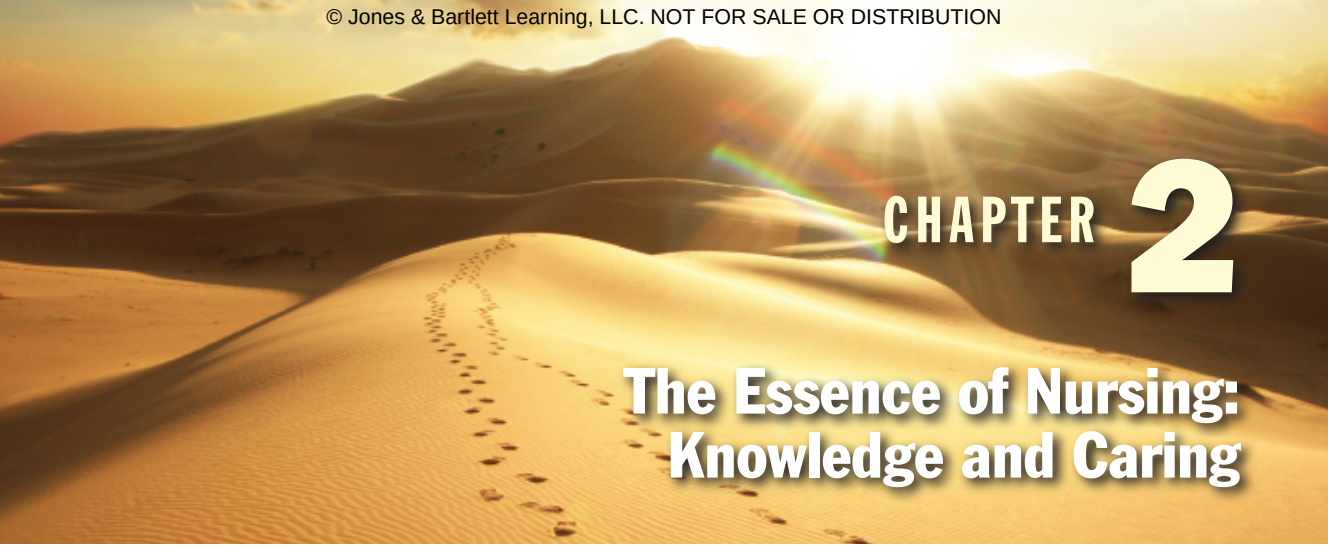

CHAPTER 2

The Essence of Nursing: Knowledge and Caring

CHAPTER OBJECTIVES

At the conclusion of this chapter, the learner will be able to:

- Discuss issues related to defining nursing
- Examine the knowledge–caring dyad
- Describe knowledge, knowledge worker, and knowledge management
- Explain the meaning of caring to nursing
- Discuss the relevance of scholarship to nursing
- Describe the relationship of theory to nursing and to critical nursing theories
- Discuss the importance of research to nursing
- Illustrate how professional literature and new modalities of scholarship are part of nursing scholarship
- Compare and contrast the major nursing roles

CHAPTER OUTLINE

KEY TERMS

Advocate
Caring
Change agent
Clinical reasoning and judgment
Collaboration
Counselor
Critical thinking
Educator
Entrepreneur
Identity
Intuition
Intrapreneur
Knowledge
Knowledge management
Knowledge worker
Provider of care
Reality shock
Reflective thinking
Research
Researcher
Role
Role transition
Scholarship
Status
Theory

Introduction

In 2007, Dr. Pamela Cipriano, editor in chief of *American Nurse Today*, wrote an editorial in honor of Nurses Week entitled, "Celebrating the Art and Science of Nursing." This is the topic of this chapter, though the title is, "The Essence of Nursing: Knowledge and Caring." Knowledge represents the science of nursing, and caring represents the art of nursing. Along with this editorial and the theme of Nurses Week 2007 is the 2006 publication by Nelson and Gordon, *The Complexities of Care: Nursing Reconsidered*. The authors stated, "Because we take caring seriously we (the authors) are concerned that discussions of nursing care tend to sentimentalize and decomplexify the skill and knowledge involved in nurses' interpersonal or relational work with patients" (p. 3). Nelson and Gordon make a strong case supporting the problem of nurses devaluing the care they provide, particularly regarding the required knowledge component of nursing care and technical competencies needed to meet patient care needs and focus on the caring. This chapter explores the knowledge and caring of nursing practice. Both must be present, and both are important for quality nursing care. Content includes the effort to define nursing, knowledge and caring, competency, scholarship in nursing, the major nursing roles, and leadership.

