

Careful nursing: a model for contemporary nursing practice

Therese Connell Meehan BSN MA PhD RGN

Lecturer in Nursing, School of Nursing and Midwifery, University College Dublin, National University of Ireland, Ireland

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Correspondence:

Therese Connell Meehan,
School of Nursing and Midwifery,
University College Dublin,
National University of Ireland,
Earlsfort Terrace,
Dublin 2,
Ireland.
E-mail: therese.meehan@ucd.ie

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Background. Careful nursing, a system of nursing developed in Ireland by Catherine McAuley in the early years of the 19th century and used by Irish nurses at the Crimean war, has been described as Ireland's legacy to nursing. Although records of careful nursing have been preserved, it has received little attention in the nursing literature.

Aim. The purpose of this study was to conduct a preliminary content analysis of the mainly primary source historical documentation of the careful nursing system and present it within the structure of a contemporary conceptual model of nursing.

Methods. The documents describing the careful nursing system were studied and re-studied to gain understanding of the philosophical assumptions underlying careful nursing and of the thinking, attitudes, actions and practice of the nurses. Content relating to the four central nursing concepts was identified and summarized.

Results. Careful nursing definitions of person, environment, health and nursing are presented. Ten key concepts of careful nursing practice are identified as disinterested love, contagious calmness, creation of a restorative environment, 'perfect' skill in fostering safety and comfort, nursing interventions, health education, participatory-authoritative management, trustworthy collaboration, power derived from service and nurses' care for themselves. The spiritual dimension of human life and the spiritual in nursing emerge as important characteristics of the model.

Conclusions. The results of this preliminary analysis require further verification and critical examination. However, the careful nursing model illuminates important aspects of professional nursing and could be further developed to conceptualize and guide nursing practice.

Keywords: nursing history, Irish nursing, careful nursing, conceptual model, spiritual

Introduction

The careful nursing system used by the group of mainly Irish nurses who cared for the sick and wounded British soldiers during the Crimean war of 1854–1856 has been described by Doona (2000) as Ireland's legacy to nursing. A nursing system of such apparent effectiveness invites further investigation. Before the end of the war Nightingale herself requested details of the system. Bridgeman's (1854–1856) diary records that 'Miss N. took notes on our manner of

nursing which [Bridgeman] explained to her, as she hoped someone might profit of it' (p. 367). Whether Nightingale (1859/1970) incorporated her notes made at the Balaclava Hospital into *Notes on Nursing* is not recorded.

Nonetheless, descriptions of the careful nursing system have been preserved and can be used to examine the philosophy and concepts inherent in this manner of nursing. In this paper, a preliminary analysis of the mainly primary source documentation of the careful nursing system is presented as a contemporary conceptual model of nursing.

Firstly, the origin of careful nursing is reviewed briefly and a structure of contemporary nursing knowledge outlined. The rationale for this analysis is to provide a foundation for further work on the topic.

Origin of careful nursing

Careful nursing was originally developed by a distinguished Irishwoman, Catherine McAuley, early in the 19th century. This was a time of oppression, poverty and recurring famine in Ireland. Chronic illness and epidemics of infectious diseases were constant threats to life and health. Nursing as a social service had been rendered almost non-existent by the effects of the Reformation. McAuley was one of a number of women who sought to re-establish nursing service, especially for the sick poor. She developed her knowledge of nursing over several years, beginning around 1798, by nursing sick family members and friends and going out consistently to nurse the sick poor in their homes in and around Dublin (Moore 1841/1995, Harnett 1864). As an educated and cultured woman whose family had strong medical connections, she was well versed in the medical knowledge and scientific achievements of the time. She also read widely the principles and work of earlier nurse figures such as Catherine of Siena, Catherine of Genoa, and John of God (Sullivan 1996). Thus, she brought a broad knowledge and an active mind to her nursing work. Like-minded ladies joined her in this work and in 1828 they founded in Dublin the Institute of Our Lady of Mercy. As part of the Institute they established a home and hospital visiting nurse service.

These emerging nurses considered themselves a secular group in the common 19th century meaning of the term. That is, although they were faithful Catholics and Protestants, they were concerned with the world and its affairs. However, the plain, dark costume they adopted and their merciful work gave them a religious appearance. This impression together with existing social and political conditions led to a directive that they either form a religious order or give up their Institute. At first McAuley was firmly opposed to the idea of a religious order but as their work grew and its importance became more evident, she agreed to it (Moore 1841/1995, Harnett 1864). In 1831 they became the Religious Sisters of Mercy, and over time became major providers of nursing services in Ireland and around the world.

