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English for Professional Nursing

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English for Professional Nursing

Mit 15 Abbildungen

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Foreword

This book has been written for nurses and midwives as well as nursing and midwifery students who would like to learn or brush up on their nursing and medical English. It also gives information on preparing for working and studying abroad as well as different aspects of the British and American health care systems.

The book is not intended to replace any nursing or anatomy textbook.

The authors have focused their experience and knowledge on important areas of nursing and nursing science so that the reader is introduced to English terminology used in these ares. We are aware that not all areas of nursing can be presented in detail. Basic research principles, including references to nursing research, plus advice on the application process, whether it be to work or study abroad, complete the information.

It's not necessary to read the book from beginning to end as the chapters are written as separate entities. Therefore each chapter can be referred to individually depending on the reader's needs. Relevant exercises and vocabulary lists support and encourage the reader in the individual subject areas. Important texts from the book are also available as audio files.

More information on the book can be found on the homepage.

The authors are very grateful to all those who have contributed to and supported the writing of this book. Here, we would like to express our sincere thanks to Christina Aere, Dorothy Boland, Selina Brückmann, Andreas Grau, Judith Holzknecht, Barbara Mohr-Modes, Anja Siegle, Kristie Walter, Manuela Weidlich and Tayside Health Board. A very special thank you goes to Susanne Moritz, the project manager from Springer Publishers, Berlin. This book is a result of her very competent and patient support and her ability to motivate exactly at the right time. Our special thanks also go to the editor, Dr. Mary Gossen who very prudently and constructively turned the manuscripts into the finished product.

Whether you are using this book to practise or refresh your English skills or whether you have decided to venture into an exciting and new experience studying or working in an English-speaking environment, we, the authors, would like to wish you lots of fun and success!

Norma Huss, Sandra Schiller, Matthias Schmidt
Esslingen, Hildesheim, Eilenburg
August 2013

Contributions by
Christina Aere. Health Care Teams and Team Collaboration. (▶ Sect. 2.1). Introduction: The Experience of Studying and Working Abroad. (▶ Sect. 7.1).
Selina Brückmann. Presentation: The German Health Care System. (▶ Sect. 6.3).
Judith Holzknecht. Talking about not Feeling Well. (▶ Sect. 1.3). The Multi-Professional Setting within a Hospital in the United Kingdom. (▶ Sect. 2.4). MRSA (▶ Sect. 2.8.2). VRE (▶ Sect. 2.8.3). Exercise: Directions and Planes of Reference. (▶ Sect. 4.5.2)
Barbara Mohr-Modes. The International Classification of Functioning, Disability and Health (ICF). (▶ Sect. 1.5). Asking and Giving Directions in a Hospital. (▶ Sect. 2.5)

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Health and Health Care

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1.1 The Nursing Workforce and the Role of Nursing in Today's Health Care Environment

Nurses are not only the largest group of health care professionals but also a crucial part of the health care team, as they have the most frequent patient contact and provide direct physical care. Although the focus of nursing has always been on caring for people with actual or potential health problems, caring for people during acute phases of illness, caring for people in the area of rehabilitation or restoration of health and caring for people during the last stages of life, the practice of nursing has undergone significant changes in the past decades. Today the profession of nursing is characterised by diversity in specialisations and workplaces. Nurses are faced with an amazing breadth of opportunities as they work in various roles within hospital as well as community settings. In recent years nurses have become more involved not only in caring for the elderly or for chronically ill or disabled persons in their communities but also in supporting vulnerable groups (e.g. young mothers with children) and providing health education to whole populations.

Figures from the USA show that the nursing workforce there is expected to grow quickly over the coming years. According to the US Bureau of Labor Statistics, employment of registered nurses is expected to grow by 26% in the decade from 2010 to 2020, i.e. faster than the average for all occupations. The causes of this growth are seen primarily because of technological advancements, an increased emphasis on preventative care and the demographic change towards a larger elderly population that lives longer and stays more active, thus demanding more health care services. However, in the USA the nursing workforce has not only increased in numbers in recent years, but also become more diverse and better educated. Nowadays, 36.8% of nurses have bachelor's degrees (compared to just 22.3% in 1980) and 36.1% have associate degrees (compared to 17.9% in 1980). Additionally, the number of advanced degrees (master's degrees or doctorates) has also increased. In the United Kingdom there has been a similar trend towards an academic nursing workforce. The updated standards for pre-registration nursing education published by the Nursing and Midwifery Council (NMC) state that from 2013 onward, new entrants to the nursing profession have to study for a degree in nursing at university. An expected consequence of this may be an improvement in standards of care in nursing and an enhancement of the professional profile of nursing, making it more attractive to potential applicants.