Nursing: How Do We Define It?

Definitions of nursing were briefly discussed in Chapter 1, but defining nursing is relevant to this chapter and requires further exploration. Can nursing be defined, and if so, why is it important to define it? Before this discussion begins, the student should review his or her personal definition of nursing that was written as part of the critical thinking activities in Chapter 1. Students may find it strange to spend time on the question of a definition of nursing, but the truth is, there is no universally accepted definition by healthcare professionals and patients. The easy first approach to developing a definition is to describe what nurses do; however, this approach leaves out important aspects and essentially reduces nursing to tasks. More consideration needs to be given to (1) what drives nurses to do what they do, (2) why they do what they do (rationales, evidence-based practice [EBP]), and (3) what is achieved by what they do (outcomes) (Diers, 2001). Diers noted that even Florence Nightingale's and Virginia Henderson's definitions, as described in Chapter 1, are not definitions of what nursing is, but more what nurses do. Henderson's definition is more of a personal concept than a true definition. Henderson even said that what she wrote was not the complete definition of nursing (Henderson, 1991). Diers also commented that there really are

no full definitions for most disciplines. Yet nursing is still concerned with a definition. Having a definition serves several purposes that really drive what that definition will look like (Diers, 2001). These purposes are:

- Providing an operational definition to guide research
- Acknowledging that changing laws requires a definition that will be politically accepted—for example, in relationship to a nurse practice act
- Convincing legislators about the value of nursing—for example, to gain funds for nursing education
- Explaining what nursing is to consumers/patients (though no definition is totally helpful because patients/consumers will respond to a description of the work, not a definition)
- Explaining to others in general what one does as a nurse (then the best choice is a personal description of what nursing is)

One could also say that a definition is helpful in determining what to include in a nursing curriculum, but nursing has been taught for years without a universally accepted definition. The American Nurses Association (ANA, 2010a) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (p. 66). Some of the critical terms in this definition are explained next.

- *Promotion of health:* "Mobilize healthy patterns of living, foster personal and family development, and support self-defined goals of individuals, families, communities, and populations" (ANA 2010a, p. 23).
- *Health:* "An experience that is often expressed in terms of wellness and illness, and may occur in the presence or absence of injury" (ANA, 2010a, p. 65).
- *Prevention of illness and injury:* Interventions taken to keep illness or injury from occurring, for example, immunization for tetanus or teaching parents how to use a car seat.
- *Illness:* "The subjective experience of discomfort" (ANA, 2010a, p. 65).
- *Injury:* Harm to the body, for example, a broken arm caused by a fall from a bicycle.
- *Diagnosis:* "A clinical judgment about the patient's response to actual or potential health conditions or needs. The diagnosis provides the basis for determination of a plan to achieve expected outcomes. Registered nurses utilize nursing and medical diagnosis depending upon educational and clinical preparation and legal authority" (ANA, 2010a, p. 64).
- *Human response:* The phenomena of concern to nurses that include any observable need, concern, condition, event, or fact of interest actual or potential health problems (ANA, 2010b, p. 40).
- *Treatment:* To give care through interventions—for example, administering medication, teaching a patient how to give himself or herself insulin, wound care, preparing a patient for surgery, ensuring that the patient is not at risk for an infection, and so on.
- *Advocacy:* The act of pleading for or supporting a course of action on behalf of individuals, families, communities, and populations—for example, a nurse who works with the city council to improve health access for a community.

Seven essential features of professional nursing have been identified from definitions of nursing (ANA, 2010b, p. 9):

1. Provision of a **caring relationship** that facilitates health and healing
2. **Attention** to the range of human experiences and responses to health and illness within the physical and social environments

3. **Integration of assessment data with knowledge** gained from an appreciation of the patient or the group
4. **Application of scientific knowledge** to the processes of diagnosis and treatment through the use of judgment and critical thinking
5. Advancement of professional nursing knowledge through **scholarly inquiry**
6. Influence on social and public policy to **promote social justice**
7. **Assurance of safe, quality, and evidence-based practice**

In this list, terms that indicate the importance of knowledge and caring to nursing are in bold. Knowledge and caring are the critical dyad in any description or definition of nursing, and they both relate to nursing scholarship and leadership.

