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PHILOSOPHY OF NURSING: CARING, HOLISM, AND THE NURSING ROLE(S)

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1. Introduction

One of the central philosophical questions about nursing is: Who is a nurse? In other words, is the nursing role defined by distinctive responsibilities, abilities, or domains of knowledge? And if so, what are they? This is a question of identity for practicing nurses. New nurses will often wonder whether a problem falls within their domain of expertise or responsibility. Should I respond directly, they ask themselves, or do I need to refer this problem to the physician (or social worker, or nutritionist, or housekeeping, or . . .)? Questions of identity are not only about how one regards oneself. Identity is also a matter of how a person is regarded by others. What a nurse is asked to do by a patient or by other members of a health care team depends in part on what they think “nurses” ought to do. The question of identity is also important to the nursing profession. Nursing is regulated and licensed. Decisions must be made about the content and assessment of nursing curricula, as well as the legal boundaries of professional responsibility. Such decisions depend, at least in part, on judgments about the proper responsibilities, abilities, and expertise of nurses: they depend on who nurses are.

The question of identity is made difficult by the enormous variety of health care activities in which people with nursing credentials engage. Nurses are stereotypically employed in hospitals, but nurses also conduct research, teach, serve as administrators, or work in community health settings. Even if we restrict our concern to nurses who have direct contact with patients, there is wide variation in responsibilities and expertise. Consider the following three examples.

Example 1: James is a Licensed Practical Nurse (LPN) in a small hospital. He received his training in one year of community college education, leading to the National Council Licensure Examination (NCLEX-PN). He works with hospital patients recovering from surgery. This means that he makes rounds to check bandages and vital signs, change dressings when needed, and deliver prescribed medication. When patients need assistance, he will help them eat or use the bathroom. Because he spends a lot of time with patients, he often hears their personal stories. He is also often the first to recognize status changes, such as increased body temperature, pain, or bleeding. His work is supervised by a staff nurse, who was educated with a four-year Bachelor of Nursing Science (BSN) degree and who has a Registered Nurse (RN) license. While the patient treatments he implements are ordered by a physician, he has little direct interaction with the physician. Important information about the patients is communicated to James by the staff nurse.
Example 2: Lakshmi is an RN who works in the behavioral health division of a large teaching hospital. She obtained her BSN degree through four years of work at a university-affiliated nursing school. While an undergraduate, she took a number of courses in psychology and biology. After passing her licensure exam and practicing for several years, she went back to school and received a Master of Science in Nursing, specializing in psychiatric nursing. Many of the patients she sees have experienced an acute psychological crisis. She conducts evaluations and consults with a psychiatrist (MD) to develop care plans that respond to the individual patient's needs, complementing pharmacological interventions or helping to manage their side effects. While the laws of the state where Lakshmi works do not permit advanced practice nurses to prescribe medication, she has colleagues in other states who may do so. As a part of a teaching hospital, her unit receives medical students and residents. Her relationship with young physicians is ambiguous and often difficult. She has much more experience than they do, but the physicians have authority to sign off on prescriptions and care plans. Her duties include supervision of several LPNs and non-nursing hospital staff who help feed, bathe, toilet, and, when necessary, restrain patients. While not an official part of her job description, she works more directly with the patient's families than do the psychiatrists in her unit. She educates families about the patient's condition and treatment options, listens to their concerns, and uses this information to shape the patients' care plans.

Example 3: Keisha is a nurse practitioner (NP) in a rural clinic. She passed her licensure exam for the RN after completing her BSN in a four-year nursing school. She went on to get a Master in Public Health (MPH) and worked for several years in the county health department. As a public health nurse, she conducted home visits for the elderly, developed and implemented educational programs, and conducted research for the health department. Seeing a need for more clinics in her area, she worked toward a Doctor of Nursing Practice degree and took the exam to get her NP license. She is now one of three NPs who staff the clinic. She sees patients in the clinic, treating the full spectrum of health needs from the treatment of minor ailments to the management of chronic disease. She diagnoses patient conditions and recommends treatments. State law requires that clinics be supervised by an MD. The physician who supervises her clinic rarely interacts directly with patients. Her primary responsibility is to sign off on the prescriptions, care plans, or referrals recommended by the NPs from two clinics in the area. Patients in the area also have access to clinics staffed by physicians, but many choose a nurse practitioner as their caregiver, saying that they feel like they get a more holistic approach to their health care.

