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Interview Lynda Juall Carpenito-Moyet

"We can not define Nursing without defining nursing diagnoses as a science."

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University lecturer Lynda Carpenito gave Enfermería Global an interview while she was in Murcia on a recent visit to participate in the VII Spanish Nursing Diagnoses, Taxonomy and Nomenclature Association Congress, which was held at the Universidad Católica San Antonio in Murcia.

Enfermería Global (EG): These lectures focus your attention on the opportunity to incorporate 'surveillance diagnosis' or 'collaborative clinical problems' as nursing diagnosis options. NANDA is considering changing the definition of nursing diagnoses in order to include collaborative clinical problems or 'surveillance problems' in the taxonomy. What do you think about this? What are the implications of the new NANDA-I nursing diagnoses proposal?

Linda Carpenito (LC): The proposed definition of NANDA is an attempt to try and include in the NANDA taxonomy a type of nursing focus or nursing problem that to-date has not been a nursing diagnosis.

My work specifically identified that it is a collaborative problem, twenty-something years ago, maybe in '86. I took the position that all diagnoses, that nurses make and treat and have responsibility or accountability for, are not nursing diagnoses; that there is another group called *collaborative problems*. Up until now I have labelled them as potential complications, potential complications cardiovascular and/or potential complications respiratory.

About two years ago, an article was published in NANDA about a new, different type of nursing diagnosis called surveillance. This was proposed as a type of problem that nurses had to monitor and then respond to changes in the patient's conditions. Similar to what I call collaborative problems but not the same. NANDA, in its proposal for a change in the nursing diagnosis definition, have added monitoring and surveillance to the definition in hope to perhaps take what I've called collaborative problems - what someone else may call surveillance diagnoses - and put them under the NANDA classification system.

I am opposed to naming medical diagnoses in new terminology and then calling it a nursing diagnosis. To me, it certainly doesn't add clarity because we are now changing the name of something called cirrhosis of the liver or myocardial infarction, it doesn't change the fact that it is still not a nursing diagnosis.

The dilemma that we have had for over thirty years is that all nurses will agree that they themselves have responsibilities and accountabilities to pneumonia, to diabetes mellitus, to bleeding, to haemorrhage, to cardiac problems – we all agree on that. The question is: how do we incorporate that part of our practice into nursing diagnosis? And even/or should we?

Lynda Carpenito

My recommendation has always been, in my work, to look at NANDA nursing diagnoses in a different light to collaborative problems. NANDA doesn't need to develop them more, they are already well established in the literature, they come from medicine and they have nursing and medical responsibilities. NANDA should continue developing and refining nursing diagnoses that are not on the list, and those on the list that need to be researched and refined.

Even then, there still lies the question that this group is predominantly not on the NANDA list and it is critical for nurses in curing patients. The question is; should we call them a nursing diagnosis or should we call them something else, for example as I do, collaborative problems?

We met in Miami, in November of 2008, and there was again a proposal for a change in the definition - the one that you mentioned, but it was not very well supported. I presented a recommendation paper at that conference and one recommendation I made was perhaps we

can call these collaborative problems "*risk for complications of*", which would be different to a risk nursing diagnosis. If we did that, we could then redefine that particular type as a collaborative nursing diagnosis. We don't even have to call them that because that particular diagnosis needs medical and nursing interventions for successful outcomes. The reason I recommended that is because there is still a group of people who believe that the most important focus for nursing is nursing diagnosis. I don't agree, I think the most important focus for nursing is either nursing diagnosis or the collaborative problem, depending on what's wrong with the patient. But if we were going to continue to be stuck at this junction, so to speak, because somebody wants this to be called the nursing diagnosis, then I'd say fine, call it this but define it differently.

My recommendation that I've always made in my work is not to call these nursing diagnoses, but to call the whole list "conditions that necessitate nursing care". Some of them are nursing diagnoses and others are collaborative problems. There is no need to spend nursing energy researching what collaborative problems look like because we already know that! Spend our energy doing what we should be doing and that's refining nursing diagnoses. Just this year, in November, we approved a new nursing diagnosis called *dysfunctional gastrointestinal motility*. What is that? I have no idea.

E.G.: Although the use of nursing diagnoses in care practice and their presence in nursing study plans is evident, it is also evident that they are not used in the same way everywhere – neither within the same country nor between countries. How do you think this problem could be solved and how important do you think it really is?

L.C.: Well, first of all, most nurses around the world do not know that eighty per cent of nurses in the United States only go to school for two years. Eighty per cent!

Forty per cent of them go back to school for two more years but their education is not a professional one, not for two years. So, we are talking about technicians: technical nurses who were initially created to assist professional nurses. That never happened. Hospitals made no differentiation between a baccalaureate four-year graduate and a two-year graduate associate degree.

They started making the differentiation for management positions to be an educator in the hospital, but for the nurse working on the unit there were no more expectations for a four-year graduate than a two-year.

And the reason I say that to you is because it's pretty impossible to imagine that a two-year graduate would embrace something like nursing diagnosis, or its concept. Most students graduate believing that they will never have to write another nursing diagnosis. It's only something they did for school and many of them are right.