Their nursing work consisted of physical care and emotional consolation provided from a spiritual perspective. McAuley (1832) advised that it was important to 'relieve the distress first and to endeavour by every practicable means to

promote the cleanliness, ease and comfort of the Patient' (p. 5). She stressed that in all things 'Great tenderness must be employed' (p. 5), and that gentleness, kindness and patience must characterize all interactions with patients. The nurse 'should speak in an easy, soothing, impressive manner so as not to embarrass or fatigue the poor patient' (p. 5). They provided every possible comfort and consolation to dying patients, and for recovering patients they continued to provide sustenance and guidance during the important period of convalescence (The Morning Register 1832). Teaching people to care for and help themselves was considered essential to the development and well-being of the whole person and the health of the community (Harnett 1864, Carroll 1866).

Their nursing work was well illustrated during the epidemic of Asiatic cholera which struck Ireland in 1832. The Central Board of Health opened temporary cholera hospitals, one at the Townsend Street Depot where McAuley took responsibility for the nursing (Harnett 1864). They worked there daily for long hours keeping patients as clean and comfortable as possible, administering food, fluids and palliatives and giving all possible spiritual and emotional consolation. McAuley supervised patient care and the work of the hired nurses, and took full responsibility for the dying and the dead (Murphy 1847, Harnett 1864, Carroll 1866, 1883). The chief physician, Dr Hart, 'gave her the fullest control' and 'often held long conversations with her on the affairs of the hospital' (Carroll 1883, p. 295). A physician who worked alongside them later recalled that 'They were of the greatest use...the Hospital could not be carried on without them' (Carroll 1883, p. 295). About 3700 patients were treated at the hospital over its 7 months of operation. The chief physician attributed the hospital's relatively small percentage of deaths, about 30%, in comparison with the considerably higher percentage elsewhere, to McAuley's wise administration (Carroll 1883).

Their nursing skills spread and developed further as more ladies joined them. One was an experienced nurse from Limerick, Joanna Bridgeman, who would later have a major influence on nursing at the Crimean war. Of the nurses who worked with McAuley at the Townsend Street Depot Hospital, Clare Moore took careful nursing to the Bermondsey area of London. Twenty-two years later she accompanied Florence Nightingale to the Crimean war and, as her most valued assistant, guided the nursing care at the Scutari hospitals (Nightingale 1856). In 1843, Frances Warde took careful nursing to Pittsburgh, Pennsylvania from where it spread unobtrusively but with great effect across the United States of America (USA) (Bauman 1958).

Structuring nursing knowledge

In contemporary society, knowledge that guides the work of professional disciplines is commonly structured in conceptual models. Most nursing models are built upon four concepts; person, environment, health and nursing; and statements of relationships among them. These four concepts are said to form the essential structure of nursing knowledge and to distinguish nursing as a professional discipline (Fawcett 2000). Different nursing models emphasize different approaches to nursing depending upon their underlying philosophical assumptions. For each model philosophical statements of beliefs and values, which are assumed to be true, determine how the four central concepts and relationships among them are defined. Thus, each model presents a distinctive view of nursing knowledge and practice. Nursing models guide nurses' thoughts, attitudes and actions as they engage in the nursing process and serve as a basis for nursing theory development and research.

Most conceptual models of nursing have a central theme, for example, Watson's (1999) focus on nurse caring or Orem's (2001) emphasis on patient self-care. The central theme in careful nursing is the spiritual dimension of human life and the spiritual in nursing. Assumptions about the four central concepts all build upon an underlying assumption that there exists a Supreme Loving Being who gives rise to the universe, permeates all living systems and is the ultimate source of love, compassion, healing and wholeness.

Although careful nursing originated within a Christian worldview, many of its assumptions and principles are shared by non-Christian religions and can also be conveyed in broad, yet philosophically congruent, spiritual terms. It is noteworthy that McAuley initially developed careful nursing as a secular endeavour, meaning that her early work was not associated with any particular creed. Likewise, for contemporary practice the assumptions and concepts of the model are expressed in broad spiritual terms. Thus, the model has the potential to be meaningful to nurses who recognize the spiritual dimension of human life and value the spiritual in nursing.