These three examples are a partial representation of the wide variety of roles that are counted as “nursing” in contemporary health care. (The variety is even broader than portrayed here, since all three of these examples are drawn from the American context; nursing varies internationally as well.) While there is variety, there are patterns too. All three examples highlight the way that nurses in clinical practice tend to be on the first line of patient care. In hospital settings, nurses often spend more time interacting with patients and families than do physicians or other health professionals. This is partly because duties like changing bandages, taking vital signs, or educating patients require lengthy personal interactions. The character of their typical interactions with patients has several consequences for nurses.

First, nurses are often the nexus of a patient's care. This is particularly true of nurses who are trained to the RN level and who work in hospital settings. These nurses often find themselves acting as the link between the physician, the patient, and the patient's family. The nurse must communicate changes in the patient’s health status or patient concerns to the physician. She must help the patient and his or her family understand the diagnosis and treatment. In a hospital's complex environment, the nurse often ends up with the responsibility of making sure that all of the pieces of patient care fall into place. Nurses, then, must understand the full
range of factors that influence a patient's health and the elements of the health care system that address them. A further consequence of nurses' front-line status is that nurses are educated in a distinctive way. While the duration of their nursing education may vary from two to eight or more years, nurses are educated in specially accredited schools and must pass specialized exams. A Bachelor of Nursing Science degree invariably requires substantial clinical practice. Coursework will include basic science—anatomy, physiology, pharmacology, genetics—and it will also emphasize the cognitive, emotional, and social aspects of disease and health.

2. Philosophical Questions and the Nursing Role(s)

Against this background, we can ask again: What, if anything, is distinctive of the nursing role? Nursing occupies a place in the division of labor, but is there any good reason why health care roles are divided as they are? If we look across the range of societies, we see health care roles divided in a variety of ways. In traditional societies, childbirth was often attended by specialists, typically female, while the treatment of non-pregnancy-related conditions was delegated to others. By contrast, in 18th-century America, midwives were the only source of health care for those not rich enough to afford the physician or too ill to wait for him to arrive on his occasional rounds. The contemporary European and North American articulation of roles in health care dates largely to the development of modern hospitals and clinics in the 19th century. Florence Nightingale proposed a model of nursing that remains central to contemporary thinking (Nightingale 1969 [1860]). Nurses were to be responsible for the environment of the patient, including the layout of the patient's room, nutritional needs, bandages, and medication. Nightingale's conceptualization of nursing was strongly gendered and hierarchical. Nursing was to be a profession for unmarried, middle-class women, and nurses generally acted at the behest of physicians. As hospitals became more complex, the nursing role became more specialized, more varied, and often more autonomous. Nurses began to specialize in things like surgical care or community health. Some of their earlier responsibilities, such as cooking, doing laundry, or cleaning floors, were allocated to others.

Clearly, many aspects of the nursing role depend on the immediate context. Where physicians are rare and expensive, nursing action must expand to cover a variety of patient needs. In a hospital, where a large number of patients must be served, it makes sense to divide roles more finely. One might conclude that our main question—what is the nursing role?—does not have an interesting general answer. To understand the nursing role, we need only to look at a particular time and place, and to describe the responsibilities actually taken up by those called “nurses.” We might call this answer to our question the social-relativist answer: the nursing role is determined by the social environment. The nursing role is relative to the social environment in the sense that its character depends on the environment. In the three examples, a social-relativist would say that the duties of each nurse are fixed by the hospital or clinic, and that's all there is to it.