The North American Nursing Diagnosis Association (2011), which describes nursing interventions; the Nursing Interventions Classification (University of Iowa, 2011); and the Nursing Outcomes Classification all reflect attempts to define the work of nursing (University of Iowa, 2011). These initiatives are discussed in more detail in Chapter 9. Maas (2006) discussed the importance of these initiatives, which she described as the building blocks of nursing practice theory, and noted that "rather than debating the issues of definition, nursing will be better served by focusing those energies on its science and the translation of the science of nursing practice" (p. 8). The conclusion is that (1) no universally accepted definition of nursing exists, though several definitions have been developed by nursing leaders and nursing organizations; (2) individual nurses may develop their own personal description of nursing to use in practice; and (3) a more effective focus is the pursuit of nursing knowledge to build nursing scholarship. The first step is to gain a better understanding of knowledge and caring in relationship to nursing practice.

Knowledge and Caring: A Total Concept

Understanding how knowledge and caring form the critical dyad for nursing is essential to providing effective, safe, quality care. Knowledge is specific information about something, and caring is behavior that demonstrates compassion and respect for another. But these are very simple definitions. The depth of nursing practice goes beyond basic knowledge and the ability to care. Nursing encompasses a distinct body of knowledge coupled with the art of caring. As stated in Butcher, "A unique body of knowledge is a foundation for attaining the respect, recognition, and power granted by society to a fully developed profession and scientific discipline" (2006, p. 116). Nurses use **critical thinking** as they apply knowledge, evidence, and caring to the nursing process and become competent. Critical thinking is discussed more in Chapter 9. Experts like Dr. Patricia Benner who led the Carnegie Foundation Study on nursing education (Benner, Sutphen, Leonard, & Day, 2010) suggest that we often use the term *critical thinking*, but there is high variability and little consensus on what constitutes critical thinking. **Clinical reasoning and judgment** are very important and include critical thinking.

Knowledge

Knowledge can be defined and described in a number of ways. There are five ways of knowing (Cipriano, 2007) that are useful in understanding how one knows something. A nurse might use all or some of these ways of knowing when providing care.

1. Empirical knowing focuses on facts and is related to quantitative explanations—predicting and explaining.
2. Ethical knowing focuses on a person's moral values—what should be done.
3. Personal knowing focuses on understanding and actualizing a relationship between a

nurse and a patient, including knowledge of self (nurse).

4. Aesthetic knowing focuses on the nurse's perception of the patient and the patient's needs, emphasizing the uniqueness of each relationship and interaction.
5. Synthesizing, or pulling together the knowledge gained from the four types of knowing, allows the nurse to understand the patient better and to provide higher quality care.

The ANA (2010b) identified the key issues related to the knowledge base for nursing practice, both theoretical and evidence-based knowledge. This is the basic knowledge that every nurse should have to practice. Nurses use this knowledge base in collaboration with patients to assess, plan, implement, and evaluate care (pp. 13–14).

- Promotion of health and wellness
- Promotion of safety and quality of care
- Care, self-care processes, and care coordination
- Physical, emotional, and spiritual comfort, discomfort, and pain
- Adaptation to physiologic and pathophysiologic processes
- Emotions related to experiences of birth, growth and development, health, illness, disease, and death
- Meanings ascribed to health and illness, and other concepts
- Linguistic and cultural sensitivity
- Health literacy
- Decision making and the ability to make choices
- Relationships, role performance, and change processes within relationships
- Social policies and their effects on health
- Healthcare systems and their relationships to access, cost, and quality of health care
- The environment and the prevention of disease and injury

Knowledge Management

Knowledge work plays a critical role in healthcare delivery today, and nurses are **knowledge workers**. Forty percent or more of workers in knowledge-intense businesses, such as a healthcare organization, are knowledge workers (Sorrells-Jones, 1999). **Knowledge management** includes both routine work (such as taking vital signs, administering medications, and walking a patient) and nonroutine work, which (1) involves exceptions, (2) requires judgment and use of knowledge, and (3) may be confusing or not fully understood. In a knowledge-based environment, a person's title is not as important as the person's expertise, and use of knowledge and learning are important. Knowledge workers actively use:

- Collaboration
- Teamwork
- Coordination
- Analysis
- Critical thinking
- Evaluation
- Willingness to be flexible

