Learning Disabilities Nursing: a model for wellness diagnoses*

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The idea that nursing diagnoses confirm the relevance of the medical model of nursing has been proposed by many authors, who argue that it is solely another approach to the categorisation and reductionism said to be inherent in that model (Stolte 1996, Reed and Watson 1994, Holden 1990, Gleit and Tatro 1981). This has been refuted by Gordon (1994) who has alluded to the need for nursing to reaffirm its ownership of activities such as 'diagnosis' and 'intervention'.

Whereas the clarification which nursing diagnoses have offered to problem identification is indeed welcome (Gordon 1994), it must be acknowledged that their relevance is based on the premise that there is a problem which requires intervention, such that the outcome will represent a development perceived by the patient and nurse to be positive. This has, however, been potentially alienating for nursing subgroups that do not have their grounding in problem-focused care. Learning disabilities nursing is one such subgroup. Apart from the fact that it is decidedly different from the more traditional clinical nursing groups in that it is neither illness-focused nor hospital-based, it is firmly grounded in qualitative rather than quantitative aspects. In addition, its relevance from a health-care perspective is recognised in only a handful of countries.

In this paper the historical basis for the adoption of a nursing diagnostic approach is recounted. This, in association with a discussion of the development of nursing within Irish learning disability services, is then examined within the context of Sheerin and Sines' (1999) 'developmental potentials' approach to personhood. The implications of such an approach are presented, and the potential for addressing the concept of 'wellness diagnosis' across all areas of nursing is discussed.

Keywords: learning disabilities; nursing diagnosis; intervention; development
Introduction

This paper represents a theoretical reflection on the diagnosis-intervention-outcome approach, in relation to its applicability within the field of learning disabilities nursing. It examines the essentially needs-driven basis of the classification systems that are currently in receipt of increasing attention, world-wide, and assesses the potential for addressing nursing phenomena in relation to people with learning disabilities, using such needs-driven approaches. It suggests that such approaches are conceptually at odds with the paradigm that is current within that discipline, for, similarly to some other areas of nursing, for example, community nursing, the phenomena of interest may not be pathological in origin. Rather than destructively criticise these systems, however, this paper supports the movement for some form of taxonomic approach, and, in the light of the perceived inappropriateness regarding the current systems, suggests the need for further refinement of the basic concepts, such that it might address wellness diagnoses without producing conceptual disharmony.

The Medical Model and Nursing Diagnosis

That nursing and medicine have been inextricably linked throughout their histories is testified to in the many treatises on the origins of these two professions. Indeed, it appears that many current aspects of the medical role originally fell within the realm of nursing, and that there has been a crossing over of roles during the past two hundred years that has seen medicine become professionalised and regularised at the expense of nursing (Ehrenreich and English 1973, Webster 1993). This development challenged a situation in which both nursing and medicine were provided by lay practitioners. Dolan et al (1983) alternatively suggest however, that from the earliest times, the role of the ‘nurse’ and that of the ‘physician’, whilst complementary, were also quite different. The nurse was an intuitive, and almost invariably, female
practitioner who was oriented towards the maintenance and/or reestablishment of
wellness, whereas the physician was usually a man, with disease-oriented skills,
whose focus was on illness itself (Dolan et al 1983). The regularisation of medicine,
with its employment of impressive ‘curative’ techniques (Sheerin 1999), created an
ever-growing chasm between the trained physicians and the untrained, lay nurses.

It was against this background of gender-based inequality and the growing imagery,
within society, of the physician as the curer, that professional nursing began to
develop, with the nurse becoming the subservient health care professional, offering
what Ehrenreich and English (1973) describe as “the wifely virtue of absolute
obedience” (p.54). This relationship developed further, with the onset of scientific
medicine, to a point whereby the nurse became the ‘eyes and ears’ of the physician,
being seen to be the person who could monitor the progress of the doctor’s cures
(Chung and Nolan 1994). It is important to note that this placed the developing role of
the nurse within the context of an illness-oriented approach to health care. Thus,
professionalisation of nursing carried with it a forfeiture of the essential aspects of
intuitive, wellness-oriented care, which had characterised it throughout history, with
the implication that cure was more important than care.