The social-relativist position is probably correct as far as it goes, but is it an answer to our question? When individual nurses ask “What is the nursing role?” they are often concerned with the propriety of demands made upon them: is this the sort of duty that I ought to be responsible for? There are “oughts” embedded in the questions of nursing policy, management, education, and licensure as well. The question of the nursing role is “normative” in the sense that it involves judgments about what is good, valuable, or right for nurses to do. This is what makes it a philosophical question. The environment in which a nurse acts is relevant to answering the normative questions about the nursing role, but it is not the full answer. Because of differences in the environment, the duties of a staff nurse in a teaching hospital should be different from a nurse practitioner in a rural clinic, and both ought to be distinct from the
responsibilities of the physician. But more needs to be said to explain why the nurses ought to be responsible for one dimension of patient care rather than another.

When nurses reflect on what their role ought to be, their accounts invoke special characteristics of either the nurse or the nurse-patient interaction. In the sections below, we will explore two commonly mentioned ideas. First, caring is central to nursing. Caring is an attitude that might be distinctive of a nurse's comportment, and it may also refer to the way in which a nurse cares for the patient. What these ideas of caring entail, and whether caring can serve as a justification for the nursing role, will be explored in Section 3. Second, nurses possess specialized knowledge or expertise. Section 4 will turn to the character of nursing knowledge and give particular attention to the idea of “holism,” which has been used to characterize both nursing knowledge and nurse-patient interactions.

### 3. Care and Self-Care

In trying to characterize what the nursing role ought to be, a number of nurse scholars have used the idea that nurses help a patient care for him or herself. Virginia Henderson used this idea to create a well-known and influential definition of nursing:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaidered if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson 1966: 15)

This conception of nursing puts the patient and his or her abilities in the center of the picture. If we think of a nurse like James in Example 1, it is easy to see the attraction of this definition. If I cut my finger with a knife, I clean it, bandage it, and keep an eye out for infection. Patients who have undergone surgery have temporarily lost this ability to care for themselves. They may need to be fed, bathed, and have their clothing changed. In addition, they have incurred a host of new needs for which they do not have the training: monitoring vital signs, inserting IVs, administering medication. The role of the nurse is to fill the gap between what patients can currently do for themselves and what they would do if they had the “strength, will, or knowledge.” Dorthea Orem called this gap the “self-care deficit” (Orem 1971), and similar ideas have played a role in other theories of nursing (Orlando 1961; Wiedenbach 1964).

An argument in favor of the self-care conception of nursing is that it both distinguishes the domain of the nurse from that of the physician and explains the relationship between them. Physicians are, arguably, charged with responsibility to diagnose and treat disease. This is only possible if the patient continues to receive adequate nutrition, bathes, has a clean environment, receives medications at the right times, and so on. In ordinary conditions, we do these things for ourselves. Disease or injury can compromise a person's ability to care for him or herself, and a self-care deficit arises. A necessary health care role, then, is to support the medical treatment prescribed by the physician by ensuring that all of the patient's self-care activities are carried out. This is the nurse's role.

While the idea that nurses address the self-care needs of the patient has been popular, it has also been subject to objections. A first concern is that such a definition puts the domain of nursing responsibility squarely within a hierarchical relationship to the physicians. While there may be contexts where a central responsibility for treatment and recovery is appropriate—surgery or emergency care might be examples—there are many domains of health care where more autonomous action by nurses is necessary. Nurses who conduct visits to home-bound...
patients encounter a wide range of conditions, some of which are not under the direct care of a physician. In the case of Keisha, the Nurse Practitioner (Example 3), she has substantial professional autonomy and needs it to carry out her responsibilities. While the physician has a supervisory role, it does not make sense to think of the nurse practitioner's role as simply keeping the patient properly fed and cleaned so that the physician's treatment can take effect.

