Henrietta Stockdale memorial lecture

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What would Sister Henrietta have thought?

It is such a privilege to be invited to give this address on the occasion which, on an annual basis, honours Sister Henrietta Stockdale and the amazing contribution she made to nursing in South Africa. I would like to start by thanking the College for the invitation and the Academy of Nursing of South Africa (ANSA) for sponsoring my visit. ANSA is an independent, non-governmental association of members (Fellows) whose vision it is to recognise, utilise and promote excellence in nursing and midwifery in South Africa and to enhance optimal health care for all South Africans. I like, therefore, to think that this event is an appropriate one for ANSA to support as there is no doubt that, had Sister Henrietta lived today, she would have been made a founder member.

On a more personal note, I find it relatively easy to relate to Sister Henrietta's life and work as I too started my nursing career in England. Of no real consequence but nevertheless coincidental, she moved to South Africa exactly 100 years before I returned to continue my career in this country. I can see some of you bringing out your mental calculators and working out my age and I can confirm that I should be well and truly retired but am still going!

My address is entitled, "What would Sister Henrietta have thought?" My intention is to look at various aspects of her life and give some thought to what she would have thought had she been part of the nursing profession in South Africa today – 150 years after she first arrived.

Sister Henrietta was a missionary nurse and a member of Community of St Michael and All Angels, taking her vows and becoming a religious sister in 1875. She was clearly motivated by strong religious convictions to assist the people in what was then a British colony.

This brings me to my first thought in reflecting on Sister Henrietta's life and work. Like many colonials, I have no doubt that her intention to do good was firmly established and embedded in the framework of the time. The discomfort I feel is that it seemed perfectly acceptable to impose their Christian values and ideals on the local population. I wonder whether she ever gave thought to the idea that her faith-driven compassion and dedication, while admirable, might have been seen as imposing a specific worldview on her patients and trainees and conflicted with the beliefs and practices of the diverse populations she served.

Religious orders including the Anglican Sisterhood to which Sister Henrietta belonged, and the Catholic Church missions played a significant role in healthcare in South Africa and by the mid-twentieth century they had, between them, established 73 hospitals all of which provided care to all irrespective of the patients' race or religion and actively opposed Apartheid policies which often led to conflict with the state. By the 1970s they had, as a result, and to a large extent, withdrawn from direct healthcare provision. This transition reflected broader changes in South Africa's healthcare landscape and the government's increasing control over health services.

Some religious communities continue to provide clinic services in some underserved areas and often provide holistic care that incorporates spiritual support, which many patients find valuable. This is not a hugely researched area of practice, but a study conducted at Jubilee Health Centre, a faith-based primary healthcare clinic in Cape Town by Porter and Bresick in 2016 would have been interesting to Sister Henrietta.[1] Many of the patients included in the study were migrants who chose to attend this clinic because they received quality care, and because of the good staff–patient relationship and patient-centredness rather than the clinic's religious practices (which included prayer with patients). Surely secular health services should be able to provide the same quality care to all patients whether they are undocumented foreigners or influential politicians or rich and famous people?

Every nurse in this audience has learned about caring – what it constitutes, how to care and there are dozens of textbooks

describing how to do this, but I was disturbed to discover an article published last year by Khalili et al. who were driven to conduct a concept analysis on "poor care".[2] These authors point out that "care" is the fundamental tenet of nursing, but "poor care" is so frequently written about in the media that they felt it was necessary to have a common understanding of the term. It seems rather trite for these authors to have said that poor care can be regarded as the counterpoint, or opposite, of good care which, they continue to define as "providing human needs through attention, empathy, respectful interactions with the patient along with a sense of responsibility, and essential and comprehensive patient support". What is of more significance are the antecedents to poor care – activities, situations, or events that occur before the concept and can lead to poor care.

These included vulnerability and complexity of the patient's condition; the increase in workload caused by the insufficient nurse-to-patient ratio and the various tasks assigned to them; improper interactions and communications of healthcare providers; inadequate documentation; lack of knowledge and skills, especially in the evaluation and management of critically ill patients; conditions of the organisation including the lack of supervision; and inadequate resources and/or excessive reliance on equipment.

Thinking back to Sister Henrietta's time, I need to explain something about the first antecedent – the vulnerability and complexity of the patient's condition. Even when I trained at a London teaching hospital – nearly 100 years after Sister Henrietta had trained, we had a policy that would shock the young people in the audience. No patient over the age of 70 years was allowed to be resuscitated should they have a cardiac arrest nor were they allowed to be admitted to intensive care units. Today this seems unethical but when I, as an eighteen-year-old student, enquired why, I was told that "it is in the Bible". Psalm 90 verse 10 actually says, "The days of our years are threescore years and ten; and if by reason of strength they be fourscore years yet is their strength labour and sorrow; for it is soon cut off, and we fly away". So, the authorities at the time said it was unthinkable to go against this doctrine – when it was your time it was your time and who would want to live longer to live in labour and sorrow?