Currently about one in three nurses in the UK is aged 50 or older, so the ageing of the nursing workforce has become an issue of concern. According to the 2011 UK Nursing Labour Market Review there has been an annual trend of small declines in the number of UK-registered nurses and midwives since 2007. What is more, the nursing workforce has been particularly badly hit by recent cuts in the public health care

sector funding. However, considering the increasing health care needs of an ageing population, the greater diversification of the workforce due to the new emphasis on care outside of hospital, support for self-care and a growing public health agenda as well as the rising professional standards, nursing will continue to play a key role in the health care sector in the United Kingdom.

Discussion

1. Every profession has its own domain, its own core subject area. What do you think is the central point of self-reference for nursing? Please make some notes and then discuss your ideas with your fellow students.
2. How would you define nursing? Please take some notes and then discuss your definition with one of your fellow students. Now have a look at the following definitions from authoritative professional sources and compare them with your own ideas:

» Nursing is the protection, promotion, and optimisation of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations. (ANA 2013)

» Nursing is […] the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death. (RCN 2013)

▶ Chap. 2 Nursing Fields of Activity and Clinical Practice
▶ Chap. 6 Nursing Science
▶ Sect. 6.5 Defining Nursing

Audiofile available online

1.2 Introduction to Health and Ill Health

1.2.1 Health

In its most basic form the word »health« refers to the **absence of disease**. The most commonly accepted definition of health is that of the World Health Organization (WHO), which states that »health is a **state of complete physical, mental and social well-being** and not merely the absence of disease or infirmity« (WHO 2013a). By extending the meaning of health to encompass the psychological and the social dimension, this by now classical definition stated that disease and infirmity cannot qualify health if regarded in isolation from **subjective experience**. In the 1970s and 1980s, the WHO's holistic view

of health was further widened to include the components of intellectual, environmental and spiritual health. This broad understanding of **health** as **»well-being«** has ultimately also contributed to the current popularity of the concept of »wellness« in industrialised countries.

However, the WHO definition has also met with some antagonism: some critics argue that such a comprehensive notion of health makes it difficult to distinguish »health« from »happiness«, while others maintain that health cannot be defined **as a state** at all, but must be seen **as a process** influenced by the shifting demands of daily living and the fluctuating meanings people attribute to their lives. They therefore consider the WHO definition to be more idealistic than realistic.

1.2.2 Disease and Illness

Physicians typically make a distinction between disease and illness. In their understanding, the term **disease** usually refers to a structural problem in the body that can be measured, studied under a microscope or diagnosed by a test. A disease is an abnormal condition of the body or mind that causes discomfort, dysfunction or distress to the person suffering from it. »Disease« is sometimes used as an umbrella term that includes syndromes, symptoms, injuries, disabilities, deviant behaviours etc. In contrast, a person's subjective perception of having poor health is generally called **illness** or **sickness**. This crucial distinction between the two terms means that one person can have a disease and still feel healthy and fit, while another one feels ill and is convinced he or she is suffering from an illness, even though no disease can be detected.

Diseases can be serious, like amyotrophic lateral sclerosis (ALS), or trivial, like the common cold. Some diseases are silent, like diabetes or high blood pressure, and only discovered by performing a test. Hereditary diseases, like haemophilia, are genetically passed from parents to children. Most congenital diseases are hereditary. While some diseases, such as acquired immunodeficiency syndrome (AIDS), are contagious or infectious, others cannot be spread from person to person. Industrial diseases like pneumoconiosis are caused by hazardous or polluted work environments.

The recognition of a specific medical condition as a disease can have significant positive or negative social or economic implications for the individual as well as for public or private health care providers. Whether a condition is considered a disease may vary from culture to culture or over the course of time. Post-traumatic stress disorder, whiplash injury, attention deficit hyperactivity disorder or even obesity are just some examples of conditions that were not considered diseases some decades ago or are not recognised as such in all countries.

