The Essence of Nursing Practice

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Philosophy and Perspective
The Essence of Nursing Practice
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Preface

This book has been in the making for the past 30 years or so. It has brewed from the countless hours spent with students and colleagues regarding “nursing practice” as a concept and an area of study. I designed and taught courses on theories of nursing practice in the master’s and PhD programs in nursing at the University of Rhode Island, College of Nursing from the beginning of the 1980s. During my years teaching these courses on theories of nursing practice and delineation of concepts in the nursing practice domain, I have struggled with my students and colleagues regarding how best we could characterize the essential features of nursing practice in a normative stance. I believed then and continue to believe that the construct of nursing practice has to be specified by extracting elements encompassed within it, which are necessary for the practice of nursing to be of the highest quality. This means it is imperative to describe nursing practice in terms of how it should be practiced. Developing nursing practice either for beginning practitioners or advanced clinicians requires a guidepost toward which nurses’ practice has to move to achieve the highest quality possible.

An analytical model of nursing practice is presented in this book as this guidepost and as a framework to delineate critical and essential elements of nursing practice. The literature is lacking in these sorts of comprehensive and analytic models to illustrate and examine features of nursing practice, and this has perhaps led education of nurses for nursing practice to be generally compartmentalized in relation to clinical problems. The model of nursing practice advanced in this book includes five structural levels—perspective, knowledge, philosophy of practice, dimension, and process—as the interconnected analytical structures that provide guidelines for how nursing practice needs to be configured and what elements are to be integrated to formulate nursing practice.
practice. Reed states that “the practice of nursing is an art of combining the contingencies of the moment, including diverse patterns of knowing, with systematic and scientific knowledge to create a caregiving situation” (2011, p. 20). In order for nurses to practice nursing in this sense, they have to rely not only on the knowledge, patterns of knowing, and the situational contingencies but more critically have to know the way to integrate these aspects to make their practice to be *nursing*. This integration does not occur naturally, but through an “intentional” application of various processes involved in human practice to make it nursing. The model is applied to delineate and examine factors that go into this integration for nursing practice. The major aim for the book is to sensitize nurses, both at the beginning and advanced levels, to the complexities involved in the practice of nursing, and to provide material necessary for an in-depth understanding and analysis of nursing practice in order to advance their practice.

The book is designed primarily for graduate students in nursing, especially those in advanced practice nursing programs at the master’s and doctoral (DNP) programs who are engaged in clarifying the process of advanced nursing practice, and those in PhD programs who are interested in addressing epistemic questions related to nursing practice as generic subject matter. Senior-level undergraduate nursing students can benefit from this book if it is incorporated into their senior-level courses dealing with professional nursing, as it will provide a base with which they can begin to examine clinical practice in beginning practitioner roles. It will also be useful to nurses in practice in reflecting upon their own practice to develop their practice further. The book will be a resource to nursing educators in course designs and teaching of nursing practice regardless of clinical specialization.

I have been fortunate to be associated with many colleagues and graduate students who have stimulated and contributed to my thinking contained in this book. Among them, I must acknowledge three individuals specifically. Dr. Donna Schwartz-Barcott who, as a colleague at the University of Rhode Island, College of Nursing for nearly 30 years, has been a tireless sounding board and support for me. Dr. Inger Margrethe Holter of Norway has encouraged me over the years to continue with the line of thinking I hold about nursing practice, and has asked me to write an abridged version of my model for publication in a Norwegian nursing textbook. Also, Dr. Björn Sjöström of Sweden is acknowledged and fondly remembered. He was a wonderful colleague who had challenged me to work through various philosophical underpinnings of nursing practice in many hours of discussions at our meetings in all parts of the world, including one on a cold winter evening at a railway station in a small village in Sweden on our way to a conference. He helped

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greatly in crystalizing my thinking, especially in relation to pragmatism for the study of nursing practice. In addition, many of the ideas contained in this book have been expressed at various presentations made at annual meetings of the Eastern Nursing Research Society, at the New England Knowledge Conferences for Nursing Knowledge Development held at the University of Rhode Island from 1990 to 1994 and at Boston College from 1996 to 2001, and at other seminars for graduate students and faculty in Norway and Korea. The audiences at these presentations have been of great help through voicing their ideas and debates in clarifying my thinking.

Finally, I acknowledge the constant support provided by my husband, Hyung G. Park, who has encouraged me relentlessly to continue with this project even in our “retirement.” It is to him that I dedicate this book.

My hope is that the book can serve as a springboard for lively discussions and debates regarding the nature and essence of nursing practice in our pursuit to advance nursing practice.

—HESOOK SUZIE KIM
CHAPTER 1

Introduction

Nursing as a form of service has a long history, dating back to informal caregiving in ancient times to the current, highly organized, and disciplined professional practice. Although nurses hold various positions and roles within the health care system being engaged in direct patient care, administration, quality assurance, education, and research, it is what nurses do in direct patient care that constitutes the core of nursing as a practice discipline. Nurses in direct patient care are engaged in their practice as staff nurses, clinical specialists, master clinicians, advanced practitioners, or clinical supervisors in acute-care hospitals; long-term care institutions such as, nursing homes, chronic-care hospitals, or rehabilitation centers; home-care situations; community health care settings such as, group homes, schools, and health centers; clinics/ambulatory settings; and private offices. Although how nurses practice varies greatly across these settings depending on what patients generally require, which other professionals and nonprofessionals are there together with the nurses, and what the purposes of the settings are in relation to patient services, nurses are invariably the major players responsible for ensuring patients receive the care and treatments necessary to manage their health.