I raise this point as in Sister Henrietta's day the patients were certainly vulnerable but if their condition was complex, there was little one could do other than what we would today call "palliative care". This would have had a knock-on effect to the second antecedent of poor care – the increased workload. Knowing that today the daily nursing activities taking up the most time are administering scheduled medication (23,7%), documentation (21,1%) and monitoring and measurement (12,5%), I wonder what Sister Henrietta would have thought of today's documentation requirements.[3] With computers not having been invented, all documentation in her time would have been done manually and they had not "invented" the nursing process or subjective and objective data or even nursing diagnoses. The documentation was simple – a "Kardex", which was a written report of the patient's condition and the nursing care that had been given as well as progress made. Various documents such as TPR charts and intake and output charts would have accompanied these notes and instructions from the doctor, including prescriptions. Those intake and output charts were treated with great reverence and formed an important part of assessing a patient's wellbeing. Even in my day, the night nurses were responsible for calculating the fluid balance of every patient and if one went off duty after a long night and the ward sister found that there was an error or omission on the fluid balance chart, one was called back from one's bed to correct it. I am guessing that the HR departments and union reps would take a dim view of this practice nowadays, but it made us diligent about completion of those records.

I want to move on to another important aspect of Sister Henrietta's significant contribution to the establishment of formal nurse training in South Africa. As Charlotte Searle points out, Sister Henrietta introduced nurse training into South Africa with the specific objective of providing trained nurses for hospitals – hers at Kimberley Hospital in 1877 and at many others as she encouraged her students, on completion of their training, to go to other hospitals and start additional training schools.[4] We probably take for granted today that she insisted that the students followed a well-planned curriculum and that theoretical lectures preceded practice with clinical experience obtained in medicine and surgery, district nursing and "welfare work", but at the time this was a fairly new idea. Bear in mind that Florence Nightingale, who pioneered this approach, had only started her training school at St Thomas' Hospital in London in 1860 – a mere 17 years previously and a whole continent away.

I can almost hear you thinking – what has changed? Well, it is true that we teach our students to base their practice on theoretical principles and that they start in "college" or at "university" but the huge shift which occurred, mainly in the 1980s, was the move from student nurses as employees of a hospital to students of an educational institution – initially still paid by a sponsoring hospital but latterly self-funded with many on provincial bursaries. I suspect Sister Henrietta would have thrown her hands up in horror as the sole purpose of training in her mind was to staff the hospitals with well-qualified skilled nurses. As soon as students were no longer part of the staff establishment of a hospital and become "supernumerary", the landscape changed. Students do not see themselves as part of the nursing workforce, contributing to daily care of patients, but rather view their time in the wards as an opportunity to practice skills and get them "signed off". Professional nurses on the other hand see students as an irritation because of this, rather than, as in Sister Henrietta's day when they were an integral and indispensable part of the nursing team.

Sister Henrietta is remembered for being instrumental in advocating for the legal recognition and registration of nurses. Her efforts led to the passing of the Medical and Pharmacy Act of 1891 in the Cape Colony, which made South Africa the first country in the world to regulate the nursing

profession legally. This legislation required nurses to undergo formal training and pass examinations to be registered. I don't think any of us here would argue that registration of nurses is a good and necessary idea but let's pause a bit and think about the implications and changes that have occurred leading on from this practice.

The term professionalism was first used when it was recognised that certain occupational groupings of people provided a service to the broader community and therefore needed special consideration. This implied that there was a tacit or silent contract between society and the professional person. This in turn meant that the professional person was accorded the status, authority and privilege to carry out their obligations.[5]

The original Latin meaning of "profess" indicated that one was willing to make a public declaration that something was important. What was usually important then was religion and the meaning was taken to mean the public act of taking religious vows (Webster's Third New International Dictionary). From that focused starting point of a religious vow, its meaning expanded to include open declarations of belief that are nonreligious.

This early concept of professionalism where certain occupations were valued was important for stability and civility of the social system. It meant that members of a particular profession were collegial, mutually supportive and cooperative. There was a relationship of trust between practitioner and client and competence was assumed to be guaranteed due to the professional person's education and licensing.

Through the professionalisation process, occupations gain prestige, autonomy, and a specialised body of knowledge. From sociologist Talcott Parson's viewpoint, professionalism, involves fulfilling specific roles and responsibilities within the social structure while adhering to professional norms and standards. All well and good so far, but as time went on, professionals became dismissive of the ideology of professionalism and instead used the concept to further their own interests. It became a process of "dominance over an occupation intended to the professional's own occupational self – interest with respect to salary, station and power as well as establishing a monopoly protection over an occupational jurisdiction" (Encyclopaedia Brittanica). The professions were then largely controlled by professionals themselves through professional organisations.