The case of Lakshmi (Example 2) adds additional layers of complexity. Patients with a severe mental illness may never be independent. Moreover, some of her patients have never been competent to make their own decisions. What does it mean for the nurse to perform for such a patient an activity that he or she would have done if s/he “had the necessary strength, will, or knowledge”? In response to this sort of problem, some nursing scholars have argued that to care for patients is to respond to their needs, whether or not these are part of an individual's ordinary self-care activities (Edwards 2001).

Thinking of caring-for as a matter of responding to needs raises another concern about the self-care conception of the nursing role. How are a patient's needs determined? Health is not simply a biological matter. Life aspirations, family considerations, and other values also determine a person's health care needs. Health care providers are obligated to respect the health-care choices of competent patients; to respect their “autonomy.” The idea of doing for a competent patient what s/he cannot do for him or herself presupposes, one might argue, that the nurse, not the patient, is determining the patient's needs. When the self-care conception of nursing is used to guide nursing for competent adults, it may fail to respect the patient's autonomy; it is “paternalistic” (Mitchell and Cody 1992). Thinking through this objection may require us to reevaluate our understanding of autonomy and paternalism in relation to the nursing role (Risjord 2014).

The conception of nursing as addressing self-care deficits emphasizes the relational aspect of the concept of care: to care is to care for someone or something. Caring is also an attitude or stance. Henderson's definition of nursing, quoted above, is notable for the absence of any caring attitude on the part of the nurse. The “unique function of nursing” could apparently be carried out by machines. To be more charitable, we might read Henderson as presupposing that the nurses have a caring attitude and that such an attitude is necessary to provide good care for the patient. The next question, then, is about this implicit notion of caring. What sort of attitude or stance do “caring” nurses exhibit, and why is it necessary for good patient care?

Kristen Swanson has argued that a nurse's therapeutic actions (as described by Henderson, for instance) are supported by three other dimensions of caring, what she calls “maintaining belief,” “knowing,” and “being with” (Swanson 1993). (We will discuss the characteristics of nursing knowledge in more detail below, and thus focus on the other two dimensions here.) “Maintaining belief” denotes an attitude of support for the patient as he or she confronts or copes with a health problem. It is a faith that the patient can get through the crisis, or if the condition is chronic or terminal, find ways to come to grips with it. Maintaining belief is an attitude shared by teachers and coaches: if the coach didn’t think I could get better at my tennis backhand, there would not be much point in her instructions. “Being with” is a matter of being “emotionally present” to the patient, including “not just the side-by-side physical presence but also the clearly conveyed message of availability and ability to endure with” the patient (Swanson 1993: 355). “Being with” captures the affective dimensions of nursing care, but it is more than empathy. The attitude must be communicated to the patient (and perhaps the family). And there must be limits to emotional availability. Human life is full of tragedy, and asking nurses to share unconditionally in their patients’ suffering would be an impossible demand.

Adding Swanson's analysis of the nurse’s attitude or stance to Henderson’s characterization of nursing’s therapeutic domain clearly provides a more complete picture of nursing care. It also
might be defended in a way that does not depend on a hierarchy between nurse and physician. Steven Edwards argues that caring is grounded in the fact that humans are vulnerable; we have the capacity to feel pain and to suffer (Edwards 2001). Human vulnerabilities give rise to the needs, and these are only partly met by medical diagnostic and treatment regimes. Faith in the patient, specialized knowledge, and emotional support may not be biologically necessary (in the way that nutrition or infection control are), but they too contribute to the patient's health and ability to heal. This sort of support requires a health care professional with direct and extended contact with the patient, and this would be the nursing role.