There has, throughout the past few decades, been a concerted effort made to regain
what was lost, and to explicate what the essence of nursing is, thus identifying the
unique contribution that it offers to health, its promotion and maintenance. This has
been evidenced, largely within acute general nursing, by the development of
conceptual and theoretical frameworks, centred on the idea that the person is an
holistic, integrated being, with individually determined needs (Gordon 1994, Roper et
frameworks represented a growing consensus that the medical model was at variance
with the values and beliefs that were seen to be inherent in nursing care. They also served to identify the major areas of interest to the nursing profession, through their contribution to the four-part metaparadigm (Fawcett 1995). This provided a basis for the testing of hypotheses, and for the development of an embryonic knowledge base in which to ground nursing approaches (Meleis 1997). In as much as the application of these frameworks was centred on a scientific, problem-solving approach to health and illness, the scientific approach to nursing further flourished. Furthermore, nursing research was producing empirical data to challenge or confirm the veracity of traditional nursing interventions. It is this writer’s contention that these developments served, not to promote the unique contribution of nursing, but rather, to confirm the relationship between nursing and medicine, which had seen the former shed its qualitative nature in favour of a subservient role, within an illness-oriented approach to care (Chung and Nolan 1994).

**Development of nursing within a medical model**

The consequence of this relationship was that modern nursing developed within the context of a model, which emphasised diagnosis, treatment and cure (Reed and Watson 1994, Holden 1990). Health care was thus viewed from an illness, or problem focused perspective, and was addressed using the scientific deductive methodology inherent in the nursing process (Gordon 1994). The similarities between this problem-solving approach to nursing care (Gordon 1994, Hunt and Marks-Maran 1986) and that which is found within the illness-oriented medical model (Hope et al 1989) are evident from table 1.
<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Nursing Process</th>
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<tbody>
<tr>
<td>Assessment of Illness</td>
<td>Assessment of Therapeutic Problems</td>
</tr>
<tr>
<td>Planning of intervention</td>
<td>Planning</td>
</tr>
<tr>
<td>Treatment</td>
<td>Intervention</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Evaluation</td>
</tr>
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</table>

Table 1 Two approaches to addressing health care

This scientific approach, which became popular in the mid-twentieth century, was an attempt to formalise the cognitive process of problem solving, and by doing so, to improve the professional profile of nursing within the nurse-doctor relationship. However, as is reflected within the literature, the written evidence of this cognitive process – the care plan – was frequently not properly completed and, thus called into question the appropriateness of such an approach to nursing care (Davis et al 1994, Fonteyn and Cooper 1994, McCrae 1993, Howse and Bailey 1992, Gwozdz and Del Togno-Armanasco 1992, Brider 1991, de la Cuesta 1983, Henderson 1982.).

Henderson (1982) suggests that a major shortcoming of the process of nursing was that, as a rational approach, it did not take account of the often irrational, intuitive aspects of nursing care, and so, created a dissonance between clinical nurses’ conscious and unconscious perceptions of what they did.

This determination to demonstrate the cognitive process that underpinned the application of nursing was further expressed by Bonney and Rothberg (1983), who used nursing diagnosis, in the 1950s as a client-evaluation tool. Subsequent decades have seen the concept of nursing diagnosis continue its development within the context of an attempt to classify those phenomena that are diagnosed and treated by
nurses. This is indeed a laudable endeavour, and one that will, undoubtedly, produce a universal understanding amongst nurses to surpass other linguistic barriers.

**Learning Disabilities Nursing**

The discipline of learning disabilities nursing has been a reality, in Ireland, since the early 1960s, when An Bord Altranais (the Irish Nursing Board) opened its Mental Handicap Nursing Register. It is interesting to consider, briefly, the reason why learning disability became a focus of nursing in Ireland, whereas it was addressed from differing perspectives in very many other countries.

The experience of people with learning disabilities in Ireland, throughout history, mirrors that of such people in many parts of the world. Whilst they had, by-and-large, existed unnoticed throughout the Middle Ages, when the emphasis was on manual, rather than educational ability, the onset of the Industrial and Scientific Revolutions, brought a growing identification of those people, in society, who could not learn (Brandon 1957) and so, could not partake in the developments that were taking place within western states. This served to highlight the existence of learning disabled people, in industrialised society, thus demonstrating their difference and disability. As a consequence of their apparent ineducability, and so, lack of potential with regard to productivity, learning disabled people formed an increasingly large portion of the underclass, and so, gravitated towards the poor law institutions (Rafter 1992). This further singled out the learning disabled as a problematic group.

The nineteenth century was also marked by developments in scientific knowledge, which were to compound the problems of the learning disabled. These specifically related to advances in the understanding of genetics and evolution, and to their impact upon societal thought. The new theories proposed by Mendel and Darwin,
respectively, challenged the long-held social beliefs that had been supplied by philosophers and theologians (Worsley 1992), and as these theories became more widely accepted, assumptions began to be made regarding those who were seen to be unfit or deviant in society. The newly-formed Eugenics movement held that the children of learning disabled parents would always be themselves disabled, due to the belief that “feeblemindedness… behaves as a Mendelian recessive” (Downing 1931 quoted in Brandon 1957, p.711). Allied to this was the negative eugenic stance that the ‘unfit’ should be prevented from reproducing, for it was considered that allowing persons with learning disability (the unfit) to procreate, would lead to a preponderance of learning disabled persons in society, and would ultimately threaten social security (Rafter 1992).