Let's pause again. Are we there? Do we not have control over our own interests through nursing unions/ professional associations? Are we merely furthering our own interests? The SA Nursing Council makes sure our profession is protected by not, for example, admitting care workers. Why is this the case? That grants us dominance over our nursing profession but is that the right thing to do?

The SA Nursing Council's mandate is to advocate for the interests of the public. It does this through regulating nursing and midwifery. The SA Nursing Council has 25 members, nine of whom are not nurses and two from the "sub-categories". Is the profession largely controlled by professionals themselves? Considering all members are appointed by the Minister of Health does that make a difference?

So, enter today's type of professionalism which is characterised by significant managerial control. Organisational objectives now define the relationship between clients and professionals, with professionals being set performance targets that they are required to meet. This shift has several implications for both professionals and clients. Firstly, the imposition of managerial control can undermine professional autonomy. Traditionally, professionals such as doctors, lawyers, and teachers relied on their expertise and ethical standards to guide their practices. However, with the increasing influence of managerial oversight, these professionals often find their judgment and decision-making processes constrained by organisational priorities and metrics that may not always align with the best interests of their clients or patients.

Sister Henrietta advocated for registration and licensing to protect the public by making sure anyone who referred to him/herself as a nurse was "properly" educated and could provide safe care. I wonder what she would think about the standard operating procedures and standardised care plans we use today to guide nursing practice instead of the nurse relying on her own knowledge and skills and adapting those to the patient's needs? We know she was dedicated to improving the standards of nursing practice and that she emphasised the importance of hygiene, discipline, and compassionate care. I wonder whether the nurses she trained needed a poster designed by the World Health Organization on the five habits of handwashing to be placed above every washbasin in every hospital in the nation. Or would they have been taught the procedure and then done it the correct way because it was right without being reminded or observed?

Would she have approved of the Department of Health having such a strong influence on the selection of the members of the SA Nursing Council? Would she not have seen this as political interference in what she intended to be an autonomous body?

That Sister Henrietta was a formidable leader seems to be undisputed. She is reported to have shaped the nursing profession through her vision, advocacy, and implementation of standards. Her leadership was crucial in establishing nursing as a respected and essential profession. Searle tells us that, "it was part of the leadership qualities of Henrietta that she could win medical men of standing to her cause and get them to devote themselves wholeheartedly to its furtherance".[4] Searle also tells us that Sister Henrietta had influence over Cecil John Rhodes who, amongst other positions, was prime minister of the Cape Colony, so clearly she moved in important decision-making circles.[4]

So, what would Sister Henrietta think about the nurses in the country today in terms of their drive and attempts to take the lead in important issues? I can almost hear you say, we have a problem today because there are historical and gender barriers, there is a lack of mentorship and role models, it is because of the toxic workplace culture where nurses feel undervalued and have less autonomy than doctors or it is because we have not received leadership training. Well, looking at Sister Henrietta's time in South Africa, she must have had all those issues to deal with. There were certainly gender barriers and doctors were kingpins and I doubt she had any formal leadership training. In 1877, I am sure the hospitals as workplaces were no picnic and yet Sister Henrietta took the lead.

It would seem that her blend of natural leadership traits and passion, along with a keen understanding of the societal need for structured nursing care, allowed her to rise as a leader in nursing, despite the barriers of her time. She certainly would have had to be an effective communicator and her ability to influence key stakeholders without formal leadership training is a testament to her interpersonal skills and her capacity to inspire change. We should also not forget that as a member of the Anglican religious order, she had the support of her community, which valued service to the sick and to education. This backing likely gave her some leeway in taking on leadership roles, as religious women were often granted more flexibility in certain professions like nursing. The shortage of professional medical care in South Africa at the time created opportunities for someone like her to step into a leadership role. She seized this moment to fill the gap, ensuring that nursing would become a respected and regulated profession.

Given that Sister Henrietta seized the moment to fill a gap, I would suggest that we have such an opportunity today and it is more important than ever that nurse leaders ensure that nursing is, or maybe even becomes, a respected profession once more. We have an existing shortage of nurses that is only going to become critical in the coming years. Right now, none of our provinces meet the suggested World Health Organization ratio of nurse per 10 000 population needed to provide adequate universal health coverage. By the year 2030, unless drastic measures are taken to increase nurse training, the country will be short of 260 458 nurses. For those of you who intend to live another thirty years from now, the country will be short of just over 400 000 nurses.