As occurs in many different fields and settings within the health care system, nursing practice encompasses many different sorts of actions and relationships. These range, for example, from deciding upon the best way to help a patient become competent doing his own colostomy care, to arranging for a patient’s discharge to a nursing home after a stroke. However, it is not such actions or relationships per se as discrete entities that make nursing practice what it is, but it is in how they are put together by a nurse in the context of the patient as a person in need of assistance and service. Claire Fagin, in her
introduction to Suzanne Gordon’s book *Life Support*, articulates this by stating that even “emptying a bedpan” by a nurse, just as any other aspect of nursing practice, must be considered in “the context of a larger focus on the total patient” (Gordon, 1997, p. xviii). Nursing practice should not be equated with discrete actions such as assessing patients, giving medications, teaching patients, comforting, and discharge planning, however valuable and essential these are as segments of nursing practice. Such discrete actions are “techniques” unto themselves, which can be performed skillfully by anyone who is given training or has experience. And because techniques are only tools and methods applicable in the context of a goal, design, or production, it is the context of application that is of utmost importance. In nursing practice, various “techniques” are brought forward and applied in the context of patient care with the goal of enhancing healthful living or peaceful dying for patients. A nurse-midwife sits with a woman in labor, “doing nothing” as Kennedy (1999) puts it, but this “sitting” as a technique is a part of carefully constructed nursing practice for patients in labor, which involves noticing the progress, constant vigilance and surveillance of abnormal presentations, and bringing supportive presence. Sitting as a technique certainly is simple enough for anyone to perform; however, it becomes an essential aspect of nursing practice in this context not for its technical complexity but in its meaning and goals.

Often when teaching beginning nursing students nursing faculty may emphasize skill development in nursing “techniques” in isolation from the context of total nursing practice, which may be a necessary approach in teaching. However, it is not until such skills are put into a total package of nursing care that they come to have “nursing” meanings. Moreover, in the pressure-driven, time-constraining situations of the current health care arena, nurses sometimes are technique-oriented, often working with a list of activities to be carried out within a given span of time, with the completion of tasks as their primary focus. Tasks and techniques that are carried out by nurses with no relation to the meaning structure of nursing practice stand as separate strands dangling without being woven into what Baer and Gordon (1994) called “the tapestry of nursing.” Gordon describes nursing “as a tapestry of care woven from countless threads into an intricate whole” (1997, p. 20). The nature and essence of nursing practice described and specified in this book is based on the notion of this tapestry not in the conventional, one-dimensional form, but in a complex, multidimensional work of integration and coordination. To begin with, nursing is a socially mandated form of human service, of which the nature and the demands change along with the changes that occur at larger social institutions and culture. Hence, the practice of nursing cannot be presumed to remain static in its character, but should be considered to evolve and change.
1. INTRODUCTION

THE DEFINITION OF NURSING PRACTICE

Writing in the cultural, scientific/technological, and societal backdrop of Europe and England in the 19th century, Florence Nightingale in her Notes on Nursing (1859/1946) considered human suffering, not of diseases themselves but suffering in diseases, the primary focus of nursing attention and suggested nursing to be critical in assisting the reparative process of nature. She wrote, “It [nursing] ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient” (1859/1946, p. 6), and referred to it as sanitary nursing, differentiating this aspect of nursing from what she called the handicraft of nursing practiced in “surgical nursing” (1859/1946, p. 71). However, her notion of nursing expressed in these Notes addressed nursing in the context of “personal charge of health in others” in a generic sense rather than as a professionalized notion. Although Nightingale’s ideas and her work have revolutionized the societal approaches to nursing and nursing education, the current ideas regarding the meaning of nursing reflect a great deal of change from this notion of sanitary nursing.

Henderson defined nursing more than four decades ago by stating that “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 unaided 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” (1961, p. 42). This became the cornerstone for nursing practice in the second half of the 20th century, especially in the United States. Henderson, reflecting on her earlier writing in 1991, expanded this notion by putting more emphasis on primary health care as an expanding nursing responsibility, and nurses’ role in helping patients with “a good death” (1991, p. 33).

In the background of Henderson’s definition, and in reflection of the current situation of health care and nursing, the World Health Organization (WHO) Expert Committee on Nursing Practice, which convened in Geneva in 1995, proposed a functional definition of nursing. This definition emphasizes nursing’s role in helping individuals, families, and groups in addressing and achieving their physical, mental, and social potential in the context of their everyday lives. Nursing functions encompass promotion and maintenance of health; prevention of ill health; and care during illness, rehabilitation, disability, and dying. It furthermore specifies that nursing has to uphold the values of self-determination and people’s involvement in all aspects of health care. Nursing as an art and a science requires both specialized knowledge and
knowledge from related fields applied to carry out its functions (WHO Expert Committee on Nursing Practice, 1996).

These statements in the definition reflect the current ideas of professional nursing practice and circumscribe the general characteristics of nursing. The definitions of nursing from that of Florence Nightingale to the most recent one by the WHO panel suggest the evolving nature of nursing practice in the context of both the internal and external forces that shape the nature of nursing practice in societies. However, there are major threads that remain constant regardless of the time and place. These are nursing’s focus on people’s health and illness, not on diseases, and its service orientation and person orientation.