1.2.3 Signs and Symptoms

The classification of a particular feature in health care as a sign or a symptom strictly depends on who observes it. Any sensation or change in health function experienced by the patient is considered a **symptom**, which may be characterised as weak, mild or strong. Thus, symptoms refer to a patient's subjective report of the state he or she is in. Pain, nausea, fatigue etc. are symptoms as they can only be perceived and related by the patient. The cause of concern which makes a patient seek medical advice is called a »presenting symptom« or »presenting complaint«, whereas the symptom leading to a diagnosis is known as the »cardinal symptom«.

In contrast, a **sign** is regarded as »objective« evidence of the presence of a disease or disorder as detected by a physician or a therapist during the physical examination of a patient. The expression »clinical sign« is also common – it emphasises that the observation takes place in a clinical context. Nystagmus, ataxia, joint inflammation, muscle spasm etc. are by necessity signs, as they can only be identified by physicians or other health professionals. They can give the doctor or nurse important clues about which disease may lie behind the patient's symptoms.

A collection of signs or symptoms that occur together is commonly called a **syndrome**.

1.2.4 Illness Behaviour and Cultural Influences

The term »illness behaviour« is used to describe a patient's thoughts, reactions, and coping mechanisms in case of illness, e.g. regarding perception and understanding of sickness, seeking help for health problems, utilisation of health care systems, and benefits gained from health care. The expression »health behaviour«, on the other hand, refers to what people do to maintain their health, e.g. following guidance on nutrition, exercise, hygiene, and preventive check-ups. These behaviours are influenced by individual factors, e.g. education and past experiences, but also by social or cultural factors. This needs to be recognised by health professionals if they want to understand their patients properly.

However, they do not only need to be aware of their patients' cultural backgrounds, but also of their own cultural beliefs and biases. This includes the critical reflection and possible modification of the health care services they provide. The provision of health care needs to be based on a culturally sensitive attitude, appropriate cultural knowledge and skills that are flexible enough to provide culturally relevant, effective care for patients from a variety of backgrounds.

Active Vocabulary: Odd One Out

Decide which of the words listed below is *not* a synonym for the words underlined in the three texts above. Please look up unfamiliar words in a general dictionary. One example has already been done for you.

commonly (in line 3)	widely – publicly – usually
merely (in line 6)	~~gradually~~ – only – simply
to encompass (in line 7)	enclose – inhabit – include
current (in line 14)	topical – present – remote
comprehensive (in line 17)	concise – elaborate – extensive
notion (in line 17)	idea – understanding – theory
to distinguish (in line 18)	differentiate – vary – discriminate
to maintain (in line 19)	claim – argue – keep
to make a distinction (in line 25)	to differentiate – to distinguish – to vary
to refer to (in line 26)	to deduce – to denote – to signify
crucial (in line 33)	critical – trivial – essential
to detect (in line 37)	to discover – to identify – to settle
to pass (in line 41)	to transfer – to hand on – to partake
significant (in line 48)	important – critical – neglectable
to vary (in line 50)	to differ – to be distinct – to diminish
to recognise (in line 54)	to verify – to acknowledge – to see
to seek (in line 64)	to look for – to search for – to obtain
benefit (in line 82)	advantage – drawback – gain
to maintain (in line 84)	to preserve – to sustain – to decrease
factor (in line 86)	influence – determinant – modifier
bias (in line 92)	predispotion – prejudice – liking
appropriate (in line 94)	desired – suitable – apt

Active Vocabulary: Health and Ill Health

The English equivalents to these German words are used in the text. What are they?

gesund = _____
Gesundheitsförderung = _____
gute körperliche Verfassung = _____
Krankheitsprävention = _____
Schwäche, Gebrechlichkeit = _____
Wohlbefinden, Gesundheit = _____
abweichendes Verhalten = _____
Adipositas = _____
Behinderung = _____
Fehl-, Dysfunktion = _____

Krankheit = _____
Krankheit (spezif.) = _____
Krankheit, Unwohlsein, Übelkeit = _____
Kummer, Verzweiflung, Not, Leiden = _____
posttraumatisches Belastungssyndrom = _____
schlechter Gesundheitszustand = _____
Schleudertrauma = _____
Unbehagen, Unwohlsein = _____
Verletzung = _____

Discussion

1. Do you consider the WHO definition of health to be realistic or idealistic? Give reasons in support of your answer.
2. Are there any other widely recognised definitions of health?
3. Can health be defined as a state? Give reasons in support of your answer.
4. Do you think that health exists in our society? What are the implications for global public health?

