

Thoughts About Nursing Conceptual Models and the “Medical Model”

Nursing Science Quarterly
2017, Vol. 30(1) 77–80
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DOI: 10.1177/0894318416680710
nsq.sagepub.com



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Abstract

This essay, written to celebrate the 30th anniversary of *Nursing Science Quarterly*, focuses on the distinctions between the discipline of nursing and the trade of medicine. The distinctions are drawn from content found in nursing conceptual models and from literature about the elusive content of the so-called “medical model.”

Keywords

conceptual models, medical model, nursing

It is an honor to have the opportunity to prepare this essay for publication at the beginning of a year of celebrating of the 30th anniversary of the founding of *Nursing Science Quarterly*. I thought it appropriate to begin the anniversary celebration by sharing my thoughts about distinctions between nursing and medicine.

Nursology Is a Discipline

I have begun to refer to our discipline as nursing, rather than nursing (Fawcett et al., 2015), to the end that everyone—nurses, other healthcare team members, and the lay public—begins to recognize and acknowledge nurses as members of a discipline. The central purpose of nursing is generation, testing, dissemination, and application of discipline-specific knowledge used by nurses to address the health of human beings in the context of their environments (Donaldson & Crowley, 1978), with the understanding that health encompasses a continuum from high-level wellness to severe illness and dying, across the life span.

Nursology’s Discipline-Specific Knowledge

Formal knowledge, in the form of conceptual models and theories, is distinctive—if not unique—to each discipline. A review of literature reveals many different conceptual models of nursing. Among the best known are Johnson’s behavioral system model, King’s conceptual system, Levine’s conservation model, Neuman’s systems model, Orem’s self-care framework, Rogers’ science of unitary human beings, and Roy’s adaptation model (Fawcett & DeSanto-Madeya, 2013). The goals found in the content of Johnson’s, King’s, Levine’s, Neuman’s, Orem’s, Rogers’, and Roy’s conceptual models highlight the focus of nursing—distinctive knowledge that guides research, practice,

education, and administration of nursing services within the context of each conceptual model (see Table 1).

The contents of Johnson’s, King’s, Levine’s, Neuman’s, Orem’s, Rogers’, and Roy’s conceptual models are consistent with the current National Institute of Nursing Research (NINR) themes for future targeted basic, applied, and translational nursing research—“symptom science—promoting personalized health strategies; wellness—promoting health and preventing illness; self-management—improving quality of life for individuals with chronic illness; and end-of-life and palliative care (EOL-PC)—the science of compassion” (Grady & Gough, 2015, p. 513). All of these conceptual models emphasize individual-centered nursing practice processes, including assessment, planning, intervention, and evaluation. All emphasize promotion of wellness and prevention of illness. All go beyond the NINR theme of self-management by addressing quality of life for all people—well, acutely ill, and chronically ill. All encompass compassionate care across the life span, not only at end of life.

Medicine Is a Trade

I have never been able to locate any obvious or explicit knowledge that is distinctly medical. A September 18, 2016 search of the Cumulative Index of Nursing and Allied Health (CINAHL Complete) using the search term “medical model” yielded 816 publications. An admittedly quick review of a random sample of the retrieved publications revealed that the term *medical model* was not defined but rather used in a way suggesting that any reader would know what the term means. Review of the publications also revealed that interest is on the influence of the so-called medical model in various

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Table 1. Practice Goals of Seven Conceptual Models of Nursology.