Nursing practice is a form of human service, which is specifically anchored on the benefit of others (i.e., clients, patients, or service users), requiring the practice to be intentional, thought-out, and goal-directed. Nursing practice is a complex of online engagement in human actions, oriented to helping patients live their lives as well as possible in the context of health, illness, and dying. It is totally person-specific and established activities of nurses as agents of specific responsibilities. This means that each nursing situation involving a patient is unique in its demand for nursing actions. A patient in a specific time and context requires of the nurse in practice to respond to the patient- and situation-specific demands, needs, and considerations. Nursing situations vary within a broad spectrum of acuteness, complexity, seriousness, and meaning, ranging, for example, from a patient at a clinic who is newly diagnosed with diabetes having only a few problems of living to a patient in an intensive care unit who has gone through an extensive bypass surgery to deal with a coronary arterial obstruction, and to an elderly patient in a nursing home who is frail, confused, and dependent. Nursing practice occurs with patients who are located in various situations of living, including short-term or long-term institutions within the health care system, as well as in their homes. Nursing practice involves human beings both as recipients of nursing care (the patient) and as agents of nursing acts (the nurse). Because nursing practice is a special class of human actions, having a normative goal orientation as its starting point, our consideration of nursing practice must be framed within a normative model. That is, when we talk about nursing practice, we must deal with what it ought to be, which then can be used as the basis for examining what it is (i.e., how it is actually practiced). Nursing practice is defined as the following, encompassing several key ideas to identify nursing as a specific form of human service:

*Nursing practice is a goal directed, deliberative, action oriented, and coordinated work for and with patients for enhancing healthful living or peaceful dying, in which patients and nurses share the ontological realities of human*
features and life, and of human agency. Nursing practice is an intentionally coordinated process consisting of scientific, technological problem solving, human-to-human engagement, and services to patients with specific needs. It occurs in social situations of health care in which nurses assume particular sorts of responsibilities. (Kim, 2010, pp. 48–49; see Figure 1.1)

Nursing practice is goal directed, meaning it is oriented to helping patients to deal with problems and issues pertaining to their health, both in times of health and illness. This goal is socially and legally mandated, as nurses are licensed to practice in accordance with the law that specifies what the practice must entail. The goal orientation of nursing practice is also articulated in the mandates advanced by professional nursing organizations such as the American Nurses Association (ANA). The ANA in its Social Policy Statements specified that nursing “is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human responses, and advocacy in the care of individuals, families, communities, and populations” (ANA, 2003, as quoted

FIGURE 1.1 Components of nursing practice embedded in the definition of nursing practice.
in ANA, 2010c, p. 10). Nurses themselves, patients and their families, professionals such as physicians, nonprofessionals, as well as laypersons expect nursing practice to be oriented to goals related to patients’ health. The goal is related to enhancing patients to gain or sustain healthful living or peaceful dying.

Nursing practice is deliberative, in that it is designed and intentional to address the goals for patients. It requires nurses to know how to mobilize their own resources, both instrumental and cultural (such as knowledge, skills, techniques, attitudes, and values), and resources in patients and the environment deliberatively and intentionally. In practice, nurses need to be aware of and take into consideration the consequences of their actions in patients through their deliberations. Deliberation is making choices; Aristotle says that we deliberate about things that are in our power and that could be done in one way or another in order to achieve a given end. Aristotle, in his *Nicomachean Ethics*, articulates the characteristics of excellence in deliberation as that is aimed at an end, involving an inquiry into “a particular kind of thing,” as “a kind of correctness,” and involving reasoning, thus summarizing this by stating that “excellence in deliberation in a particular sense is that which succeeds relatively to a particular end … [and] will be correctness with regard to what conduces to the end of which practical wisdom [phronesis] is the true apprehension” (Aristotle /Ross, 1980). In this sense, deliberation is what occurs in a situation of practice aimed at a goal or an end that is viewed to be “good”—“goodness” in nursing being located in the outcomes of patients.

Nursing practice is action oriented, as it is doing that eventually counts in practice. Practice occurs because nurses are engaged in actions such as assessing patients, observing, carrying out treatments, caring, communicating, teaching, or counseling. In addition, such doings require doing them correctly and skillfully, doing them at the right moments, doing them in concert with other things happening at the same time, doing them with foresight, and doing them valuing patients’ identities, worth, wants, and humanity. Nursing practice as doing is praxis, in the sense that it is originally articulated by Aristotle as doing and acting guided by a moral disposition to act truly and rightly with a commitment to human well-being (Aristotle/Ross, 1980; Lobkowicz, 1967, pp. 9–15). Praxis to Freire means “reflection and action upon the world in order to transform it,” and refers to “the dialectic relation between the subjective and the objective in which men [sic] engage and confront reality by critical intervention for transformation of it” (1970/1992, pp. 36–37). Along this line of thinking, Holmes and Warelow proposed nursing “as a form of praxis” in which it is “seen as a standard of excellence, an ideal ethical goal for which to strive; it is also what Marxists would describe as an attempt to make an irrational world more rational, or a way of making useable sense of one’s practice world” (2000, p. 175).
Nursing practice as doing in this sense transcends the mere acting or performing and elevates it to the realm of morally committed human actions of nurses.

_Nursing practice is a coordinated work for and with patients._ Nurses are responsible for coordinating various sectors and players in the health care system to bring about the goals for patients. Nursing, in general, is not practiced in an isolated, separated, solo format, but is practiced in concert with others engaged together within a same time period or connected in a network of relationships. Nurses in hospitals, even under the primary nursing format of organized nursing service, work with other nurses on a same unit during a given shift, nurses from other shifts assigned to same patients, and nurses on other units who may have cared for the same patients or who will be caring for them later. Nurses not only coordinate the work of each other, as many nurses are involved in providing care to patients at different times and are responsible for different things, but also coordinate the work of physicians, various therapists, para-professionals, and other assistive workers so that patients receive appropriate care, therapy, and attention from these people. More importantly, nurses coordinate with patients and their families so that patients’ needs, wants, and resources are brought into patient care. Nursing practice is primarily “working with” patients not upon patients, as patients are not receptacles of care provided by nurses but are coparticipants in the process of care. As coparticipants in the process of care, patients are involved in transforming their lives and actualizing their potentials for healthful living in concert with nurses. Therefore, the coordination required in nursing practice is encompassed within the notion of collaborative practice.

