The Scientific Meeting closed its report with a quotation that admirably summarizes the views of the participants and deserves to be reproduced in full:

" Too often it is assumed that rehabilitation should begin only after cure of the disease. In some diseases that sequence may be logical. In the case of leprosy, most of the psychological harm is done in the first few months after the diagnosis is made. It is then that despair strikes. It is then that the patient's whole world crumbles away. It is then that he begins to feel persecuted and to feel that no effort is worth while. That is the root of apathy, and it is a root that deepens and ramifies widely. Rehabilitation must start on the day of diagnosis, or as soon thereafter as the social worker can introduce the patient to the new world that for such a short time must replace his old, until he is ready to return, freshly equipped and with a welcome awaiting him."

THE CHANGING SCENE IN NURSING

The International Nursing Review [1] *has recently published an interesting article on the development of nursing services and hospital techniques entitled " The changing scene in the United States ". We reproduce a number of extracts, since the article deals with a very present problem which has more or less generally to be faced. The author, Miss Olga Weiss, R.N., who is herself a nurse, has published several works, in particular on the nurse-patients relationships in Psychiatry.*

The Patient Changes.—Twenty or thirty years ago, the average patient was less well read, knew less about the human body, and

[1] Vol. 8, number 5, London, September-October, 1961.

had much less access to information about processes than today. He was, also, probably less educated, worked longer hours, had fewer leisure activities in his restricted leisure time, and accepted pain and illness as a normal part of existence in a fairly harsh world. Today, the average patient is probably a high school graduate, and often a college graduate, works fewer hours, has many more leisure activities in his greater amount of free time, is fairly well read, and is bombarded with health information via the visual and auditory senses. In fact he can hardly escape learning about aspects of the human organism that few nurses knew about thirty years ago. He has access to pamphlets, booklets, books, illustrations, and can't escape advertisements in car, railroad, public places, or offered him through his daily mail. Various campaigns by interested groups inform him about—and request funds for—cystic fibrosis, rheumatism, arthritis, poliomyelitis, mental illness, and cancer . . .

This patient, then, is the person coming into hospital today. He has probably taken various medications at home—not always under the guidance of a physician, but rather as a victim of high pressure salesmanship. He is, in short, a victim of much information but little knowledge about his illness. He is going to ask the nurse questions and he is going to want answers. He is not going to accept treatment docilely as an unknowing person accepting the loving kindness of a paragon of virtues—the nurse. In fact, he is going to be highly critical of his nursing because he has built up a preconceived image of the nurse.

Under pressure of pain and discomfort, he is needful of nursing care, and may be demanding of it. He has heard that nurses are now more educated than heretofore, that nurses work with him rather than for him or to him, and he is probably confused. The amount of technical knowledge and education the nurse has is of no interest to the patient when he is in most need of that technical knowledge. At that time, he wants comfort, release from pain and anxiety, and loving care. But his definition of nursing care is not the nurses's definition.

The Nurse Changes.—The nurse is in a dilemma largely of her own making, but growing from the rapidly changed social system in which she lives. She, too, is better educated, has more leisure,

and more knowledge than the nurse of thirty years ago. She too, has clung to an old image of the nurse, and because this is—in a sense—a self image, she has greater difficulty in altering it. She sees herself, and wants to see herself, as the kind, loving person who gives comfort to the sick. Most often, she wants to be at the patient's side, allaying pain and anxiety. But she has tremendous pressures which keep her from reaching the patient. She is carrying out technical functions undreamed of by physicians three decades ago, which demand expert knowledge and skill of a far broader range of subjects than simple nuısing measures, cookery, and housekeeping. She must handle equipment which requires a knowledge of physics, electronics, as well as anatomy and physiology. She must know basic chemistry and physiological reactions to synthetic drugs. She must be able to give expert care to patients in acute phases of disease which they could not have withstood thirty years ago, and she must give equally expert care to patients who have received surgical treatment which is nothing short of miraculous. She must do this for a group of patients, each of whom would have required the full attention of a single nurse a few years ago. She must direct the work of a number of assistants who are necessary because of the complex equipment and variety of treatments carried out in the hospital today, and she must let someone else take responsibility for housekeeping and dietary treatment—although she is still held responsible for the patients' environment and total treatment for the full 24 hours . . .

Changed Relationships.—Much written material speaks of the nurse/patient relationship, the nurse and her patient or the nurse and the doctor—as if the nurse has only one patient, only one doctor, in her working day. Nurse/patient relationships, nurse/doctor relationships, nurse/family relationships are all very well, when there is only one patient, one doctor, one family with whom the nurse relates. But in the course of the average 8-hour day the nurse has the care of a number of patients, who have families, and a number of doctors, each of whom wants her entire attention for his patients, and a number of other workers who look to her for guidance if not direct supervision. In a sense, we perpetuate the false image of the nurse with a patient, when in reality, the picture

is of the nurse almost overwhelmed with patients, doctors, ancillary (auxiliary) workers, and a number of added personnel—all demanding her immediate and urgent attention.

Certainly, the nurse has learned certain skills and arts (although I feel these are not stressed nearly enough in today's curriculum). But she has been taught a great many other things, also, and has been taught that all are her responsibility. Not the least of these are the varied measurements and observations which were once the task of the physician alone. Now, it is the nurse who is responsible for them—and many of the observations and measurements cannot be made in the course of what old-timers knew to be nursing care. One cannot observe a patient's blood pressure while giving him a bath, nor check the artificial kidney or heart-lung machine while giving comfort measures. These are serious observations made with delicate and complicated apparatus, and they require the nurse's undivided attention—about the one thing today's nurse does not possess. All her attention is divided, and she is in a quandary trying to meet innumerable demands while satisfying her own deep inner calling to be a nurse—in that old image of a calm, comforting person.

The Changed Hospital.—The hospital itself is vastly changed. It strives for efficiency while trying to meet constantly changing demands, new and expensive equipment, an increasing number of patients, an increasing number of staff, and added expensive services. Two supposedly stable points of reference remain—the doctor and the nurse. The public clings to its old images ; even the doctor and nurse cling to the old image. But who speaks for the new image ? The sociologist, the economist, the psychologist *in their roles* present a new image . . . He wants, then, the old image —the healer, the comforter. This split between reality and fantasy is curiously present in all of us. In theory, we approve the changing scene, in practice, we reject the reality imposed by the newer pressures. We like the automatic beds which the patient can raise or lower by pressing a button, but we miss having the nurse raise or lower the bed, fluff the pillow, and speak a comforting word or two. We like early ambulation, which prevents complications of serious illness or surgery, but we miss the comfort of attention given to the

bedfast patient. In effect, we are told by modern science to be brave and require less coddling, but when we are ill, we want coddling—and who is to say coddling—or comfort—is not justified once in a while, even in this electronic age of miracles and changing scenes ?

Those of us in nursing who lived through these major changes want the satisfaction we got in giving nursing in the ' old days ', even as we approve the remarkable advances which keep people alive and prevent the serious disability which went with the other era.

For the sake of society, we would not relinquish the scientific advances, but as members of society, we are not happy with the price we are paying.

This is truly our dilemma, and the choice is ours. Where then do we go from here ?