**Institutionalisation**

As a consequence of these beliefs and in order to prevent the perceived threat to society, the Eugenicists focused their attention on a specific group: poor, learning disabled women of childbearing age. Indeed, Rafter (1992) argues that the Eugenics movement in the United States, under the leadership of Josephine Lowell, actually criminalised the fact of being female and learning disabled, this being confirmed in the stated view of the Newark Custodial Asylum that the uncontrolled female body was “immoral, diseased, irrational, mindless” (Rafter 1992, p.25). Segregation was chosen in the form of prophylactic institutionalisation. This not only removed the learning disabled women from society, but also denied them the possibility of having a reproductive future. Sexual controls were subsequently imposed on learning disabled men (Rafter 1992). Whereas it is often stated that Eugenics did not have an effect on Irish services, one only has to consider the fact that Dublin was the second city of the British Empire, at that time, and that many major scientific discoveries
were made there. It is inconceivable to suggest that the negative consequences of the scientific movement did not also affect societal thought within Ireland. This is supported by the history of the older, segregated, residential services that were set up in the late 19th Century.

This all served to uphold and indeed further the stigmatism and prejudice that had existed towards those people with learning disability, but, whereas previous confinement movements had removed them to institutions, on the basis of custodialism, this new institutionalisation was to provide the grounding for the growth of a medical paradigm of care, centering on these people as disabled, abnormal and unfit.

The regularisation of medicine during the 18th and 19th centuries into a male dominated medical profession was also to have profound implications for people with learning disabilities. As social acceptance of science grew, so also did the profile of the physician (Ehrenreich & English 1973), and, with the enactment of the UK Lunatics Act of 1845, there was provided a context for the application of scientific methodologies to such people. This act provided for the confinement of learning disabled and mentally ill people in large institutions, for the purpose of medical intervention (Chung & Nolan 1994). The Eugenic identification of these people as being unfit and abnormal also placed them within the focus of the medical profession, and as the Poor Law workhouses began to be increasingly populated by people with mental disorders and disabilities, these too eventually were placed under the governance of physicians (Finnane 1981). Armed with the belief that science could predict and control, they set about applying their heroic treatments.
As nursing developed further, it was still heavily influenced by medicine, with many of the initial training courses having been devised wholly, or in part, by the medical profession. Within the field of learning disability, this dependence upon a positivistic medical model of disability, based on an identification of the person as being 'abnormal' and 'different', was, similarly, the context within which early nursing developed there. This was to remain the character of the nursing approach to caring for persons with learning disability right up to, and after the commencement of specialised nurse training in the late 1950s.

**Learning Disabilities - A New Paradigm**

Whereas it must be conceded that the medical model of nursing has served society well in the battle against illness and disease, it is increasingly considered to be inadequate and inappropriate within learning disability nursing, for, as these nurses start to explore their realm of responsibility, they are beginning to identify the importance and value of qualitative, holistic approaches to care that have been inherent in nursing for many years (Sheerin 1999). This is especially true where nurses see other professional groupings addressing issues of learning disability from alternative perspectives, and other countries addressing services from vastly different paradigms (Sines 1995, Mercer 1992).

**A New Model of Nursing**

As learning disability nurses move away from the institutional, and towards community-based environs, there appears to be a concurrent movement towards this alternative paradigm, with calls for a new approach to addressing learning disability issues, from a qualitative perspective, whilst remaining within the context of nursing (Turnbull 1997, Barr 1996, Sines 1995, Mercer 1992). It is unfortunate however that,
with the exception of Green (1988), few serious attempts have been made to conceptualise and share the beliefs inherent in this alternative paradigm. In the absence of such conceptualisations, the medical model may continue to be prevalent.

A handful of authors have attempted to explore the application of nursing models, developed in other nursing disciplines, to the care of people with learning disabilities. A search of the Cumulative Index of Nursing and Allied Health Literature and English Nursing Board databases, however, yielded only two such papers. Duff (1997) suggests that the lack of research-based evidence indicates the application of such models in learning disabilities nursing to be inappropriate.

It is this writer's contention that, in keeping with international and cross-disciplinary trends, this paradigm shift within learning disabilities nursing, away from the problem-orientation of the medical model of nursing towards a developmental model that is focused instead on wellness and on the abilities of the person, is essential. Whilst such a move may not sound radical to non-nurses, or to nurses working in countries where learning disability is not a focus of nursing, it does have major implications for this discipline of nursing, as it demands modification of some of the most dearly held tenets in nursing, including the problem solving approach to care planning.