The careful nursing conceptual model

The careful nursing model as it is presented here is based on a preliminary analysis of documents which describe careful nursing. These include McAuley's original guide to the visitation of the sick (1832), her letters (Neumann 1969), selected letters and manuscripts of her closest associates as they have been meticulously edited by Sullivan (1995), and near-contemporary biographies of McAuley (Moore 1841/

1995, Harnett 1864, Carroll 1866). Documentation from the Crimean war includes the diaries of the nurses (Bridgeman 1854–1856, Croke 1854–1856a, 1854–1856b, Doyle 1897), other descriptions of their practice (Murphy 1847, Taylor 1856, 1857, Carroll 1883) and British army correspondence (Codrington 1856).

The documents were studied and re-studied to gain understanding of the philosophical assumptions underlying careful nursing as well as the attitudes, actions and practice of the nurses. Content was analysed and hand-coded (Weber 1985). Content relating to the four central nursing concepts was identified and summarized. Definitions of the four central concepts were derived primarily from the documents written by the nurses. Most content was found to be related to nursing practice and this was examined for themes. Themes were examined and re-examined to further clarify meanings and some themes merged. Ten themes were finally identified as the main concepts of nursing practice. The names of the practice concepts were evoked by the documentation but created by the researcher.

Central nursing concepts derived from the careful nursing documents

Person

The human person is a spiritual, physical, emotional and social being. The spiritual dimension is fundamental and unifying, giving form to the person as a unitary expression of the Supreme Being's love, purposefulness and healing presence in the world. At the same time, the physical, emotional and social dimensions of the person are considered extremely important because they are inseparable expressions of the person's spiritual nature. As a unitary human being, each person is unique and possesses distinctive creative capabilities and a meaningful purpose in life. Each possesses inestimable dignity and worth, as well as an intrinsic order, beauty and strength. Each person has inalienable rights and persons able to reason have certain responsibilities. Each person has the potential for good, although this is not always actualized. There also exists in the human person a potential for maleficence which cannot be discounted.

Environment

The environment encompasses the spiritual, physical, emotional and social surroundings of the person and is permeated by the Supreme Being's love, purposefulness, and healing presence in the world. This is reflected in its physical, emotional and social aspects, such as physical beauty and order, emotional calm and gentleness, and harmonious social relationships. The environment may also contain potential or

actual maleficent forces which can emerge from within human persons, but these forces are amenable to human attitudes and actions intended to enhance its healing capacity. As contributors to each other's environments human persons can foster healing, well-being and healthy human development and also serve as instruments for the Supreme Being's healing power.

Health

Health is a unitary experience of harmony, personal dignity, relative contentedness and having a sense of purpose in life. Ideally, it is associated with the relative absence of disease. It includes the ability to experience a personal relationship with the Supreme Being through prayer or meditation, to express this experience in loving relationships with others and to seek to fulfil a perceived purpose in life. Healing is a natural restorative process which has its source in the Supreme Being and can be fostered by restorative spiritual, physical, emotional and social influences in the human person and the environment. Health also includes the ability to accept, provisionally and with equanimity, influences and circumstances which are seemingly unjust but may be very difficult to alter.

Nursing

Nursing is a human response to human needs for protection, assistance and consolation during times of sickness, injury, suffering and impending death. The impetus to be a nurse has its source in the spiritual dimension of the person and is associated with fulfilling a perceived purpose in life. Nursing can be a way of sharing in the Supreme Being's love for humanity through being available to act as a healing instrument. It includes seeking for 'perfect' knowledge and skill in preventing illness, relieving pain and suffering, caring for the sick and wounded, and fostering the health of the whole human person, as well as providing comfort and consolation to the dying.

Nursing is both an intellectual endeavour and an art. A broad education in the arts and sciences combined with close and continuous observation and experience in practice is the foundation for developing and using nursing knowledge. The art of nursing includes refinement in the attitudes and actions of practice, meticulous attention to details of patient care, expression of great tenderness in all things, and the ability to apply these principles under almost any circumstances. It is predicated upon quiet determination, prudence, perseverance, humility and a cheerful spirit. It includes being always ready to cope with difficult situations; being never surprised and never put out. There is little place in nursing for hard and fast rules. Rather, excellence in nursing practice is the product of a broad education, refined

behaviour, perfect discipline, discernment, forbearance and good judgement.

The ten themes, or key concepts, that emerged from the accounts of nursing practice are listed in Box 1, and merit further elaboration.