Questions

1. What are the various possible causes of disease?
2. Why is it relevant that a condition is recognised as a »disease«? Some reasons are mentioned in the text but you can probably think of some more.
3. Can you give any examples of cultural or historical differences in illness perception or the recognition of diseases?
4. What is the difference between a symptom and a sign?

Discussion

»Individuals from different cultures perceive and experience illness within the context of their cultural backgrounds. These experiences are not uniform, and attempts to discount them will lead to significant dilemmas in their treatment« (Bonder et al. 2002).
What do you think of this statement? Can you give any examples from your own professional experience that support or refute it? Please discuss.

Audiofile available online

1.3 Talking about Not Feeling Well

Jenny is a Registered Nurse (RN) and works in an acute hospital in Birmingham. Today she is out to meet her best friends, Judy and Daniel, for lunch. Judy works in the private sector as a health care assistant and Daniel is a physiotherapist.

Jenny: Hi folks, how is it going?

Judy: Oh, as usual very busy. How are you? I haven't seen you around much!

Daniel: That's right, it feels like we haven't seen you for ages!

Jenny: Ah well, I'm fine. You know what it's like…

Daniel: Oh well, indeed. So what will we have for lunch then?

Judy: I don't know… What about something light, perhaps a salad?

Jenny: Sounds great, salad it is then.

Judy: Yeah, really, I'm not in good form today. I'm feeling a bit light-headed and nauseous. I think we might have another one of these bugs going around – another winter vomiting bug, you know. So I just feel a little weak.

Daniel: Isn't it strange the way you can never really get rid of these bugs? They just seem to spread around on a regular basis. And we have such strict hygiene rules in our hospitals, if you think of it. It's appalling!

Jenny: Well, the general public has quite a lot to do with it as well, you know. People simply don't understand the nature of the problem and that they are a primary source of spreading infection in the hospital if they don't disinfect their hands and wear aprons.

Judy: That reminds me of one of my elderly ladies who I used to look after. She caught a bug last year and RIP'd shortly after. Really sad story. She was such a fighter and… there you go! And if I think of her son – always on sick leave! For benefits, you know. He never admitted it, but it was so obvious! He was in a car crash five years ago and suffered from bad whiplash afterwards. I believe he was really bad immediately after that, but come on, five years later?! I don't know…

Daniel: It is quite a bad condition, whiplash, you know… you can't just get rid of it very easily. It often takes a long time and a lot of physio to sort you out again.

Judy: I know, but he is a real hypocrite. On benefits and ongoing sick leave ever since it happened, but a lot of cash-in-hand jobs, if you know what I mean. Really awful! Well, I suppose you always get those, don't you?

Jenny: But you also get a lot of decent people, you know that. We had a gentleman in the other day and he suffered from a really bad flu. Also

he had a nasty injury to his right shoulder. He had fallen off some scaffolding, he's a builder, you know. Mr Simmons said he was going to sign him off for a week, but he refused. Well, initially he did, but agreed to it in the end. He simply could not have gone back to work straight away. See, you do get all sorts in our jobs.

Judy: Well, I suppose you are right, but let's not spend our time talking about being ill all the time.

Daniel: We're off for the moment, so let's talk about nicer things than that, okay? Look, our lunch! Have a nice meal!

Note

While surgeons carry the appellation »Dr« in North America, fellows of the Royal College of Surgeons in the UK are referred to as »Mr« or »Ms«. This peculiar habit is a reference to the historical origin of surgeons who did not attend medical school but were simply skilled tradesmen.

Exercise

Make a list of all the words related to states of health that you can find in the dialogue. What do they mean in German?

Exercise

What are the German meanings of the words in the list below? Find a conversation partner to talk about the state of your own (or other people's) health and fitness and see how many words from the text or from the list below you can use. Feel free to make something up altogether.

Active Vocabulary: Not Feeling Well

in good health	in good shape	to be taken ill	to fall ill
unwell	miserable	exhausted	weakened
infirm	feeble	bedridden	to be off colour
to feel kinda funny	to feel run down	to be/feel under the weather	to be/feel out of sorts

Note

In American English »being sick« or »feeling sick« means »krank sein« or »sich krank fühlen«. In British English the expression »being ill« or »feeling ill« is more common. In British English, »feeling sick« or »being sick« may be used synonymously with »feeling ill« or »being ill« but it can also mean »feeling nauseated« and »vomiting«.