The identification of the person - whether client or patient - as a human being who has innate, individual potentials for development also challenges the process by which we label and categorise people, for we are all human beings with potentials for development. With this focus, disability has the potential to move from being the central focus of interest, regarding the learning disabled person, to becoming a secondary issue, in favour of ability. A danger for learning disabilities nursing is, however, that such a shift may further distance it from mainstream nursing, perhaps to
an extent such that it will be alienated altogether and may be forced to separate from that mainstream.

One attempt to provide a conceptual basis for nursing within the discipline of learning disabilities has been devised by the writer, in collaboration with Professor David Sines of the University of Ulster (Sheerin and Sines 1999). This conceptual approach to personhood, seeks to create a theoretical basis for addressing the application of the alternative paradigm (fig.1), whilst maintaining, and indeed, affirming the place of learning disabilities nursing within the wider nursing profession. The concepts underpinning the model of personhood are based on a belief that all humans have individually determined potentials for development. These ‘developmental potentials’ refer to levels of development, that individuals have the innate capacity to attain, the magnitude of which may vary according to internal and external factors (the environment). The potentials for development may be physical, social, and/or psychological, thus correlating closely to Engel’s bio-psycho-social model of the person (Engel 1977), which describes a multi-causational approach, assuming there to be biological, psychological and social aspects of person-hood (Holden 1990).

The beliefs and values inherent in this model can be synopsised in relation to Fawcett’s (1995) four key concepts of nursing (table 2).

It can be seen from this table that this client-centred approach focuses, from the initial assessment, on neither the needs of the person, nor on the problems, nor on the illness or disability. It focuses, rather, on the abilities of the individual, through the assessment of his/her potentials for development, within various defined areas. This, then becomes the context for identifying the issues that are preventing the individual from achieving attainment of those potentials for development. Within the triadic
approach (fig. 2i), this is the stage of nursing diagnosis. These issues, which may be intrinsic or extrinsic in origin, relate purely to interfering factors, and not innate needs.

Figure 1: A conceptual representation of the developmental potential model of personhood (Sheerin and Sines 1999).

<table>
<thead>
<tr>
<th>PERSON</th>
<th>An integrated human being with individually determined potentials for development.</th>
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<tr>
<td>HEALTH</td>
<td>Movement towards the attainment of one’s developmental potentials.</td>
</tr>
<tr>
<td>NURSING</td>
<td>A profession that assists the person in the attainment of his/her developmental potentials.</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>Internal and external aspects that may encourage or impinge upon the ability of the person to attain his/her developmental potentials.</td>
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Table 2. The Developmental Potential Model of Personhood
or problems. As such, therefore, the terms 'diagnosis', and 'nursing phenomena' (ICN 1996) may be inappropriate, as they are defined within the context of "problems" (Leih and Salentijn 1994 p.314) and "human needs" (ICN 1996 p.13), respectively. Whereas Gordon (1994) states the need for nursing to reclaim the fact that they use the cognitive process of diagnosis, the fact that learning disability nurses are increasingly identifying themselves as being essentially different from other nurses, strongly suggests a need to move away from terminology that may be construed to be biomedical in nature. Accordingly, a new term 'interventional foci' is suggested, for it solely describes the process of identifying the issues that are to be the focus of the nursing intervention. It will now be obvious that the triadic approach of diagnosis, intervention and outcome does not adequately address the approach to decision making in learning disabilities nursing, within such a paradigm. Rather, a four-part approach is demanded here, with an assessment of potentials being the first step (fig. 2 (ii)).

Figure 2: Two alternative approaches to the 'diagnostic' process.
It is suggested that this approach may represent a novel structure for addressing the concept of wellness diagnosis, as all people can be seen to be striving towards the attainment of their potentials for development. This is also applicable to familial and societal development, and to the identification of issues which become the focus of nursing interventions in relation to health promotion and education. Indeed, it may be considered as an overriding approach to addressing all nursing diagnoses, as pathology may be seen to be merely an interventional focus that prevents an individual from attaining his/her potential(s) for development at a given time.

**Conclusion**

In conclusion, it is the assertion of this writer that the alternative paradigmatic approach, that is inherent within the discipline of learning disabilities nursing, provides an invaluable, and novel context for the examination of wellness diagnoses. It supports the amendment of the three-element approach to classifying nursing practice, in favour of introduction of a fourth part assessing the individual's potential for development, the context within which the issues of interest to nursing intervention may be addressed. It further calls for the introduction of the term 'interventional foci' to describe the issues that impinge on the person's ability to attain his/her potentials for development, and which, consequently, become the focus of nursing intervention.
References


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