Sister Henrietta's training philosophy was built on the idea that the nurses she trained should go and train others. Since the nursing colleges became "autonomous" from the hospitals in the 1980s, professional nurses seem to believe that they bear no responsibility to support and teach student nurses. Rather, they seem to believe, it is the task of the nursing education institutions. This just is not a viable possibility as nursing students who need to spend a great proportion of their time in the clinical field learning how to care for patients need to learn from the skilled and up to date mentors are the professional nurses. Students also bear some responsibility for the situation that has arisen as they often refer to themselves as supernumerary. The solution is simple – allow the students – no – insist the students – be an integral part of the nursing unit team where they are indispensable and provide nursing care under direct or indirect supervision depending on their level of seniority and experience. Get the more senior students to teach the junior students – make them feel valued instead of a burden.

To go back to the numbers issue or the shortage of nurses in the country, Sister Henrietta may well have been pleased to see that nursing programmes are now part of higher education. This was a necessary and logical move given that we now have a qualifications framework which aims at ensuring consistent education and training standards across various sectors, allowing qualifications to be recognised and trusted nationwide, and to compare qualifications between different fields and ensure articulation between levels, making it easier to pursue further education or career advancement. All nursing programmes are pegged at a higher education level in recognition of the level of knowledge needed to practise nursing within all our categories. I suspect she would not have been happy at the delays that occurred in implementing the regulations – a delay which has undoubtedly impacted negatively on the numbers of nurses we are now able to train.

That Sister Henrietta would have approved of the fact that nursing education institutions have to be accredited in order to offer nursing programmes, I think she might just have raised an eyebrow at the idea that nursing education institutions have to be accredited by two different statutory bodies – the Council for Higher Education and the SA Nursing Council because changes were not made timeously to the Nursing Act that still requires NEIs to be accredited by the Nursing Council despite the changes in national legislation. This adds to the delays in getting accreditation and therefor the training of sufficient nurses for the needs of the community.

We clearly cannot bring Sister Henrietta back to life but surely we can use her tenacity, foresight and commitment to resolve the problems plaguing nursing and nursing education. What would she have done? She would likely approach today's challenges with her signature qualities of advocacy, vision, and a strong commitment to professional standards.

She believed in a standardised, legally recognised training system which we have but I suspect she would likely advocate for streamlining the accreditation process, pushing for collaboration between accrediting bodies to ensuring uniformity in educational standards. She would likely promote dialogue between stakeholders, including government and educational institutions, not only to simplify and align the accreditation process, but to reduce other bureaucratic inefficiencies that are proving a barrier to training sufficient nurses.

In addressing the shortage of nurses today, she would undoubtedly advocate for expanding nursing education opportunities, possibly pushing for an accessible, targeted bursary system, separate from NSFAS funding that required nursing students to "pay back" their bursaries through service rather than financial repayment. She would have lobbied the Nursing Council to drop impediments to further specialist education by removing the requirement to be registered as a midwife before being permitted to train as specialists – especially in areas such as nephrology nursing where there seems to be no logic in insisting on a midwifery qualification. She would probably have advocated for a streamlined system for existing enrolled nurses who currently have no career path to upgrade their qualifications. She would also have advocated for improved working conditions to retain talent, realising that the shortage of nurses needs to be resolved simultaneously as the two issues are interrelated. She would likely lobby for policy reforms to ensure sustainable workforce planning in health care, in line with national health needs and the population increase.

As a champion of ethical conduct and standards, she would likely initiate campaigns promoting the importance of professionalism in nursing. She might advocate for mentorship programmes, ongoing professional development, and stronger ethical guidelines within healthcare institutions. Addressing the culture within health care, she would push for leadership training and values-based education to instil professionalism at all levels.

As a tireless advocate for legal recognition of nurses, would understand the importance of turning policy into action. She would likely emphasise the need for strong leadership in nursing management to ensure that policies are effectively implemented. She might form task forces or advisory bodies focused on monitoring and evaluating policy adherence, working closely with health authorities to ensure that policies impacting nurses are practical, enforced, and updated as needed.

All these actions are within our reach today. What we need to learn from Sister Henrietta is that stakeholders need to be united with a common vision to do the right things rather than protecting turf. Nurses as empowered individuals and groupings need to strive to ensure that the profession continues to be both respected and indispensable to the healthcare system.

The slogan "yes we can" springs to mind and in closing I would like to point out that while Barack Obama used this slogan during his political campaign, it was a direct translation of rallying cries of the farm workers movement led by César E Chávez, founder of the United Farm Workers, an organisation devoted to defending the rights of farmhands and field workers across the country. Chavez fought for fair wages, humane treatment and safer working conditions for California's farm workers through nonviolent means and was certainly a philosophy held by Sister Henrietta so I would like to end by suggesting we as nurses, be the forceful leaders for change and embrace the idea "yes we can" and make a firm commitment to make our profession one that would make Sister Henrietta proud.

I thank you.

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