Exercise: Opposites

These adjectives are all used to talk about diseases, their symptoms and effects. Match the words in italics with their opposites in the table. The first one has already been done for you as an example.

acquired	alive	chronic	ill	malign
mild	minor	robust	susceptible	tense(d)

1. The opposite of *healthy* is _____ *ill* _____.
2. The opposite of *major* is _____.
3. The opposite of *dead* is _____.
4. The opposite of *acute* is _____.
5. The opposite of *severe* is _____.
6. The opposite of *benign* is _____.
7. The opposite of *congenital* is _____.
8. The opposite of *resistant* is _____.
9. The opposite of *relaxed* is _____.
10. The opposite of *delicate* is _____.

Active Vocabulary: Pain

These words are commonly used to describe pain in the English language. What are their German equivalents? The first one has already been done for you as an example.

aching	*dumpf, anhaltend*
burning	
cramping	
cutting	
deep	
dull	
excruciating	
exhausting	
gnawing	
intense	
nagging	
nauseating	
numb	
penetrating	
pinching	
pressing	
radiating	
sharp	
shooting	

stabbing	
stinging	
superficial	
throbbing	

1.4 Disability

1.4.1 Defining Disability

Disability is part of the human condition: most people will experience temporary or permanent impairment and the associated difficulties in functioning at some point in their lives. Disability is by necessity a subjective experience, but one that is shaped by diverse contextual factors as well as the collective understanding of its nature prevalent in a particular society or community. This makes it a complex, dynamic and multidimensional concept contested in various socio-political and academic discourses.

Mainly due to the influence of self-help organisations of people with disabilities, attitudes towards disabled people have changed in the last decades. The shift from a »medical model« focussing on an individual, medical perspective to a »social model« providing a structural, social perspective has increased attention to the social and physical barriers in disability. A balance between these two approaches is achieved by the »bio-psycho-social model« of the ICF (International Classification of Functioning, Disability and Health), which understands functioning and disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental.

As a consequence, disability is increasingly seen from a human rights perspective and policy aims at community and educational inclusion. This is reflected by the adoption of the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD) in 2006.

The Preamble to the CRPD acknowledges that disability is »an evolving concept«, but also stresses that »disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others«. The opportunities for social participation of disabled people can be increased when the barriers hindering them in their everyday lives are addressed. ▶ Sect. 1.5 The International Classification of Functioning, Disability and Health (ICF)

World Health Organization Definition of Disabilities (WHO 2013b)

Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.

People with disabilities have the same health needs as non-disabled people –for immunisation, cancer screening etc. They also may experience a narrower margin of health, both because of poverty and social exclusion, and also because they may be vulnerable to secondary conditions, such as pressure sores or urinary tract infections. Evidence suggests that people with disabilities face barriers in accessing the health and rehabilitation services they need in many settings.

Discussion

1. What are the advantages of considering disability not only as a health problem?
2. What are the consequences of seeing disability from a human rights perspective?
3. What is your vision for an inclusive society? What strategies are necessary to achieve this goal? Write down your own ideas on this topic. Then get together with 2 or 3 fellow students to discuss and plan some activities to support an inclusive society.

1.4.2 Health Professionals and Attitudes toward Disability

The following text is taken from Tufano (2000).

»The formulation of a person's attitudes and beliefs regarding disability is contingent on various influential sources. Some of these factors are external sources that we learn from our environment, such as society's use of language, the media's stereotyped images of persons with disabilities or the theoretical bases that constitute medical treatment and rehabilitation. Other sources are internal and assimilated into our belief system, such as our values about humankind and health, and our tolerance to differences.

»Rehabilitation is an interactive process in which both the client and health care professional constantly influence each other in the therapeutic relationship. Each of us has unique perceptions about wellness and illness, normal and abnormal behaviours, and what consti-

tutes a positive and negative body image. Our emotional reactions and anxieties about our own well-being can easily be projected onto others if we do not recognise and identify their existence within ourselves. Common expressions of sympathy and pity are efforts to alleviate our own discomfort when viewing a person with a disability. Often, our perceptions about this person are inaccurate and our attitudes are based on previously learned images or prior experiences. Concerned health professionals always directly check out their perceptions with those of their clients rather than forming assumptions based on external or internal influences. Health care workers know that faulty beliefs and stereotypes reinforce the development of negative attitudes toward persons with disabilities, and they make direct efforts to change these attitudes into positive ones.

