Perhaps the fundamental change to affect present-day nursing is in the education of nurses that came with Project 2000. My appraisal is based on the particular geographical area with which I am most familiar, but I am informed of the situation in other places. I am aware that standards can vary from one place to another, so my aim here is to indicate where the *average* of present-day nursing supports or refutes the high standards set by Florence.

This is not the place to analyse the pros and cons of Project 2000 and its modification, but it has had considerable influence on present-day nursing. So when I decided to investigate the possible reasons for the poor nursing care my friend received (see above), I felt there might be certain aspects that could be implicated in limiting the achievement of high standards of care, as follows.

1) From the grass roots level there seemed to be a big divide between the university and the clinical areas. The divide was partly logistic, in that it was difficult to travel from one to the other, and partly social, in that there did not seem to be much communication or respect between the two. The divide is also partly because of the separate funding from academia and the NHS.

2) Having studied for the Sister Tutor Diploma, I was surprised that today's students spent several months at the university without any experience of the clinical aspects. In order to impart knowledge the recipient must have a basic knowledge on which to build the new. As all knowledge for nursing relates, in some respect, to people who are ill or disabled, it was a priority from the beginning in the preliminary training schools that students spent one day a week in the clinical areas and they were encouraged to share observations and questions. I gather that today's prospective students are advised to get some experience working as care assistants before starting the course, but as this will be unsupervised experience it may be counter-productive. The other thing that surprised me was that teaching the theory of the 'whys' and 'hows' of nursing skills was taught in the university, while the practice was taught in the clinical areas. Skills that are rote-learned without the understanding tied in are less well remembered and will not be safely modified for changed circumstances. There is also an assumption about skills being taught to new students 'on the job' by co-workers that is referred to as the dangers of 'learning alongside Annie', where it is seen as easy for poor practices to get passed on, especially when nurses and students are working under pressure and where 'teaching' skills are lacking.

3) For me, the most disturbing differences in nursing that I noticed were in the relationships between nurses and patients, and in the values and attitudes that contributed to the 'ethos' on the wards. For the vast majority of people, being admitted to hospital is a very important and anxiety-generating incident in their lives, and they will be very alert to anything that either allays or increases their anxiety. There is scientific evidence to show that the cortisol and

adrenaline, released in anxiety, have many detrimental effects in the body that delay healing. Florence was aware of this and all the aspects of care that she called 'the handicraft of nursing' were about reducing anxiety and keeping the patients calm, while ensuring that all the activities of daily living were attended to.

4) As outlined above, Florence also knew it was important to recognise that the emphasis on caring 'for' the patients does not exclude the importance of the patient's own contribution to their recovery. Florence also recognises that although they may be dependent on the nurses while ill, the patients are their equal in the sight of God and what they can offer should be accepted by nurses. In one of her addresses to her nurses she states:

I am not all saying that our patients have everything to learn from us. On the contrary, we can, many a time, learn from them, in patience, in true religious feeling and hope. One of our Sisters told me she had learned more from her patients than from anyone else. And I am sure I can say the same for myself. The poorest, the meanest, the humblest patient may enter into the kingdom of heaven before the cleverest of us, or the most conceited.

As an aside – I would teach students that if they do not know how to do something it is better to admit this to the patient, and then ask the patient if they know how it is done and would they be willing to help. If the answer is 'no' then the student must seek help. On no account should they guess and struggle. Equally, the patient is the 'expert' on his own illness experience and that can be very useful when shared with students. This is now known as 'partnership in caring'.

It is often worries about basic things like getting to the toilet or not being able to clean their teeth, that cause more anxiety than their illness for the patients and yet, because nurses have taken on more and more 'treatment' aspects of care, there seems to be a downgrading of these 'fundamental' nursing aspects of care. This means that the most important and skilled care, in terms of safety, welfare and the concerns of the patients, become delegated to care assistants. This also means that the opportunity for skilled observation (the skill that definitely needs sound theoretical underpinning) which this aspect of nursing offers, is missed.

Despite the failed effort of 'The Study of Nursing Care Project' to devise a means of measuring 'standards of nursing care', nobody else has managed to find a way to do it since. However, my intuition tells me there is room for improvement in some situations, both in the delivery of safe and effective care, but also in the conditions that are provided for nurses to carry out their care.