One might object that using this concept of care to define the nursing role either fails to be unique to nursing or excludes some appropriate activities. It is certainly true that each of the proposed aspects of care is or should be shared by other health care professionals. A physician who was emotionally disengaged or who exhibited no faith that the patient could cope would be a poor physician. Hospital cooks and nutritionists also meet the patients' needs. On the other hand, this conception of caring might seem too demanding. Arguably, at least some nursing activities can be conducted without the emotional engagement described above (Seedhouse 2000). Nurses who are responding to acute crises in an emergency room or on a battlefield might be examples. Moreover, many nurses do not have direct responsibility for patient care: they run research programs, administer staff, teach, or analyze policy. It is not clear how the dimensions of caring discussed above would figure in their roles. Are we to conclude that such health care practitioners are not nurses, despite their titles, credentials, and training?

The foregoing objections arise insofar as caring is taken to be a description of nurses' attitudes and activities. In the discussion of the social-relativist conception of the nursing role, we noted that a mere description of nurses' duties does not answer our question. Similarly, a mere description of nurses' attitudes will not answer our question either. The question is a normative one: how should we understand the nursing role? In Edwards' argument that the nursing role is grounded in human vulnerability to pain and suffering, he notes:

Nursing can be understood as a moral response to this [vulnerability]. Thus nursing is exposed as an essentially moral enterprise.

(Edwards 2001: 112)

Caring, then, is not a description of nurses, it is a moral dimension of nursing practice. It is an ideal or value embedded in the call to nursing. Treating caring as a value goes some way toward mitigating the foregoing objections. There may be particular nursing activities that do not require the attitude of caring or that do not respond directly to patient needs. But insofar as they are within the appropriate scope of a nurse's duties, they should be consistent with promoting or achieving a caring response to human vulnerability. And as a value, caring should be shared by physicians and other health care personnel. The difference is not in the possession of the value, but the range and type of needs to which nurses respond.

4. Holism and the Nursing Perspective

One way in which nurses make a distinctive contribution to health care is through their particular knowledge or expertise. Florence Nightingale was instrumental in the creation of a nursing profession because she was able to synthesize and express the knowledge that nurses bring to patient care. Nurses, on her view, understood the larger context in which patient healing could take place. This included the light and air in the patient's room, the patient's emotional, cognitive, and spiritual needs, as well as wound care, nutrition, and so on. Later,
nurses recognized the social environment of the patient—his or her family, community, and the larger cultural context—as important too. In the early 20th century, nurse scholars argued that nursing was a profession, because it encompassed a unique domain of knowledge.

What is the knowledge distinctive of nursing? Clearly, nurses share much knowledge with other health care providers—knowledge of anatomy, disease process, pharmacology, and psychology, for example—and this is entirely appropriate, even necessary. Many have argued that this shared knowledge must fall within a distinctively nursing perspective on health, healing, and health care. The challenge, then, is to articulate what this distinctive perspective amounts to.

Some contrast the nursing perspective with the medical perspective. Medical research has made great strides through better understanding of the biological underpinnings of normal physiological function and its disruption. This understanding informs medical diagnosis and treatment. If nurses adopt a “medical model” it would, arguably, shape nursing interactions:

The medical model forces nursing to view health-illness manifestations as organic phenomenon where emphasis is upon disorders in the structure and function of the body. With this disease-oriented approach to clients, the nurse is concerned with underlying defects or structural aberrations . . . The utilization of the medical model compels a person to view disease as the failure of the body as a physiochemical machine, and patients are helped by interventions in bodily processes. . . .

(Phillips 1977: 5)

While the medical model is helpful in organizing knowledge about patients, according to Phillips, it limits nursing. Nursing needs to integrate knowledge of the patient’s larger context, such as the patient’s emotional or psychological state, relationship to his or her family, or social position. Phillips argues that this larger context should not be understood as mere extension of a mechanistic perspective to emotions or social relationships. If nursing is to be a distinctive profession, it needs a unique framework within which to develop nursing expertise. Phillips suggests that the unique framework for nursing is a model that “views man in his totality in his interaction with the environment” (Phillips 1977: 7). While Phillips does not use the term, many who characterized the nursing perspective in this way call it “holism.” The nursing perspective sees the patient and the patient’s health care as something more than a mechanistic process. The parts combine irreducibly into a whole; in this sense, it is “holistic.”