»An effective health professional is concerned about the person first and how rehabilitation and treatment could be collaboratively arranged for the client. With the knowledge of various treatment models, the health professional provides unconditional positive regard and individualised care, always conscious to present a positive attitude within this process. The client's feelings are acknowledged in the form of empathy, not sympathy, with the intent to empower and assist the client to accept and adjust to one's disability.

»Finally, health professionals recognise that they are role models for others within the medical community, as well as society in general. They are aware of the power of their language when describing persons with disabilities and subscribe to defining disability in a positive, humane manner. Effective health professionals are dedicated to personal reflection and change regarding their own attitudes, beliefs and perceptions, which significantly affect the rehabilitation process. In essence, they demonstrate a commitment to clients that offers a non-judgemental and unconditional regard for the person, regardless of the disability.«

Questions/Discussion

1. How does Tufano (2000) state the responsibility of health professionals towards clients with disabilities?
2. Do you agree with her? Give examples from your own professional experience.

1.5 The International Classification of Functioning, Disability and Health (ICF)

In 2001 the World Health Organization (WHO) developed a new version of the International Classification of Disease (ICD-10), the International Classification of Functioning, Disability and Health (ICF). In comparison to the ICD-10, a major change in the language that is used in the ICF can be observed. The ICF uses **client-oriented, resource-oriented** and **contextual** formulations, for example, »classification of disease« is now »classification of functioning«. The contextual factors of a client's health condition are given greater consideration.

Disability and functioning are seen in the ICF as resulting from an interaction between health conditions, e.g. disease, disorder, injury and contextual factors.

Components of contextual factors include the following:

- external – environmental factors, i.e. social attitudes, architectural environment, legal and societal structures, climate etc.
- internal – personal factors, i.e. gender, age, attributes, social class, educational level, profession, present and past experiences, general behavioural patterns, adaptability, character and other factors that can influence how a disability is experienced by an individual.

Human functioning can be described at three levels:

- at the level of the body or individual body parts,
- at the level of body systems functioning as a whole, i.e. physiologically and psychologically and
- at the level of social context.

Impairments of body structure or function represent deviations from certain generally accepted population standards and can be temporary or permanent; progressive, regressive or static; intermittent or continuous.

A **disability** can include dysfunctions on one or more levels:

- activity limitations and
- participation restrictions.

Definitions of **ICF components** in the context of health:

- body functions = physiological functions of body systems (including psychological functions),
- body structures = anatomical parts of the body such as organs, limbs and their components,
- impairments = problems in body function or structure such as significant deviation or loss,
- activity = execution of a task or action by an individual,
- participation = involvement in a life situation,
- activity limitations = difficulties an individual may have in executing activities,
- participation restrictions = problems an individual may experience in involvement in life situations and
- environmental factors = physical, social and attitudinal factors in the environment in which people live and conduct their lives.

The aim of this new vocabulary is to create a **new communicative basis for all health professionals**, which may enhance the further development of interdisciplinary collaboration. In patients recovering from an acute episode of illness or injury, in addition to the provision of adequate medical treatment, the early identification of their needs for rehabilitation care is crucial. This process requires efficient com-

munication between various health professionals as well as the patient to make sure that all rehabilitation goals are effectively addressed. In contrast to traditional nursing taxonomies often applied in Germany, which were not designed for interdisciplinary use, the ICF may provide a basis for such an interdisciplinary communication process.

Active Vocabulary: International Classification of Functioning, Disability and Health (ICF)

The English equivalents to the following words can be found in the above text. What are they?

Aktivität, Handlung = _____
Behinderung = _____
Funktion = _____
Gesundheitsumstände = _____
Handlungseinschränkung = _____
Kontextfaktor = _____
Körperfunktionen = _____
Körperstrukturen = _____
Partizipation, Mitwirkung = _____
persönlicher Faktor = _____
Schädigung, Funktionsstörung = _____
Teilnahmebeschränkung = _____
Umweltfaktor = _____

Discussion

The ICF relates health and wellness to engagement in daily activities and ability to participate in society. Nursing in Germany, however, traditionally conceptualises disability from largely medical and individual perspectives that do not consider its social dimensions.

Get together with fellow students and discuss the following two points:

1. How can the ICF provide a useful conceptual framework for nursing education, practice and research?
2. Can language really make that much difference? Classifying »function« instead of »disease« – a definite plus for client care?