Knowledge workers recognize that change is inevitable and that the best approach is to be ready for change and view it as an opportunity for learning and improvement. Nurses use knowledge daily in their work—both routine and nonroutine—and must have the characteristics of the knowledge worker. They work in an environment that expects healthcare providers to use the best evidence in providing care. "Transitioning to an evidence-based practice requires a different perspective from the traditional role of nurse as 'doer' of treatments and procedures based on institutional policy or personal preference. Rather, the nurse practices as a 'knowledge worker' from an updated and ever-changing knowledge base" (Mooney, 2001, p. 17). The knowledge worker focuses on acquiring, analyzing, synthesizing, and applying evidence to guide practice decisions (Dickenson-Hazard, 2002). The knowledge worker uses synthesis, competencies,

multiple intelligences, a mobile skill set, outcome practice, and teamwork, as opposed to the old skills of functional analysis, manual dexterity, fixed skill set, process value, process practice, and unilateral performance (Porter-O'Grady & Malloch, 2007). This nurse is a clinical scholar. The employer and patients value a nurse for what the nurse knows and how this knowledge is used to meet patient care outcomes—not just for technical expertise or caring, though these are also important (Kerfoot, 2002). This change in a nurse's work is also reflected in the Carnegie Foundation Report on nursing education, as reported by Patricia Benner and colleagues (2010). Benner suggested that instead of focusing on content, nurse educators need to focus on teaching the skills of how to access information, use and manipulate data (such as those data available from patient information systems), and document in the electronic interprofessional format.

Critical Thinking, Reflective Thinking, Intuition, and Clinical Thinking and Judgment: Impact on Knowledge Development and Application

Critical thinking, **reflective thinking**, and **intuition** are different approaches to thinking and can be used in combination. Nurses use all of them to explore, understand, develop new knowledge, and apply knowledge. What they mean and how are they used in nursing follows.

CRITICAL THINKING. Critical thinking is clearly a focus of nursing. The ANA standards state that the nursing process is a critical thinking tool, though not the only one used in nursing (ANA, 2010a). This skill uses purposeful thinking, not sudden decision making. Alfaro-LeFevre identified the following four key critical thinking components of critical thinking (2011):

1. Critical thinking characteristics (attitudes/behaviors)
2. Theoretical and experiential knowledge (intellectual skills/competencies)
3. Interpersonal skills/competencies
4. Technical skills/competencies

In reviewing each of these components, one can easily see the presence of knowledge, caring (interpersonal relationships, attitudes), and technical expertise.

A person uses four key intellectual traits in critical thinking (Paul, 1995). Each of the traits can be learned and developed.

1. *Intellectual humility:* Willingness to admit what one does not know. (This is difficult to do, but it can save lives. A nurse who cannot admit that he or she does not know something and yet proceeds is taking a great risk. It is important for students to be able to use intellectual humility as they learn about nursing.)
2. *Intellectual integrity:* Continual evaluation of one's own thinking and willingness to admit when your thinking is not adequate. (This type of honesty with self and others can make a critical difference in care.)
3. *Intellectual courage:* Ability to face and fairly address ideas, beliefs, and viewpoints for which one may have negative feelings. (Students enter into a new world of health care and do experience confusing thoughts about ideas, beliefs, and viewpoints, and sometimes their personal views may need to be put aside in the interest of the patient and safe, quality care.)
4. *Intellectual empathy:* Conscious effort to understand others by putting one's own feelings aside and imagining oneself in another person's place.

Critical thinking skills that are important to develop are affective learning; applied moral reasoning and values (relates to ethics); comprehension; application, analysis, and synthesis; interpretation; knowledge, experience, judgment, and evaluation; learning from mistakes when they happen; and self-awareness (Finkelman, 2001). This type of thinking

helps to reduce dichotomous thinking and groupthink. Dichotomous thinking leads one to look at an issue, situation, or problem as one way or the other, such as good or bad, black or white. This limits choices. Groupthink occurs when all group or team members think alike. One might say that this is great because they are all working together. However, groupthink limits choices, open discussion of possibilities, and the ability to consider alternatives. Problem solving is not critical thinking, but effective problem solvers use critical thinking. A combination of the two results in the following process (Finkelman, 2001, p. 196):

1. Seek the best information and data possible to allow you to fully understand the issue, situation, or problem. Questioning is critical. Examples of some questions that might be asked are: What is the significance of _____? What is your first impression? What is the relationship between and _____? What impact might _____ have on _____? What can you infer from the information/data?
2. Identify and describe any problems that require analysis and synthesis of information—thoroughly understand the information/data.
3. Develop alternative solutions—more than two is better because this forces you to analyze multiple solutions even when you discard one of them. Be innovative and move away from only proposing typical or routine solutions.
4. Evaluate the alternative solutions and consider the consequences for each one. Can the solutions really be used? Do you have the resources you need? How much time will it take? How well will the solution be accepted? Identify pros and cons.
5. Make a decision, choosing the best solution, though there is risk in any decision making.
6. Implement the solution but continue to question.
7. Follow up and evaluate; plan for evaluation from the very beginning.