_Nursing practice involves patients and nurses sharing the ontological realities of human features and life._ This means that nursing practice as a form of life needs to be understood to involve patients and nurses, involving both as humans embodying strengths and weaknesses of humanness, such as (a) bounded physicality and consciousness, (b) unbounded imagination and creativity, (c) discursiveness, (d) social, cultural, and historical situatedness, (e) interpersonal dependence, and (f) solitary, independent existence. Humans are complex beings ontologically, encompassing various forms of paradoxes. On one hand, humans cannot deny their bodies as providing the concrete basis of existence, but, on the other hand, humans transcend their bodies in their existence as it has meanings stretching beyond the matters of body, as selfhood is an essential aspect of humans determining what it means to be individual human beings. Humans use language and other symbols to communicate with each other, and engage in thoughts and activities that are based on imagination and creativity.

Humans are also social, historical entities, each with a unique biography and at the same time also sharing social and historical backgrounds with
many others. Nurses encounter each patient as a human being, who presents a human body and selfhood all at once that are framed by one’s unique biography, social, cultural, and historical situatedness, and possibilities for consciousness, transformation, and relationships. Likewise, nurses are in practice as human beings with the same qualities. This means that as patients rejoice birth, recovery, and physical and emotional triumphs, nurses exult in success, competence, and collaboration; at the same time, as patients suffer and endure pain, are in a state of disability or dependence, or face impending death, nurses in practice also suffer and endure fatigue, irritation, disappointments, or helplessness. Individual human beings are unique in their makeup, existence, and experiences, although there are some aspects of individuals that express the shared qualities of humanness. Each nursing practice occasion is a meeting of at least two human beings with their complexities, similarities and differences, and commonness and uniqueness. In this sense, nursing practice is a part of life, that of both the patient and the nurse.

Ontological realities of humanness in patients within the perspective of nursing practice must encompass the idea of the human body as the seedbed of health, disease, and illness—not as a separate entity but one that is encased with other nonbodily aspects such as selfhood, history, sociality, and culture. The locus of nursing practice begins in patients with such realities, which are connected in a complex web of sensations, meanings, and expressions, and which nurses must respond to and address in their practice.

Nursing practice involves patients and nurses as human agents. “Human agency” is a term that refers to a human’s autonomy, freedom, and responsibility in relation to one’s own actions. Humans as agents are viewed to be entrusted with choice and deliberation (Dewey, 1922/1957), having the power and right to make decisions regarding one’s actions and being responsible for one’s conduct and participation in social life. Human agency refers to having the power to act, that is, “to intervene in the world, or to refrain from such intervention, with the effect of influencing a specific process or state of affairs,” and having the “transformative capacity” for human action (Giddens, 1984, pp. 14–15). Human agency requires making choices and acting based on moral and ethical responsibility, and making a fine balance between self-interest and communal interests in social life. Nursing practice viewed in terms of human agency refers to the participation of nurses and patients in care as agents of autonomy, freedom, and responsibility. This means that both nurses and patients are to be held accountable for their choices and actions, but, at the same time, such accountability must emerge from a careful coordination of interests and choices. Imperative in this notion is the moral grounding with which human agency plays out in practice to produce a coordinated and effective social life.
The concepts of human agency differ among many philosophers and social scientists, ranging from a view that human agency is strictly contained within the self as an independent, autonomous being open to freedom to a postmodern view of human agency embedded through and through in culture, power, language, and history. For our purpose, human agency is conceived to be both free and constrained in dialectic relations to each other for the control of human actions and in the pursuit of a coordinated life. Hence, in nursing practice from the human agency perspective, it is neither the nurse nor the patient who wields final choices, but both as engaged agents. Because of this feature, nurses are called upon to act as moral agents in upholding the human agency of patients (Liaschenko, 1994), at the same time being responsible moral agents themselves.

Nursing practice encompasses an aspect of scientific/technological problem solving. Nursing within the current scientific/technological culture and the culture of economic efficacy and accountability has been entrusted with the responsibility of providing solutions for a set of human problems of health and illness. This has occurred both within nursing, as the nursing profession has sought to identify its social and instrumental identity as a worthwhile and necessary health care profession, and from external pressures to account mostly for the costs of its services within the health care system. Hence, nursing is responsible for providing solutions to problems presented by patients from the nursing perspective, utilizing scientific knowledge and technological instrumentation. Outcomes of nursing practice are measured in the context of expected results of nursing treatments, strategies, and interventions applied to solving patients’ problems.

Thus, nurses are engaged in identifying problems, thinking through possible solutions based on available knowledge and techniques, and applying such solutions in order to achieve the most possible effectiveness and efficacy in situations. Problems that nurses are responsible to address include situational problems experienced by patients such as discomfort associated with prolonged bed rest to problems of living associated with illness such as dealing with dietary and activity requirements from being a diabetic or managing chronic fatigue and weakness in a cancer patient on long-term chemotherapy.