If they work in a system that has integrated nursing diagnosis into an electronic system, nursing diagnosis becomes a little bit more visible. However, it doesn't necessarily mean that they go beyond that list that they see on the computer.

That's really the next step. The first step is you have to design an efficient system of documentation because nursing diagnosis is a documentation burden and that's what happened in the United States – it became a burden: too much writing, too much work and so it was seen then as not necessary.

In nursing schools, we require students to write a lot. Unfortunately, they're not necessarily thinking a lot, they're copying from my book or somebody else's book. That's not critical thinking. So, the faculty also have to step back and say: why are we asking students every week to write the same things over and over again?

To answer your question, if I was your teacher and I had thirty students in my class and one of my classes was going to be on the care of the patient before and after surgery, I would give them a care plan that is basic to that care and that's where they would start their care when they went to the hospital. Not to sit there that night, or the night before, copying and making it up.

There's no reason for us at this stage in our profession to ask students, or to pretend to students that they are designing and making up this care. No, instead we want them to take this paper and then assess their patient, and then the question is: do you need to change anything here for that patient and why? That's teaching critical thinking versus to copy and copy the same thing every week.

E.G.: Some computer programmes which are being used in Spanish hospitals and which include the patient's nursing record are having difficulties adapting the diagnoses correctly so that nurses can work with them. Do you think that the problem is the lack of standardisation when it comes to each group deciding what is a nursing diagnosis and what isn't or do you think there is not enough knowledge regarding the diagnoses within the nursing profession when the programmes are designed and applied?

L.C.: If nurses are asked about the development of the software that they're going to be using and about the logical connections that we want to see that make it efficient to use aren't or, in the case I've mentioned, of giving my students a care plan on a surgical patient, that should be in the computer. I should be able to just press a button and then I see a care plan for the patient after surgery. If something is not relevant, then I should deselect it.

From a student's prospective, not only should they deselect it, they should give the reason why and then that's how you start a system of student thinking - about the individual patient and not complaining about writing the same thing over and over again.

E.G.: Nursing diagnoses allow the organisation of functions and increased knowledge for research purposes. With the introduction of degree level nursing studies in Spain and other European Community countries which award postgraduate nursing certificates, nurses' ability to carry out research is recognised. Do you think it is now more important to unify criteria and train all nurses in diagnoses in the same way, in order to be able to develop and exchange knowledge through research?

L.C.: That's the intention of NANDA, to develop consistent language use. First beginning in the United States and then internationally depending on if that language, or if that concept is appropriate in that culture.

Believe it or not, in 1973 when NANDA started, the first meeting when it wasn't NANDA then, but the first meaning was totally based on the University Hospital in St Louis Missouri getting a computer and saying to the nursing department: what should we put on this? Not the diagnosis that drove focus, the interventions.

So, there's nothing to be gained in continuing to let nurses use any word they want to describe something, it would be the same chaos. Well, before AIDS was discovered or

labelled, they used *pneumonia*, they used *gay men's disease*... There were all these different words for something that we now come to know as AIDS.

Consistent language doesn't just help practitioners to talk to each other. For example, in medicine in Japan, they use the same words as physicians in Spain or the United States and because of that someone can research cirrhosis in China, in Spain and the United States.

In nursing, we haven't had that consistent terminology so if you wanted to research the concept as hopeless as a nursing diagnosis, or chronic sorrow, it didn't exist. So, when you went to the literature to try to find support for a diagnosis, a concept or even to look for some interventions, it was very hard to retrieve because the language was not consistent.

It's the same as giving students three textbooks - one in paediatrics, one in critical care and one in maternity where each author uses a different word for the same concept. It's communication chaos.

We have just been spoiled as nurses to think that being able to use any word that we want was somehow better and gave us more freedom, when in reality it gave us nothing but chaos. It kept us where we were.

We can't define nursing without nursing diagnosis as a science because what would you say: nurses do this and do this and do this... That's not a science, that's not a profession.

Professionals let their knowledge drive their actions and labelling that consistently will then help us research what are the best interventions to achieve this outcome, what are the best clinical signs and symptoms for this diagnosis. We can only do that with research; we can only do the research if we use the same terms.

So because nursing diagnosis is, was and continues to be a documentation nightmare, for students and for practicing nurses, we sometimes lose sight of the actual bigger picture of how to develop the science.

Concepts that we have today, we didn't have 20 years ago. Powerlessness was unknown in the literature in 1982. There were two articles on powerlessness and neither of them was nursing. Ten years later, it was three hundred. So naming something does give it power.

E.G.: How do you view nursing in Spain and how would you rank Spain in terms of training and professionalism**?**

L.C.: I would have no hesitation in telling you that the use of nursing diagnoses in Spain is far superior to the use of nursing diagnoses in the United States.

In Spain, both nursing diagnoses and collaborative problems are used and I have to say that because they use the collaborative problems, nursing diagnosis was more useful to them, was clearer. Things are clearer. They didn't have to argue about where's diabetes, where's cirrhosis, where's post-op haemorrhage.

There's a scholarly dialogue about nursing diagnosis in Spain that doesn't happen enough in the United States.

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