Self-assessment of critical thinking skills is an important part of using critical thinking. How does one use critical thinking, and is it done effectively?

REFLECTIVE THINKING. Throughout one's nursing education experience and practice, reflective thinking needs to become a part of daily learning and practice. Conway (1998) noted that nurses who used reflective thinking implemented care based on the individualized care needs of the patient, whereas nurses who used reflective thinking less tended to provide illness-oriented care. Reflection is seen as a part of the art of nursing, which requires "creativity and conscious self-evaluation over a period of time" (Decker, 2007, p. 76). Reflection helps nurses cope with unique situations. The following questions might be asked (Johns, 2004, p. 18):

- Empirical: "What knowledge informed or might have informed you?"
- Aesthetic: "What particular issues seem significant to pay attention to?"
- Personal: "What factors influenced the way you felt, thought, or responded?"
- Ethical: "To what extent did you act for the best and in tune with your values?"

These lead to reflection: "How might you respond more effectively given this situation again?"

Critical reflection requires that the student or nurse examine the underlying assumptions and really question or even doubt arguments, assertions, or facts of a situation or case (Benner, Hughes, & Sutphen, 2008). This allows the nurse to better grasp the patient's situation.

The skills needed for reflective thinking are the same skills required for critical thinking—the ability to monitor, analyze, predict, and evaluate (Pesut & Herman, 1999), and to take risks, be open, and have imagination (Westberg & Jason, 2001). Guided reflection with faculty who assist students in using reflective thinking during simulated learning experiences can enhance student learning and help students learn reflective learning skills. It is

recommended (Decker, 2007; Johns, 2004) that this process be done with faculty to avoid negative thoughts that a student may experience. The student should view the learning experience as an opportunity to improve and to see the experience from different perspectives. Some strategies that might be used to develop reflective thinking are keeping a journal, engaging in one-to-one dialogue with a faculty facilitator, engaging in email dialogues, and participating in structured group forums. Group forums help students learn more about constructive feedback and can also be done online with discussion forums. Reflective thinking strategies are not used for grading or evaluation, but rather to help the student think about the experience in an open manner.

INTUITION. Intuition is part of thinking. Including intuition in critical thinking helps to expand the person's ability to know (Hansten & Washburn, 2000). The most common definition of intuition is having a gut feeling about something. Nurses have this feeling as they provide care—such as, "I just have this feeling that Mr. Wallace is heading for problems." It is hard to explain what this is, but it happens. The following are examples of a variety of thoughts that a person might apply to intuition (Rubenfeld & Scheffer, 2009):

- I felt it in my bones.
- I couldn't put my finger on why, but I thought instinctively I knew.
- My hunch was that; I had a premonition/inspiration/impression.
- My natural tendency was to …
- Subconsciously I knew that.
- Without thought I figured it out.
- Automatically I thought that.
- While I couldn't say why, I thought immediately.
- My sixth sense said I should consider …

Intuition is not science, but sometimes intuition can stimulate **research** and lead to greater knowledge and questions to explore. Intuition is related to experience. A student would not likely experience intuition about a patient care situation, but over time, as nursing expertise is gained, the student may be better able to use intuition. Benner's (2001) work, *From Novice to Expert*, suggests that intuition is really the putting together of the whole picture based on scientific knowledge and clinical expertise, not just a hunch, and intuition continues to be an important part of the nursing process (Benner et al., 2008).