In addition, nurses often practice within the context of medical problem solving that focuses on diagnosing and treating diseases, participating as supporters and partners in the application of medical technologies and therapeutics. Nursing practice involves, for example, giving medications and monitoring the effects of drugs on patients, adjusting oxygen flow rates depending on patients’ oxygen-saturation levels, instituting medical therapeutic regimes,
or helping patients get x-rays. Liaschenko considers “monitoring patient responses to medical treatment the most visible, well-defined and, perhaps, common understanding of nursing practice” (1998, p. 13). Although nurses exercise a great deal of freedom in solving problems such as adjusting medication dosage or changing the timing of therapy, their work is circumscribed within the perspective of medical therapeutic effectiveness in this respect. However, this aspect of nursing practice is ancillary to the problem solving regarding patients’ nursing problems.

In both of these sorts of involvement in problem solving, nursing practice relies on scientific knowledge and technology to attend to problems in rational, instrumentally oriented processes of decision making, critical thinking, and project design. This aspect of nursing practice is prescriptive and involves strategic actions. However, solving patients’ problems in practice situations is a complex process in which presenting problems need to be contextualized and interpreted, and often “managed” or “attended to” rather than “solved” or “removed.” The notion of scientific problem solving in nursing does not necessarily mean applying standardized solutions, but approaching a patient’s problem as an individual, unique problem requiring an application of general theories and techniques fashioned for such uniqueness and individuality.

Nursing practice involves human-to-human engagement. Nursing practice occurs among people, with nurses and patients being the major players. It is a relational practice as Gadow (1995) and Bishop and Scudder (1999) suggest, in which nurses and patients are engaged with each other as humans, interacting and sharing. In human engagements, people present their selves and reveal their individualities through bodily and discursive acts. Through these acts, people arrive at constructions regarding others’ and their own wants, needs, desires, and meanings, and formulate interpersonally valid and appropriate approaches to each other regarding such constructions. Human engagements are means through which humans gain access to each other’s resources. However, patient-to-nurse engagements as relationships and interactions have a different character from that of the usual, personal engagements people establish in ordinary lives, as the patient-to-nurse engagement is framed within the respective roles of patients and nurses in the context of health care. Nortvedt (2001b) suggests that patient–nurse engagements as relationships are guided by moral responsibilities on the part of the nurse for attending to the needs and suffering of patients. Furthermore, patient–nurse engagements are akin to Freire’s view of dialogical engagements of teacher–student in learning (Freire, 1970/1992), in which the climate of mutual trust is created for growth and transformation based on humility, love of life, the world, and other humans, and faith in human power. This relational character
and mutuality in nursing practice can be threatened by power domination that is possible in all human relationships. Therefore, nursing practice as a form of human-to-human engagement needs to be founded upon mutual understanding attained through emancipatory insights and actions as suggested by Habermas (1983/1990).

**Nursing practice is a service to patients with specific needs.** Nursing practice is a form of human service aimed at helping patients with specific needs related to their health and illness. As a form of human service, it is guided by a set of ethical and moral principles and standards that shape the normative basis for the practice. Nursing’s professional organizations such as the ANA or the International Council of Nurses (ICN) set the standards of ethical conduct in nursing practice, and formulate guidelines for moral sensibility desired in practice. Hence, besides nursing practice being guided by legal mandates, it is also guided by such ethical and moral standards and guidelines to be service-oriented and patient-oriented.

**Nursing practice occurs in social situations of health care in which nurses assume particular sorts of responsibilities.** Nursing practice is assumed by nurses who are social actors with the knowledge of their specific role obligations and expectations. This means that although each instance of nursing practice is unique and individualistic because of the singularity and uniqueness of the patient, the nurse, and the situation present in that instance, nursing practice constituting human activities has the character of continuity, routineness, and reproducibility. This makes nursing practice to be social practice contextualized both within each individual social situation and within the continuing structure of practice situations. Giddens (1984) suggests that social practice is founded upon “knowledgeability” as practical consciousness of social actors regarding the conditions and consequences of their conduct, and that such knowledge “provides for the generalized capacity to respond to and influence an indeterminate range of social circumstances” (p. 22). The key characteristic of social practice in this sense is the reproducibility of institutionalized practices in social situations. This is put somewhat differently by Bourdieu (1990) who suggested that an individual’s practice is an on-the-spot coordination of situational knowledge and the habitus, through which there is a continuous shaping and reshaping of the habitus of the individual and of the social institution. An individual nurse’s practice occurs in an environment of a health care situation in which her or his practice must be coordinated within the history and structure of the setting, and both influences and is influenced by other nurses’ practice. This makes nursing practice a form of social practice that is bound both to specific time-space and to contiguous time-space contexts.

These key characteristics and elements together illustrate nursing practice in the contemporary world. Each characteristic by itself does not depict
nursing practice, but all of these as a complex set of characteristics are present in nursing practice. Nursing, whether practiced in a neighborhood health clinic or in a highly critical tertiary care unit, involves an intricate weaving and putting together of these elements for each occasion of practice and for each patient so that the goal of improving patients’ living in the context of health and illness is attained. For such weaving to occur successfully, efficiently, and finely (or beautifully), it is necessary that such weavings be guided by a normative model, a stencil, or signposts. The following chapters provide a detailed description of a model for nursing practice.

NURSING PRACTICE IN THE CONTEXT OF THE HEALTH CARE SYSTEM, SOCIETY, AND CULTURE

Nursing in modernity has developed as a profession having its place of service within organized health care systems, especially hospitals as the main location. While the increasing complexity of current health care systems requires nursing to be practiced in various settings, nursing continues to be practiced as a part of an organized service delivery system. The ANA estimates that more than 90% of nurses in practice in the United States work at hospitals, long-term care institutions, and home-care agencies. Only a small fraction of nurses works independently in private practice. This means that nurses in practice are members of organized nursing care delivery systems, which are components of health care institutions. Within such systems, nurses assume specific organizational positions as “staff nurses,” “clinical managers,” and so forth. Each position is identified with its role obligations and job description. As members of health care organizations, nurses are obligated to adhere to various forms of institutional mandates, policies, and processes. For example, in a hospital where each nursing role is composed of responsibilities in direct patient care, education, and leadership, nurses must be able to identify their practice in these three areas of service. On the other hand, if a hospital has an established formula for a clinical ladder for advancement in clinical positions, nurses in such a hospital would be required to assess their practice and experience with respect to such formula in considering advancement. Nurses in institutions work within the institutions’ nursing service departments that are organized to have specific structures, control processes, and personnel.