Disinterested love. Love within a deeply spiritual context is a hallmark of careful nursing. The term love is used in its meaning of a benevolent affection of one human being for another in so far as it is prompted by an understanding of their common relationship to the Supreme Being. It is a love bestowed irrespective of the characteristics of the person who is loved. This meaning is emphasized by the adjective disinterested used in its meaning of impartial, unbiased by personal interest or free of seeking one's own advantage. This 19th century use of the term was used in tribute to careful nursing by observers. Here *disinterested* does not mean *uninterested*, a meaning sometimes ascribed to the term today. Disinterested love is associated with a spiritual consciousness fostered by some time spent each day in meditation or prayer. It supports an attitude of great tenderness in patient care. It disposes nurses to practice with affection, kindness, sympathy, humour and a bright and joyous spirit. Within the context of disinterested love these qualities are understood to arise from the heart and reside in the will, not in the feelings or transient emotions.

Contagious calmness. Nurses' ability to preserve an inner sense of calm is reflected in an attitude of calmness which is communicated to patients and others in the surrounding practice environment. It is characterized, for example, by a gentle manner, a soothing voice, and the impression of quiet dependability. As the calmness establishes itself in patients, it eases any anxiety or fears they may have. The nurses' demeanour of calmness is nourished through the practice of meditation or prayer and an enduring trust in the sustaining love of the Supreme Being. In addition, it can be maintained even under the most adverse circumstances. It also appears to

Box 1 The 10 key concepts of careful nursing practice

- Disinterested love
- Contagious calmness
- Creation of a restorative environment
- 'Perfect' skill in fostering safety and comfort
- Nursing interventions
- Health education
- Participatory-authoritative management
- Trustworthy collaboration
- Power derived from service
- Nurses care for themselves

engender in the nurse an attitude of quiet self-confidence, and alertness to the ever-changing needs of patients and practice situations.

Creation of a restorative environment. The therapeutic value of a restorative environment was especially well recognized before the development of modern medicine. Patients' environments can be influenced and shaped to promote healthy growth and development, ease distress, protect against harmful influences and foster their natural healing capacity. Every effort is made to ensure that patients' environments are as free as possible from physical, emotional and social influences which are adverse to safety, comfort, healing and healthy human development. Nurses themselves comprise an important restorative aspect of patients' environments by imparting a sense of disinterested love and calmness, working harmoniously among themselves and with others, and maintaining a joyous spirit in their work. Healing aspects of the natural environment, such as fresh air and sunshine, can also be harnessed.

'Perfect' skill in fostering safety and comfort. This characteristic emphasizes the importance of nurses' close and continuous observation and assessment of patients, their prudent judgement and technical skill. Meticulous attention is given to all details of patients' care, whether they relate to personal care or the performance of complex techniques. Patient needs are responded to as quickly as possible. But also, attention to needs of individual patients must be prioritized according to the urgency of the needs relative to the circumstances of the practice situation. Reverence for the care of the body and recognition of the emotions' influence upon it are essential. For the critically ill, constant vigilance and technical skill are paramount. Particular attentiveness is also given to patients who appear to be approaching death to ensure that they receive every possible comfort and consolation.

Nursing interventions. Emphasis is placed on the development and revision of nursing interventions to relieve patients' symptoms and promote comfort and healing. Nursing interventions are specific healing procedures developed logically from ideas about nursing care or from observations in practice. For example, in the early years of careful nursing, nurses proposed that continuous attentiveness to critically ill patients was essential for any hope of recovery. So, the practice of 'night watching' was instituted for selected patients, a new idea at the time. During her experiences nursing cholera patients during the 1832 epidemic Bridgeman developed a specialized method of stuping (applying moist

heat) in an effort to relieve the severe muscle cramps associated with the disease.

Health education. At the time careful nursing was first developed, lack of education was one of the most serious obstacles to preventing the spread of disease and to enabling people to foster their own health. Thus, health-related education of individuals, families and groups goes hand-in-hand with careful nursing. It may be informal or formal, specific or general. As individuals are usually cared for within a family context, family members are usually included in the education provided. Education may focus on specific disease or injury-related needs, such as dietary recommendations or wound care. It may focus on reconsideration of patterns of daily living that are not leading to healthy growth and development, relative contentedness, a sense of personal dignity and meaningful purpose in life. It may also focus on particular group or community health needs.