▶ Sect. 2.1 Health Care Teams and Team Collaboration

1.6 Areas Covered in Rehabilitation Programmes

Exercise

The following areas are typically covered in rehabilitation programmes. Decide which activities from the list below are commonly performed in the individual areas. One has already been done for you as an example.

AAC	addressing attitude problems
addressing behavioural issues	alternative methods of managing pain
assistance with adaptation to lifestyle changes	bathing
breathing treatment	~~concentration~~
dealing with emotional issues	discharge planning
dressing	education about the medical condition
exercises to promote lung function	feeding
grooming	guidance with adaptive techniques
information on medical care	medication
memory	nutrition
pain medication	problem-solving abilities
skin care	social interaction at home
social interaction in the community	speech
support with financial issues	toileting
transfers	ventilator care
walking	wheelchair use
work-related skills	writing

a) cognitive skills	- *concentration* - _____ - _____
b) communication skills	- _____ - _____ - _____
c) education	- _____ - _____ - _____
d) family support	- _____ - _____ - _____
e) mobility skills	- _____ - _____ - _____
f) pain management	- _____ - _____ - _____
g) physical care	- _____ - _____
h) psychological counselling	- _____ - _____ - _____

i) respiratory care	- _____ - _____ - _____
j) self-care skills/ADLs	- _____ - _____ - _____ - _____ - _____
k) socialisation skills	- _____ - _____
l) vocational training	- _____

Exercise/Discussion

1. Which of these services are provided by nurses? Which other professionals are involved in providing services in these areas? Draw on your own experience.
2. In which areas or activities is a multiprofessional team approach common?
3. Do some research to compare the experience in your own country with that in others.

1.7 Public Health and Health Promotion

1.7.1 Public Health

Public Health is the field of health science that is concerned with preventing disease and promoting health by safeguarding and improving the physical, mental and social well-being of the population as a whole. According to the WHO more recent approaches in Public Health are based on »a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilise resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health« (WHO 1998).

Consequently, public health nursing is a field of nursing directed at the health needs of the population as a whole or of various subpopulations. Public health nurses work in the areas of population health promotion and primary health care, often with a focus on community participation and community development. Typical settings of public health nursing are, for example, people's homes, schools, the workplace, community health centres and government agencies.

1.7.2 Health Promotion and Disease Prevention

Contrary to the more traditional understanding of disease prevention in Western medicine, the field of health promotion has its roots in many different disciplines and is based on a more holistic approach to health in line with the WHO understanding of health as a complex phenomenon (▶ Sect. 1.2.1). Health and well-being are seen as the result both of the individual's self-responsibility as well as the government's responsibility for providing adequate health and social measures.

In 1978 the WHO Declaration of Alma Ata on Primary Health Care expressed a global social and humanistic approach to health by stating that the promotion of healthy lifestyles cannot be accomplished unless resources are distributed more equally and health policies developed: »The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.« This requires an analysis of the specific health care needs of specific subpopulations, the social causes of health inequalities and adequate measures to reach vulnerable groups.

The Ottawa Charta of 1986, the result of the first international conference on health promotion, has been seen as a milestone in this development. It defines health promotion as a resource-oriented »process of enabling people to increase control over, and to improve, their health«. In other words, health promotion aims at the development of lifestyle habits which healthy individuals and communities can adopt to maintain and enhance their state of well-being. However, many social determinants of health, like poverty, education and discrimination based on ethnic affiliation or gender, cannot be influenced at the individual level. The Ottawa Charta consequently sees a need for health promotion measures on the micro level of individual health behaviour and also the macro level of the government building healthy public policy. Furthermore, the strengthening of community action »in setting priorities, making decisions, planning strategies and implementing them to achieve better health« is seen as a vital approach in health promotion. All in all, the following five categories are considered essential for the goals of health promotion: building healthy public policy, creating supportive environments for health, strengthening community action, developing personal skills and reorienting health services.

There is a common distinction between the areas of disease prevention, health protection and health education. The aim of **disease prevention** is to protect as many people as possible from the harmful consequences of threats to their health, e.g. through immunisation campaigns. **Health protection** deals with regulations and policies such as the implementation of a no-smoking policy at the workplace or the commitment of public funds to the provision of accessible leisure facilities in order to promote fitness and well-being. The aim of **health**