In addition, because hospitals and other health care institutions are organized in different matrices for patient care mostly influenced by “medical” schemes for classifying patients, they have units or wards identified for specialized medical services as medical (or more specialized as cardiovascular,
neurological, respiratory, etc.), surgical (or more specialized as general, orthopedic, neurosurgical, cardiac, etc.), critical (or more specialized as medical intensive care, surgical intensive care, newborn and infant intensive care), pediatric, maternity, or psychiatric. This means that nursing practice comes to have a specific clinical character as nurses on different units or wards are exposed to clinical problems and patients typical of the units’ specific service orientations. This has partly influenced the emergence of nursing specialties during the past several decades, such as cardiovascular nursing, oncology nursing, critical care nursing, or family nursing.

Because nursing practice mostly occurs in complex organizations, such as hospitals and long-term care institutions, the impact of the organizational characteristics on nurses’ experiences within health care systems and in their practice is an important issue in relation to quality of practice and patient outcomes. The report by the American Academy of Nursing (McClure, Poulin, Sovie, & Wandelt, 1983) that identified key characteristics of the so-called “Magnet hospitals” that were successful in recruiting and retaining professional nurses provided the base for serious attention to the effects of practice environment on nurses and their practice. The study identified 14 “forces of Magnetism” in terms of (a) organizational features including the quality of leadership, management style, and organizational structure; (b) organizational practices related to staffing, orientation, education, personnel policies/programs, and career development; and (c) organizational culture in relation to professional practice models, quality of care, autonomy, and the image of nursing as factors that together influence the attraction and retention of nurses in hospitals. These became the base for the development of the ANA’s Magnet Recognition Program offered by the American Nurses Credentialing Center (ANCC) that was established in 1990. Currently, ANCC offers the Magnet Recognition Program to hospitals and long-term care facilities in the United States and internationally. ANCC functions within a conceptual framework of the Magnet Model that include five components for assessing organizational quality: (a) a transformational leadership component that encompasses quality of nursing leadership and management style; (b) a structural empowerment component that is represented by organizational structure, personnel policies and programs, community and the health care organization, image of nursing, and professional development; (c) an exemplary professional practice component that represents professional models of care, consultation and resources, autonomy, nurses as teachers, and interdisciplinary relationships; (d) a new knowledge, innovation, and improvement component encompassed by the aspect of quality improvement; and (e) an empirical quality outcomes component referring to quality of care (ANCC, 2014). The assumption is that
these forces of Magnetism are the elements that shape organizations of practice not only to attract and retain professional nurses within its organizations, but also to foster higher quality of nursing practice eventually affecting patient outcomes. Such a model was developed by Stone, Hughes, and Dailey (2008) extending the work of Stone et al. (2005) in which the linkages among the facets of the health care environment to the quality of professional practice and patient outcomes are suggested. In the model, outcomes in the staff, patients, and organization are viewed to be influenced by two forces: (a) the health care organization’s structural characteristics and (b) the microclimate embedded within staff, patients, and the organization. Structural characteristics of the organization enable such factors as leadership, technologies, communication, and financial resources, while the microclimate influences actions of staff and patients. Stone et al. (2008), in their review of the research literature, suggest that there is a consistently positive relationship between organizational climate and outcomes in patients and workers, especially in relation to patient safety outcomes and staff job satisfaction. Lundmark’s review of the literature (2008) on the Magnet quality for nursing in hospitals shows a positive relationships between Magnet qualities and nurse outcomes, such as job satisfaction, burnout, turnover, and perceived quality of care, and Magnet characteristics and patient outcomes in aggregate, such as mortality rates and patient safety, as well as in individuals, such as patient satisfaction. Although the research evidence up to date is only tentative, the evidences from organizational sciences and sociology on the impact of social environment on people’s actions suggest the importance of organizational qualities in affecting nursing practice, which, in turn, will affect patient outcomes.

Nursing practice is furthermore influenced by the economic forces and health care financing that shape the dynamics of the health care system. The introduction of diagnosis-related groups (DRGs) in the United States in the 1980s as the basis for reimbursing the costs of hospital care and prospective financing has changed the structure and management of hospital care fundamentally, causing the shortening in the average lengths of hospitalization and introducing the concept of managed care and other forms of financial control in institutional management of health care. There continues to be a controversy regarding the impacts of health care financing on nursing staff shortages, work overload, and high turnover rates. This health care financing structure also has been attributed to an increase in the acuity and intensity levels of patient care not only in hospitals but also in nursing homes and home-care institutions. As the clinical characteristics of the patient population change in this context, the demands for the types of nursing services change. This has been especially evident in the changes in home-care or community-care nursing practice, as many patients who would have stayed at hospitals were being discharged to
homes for complex nursing care. Such shifts have influenced nursing practice to become more complex.