Participatory-authoritative management. Nurses' approach to the management of nursing care is both authoritative and participatory. By virtue of their knowledge, commitment and experience, professional nurses have authority in, and responsibility for, nursing practice. Nursing assistants are informed, gently but firmly, what they must do. They are expected to complete their work with the same gentle attitude and attention to detail that the nurses expect of themselves. Discernment is required to determine when a professional nurse should carry out a procedure or when it can be delegated to a nursing assistant. This is particularly important when solutions to patients' problems require going beyond the bounds of normal practice. To every extent possible tasks are delegated according to the needs of individual patients rather than according to the nature of the tasks. Any initial hostility to this authoritative approach is soon dissipated by the nurses' participation in the work with the nursing assistants and modelling of attitudes and skills. Any changes needed in the assistants are brought about gently, as if imperceptibly.

Trustworthy collaboration. As incongruous as it may seem, this characteristic is an interpretation of what was once commonly referred to as obedience. In the 19th century the term obedience had a broad use; for example, it was common for physicians and army officers to sign themselves in writing as 'your obedient servant'. Similarly, it appears that the most skilled and responsible nurses were praised for their obedience, not infrequently to 'doctors orders'. But, these nurses were certainly not subservient. On the contrary, they were self-assured, took the initiative and were quick to question

anything they thought to be not in patients' best interests. As well as being gentle and gracious, they could be very determined, and would not rest until they found a way of getting what they thought was necessary for patients. In fact, the most 'obedient' nurse was likely to be encouraged to take full responsibility for the direction of patient care and to act as if the hospital was her own.

The components of this characteristic appear to be an immediate response to requests for assistance; intelligence, initiative and energy in solving problems and addressing issues; patience; and a courteous and respectful manner of working with others. Questioning of methods or situations is carried out with 'exquisite tact' and consideration for others. Determination is accompanied by prudent judgement and an eye to the enhancement of human relations. Nurses who work with other health professionals in this manner induce trust, respect and confidence in their professional skills. Such mutual respectfulness constitutes trustworthy collaboration in the interests of the best possible patient care.

Power derived from service. Power in nursing can be derived mainly from service rather than from having a dominant position in an organization or community. For example, the practitioners of careful nursing at the Crimean war had no claim to positional power in the British military-political-social system. At least three factors weighed against them; they were women, Catholic and Irish. Yet, without appearing to, they gained considerable power. As the war progressed they were turned to increasingly to solve almost any human crisis that arose. They quickly gained a reputation for responding immediately, calmly and effectively. The source of their power was the excellent service they provided through careful nursing.

Nurses' care for themselves. It is fundamentally important that nurses care for themselves, spiritually, physically, emotionally, and socially, because their care of others engages the full scope of their own humanness, strength and technical skill. Their diet should be the best available, they should take regular periods of rest, relaxation and exercise, and participate in social and recreational activities and hobbies. A quick wit and sense of humour also fortifies their health. Nurses' self-care supports and augments their therapeutic capacity. Possibly the most important aspect of the nurses' self-care is to set aside a time each day for meditation or prayer. Nurses' experiences during the difficult times of the 19th century suggest that this practice nurtured their disinterested love and sense of calmness, and sharpened their alertness to patients' needs. Their attention to their own care appeared to play a significant role in

keeping alive within them the spirit of their work and preserving their overall health.

Discussion

The development of careful nursing in Ireland at the beginning of the 19th century is an example of the re-emergence of nursing in Western Europe following a period of dissolution associated with the Reformation. In their widely regarded history of nursing, Dock and Nutting (1907) observed that the Sisters of Mercy 'early attained brilliant prestige in nursing' and that they 'must have had hospital training at an early date, for they had skilled nurses when the Crimean war broke out' (p. 86). In fact, McAuley and her associates established home and hospital visiting nurse services in Dublin thirty years before Nightingale wrote *Notes on Nursing*. Although social and political influences, as well as prevailing sentiments, have obscured these events, they are well documented. Much research is needed to present a more balanced view of the development of modern nursing.

The results presented in this study are considered preliminary. It is recognized that the original system of careful nursing requires further examination and that verification of the data and proposed model is needed. The results are, unavoidably, influenced by the researcher whose life is deeply influenced by the spiritual values held by the 19th century nurses, and whose higher education was undertaken at schools of nursing which value theory development. Notwithstanding these factors, the results provide the opportunity to consider whether, with further development, the careful nursing model could serve as a useful guide to enhancing contemporary nursing practice and theory development.