CONCLUSIONS

Florence managed to turn the task of attending to the sick from being a menial and often unpleasant 'job' into a rewarding and high status 'vocation'. It was her commitment to the

religious – or vocational - imperative of 'loving one's neighbour as oneself' and serving others 'for the glory of God' that had the health-promoting effect of allaying anxiety and inspiring trust and hope for the patients, and its success providing the motivating reward for the nurses. In modern secular society religious affiliation is expected to be an individual's

own affair and to see nursing as a 'vocation' is a somewhat downgraded concept. A vocation used to be seen as a 'calling' to serve God through service to one's fellows but now, in higher education, it is seen as defining training for jobs that do not need academic preparation.

So, what has nursing become in the twenty-first century? Is it, perhaps, a scientifically-based professional activity that offers men and women a rewarding career? It seems to me that very few nurses spend more than the first few years after registration doing hands-on nursing. Ward sister/charge nurses are appointed at a younger age than previously, and stay in post for fewer years and, sadly, the concept of burn-out is sometimes given as a reason for their leaving. This means that the really important contribution of 'the wisdom' of the ward sisters to high standards of nursing care has vanished. The replacement for this is scientifically-based evidence for the practice and skills of nursing, which does not include the religious and intuitive components of the central relationship aspect of nursing.

Maternal-infant bonding

It is here that I share my knowledge about the science that explains why the religious-based nursing care was so effective. This knowledge comes from many branches of science and it explains the neuro-chemical process that is termed 'maternal-infant bonding', which ensures that humans are sociable with each other. This is not the place to explain the complex science, so it will have to suffice to give a brief synopsis. More details may be found on other pages on this site. (See links)

Humans are very complex physical beings who have to learn very diverse patterns of behaviour in order to negotiate living successfully. The learning is dependent on a functioning physical body, that includes the brain, and the negotiation is initially dependent on a developmental process that occurs between the mother and her baby as soon as it is born. This process, called maternal-infant bonding, encourages engagement and cooperation with other people, that we call 'socialising', which is the hallmark of being human.

When babies are born they need air, food and water, warmth, rest and exercise, and protection from danger, and they are utterly dependent on others to meet these needs. All the systems of their bodies are functioning well enough to sustain life, but they will all have to grow and develop over a considerable time for them to reach maturity.

It is because this lengthy immaturity needs not only the commitment of the parents, but also the cooperation of many other people, that there is a system in the brain that, when activated, makes us feel pleasure when we feel we are acceptable, and when people are kind and generous to us. The nerve pathways of this system are latent in the newborn infant, but are activated by all the stimuli of the maternal caring behaviours. These are the sensations that the baby receives while being mothered. The experiences of **touch**, especially the mouth while feeding, **sight**, especially the mother's face, and the **sound** of the mother's voice, where baby talk and singing are shown to be important, are memorised as they stimulate the pleasure pathways in the brain and release endorphins. Once these personal pleasure pathways have been activated they establish 'needs' for approval and acceptance that can only be met by other people, and their level will be constantly monitored ever after. When people feel adequately self-confident, useful and popular they experience contentment, but if people feel lonely and unliked very high levels of anxiety are generated that lead to the 'fight or flight' response. For humans it is often not possible to get away from the situation and fighting is not acceptable, so there is a reflex process whereby a pattern of behaviour is

produced that is meant to signal the distress to others. This is called 'attention-seeking behaviour'. It is actually 'attention-needing behaviour' but, unfortunately, all humans have another reflex that drives them to reject people who annoy them for this reason. This reflex process can be seen in the behaviour of 'difficult patients' in hospital wards, and the solution, as Florence realised in the 'care' prescription that I quoted above, is to be kind and helpful and not show any annoyance, and definitely not to 'take no notice of them'.

It is possible to take all the precepts of care that Florence offered in her writings and to demonstrate the ways in which her intuitive understandings can be supported with scientific facts. What is not so easy to demonstrate is how in nursing there has to be an extra dimension beyond the scientific, which may be called 'an art' rather than a vocation for present times, but whatever it is called, it is care that is at the heart of nursing and this is what we should see as the key message of Florence's work.

Felicity Stockwell, 2010