The environment of nursing practice is also a social milieu within which social patterning in practice behaviors gets established. For example, nurses’ practice behaviors, such as pain assessment, have been shown to be patterned differently according to the culture of specific nursing units (Lauzon Clabo, 2008). The influence of the nursing practice environment on the shaping and patterning of the modes with which nurses on specific units practice has been examined by social science frameworks such as the work of Blau on structural effects (1964), Bourdieu’s theory of practice (1977, 1990), Gidden’s structuration theory (1984), and Atkinson’s culturation of medical discourse (1995). Although the orientations of these theorists are quite different, their theoretical works suggest the influence of a social unit by having established somewhat stable sets of structures, patterns, norms, and values on the actions of its members. This does not mean that individual practitioners do not have unique, individualistic ways of practice, but means that individuals contribute to the patterning within social fields as well as adopt the general patterns that are established within the fields. There would tend to be more similarities than differences in the ways nurses practice within one unit compared with nurses across different units. As long as nursing is practiced in organizational settings such as hospitals, nursing homes, and clinics, it is critical to view the effects of organization of practice on individual nurses’ practice.

At the societal level, nursing practice is influenced by developments and changes in societal demands for health care, scientific and technological advancements, forms of division of labor for health care, and overall economic level. There are different types of nursing services required for special populations or special clinical emphases that arise in societies at any given time, for example, in an epidemic, or in responding to a shift in the societal focus on different sorts of health care. Nursing throughout the modern period has been influenced greatly by the scientific and technological advancements in general and particularly in the medical sector. Nursing practice continues to assimilate such advances in its practice protocols, to develop specific nursing techniques utilizing scientific and technological knowledge, and to accommodate changes in medical technology in general. An increase in nursing research and knowledge development at the national and international levels as a societal development in recent decades also has had a critical impact on knowledge use in nursing practice.

On the other hand, the scope of nursing practice expands or constricts as the dynamics in the distribution of health care personnel resources change in societies. For example, the demand for primary health care services that were not met by physicians adequately was the impetus for the development of
the role of nurse practitioners in the United States beginning in the late 1970s, while an increase in the use of certified nursing assistants in health care institutions during the 1990s was a response to the nursing shortage and financial constraints within the health care system.

Culture as a sustaining and continuing but at the same time evolving symbolic force on social life is the seedbed of customs, rules and norms, prevailing ideologies, and beliefs. Nursing practice, similar to any other social practice, develops within a cultural environment that provides general directions and choices in social life. Dominant cultural themes of a general nature such as utilitarianism, self-determination, gender differentiation, ageism, and various forms of discrimination have influenced people’s conduct and production in general as well as the form and content of nursing practice as a social practice. For example, the change to casual, free-form attires of nurses in practice today from the starched, regulation white uniform of earlier days is a reflection of a more fundamental cultural change regarding rules, individual choices, and self-expression. A leaning toward the acceptance of nursing as a gender-neutral profession in many societies is also a reflection of cultural belief systems regarding gender and work.

From a contextual perspective, the WHO Expert Committee on Nursing Practice (1996) identified four sectors within the force field for nursing practice: (a) economic resources; (b) political, social, and cultural factors; (c) demography and epidemiology within societies; and (d) environment of practice. These sectors shape and influence nursing practice and nursing, in turn, influences them. In addition, social processes that exist in the context of nursing practice as leadership and management, working conditions, legislation and regulation, education, and research are viewed also as forces that affect how nursing is practiced in different situations. Therefore, the nature of nursing practice has to be examined and understood from the perspective of not only human action but also social and cultural contexts.

A MODEL FOR NURSING PRACTICE

A model for nursing practice is necessary to examine the nature and essence of nursing practice comprehensively and to establish the concept of nursing practice as a professional, human-service practice. For this purpose, a model that incorporates five structural components (perspective, knowledge, philosophy, dimension, and process) has been developed and is presented here as the organizing framework for the following chapters in this book regarding the essences of nursing practice. The model of nursing practice presented in this book is a normative model rather than a descriptive
model, specifying how and what nursing practice ought to be, rather than what it is.

The development of models of nursing practice has its beginning with the ideas of Nightingale. Nightingale (1859/1946) specified nursing in terms of what nurses must do in order to enhance health, prevent disease, and care for the sick. She classified these into four distinctive actions: (a) management of the environment and provision of food and feeding, (b) management of self and others for coordinated activities for the sick, (c) communication with the sick, and (d) observation. Her pioneering ideas set into motion the development of modern nursing practice in the following decades, and the concept of the nursing process became the epitomized model for nursing practice since the 1960s beginning in the United States. Nursing process as the model for nursing practice was developed within the culture of rationalistic problem solving as the basis for professional work, and had its beginning in Orlando’s work (1961) on disciplined professional practice. The model of nursing process formally elucidated by Yura and Walsh (1978) is based on a rational, deliberate process involving assessment, planning, intervention, and evaluation, and was endorsed by the ANA (1980) as the model for nursing practice. Following this development in the United States, the nursing process has become the major organizing model for nursing practice globally with the endorsements by the ICN and the WHO. As the institutionalized method for nursing practice, many nursing theorists including Henderson, Roy, Orem, and Neuman, as well as their followers, have illustrated how their nursing theories can be specified within this model, especially in terms of providing frameworks for patient assessment. The key aspect of the nursing process is a formulation of the nursing care plan based on systematic assessment and deliberation, which is then used as the guide for nursing care. The model of the nursing process is seen to have gone through various transformations from its beginning to the present, with the most recent transformation of the model being the incorporation of nursing diagnoses (North American Nursing Diagnosis Association [NANDA]), nursing interventions (Nursing Interventions Classification [NIC]), and nursing outcomes (Nursing Outcomes Classification [NOC]) as a way to systematize nursing practice and nursing documentation (Lunney, 2009).