One answer, then, to the question of what makes nursing knowledge distinctive locates nursing knowledge within a particular paradigm or conceptual framework.

The new paradigm in nursing has been characterized in multiple ways, with the major emphasis on the irreducible unity of human beings and their worlds, the dynamic unpredictable unfolding of multidimensional life patterns, and the human freedom to choose direction in life based on personal values and meanings. The human is seen as a living unity and a self-interpreting free agent. Health is seen, not as a condition to be characterized as good, bad, more, or less, but as a life pattern experienced qualitatively by humans. . . .

(Cody 2000: 96)

Understood in this way, holism is a body of substantive commitments. The propositions Cody articulates—e.g., that humans are free to choose their direction in life, or that health is a life pattern not to be characterized as good or bad—are not statements that might be confirmed or refuted by careful observation. They are assumptions or presuppositions; statements that
should be accepted by nurses to guide their practice and their empirical inquiry. The language of a “paradigm” expresses the idea that scientific knowledge is not based on observation alone. It is guided by fundamental ideas. Big differences in scientific perspectives, sometimes exhibited in dramatic historical shifts in scientific theory, are partly differences about fundamental presuppositions. On this kind of view, then, the distinctive feature of nursing knowledge is found in a unique set of assumptions.

The idea that a holistic paradigm should characterize nursing knowledge has been criticized by nurse scholars on several grounds. First, it is not clear that assumptions of the sort identified by Cody preclude a mechanistic understanding of disease processes. It is possible, for instance, for a nurse or physician to agree that a human being is a “living unity and a self-interpreting free agent” and still deploy their knowledge of pharmacology when exploring treatment options. Arguably, the best care requires both an understanding of biological micro-processes and a broad appreciation of the particular patient and his or her situation. Moreover, if a commitment to the holistic paradigm really did preclude a nurse’s use of biological knowledge, then nurses are blocked from finding or using any effective health interventions. Any action that is effective in addressing a patient’s health concern must be causally effective. To develop such interventions and understand their limitations, we need to know about causes, and this means understanding mechanisms involving organs, tissues, cells, genes, hormones, and so on.

A somewhat different conception of holism was expressed by Rosemary Ellis:

Holism, if used as the appropriate view for aiding a patient, requires that one be concerned with any factor, be it physiological, social or any other, which affects the patient’s health. It requires that the factors be treated in combination, not in isolation. It also means that the combination is not the same as the sum over each factor. Nursing requires the recognition of the inseparability and interdependence of many factors.

(Ellis 1968: 218)

The first point to notice is that this sort of holism concerns practice. Ellis is not treating holism as an assumption, presupposition, or anything else a nurse might believe or disbelieve. Holism, according to Ellis, is something that might be “the appropriate view for aiding a patient,” and it requires a specific kind of concern. It is a practical commitment to treat the factors influencing a patient’s health in combination. This means that holism is a characteristic of a nurse’s practical knowledge; her theoretical knowledge need not be holistic.

In her essay, Ellis is implicitly opposing the “reductionism” found in medicine. Physicians were portrayed in this period (and often since) as narrowly concerned with the patient’s disease or dysfunction. The nurse, by contrast, is charged with a broad responsibility for the patient and his or her environment. A reductionist approach in this domain would consider a patient’s disease or dysfunction in abstraction from the other factors. Because of her role in health care, a nurse cannot be so limited. The nursing role demands that a nurse attend to any and all factors that affect a patient’s health. To limit nursing concern to one organ system, or to one dimension of psychological or social dysfunction, would be to ignore the broader context of patient health that has been central to nursing since Nightingale’s time.