Caring

There is no universally accepted definition for **caring** in nursing, but it can be described from four perspectives (Mustard, 2002). The first is the sense of caring, which is probably the most common perspective for students to appreciate. This perspective emphasizes compassion, or being concerned about another person. This type of caring may or may not require knowledge and expertise, but in nursing, effective caring requires knowledge and expertise. The second perspective is doing for other people what they cannot do for themselves. Nurses do this all the time, and it requires knowledge and expertise to be effective. The third perspective is to care for the medical problem, and this, too, requires knowledge of the problem, interventions, and so on, as well as expertise to provide the care. Providing wound care or administering medications is an example of this type of caring. The last perspective is "competence in carrying out all the required procedures, personal and technical, with true concern for providing the proper care at the proper time in the proper way" (Mustard, 2002, p. 37). Not all four types of caring must be used at one time to be described as caring. Caring practices have been identified by the American Association of Critical-Care Nurses in the organization's synergy model for patient care (2011) as "nursing activities that create a compassionate, supportive, and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering." This model is discussed more in Chapter 15.

Nursing theories often have a focus on caring. Theories are discussed later in this chapter. One in particular is known for its focus on caring—Watson's theory on caring. Watson (1979) defined nursing "as the science of caring, in which caring is described as transpersonal attempts to protect, enhance, and preserve life by helping find meaning in illness and suffering, and subsequently gaining control, self-knowledge, and healing" (Scotto, 2003, p. 289).

Patients today need caring. They feel isolated and often confused with the complex medical system. Many have chronic illness such as diabetes, arthritis, and cardiac problems that require long-term treatment, and these patients need to learn how to manage their illnesses and be supported in the self-management process. (See Chapter 7 for more information on self-management and chronic illness as it relates to patient-centered care.) Even many cancer patients who have longer survival rates today are now described as having a chronic illness.

How do patients view caring? Patients may not see the knowledge and skills that nurses need, but they can appreciate when a nurse is there with them. The nurse–patient relationship can make a difference when the nurse uses caring consciously (Schwein, 2004). Characteristics of this relationship are as follows:

- Being physically present with the patient
- Having a dialogue with the patient
- Showing a willingness to share and hear—to use active listening
- Avoiding assumptions
- Maintaining confidentiality
- Showing intuition and flexibility
- Believing in hope

Caring is offering of self. This means "offering the intellectual, psychological, spiritual, and physical aspects one possesses as a human being to attain a goal. In nursing, this goal is to facilitate and enhance patients' ability to do and decide for themselves (i.e., to promote their self-agency)" (Scotto, 2003, p. 290). According to Scotto, "Nurses must prepare themselves in each of the four aspects to be competent to care" (2003, p. 290). The following describes the four aspects identified by Scotto (pp. 290–291).

1. The intellectual aspect of nurses consists of an acquired, specialized body of knowledge, analytical thought, and clinical judgment, which are used to meet human health needs.
2. The psychological aspect of nurses includes the feelings, emotions, and memories that are part of the human experience.
3. The spiritual aspect of nurses, as for all human beings, seeks to answer the questions, "Why? What is the meaning of this?"
4. The physical aspect of nurses is the most obvious. Nurses go to the patients' homes, the bedside, and a variety of clinical settings where they offer strength, abilities, and skills to attain a goal. For this task, nurses first must care for themselves, and then they must be accomplished and skillful in nursing interventions.

For students to be able to care for others, they need to care for themselves. This is also important for practicing nurses. Chapter 1 includes some content about caring for self and stress management. It takes energy to care for another person, and this is draining. Developing positive, healthy behaviors and attitudes can protect a nurse later when more energy is required in the practice of nursing.

As students begin their nursing education program (and indeed throughout the program), the issue of the difference between medicine and nursing often arises. Caring is something that only nurses do, or so nurses say. Many physicians would say that they also care for patients and have a caring attitude. Nurses are not the only healthcare professionals who can say that caring is part of the profession. However, what has happened with nursing (which may not have been so helpful) is that when caring is discussed in relation to nursing, it is described only in emotional terms (Moland,

2006). This ignores that caring often involves competent assessment of the patient to determine what needs to be done, and the ability to provide care; both require knowledge. The typical description of medicine is curing, and for nursing, it is caring. This type of extreme dichotomy is not helpful for either profession individually and also has an impact on the interrelationship between the two professions, adding conflict and difficulty in communication to the interprofessional team.

The use of technology in health care has increased steadily since 1960, particularly since the end of the 20th century. Nurses work with technology daily, and more and more care involves some type of technology. This has had a positive impact on care; however, some wonder about the negative impact of technology on caring. Does technology put a barrier between the patient and the nurse that interferes with the nurse–patient relationship? Because of this concern, "nurses are placing more emphasis on the 'high touch' aspect of a 'high tech' environment, recognizing that clients (patients) require human interactions, such as warmth, care, acknowledgement of self-worth, and collaborative decision-making" (Kozier, Erb, & Blais, 1997, p. 10). There must be an effort to combine technology and caring because both are critical to positive patient outcomes. This is referred to as "technological competency as caring" in nursing (Locsin, 2005). Nurses who use technology but ignore the patient as a person are just technologists; they are not nurses who use knowledge, caring, critical thinking, technological skills, and recognition of the patient as a person as integral parts of the caring process.