Departing from the nursing process model are the proposals from the phenomenological perspective for nursing practice such as those by Parse (1997, 1998) and Newman (1994) for whom nursing practice is a mutually evolving process of human-to-human engagement in the context of nursing. In addition, many expositions on description or specification of nursing practice that deviate from the concept of nursing process focus mostly on the meanings and
types of nursing actions in practice such as clinical reasoning (Benner, 2009), interaction (Peplau, 1952; Travelbee, 1964), and caring (Watson, 2012) rather than providing a comprehensive model for describing nursing practice as a set of organized, goal-directed activities. Such expositions and the nursing process model do not provide us with a comprehensive view of nursing practice specifically for the extraction of essential characteristics of nursing practice. The model presented in this chapter and used as the framework for this book has been developed to remedy this shortcoming by incorporating five critical components that are viewed to make up the total nature of nursing practice.

The model is an extension and elaboration of a model presented in an earlier work (Kim, 2010). It is configured by five sets of structures: (a) the perspective, (b) the knowledge, (c) the philosophy, (d) the dimension, and (e) the process, as shown in Figure 1.2. The model is the framework by which the essence of nursing practice can be extracted and the essential characteristics of nursing practice can be fully illustrated. It is different from the model of nursing process that focuses on the process of carrying out patient care, as the model extracts the structural elements that shape nursing practice as it ought to be practiced.
The **structure of perspective** is the base upon which all aspects of nursing practice are determined, as it identifies the guiding value systems for nursing practice. This structure of perspective consists of four value systems: (a) holism, (b) health orientation, (c) caring, and (d) person-centered practice. The guiding value systems, although evolving, provide the base for all other structures that determine the nature of nursing practice. The perspectives point to the nursing-specific ways of seeing the world, and establish the nursing frames of reference for practice. The **structure of knowledge** determines the nature of knowledge necessary for nursing practice. This structure is preconfigured by the structure of perspective but at the same time is the foundation upon which the structure of perspective can develop. The **structure of philosophy** provides the philosophical underpinnings for how nursing practice is to be carried out, and consists of three philosophical orientations: (a) the philosophy of care, (b) the philosophy of therapy, and (c) the philosophy of professional work. The **structure of dimension** refers to the characteristics that make up the nature of nursing practice and is based on five organizing rationalities to characterize nursing practice. It is constituted by the scientific, technical, ethical, aesthetic, and existential dimensions guided by five organizing rationalities, which specify five different forms of modus operandi in nursing practice. The **structure of process** encompasses how nursing practice is actualized, specifying human processes that produce actual contents and modes of nursing practice. It is composed of two processes: deliberation and enactment. The actual content of nursing practice is therefore guided by how the two processes of nursing practice are integrated into the five modus operandi of nursing practice. This means that while the structures of perspective, knowledge, and philosophy are the foundations undergirding the practice, the structures of dimension and process determine actual contents and characteristics of nursing practice. Nursing practice is thus organized about and constructed by integrating the essential elements in these five structures (as layers) to result in what nurses do for their clients.

In Chapter 2, the conceptualization of client from the nursing perspective is discussed, as the client is the central figure in nursing practice. Detailed descriptions and comprehensive expositions regarding the structures of perspective, knowledge, philosophy, dimension, and process of the model of nursing practice are presented in Chapters 3 through 7.

Chapter 8 identifies, describes, and examines the essential general tools of practice specific to nursing, which are required for and applied in nursing practice. These are behavioral and cognitive repertoires that are applicable to various sorts of nursing practice situations, and that have nursing-specific utility, meaning, and application. Chapter 9 addresses the concept of collaborative practice in terms of intra-, inter-, and cross-agency collaboration in the context of person-centered practice.
In Chapter 10, knowledge application in practice is examined applying a model of knowledge application in nursing practice. The concept of knowledge-based practice is discussed vis-à-vis evidence-based practice, and critical reflective inquiry as a generative mode of development in practice is presented. Chapter 11 deals with excellence in practice and the meaning of good practice in relation to the concept of quality of practice. In Chapter 12, the future directions for ways of advancing and developing nursing practice to meet the demands of advancing technology, of differentiated client needs, and of institutional, societal, and cultural changes are discussed.

SUMMARY AND QUESTIONS FOR REFLECTION AND FURTHER DELIBERATION

Nursing practice as human service practice involves actions that are (a) goal directed toward and deliberative for clients’ healthful well-being; (b) based on specialized knowledge, skills, attitudes, and ethics; and (c) guided by professional standards and social mandates. Nursing practice involves many different actions carried out in nursing care situations, and such diverse actions come to have the significance of nursing only when they are woven and integrated together with the nursing orientation. A model of nursing practice with five components is presented as the framework to design and evaluate nursing practice, and also as the organizing structure for the book in discussing what it would entail to produce best practice. The model, as a normative one, is composed of five integrative structures: (a) the perspective, (b) the knowledge, (c) the philosophy of nursing practice, (d) the dimension, and (e) the process. The model is applied to extract the essence of nursing practice and to illustrate the weaving of the best nursing practice.

- What are your worldviews relevant to your practice of nursing?
- What is your definition of nursing practice and in what ways is it different from the generic definitions given by the ANA, the ICN, and the author? What are the key concepts embedded within your definition? How is your definition of nursing practice reflected in your practice?
- A model of nursing practice as an analytical tool is presented in this chapter to be used as a framework to examine the essential features of nursing practice. What is your reaction to this model? Can you think of another approach to examine nursing practice analytically?
- The model is structured by five components: perspective, nursing knowledge, philosophy of practice, dimension, and process. Can you describe your own practice in terms of these five components?