At first glance the careful nursing model may appear to offer nothing really new because its assumptions and concepts are similar to those held generally by the nursing profession. It could be viewed as just another 'back to basics' approach emphasizing traditional nursing values and seemingly simple aspects of nursing practice. It could also be viewed as narrow because it is only potentially useful to nurses who believe in the existence of a personal Supreme Loving Being. On the other hand, a more searching examination of the model illuminates possibly important aspects of nursing. Also, it is widely accepted that conceptual models of nursing present distinctive perspectives of human persons and the nature of nursing, and no single model is likely suit all nurses.

The fact that the spiritual dimension of life infuses the model raises the question of how spiritual is defined. Spiritual refers to the transcendent reality of the Supreme Being. The

model's Christian origin suggests that the spiritual aspect of the person encompasses the mind and body and is the means by which the person communicates intimately with God (Aquinas 1272/1975). Aquinas' theory of unicity, built upon the thinking of Aristotle (Ross 1915), posits that the spiritual and physical aspects of the person form a unitary whole and that as a unitary being the person leads a twofold life, an outward life of the world, body and senses and, simultaneously, an inward life of the mind, spirit and communion with God. This definition is extended to be as inclusive as possible by using the term Supreme Being rather than the term God. It is proposed that this may allow for the model's use by nurses of different religious backgrounds and also by those who, although not guided by any particular religion, believe in the existence of a personal Supreme Loving Being.

Use of the model does not necessarily include nurses addressing spiritual issues with patients, unless patients desire to do this. Some patients may not wish to share the spiritual dimensions of their lives and some may not recognize the spiritual at all, and nurses must respect this. But use of the model does include nurses being attentive to the spiritual dimension of their own lives and accepting the assumptions and concepts of the model.

The model speaks directly and with emphasis to nursing practice through the ten interrelated key practice concepts. When these concepts are examined together, relationships and groupings among them become evident. As illustrated in Figure 1, they appear to compose themselves under four headings; nurses' therapeutic capacity, the therapeutic milieu within which practice takes place, clinical competence and expertise, and management of practice and influence on health systems. The historical documents explicitly emphasize the importance of clinical competence and expertise, and management of practice and relationships between them. This is where the action is, so to speak. But at the same time, the action is mediated by the therapeutic milieu within which it occurs. The nurses are the agents of the therapeutic milieu. Their capacity to enhance the therapeutic milieu, that is, their therapeutic capacity, is greatly influenced by the care they take of themselves. Thus, the care nurses take of themselves emerges as an important aspect of the model. The model suggests that it is as fundamental to nursing education and practice as are basic and advanced clinical skills and techniques.

In Figure 1 an attempt is made to illustrate the influence of the spiritual in the model by depicting the spiritual aspects – the inward life – in light type to indicate that they are not so easily discerned from the perspective of the outward life. The physical, emotional and social elements – the outward life – are illustrated in dark type because they are directly perceived. Nurses' care for themselves is in partly light type

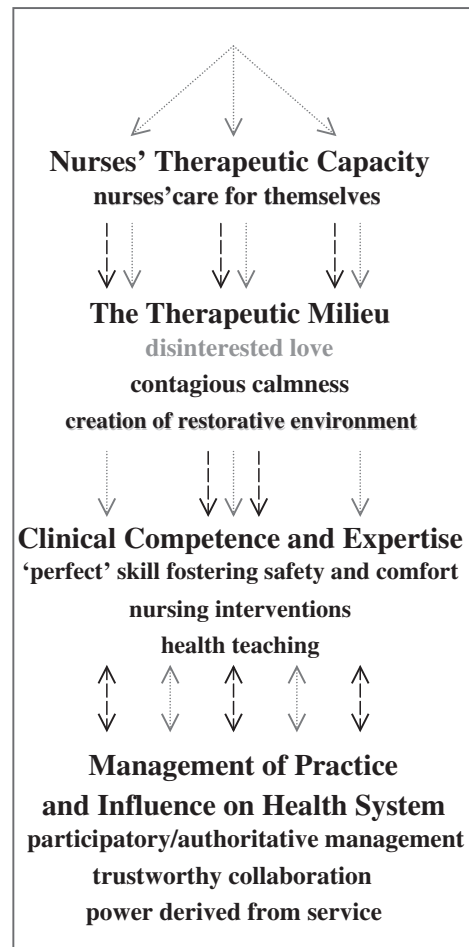


Figure 1 Grouping of key practice concepts and relationships among them (···inward life; – – outward life).