Competency

Competency is the behavior that a student is expected to demonstrate. The ANA standards define competency as "an expected and measurable level of nursing performance that integrates knowledge, skills, abilities, and judgment based on established scientific knowledge and expectations for nursing practice" (2010a, p. 64). The ultimate goal of competence is to promote patient safety and quality care. The major Institute of Medicine (IOM) report on nursing, *The Future of Nursing* (2011), identifies in its eight recommendations the need for all nurses to engage in lifelong learning. Competency levels change over time as students gain more experience. Development of competencies continues throughout a nurse's career; this is discussed more in later chapters. Nurses in practice have to meet certain competencies to continue practice. This is typically done through meeting staff development requirements. Students, however, must meet competencies to progress through the nursing program and graduate. Competencies include elements of knowledge, caring, and technical skills.

After a number of IOM reports described serious problems with health care, including errors and poor quality care, an initiative was developed to identify core competencies for all healthcare professions, including nursing, to build a bridge across the quality chasm to improve care (2003). It is hoped that these competencies will have an impact on education for, and practice in, health professions (Finkelman & Kenner, 2009). All the core competencies are covered in more depth in Section III of this textbook. The core competencies are:

1. *Provide patient-centered care*—Identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health. The description of this core competency relates to content found in definitions of nursing, nursing standards, nursing social policy statement, and nursing theories. (See Chapter 9.)

2. *Work in interdisciplinary/interprofessional teams*—Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable. There is much knowledge available about teams and how they impact care. Leadership is a critical component of working on teams—as team leader and as followers or members. Many of the major nursing roles that are discussed in this chapter require working with teams. (See Chapter 10.)
3. *Employ evidence-based practice*—Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible. EBP has been mentioned in this chapter about knowledge and caring as it relates to research. (See Chapter 11.)
4. *Apply quality improvement*—Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality. Understanding how care is provided and problems in providing care often lead to the need for additional knowledge development through research. (See Chapter 12.)
5. *Utilize informatics*—Communicate, manage knowledge, mitigate error, and support decision making using information technology. This chapter focuses on knowledge and caring, both of which require use of informatics to meet patient needs. (See Chapter 13.)

Scholarship in Nursing

There is a great need to search for better solutions and knowledge and to disseminate knowledge. This discussion about scholarship in nursing explores the meaning of scholarship, the meaning and impact of theory and research, use of professional literature, and new scholarship modalities.

What Does Scholarship Mean?

The American Association of Colleges of Nursing (AACN) defines **scholarship** in nursing "as those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that: (1) is significant to the profession, (2) is creative, (3) can be documented, (4) can be replicated or elaborated, and (5) can be peer-reviewed through various methods" (2005, p. 1). The common response to asking which activities might be considered scholarship is research. Boyer (1990), however, questioned this view of scholarship, suggesting that other activities are scholarly. These include:

1. Discovery, in which new and unique knowledge is generated (research, theory development, philosophical inquiry)
2. Teaching, in which the teacher creatively builds bridges between his or her own understanding and the students' learning
3. Application, in which the emphasis is on the use of new knowledge in solving society's problems (practice)
4. Integration, in which new relationships among disciplines are discovered (publishing, presentations, grant awards, licenses, patents, or products for sale; must involve two or more disciplines, thus advancing knowledge over a broader range)

These four aspects of scholarship are critical components of academic nursing and support the values of a profession committed to both social relevance and scientific advancement.

Some nurses think that the AACN definition of scholarship limits scholarship to educational institutions only. Mason (2006) commented that this is a problem for nursing; science needs to be accessible to practitioners. She defined scholarship as "an in-depth, careful process of exploring current theory

and research with the purpose of either furthering the science or translating its findings into practice or policy" (Mason, 2006, p. 11). The better approach, then, is to consider scholarship in both the education and practice arenas and still emphasize that nursing is a practice profession that must be patient centered. Nursing theory and research have been mentioned in this chapter and by Mason as part of knowledge and caring and scholarship of nursing. Understanding what they are and how they have an impact on practice is important if all nurses are to be scholars and leaders.