In response to Ellis’s argument for practical holism, one might point out that it relies on a false contrast between medicine and nursing. Just as physicians should not be portrayed as uncaring while nurses are caring, physicians should not be portrayed as reductionist while nurses are holistic in their practice. Practical holism should be part of good medical care too. That said, it remains true that the typical range of a nurse’s holistic concern in patient care is broader than a physician’s. As the examples in Section 1 illustrate, nurses often have a much
richer engagement with the patient’s family and personal history. Arguably, then, the scope of holistic care in nursing is broader than holistic care in medicine.

A further objection might be that while a holistic practical attitude describes many nursing situations, it does not describe all of them. While stanching bleeding, one would probably do best to attend just to the wound; the patient’s story can wait. And like the use of caring to define the nurse’s role, practical holism privileges nurses involved with direct patient care. The parallel with the difficulty we saw in using caring to define nursing suggests that the root of the problem might be the same. In the approaches we have discussed in this section, holism is taken to describe something about nurses or nursing. Perhaps we should understand practical holism as “an ideal, an abstraction mean to orient our awareness, not to depict a tangible outcome” (Thorne 2001: 261). Practical holism is an ideal or value orientation. Thinking about holism this way blunts the objection that holism does not include all nurses or nursing activities. There may well be situations where a holistic approach is irrelevant or may even be counterproductive. Nonetheless, it can remain one of the values that informs the full range of a nurse’s activities.

5. Conclusion: Thinking the Nursing Yet to Come

We have seen in the previous two sections that “caring” and “holism” are plausible ways of identifying the nursing role, subject to two provisos. First, neither caring nor holism should be thought of as a description of nursing attitudes, actions, or knowledge. Rather, they are values or ideals embedded in the practice of nursing. Second, neither should be used as an all-or-nothing contrast (e.g., caring versus curing or holism versus reductionism) with other health care providers. Both are values that ought to be exhibited to some degree by any health care provider. The difference lies in the content or scope of the value.

The astute reader will have noticed that this second proviso gives rise to a potential circularity. We began with the question of how to understand the proper scope of nursing. The partial answer developed so far is that nursing practice involves the values of caring and holism. We have insisted that the difference between nurses and other health care providers does not lie in holding caring and holism as values, but in the scope or content of the value. The kinds of situations with which they are confronted mandates the kind of caring and holism valued by nurses. But the situations confronting nurses depend on the appropriate domain of nursing action. In other words, the proper nursing role is defined by . . . the proper nursing role.

Were our project simply one of definition, circularity would be devastating. It sheds no light on the meaning of “inspiring” to define it as “having the effect of inspiring someone,” as the online Oxford English Dictionary does (Oxford Dictionaries 2015). But as the first part of this essay indicated, the question about how to understand the nursing role is not a request for a definition. It is a question that arises for practicing nurses when considering the appropriate scope of their duties. The current roles occupied by nurses have a history, and they have been formed by forces both within and outside of nurses’ control. At any point in that history, nurses can (and did) ask, is our role what it ought to be? Should we resist or advocate for changes in our role? The apparent circularity identified above is a tension between the “is” and the “ought” of the nursing role, between what the nursing role currently is and what the ideals of nursing demand of it. To understand who a nurse is, we must adjust the current nursing role(s) in the light of what they ought to be.

The deeper question to which we have come, then, is: what should the ideals or values of nursing practice be? We have seen arguments for including caring and holism among the values of nursing, but this is only the beginning of a much larger inquiry. The important point, and the one with which we must close, is that a philosophical question lies at the heart of nursing
practice. Nursing practice is implicitly committed to a variety of values. Reflecting on these values is a part of nursing, but it is not something that a typical nurse will do on a typical day in the clinic. Nursing philosophy serves, in John Drummond's phrase, as an “avant-garde” for nursing practice (Drummond 2004). Like the avant-garde in the arts, it explores the space of possibilities. Good practitioners need to tack back and forth between the avant-garde and the mainstream, using explorations of novelty to expand horizons of the familiar. An essential part of the call to nursing, then, is philosophical: to thoughtfully engage “the nursing yet to come” (Drummond 2004).

References


Further Reading