and partly dark to indicate care for both their outward lives of world, body and senses and their inward lives of mind, spirit and communion with the Supreme Being. Nurses' resulting therapeutic capacity influences the therapeutic milieu they create. Here the two concepts of disinterested love and contagious calmness are in light type to indicate their close relationship to the spiritual. Creation of a restorative environment is partly light type and partly dark to indicate that it is spiritual in as much as it is related to love and calmness, but is also very much concerned with the outward life. Nurses' therapeutic capacity and the therapeutic milieu they create influence their clinical competence and expertise, and management of practice and influence on health systems. These concepts and relationships among them are illustrated in dark type to indicate that they are primarily concerned with the outward life.

Disinterested love and contagious calmness are two important spiritual aspects of nursing illuminated by the model. Disinterested love predisposes nurses to act in certain

What is already known about this topic

- 'Careful Nursing' was a system of nursing practice and management used to good effect by two groups of Irish nurses during the Crimean War.
- Documentary sources indicate that Florence Nightingale was influenced significantly by the Irish nurses and their Careful Nursing system.
- Careful Nursing has been described as Ireland's legacy to nursing.

What this paper adds

- Identifies the principles and concepts of the Careful Nursing System.
- Presents the Careful Nursing system as a contemporary conceptual model of nursing.
- Proposes that further elaboration, critical examination and testing of the careful nursing model are merited.

ways and illuminates for them the uniqueness and innate dignity of every human person. This complex concept needs further clarification, especially the idea that it is not associated with the emotions, which are personal, but rather with the heart, a term associated with the unity of the person, and the will, a force associated with the mind and spirit of the person. It could be further examined in relation to Aquinas' (1272/1975) treatise on charity, in its original meaning of *agapē*. It could also be compared with nurses' experiences of love in nursing (Fitzgerald & van Hooft 2000), other similar forms of love such as moderated love (Campbell 1984), and with the concept of caring (Watson 1999). The term contagious calmness, first used by Proudfoot (1983), is used here to describe an inner attitude of calmness in the nurses which appears to be associated with disinterested love and to have a calming, therapeutic influence on patients.

The spiritual dimension of the model is an area for further investigation and could have important implications for nursing practice. Although some other models of nursing emphasize the spiritual, others do not (Martsolf & Mickley 1998) and none appear to encompass the depth given in the careful nursing model. Detailed elaboration of the spiritual is needed so that it can be compared with other views (Carson 1989, Bradshaw 1994, O'Brien 1999, Goddard 2000, Tanyi 2002), and contribute to the current debate on the spiritual in nursing (Draper & McSherry 2002, Swinton & Narayanasamy 2002).

Other possibly illuminating aspects of the model are participatory-authoritative management, trustworthy colla-

laboration and power derived from service. Combinations of authoritative and participatory management styles warrant further examination. Detailed examination of trustworthy collaboration could contribute to a greater understanding of the dynamics of successful nurse-doctor collaboration, and the model could stimulate renewed interest in the acquisition and use of power associated with nursing expertise.

The model supports higher education for professional nurses and the claim that nursing is both a science and an art. Its first practitioners were recognized as ladies of intellect and refinement (Doyle 1897, Neumann 1969). Comments made by and about them suggest that many were well educated in the classics, history, geography, literature and languages as well as the scientific developments of their time. It seems clear that their level of education was closely linked to their skills in reasoning and problem-solving, initiative in patient care, understanding of human emotions and interactions, and management of hospital and community services. Their refinement of manner and action was reflected in the art with which they practised, no matter what the practice setting or patient circumstances.

To evaluate fully whether the careful nursing conceptual model could be useful to contemporary nursing, further research is needed. Definitions of central concepts and nursing practice concepts require further elaboration and critical examination. A comprehensive theoretical formulation of the model should be developed and its implications specified for nursing assessment, diagnosis, intervention, expected outcomes and evaluation, as well as nursing management, education and research. Careful nursing could then be compared and contrasted with established conceptual models of nursing. In the meantime, it is hoped that this initial analysis, together with Doona's (2000) research findings, might strike chords in the profession's historical consciousness and show that historical research has the potential to contribute significantly to knowledge of contemporary nursing.

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