Conceptual Model	Goals
Johnson's Behavioral System Model	To restore, maintain, or attain behavioral system balance and dynamic stability at the highest possible level for the individual
King's Conceptual System	Help individuals, families, groups, and communities attain, maintain, and restore health, so that they can function in their respective roles, and to help individuals die with dignity
Levine's Conservation Model	Promotion of wholeness for all people, well or sick
Neuman's Systems Model	To facilitate optimal wellness for the client through retention, attainment, or maintenance of client system stability
Orem's Self-Care Framework	To compensate for or overcome known or emerging health-derived or health-associated limitations of legitimate patients for self-care or dependent-care
Rogers' Science of Unitary Human Beings	To promote human betterment wherever people are, on planet earth or in outer space
Roy's Adaptation Model	To promote adaptation for individuals and groups in the four adaptive modes, thus contributing to health, quality of life, and dying with dignity by assessing behavior and factors that influence adaptive abilities and by intervening to expand those abilities and to enhance environmental interactions

Constructed from Fawcett & DeSanto-Madeya (2013).

specialties, such as mental health (Beecher, 2009), or on a perspective for understanding various conditions, such as self-neglect (Lauder, 1999).

Therefore, I have begun to refer to medicine as a trade (Fawcett, 2014a, 2014b). Members of the trade of medicine—typically called physicians—apply the distinctive knowledge of the disciplines of anatomy, biochemistry, histology, pathology, and so on, with an emphasis on abnormalities. Lowenberg (1989) pointed out that inasmuch as many societies value robust well-being, the emphasis of medicine on abnormalities can lead to stigmatization or marginalization of the ill person, especially the person with a chronic illness.

According to Venes (2009):

The central purpose of medicine is elusive, even in the Hippocratic Oath, which is a moral code for medical practitioners . . . [that] precludes the use of surgery, euthanasia, or abortion by medical practitioners, requires that practitioners give professional courtesy to their instructors (and their children); recommends the use of diet as a primary therapeutic tool; and specifies that the medical practitioner always maintains the confidentiality of patient information. (p. 1080)

A definition of *medicine* is “the act of maintenance of health, and prevention and treatment of disease and illness” (Venes, 2009, p. 1424). A definition of *medical* is “Pert[aining] to medicine or the study of the art and science of caring for those who are ill: (Venes, 2009, p. 1420). However, no explicit definition of the so-called “medical model” could be located, nor could any explicit definition or description of the art and/or the science of medicine be located.

Lowenberg (1989) referred to the traditional medical model as the “allopathic medical model” (p. 78). Of interest

is that a definition of allopathy is “a term erroneously used for the regular practice of medicine to differentiate it from homeopathy” (Venes, 2009, p. 83). Thus, it is unclear whether Lowenberg's (1989) use of allopathic is the best adjective for the medical model.

However, Lowenberg's (1989) discussion of the allopathic medical model highlights at least some characteristics of what many people think about when referring to the medical model. The primary characteristic of the allopathic medical model is regarding human beings as objects made up of categorical systems. The patient-physician relationship is hierarchical, with the physician making decisions for the relatively passive patient. Human beings are said to adopt the sick role when confronted with illness or disease, which exempts them from taking any responsibility for causing the illness or disease and from engaging in usual role responsibilities (Lowenberg, 1989).

Distinctions Between Nursology and Medicine

Some of the nursology conceptual models include content that explicitly distinguishes the discipline of nursology and the trade of medicine. Other conceptual models include content that reflects implicit distinctions between nursology and medicine.

Explicit Distinctions

Johnson (1980) articulated an explicit distinction between the view of human beings held by nurses and the view held by physicians. She pointed out that nurses regard human beings as behavioral systems, whereas physicians view human beings as biological systems.

Orem (1985) also articulated an explicit distinction between the views of human beings held by nurses and by physicians. She explained that nurses focus on human beings' requirements for continuing therapeutic care. In particular, nurses' special concern is "the individual's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects" (Orem, 1985, p. 54). In contrast, physicians focus on human beings' life processes when those processes are disrupted by illness or injury.

Roy (1970) explicitly distinguished nursing from medicine by noting that medicine focuses on biological systems and the person's disease, with the physician's goal being moving "the patient along the continuum from illness to health" (p. 43). In contrast, nursing focuses on the person as a total being who responds to internal and external environmental stimuli. As can be seen in the Table 1, the Roy adaptation model goal is to promote adaptation for individuals and groups in the four adaptive modes, thus contributing to health, quality of life, and dying with dignity by assessing behavior and factors that influence adaptive abilities and by intervening to expand those abilities and to enhance environmental interactions.

