Artigo de opinião

My Vision for Nursing

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In 1965, she earned her Nursing diploma from St. Luke's Hospital School of Nursing, then earned her RN-MSN degree from the Frances Payne Bolton School of Nursing at Case Western Reserve University in 1987. In 1997, Kolcaba earned her Ph.D. in Nursing at the same school, and received a Certificate of Authority as a Clinical Nursing Specialist.

Her education specialized in Gerontology, End of Life and Long Term Care Interventions, Comfort Studies, Instrument Development, Nursing Theory, and Nursing Research.

Dr. Kolcaba began developing her Comfort Theory in 1991. After more research and development, she published the Evolution of the Mid-Range Theory of Comfort for Outcomes Research in Nursing Outlook, 2001. This is a comprehensive guide of the evolution of the theory and the way it can be tested and adapted to various aspects of health care.

Introduction

When asked to write about “my vision for nursing,” I responded quickly and positively. “It’s my favorite topic and a vision that I have held for years.” It is articulated in the last chapter of my book published in 2003. This present format allows me to be more focused and succinct, always a good thing for a theorist!

So to start us off, I will say simply, that my vision is Comfort Care for All which includes patients (first and foremost), their families, staff, institutions including hospitals, nursing homes, and agencies, student nurses, and communities. I fervently believe that nurses WANT to provide Comfort Care; it is THE reason we choose nursing as our life’s work.

Comfort Care is defined as a philosophy of health care that focuses on addressing comfort needs recipients in four contexts: physical (including homeostatic mechanisms as well as sensations related to medical problems), psychospiritual, sociocultural, and environmental. Comfort Care has three components: (a) and appropriate and timely intervention, (b) a mode of delivery that projects caring and empathy, and (c) the intent to enhance comfort (Kolcaba, 2003, p. 252). It is a pattern for holistic care, but is individualized for each recipient or group. Comfort is also a universal concept, meaning it is understood across most disciplines and cultures.
One can follow the pattern inherent in the comfort grid (see my homepage at TheComfortLine.com) for practice, research, and education. The grid is a 12-cell representation of a complex term or umbrella term under which pain (physical, relief) and anxiety (psychospiritual, relief) are only parts of the whole experience of comfort. The type of comfort named Relief refers to unmet comfort needs, usually of a severe nature. Ease emphasizes the importance of prevention of known risk factors that would keep a person from feeling comfortable. And transcendence addresses the most stubborn cases of persons unable to attain acceptable levels of comfort in any of the cells. The nurse continues to help the patient “rise above” or “bear with” the acute discomfort. The nurse never gives up, and provides hope - however hope is defined with the patient. In this model of care, administrators have a primary responsibility to provide the resources necessary for nurses to engage in comforting interventions. When the entire agency or institution is engaged in providing comfort care, patients will do better and the facility will benefit from increased patient satisfaction, cost savings, less staff turnover, etc. Please see the conceptual framework for three parts of comfort research on my homepage.

Comfort Care can be applied in the community as in the research question, “What features are important in creating a comfortable community?” Comfort Care, whether explicit or implicit, is essential for end of life and palliative care. In mental health, a challenge for providers is to help patients develop healthy self-comforting strategies to take the place of addictive or self-destructive habits. For these patients, physical pain plays a very small part in their comfort status.

When I was a teen, I was moved by a simple poem by Emily Dickenson. I cut it out, framed it cheaply, and hung it in my room. It continued to speak to me as I applied to nursing school, began my practice years in a variety of settings, and settled on gerontology. It spoke to me as I taught students and as I interviewed research participants, all with the goal of promoting comfort in diverse places. And now it seems especially relevant as I volunteer at a homeless shelter, providing hope and friendship along with supplies. Again, physical pain has only a small role in my clients’ comfort status. Rather, they are seeking dignity, acceptance, compassion, strength along with the few supplies. The supplies are really a portal for me to address their other needs.
Dickenson’s description of my vision for nursing, and the essence of Comfort Care follows:

If I can stop one heart from breaking,
    I shall not live in vain;
If I can ease one life the aching,
    Or cool one pain,
Or help one fainting robin
    Unto his nest again,
I shall not live in vain.

Emily Dickenson (1830-1886)

**Recipients of Comfort Care**

**Patients.** I first articulated holistic comfort care for patients in a hospital setting, as described in my book. Most comfort studies being done today are with patients. But let’s not forget…

**Their families,** who are often equally if not more stressed than their loved one in a health crisis. Nurses know there are many comforting interventions that are done for the families’ benefit, such as comfortable lounge chairs for sleeping when the patient is able to doze. Helping with dietary needs, referrals to social service or a chaplain, explaining complicated procedures or diagnoses, active listening are just a few ways expert nurses address families’ comfort.

**Staff.** In the latter part of my book, I began to consider the comfort of nurses and auxiliary staff members. Most health care providers and support staff have chosen health care for their careers because they want to help people. They need support and recognition from administrators and mentors for their comforting efforts. Examples of necessary support are predictable hours, an atmosphere of teamwork, workable assignments, strong compensation, and fair benefits for all, predicated on their levels of education and responsibility.

**Student Nurses.**

**Institutions including hospitals, nursing homes, and agencies.**

**End of Life.** (hospice, critical care)

**Psychiatric Care.**

**Communities.**
References