Implicit Distinctions

In her articulation of her vision for the future of the discipline, King (2001) distinguished between nursing care and medical care but did not write more than:

[N]ursing will provide access to health care of all citizens. The United States health-care system will be structured using my conceptual system. Entry into the system will be via nurses' assessment so individuals are directed to the right place in the system for nursing care, medical care, social services information, health teaching, or rehabilitation. (p. 284)

Levine's (1966) concept of trophicognosis reflects an implicit distinction between knowledge needed by nurses and knowledge needed by physicians. Citing the dictionary definition of diagnosis as "knowledge of disease," Levine maintained that it is "incorrect to use the term diagnosis as a synonym for the nurse's observations, judgments, problems, needs or assessments" about people's energy, structural integrity, personal integrity, and social integrity, which was what she meant by trophicognosis (pp. 56-57). Inferring from Levine's words, the distinction is that nurses need to know about a broad spectrum of patients' health concerns, whereas physicians need to know about diseases.

Implicit Distinctions Applicable to Nursing and Medicine

Although Neuman implicitly recognized distinctions in the focus and work of nurses and physicians, she and her colleagues explained that Neuman's systems model:

is easily adapted by administrators for the management of health care services in all fields, including nursing, medicine, physical therapy, occupational therapy, respiratory therapy, and so on. Consequently, both practitioners and administrators from all health care fields can use the same frame of reference for their activities, which strengthens interdisciplinary, multidisciplinary, and transdisciplinary communication. (Shambaugh, Neuman, & Fawcett, 2011, p. 153)

Similarly, the applicability of Rogers' science of unitary human beings to the practice of medicine has been discussed by three physicians. In 1987, Barber, who is a physician, maintained that Rogers' humanistic and scholarly perspective of nursing is "a model for emulation" (p. 12). Continuing, he wrote, "the new orientation of the nursing profession is achieving in a more sophisticated manner what physicians have been striving to achieve. However, while nursing is drawing closer to this goal, physicians seem to be slowly moving in the opposite direction" (p. 15).

Ten years later, two other physicians explained the value of Rogers' science of unitary human beings for their practice of medicine. Field (1997) stated, "Rogerian science has much to teach physicians and nurses about healthcare and healing" (p. 283). Gold (1997) noted, "As a physician, practicing medicine from a unitary perspective is a way of being that ... urges me to go beyond what our present system offers in order to deliver care in a manner that acknowledges and addresses the wholeness of human beings" (p. 265).

Conclusion

Some nurses' allegiance to the nebulous medical model and rejection of nursing knowledge, especially nursing's conceptual models, is a good example of what Chinn (2014) referred to as nurseogyny. She explained that she "coined the term 'nurseogyny' to name an underlying disdain and discounting of nursing that is expressed in discussions . . . and in actions everyday that discount the value of nursing" (p. 1). I can only hope that very few if any nurses are true "nursogynists" but rather are misguided about the value of the medical model, whatever that may be, to nursing practice and research.

Noteworthy is that no letters to the editor or other commentaries about my references to the trade of medicine (Fawcett, 2014a, 2014b) have been published. Therefore, I do not know whether readers agree with me or do not want to take the time to refute my position. I invite readers to now contribute their thoughts about nursing as a discipline, medicine as a trade, and the distinctions between nursing and medicine.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the authorship and/or publication of this review.

Funding

The author received no financial support for the authorship and/or publication of this review.

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The Correct Sequence of Epithets — According to Bartholomew (1948, p. 80) the following order should be used in placing epithets after one's name. Abbreviations for licensure in an area are the first to follow immediately after the name. A semicolon follows to separate these abbreviations from those of the educational degrees. Educational degrees appear in order of their issue. Abbreviations for professional societies are always the last of the epithets and are separated from the educational degrees with a semicolon. Example: Helen Doe, RN; BSN, MSN, PhD; FAAN.

Bartholomew, C. A. (1948). *Epithetology*. Red Bank, NJ: Commercial Press.