Nursing has a long history of scholarship, though some periods more than others seem to have been active in terms of major contributions to nursing scholarship. **EXHIBIT 2–1** describes some of the milestones that are important in understanding nursing scholarship.

EXHIBIT 2–1

A Brief History of Select Nursing Scholarship Milestones

1850	Nightingale conducted first nursing search by collecting healthcare data during the Crimean War.
1851	Florence Nightingale, age 32, went to the Institution of Deaconesses at Kaiserswerth to train in nursing. At that time the model was to study spirituality and healing, a result of Dr. Elizabeth Blackwell's influence.
1854–56	Nightingale applied knowledge of statistics and care training. She took charge of lay nurses and the Anglican sisters; nurses had to wear uniforms: loose gray dresses, a jacket, cap, and sash. This dress was practical because halls and rooms were drafty and cool.
1854–55	Nightingale created the first standards for care.
1860	The first training school was founded in London.
1860	*Notes on Nursing* by Nightingale was published.
1860	Prior to the 1860s and the Civil War, religious orders (primarily of the Catholic Church) cared for the sick. These early times were characterized by several significant historical events: ■ A lack of organized nursing and care led to the development of Bellevue Hospital, which was founded in 1658 in New York. ■ In 1731 the Philadelphia Almshouse was started by the Sisters of Charity, spearheaded by Elizabeth Ann Bayley Seton, a physician's daughter who married, was widowed, and then entered religious life and provided nursing care. ■ Charity Hospital in New Orleans, Louisiana, was founded in 1736 and funded by private endowment.
1860–65	The Civil War broke out. Dorothea Dix, Superintendent of Female Nurses for the Union Army, needed help with the wounded. She set the first qualifications for nurses.
1860s	Dr. Elizabeth Blackwell, first female U.S. physician, started the Women's Central Association for Relief in New York City, which later became the Sanitary Commission. Also: ■ The New England Hospital for Women and Children in Boston, Massachusetts, opened in 1860. During its early years there was no structured care. ■ Woman's Hospital of Philadelphia opened in 1861, also with no structured care. ■ In 1863, the state of Massachusetts began the first board of nursing, the first attempt at regulation of the practice of nursing.

EXHIBIT 2–1 *(Continued)*

1870s	The first nursing school graduate was Linda Richards in 1873 from the New England Hospital for Women and Children in Boston, Massachusetts. Other items of note: ■ Although a plea for attention to the hospital environment had been made by Nightingale, it wasn't until the 1870s that lights were introduced. ■ Written patient cases were instituted during this time, replacing the verbal reports previously used. ■ Hospitals began to examine the causes of mortality among their patient population. ■ Mary Mahoney, the first black nurse, graduated in 1879.
1873	Three nursing schools were founded: ■ The Bellevue Training School in New York City, New York. ■ The Connecticut Training School in New Haven, Connecticut. ■ The Boston Training School in Boston, Massachusetts.
1882	Clara Barton, a schoolteacher, founded the American Red Cross.
1885	The first nursing text was published: *A Textbook of Nursing for the Use of Training Schools, Families and Private Students*.
1884	Alice Fisher, a Nightingale-trained nurse, came to the United States.
1884	Isabel Hampton Robb wrote *Nursing: Its Principles and Practice for Hospital and Private Use*.
1890s	The Visiting Nurses Group started in England.
1893	The American Society of Superintendents of Training Schools was formed. Other events of note include: ■ The Henry Street Settlement, a community center in New York City, was founded by Lillian Wald. This was the beginning of community-based care. ■ The Nightingale Pledge was written by Mrs. Lystra E. Gretter as a modification of the doctor's Hippocratic Oath. The pledge was written for the Committee for the Farrand Training School for Nurses, Detroit, Michigan.
1897	The University of Texas at Galveston moved undergraduate nursing education into the university setting.
1900	The first graduate nursing degree was offered by Columbia Teachers College. In addition: ■ As nursing moved from a practice-based discipline to a university program, subjects such as ethics were introduced for the first time. Isabel Hampton Robb, considered the architect of American nursing, wrote *Nursing Ethics*, the first ethics text for nurses. ■ Both textbooks and journals for nurses became available. Among the first of the journals was the *American Journal of Nursing*.
1901	Mary Adelaide Nutting started a 3–6-month preparatory course for nurses; by 1911, 86 schools had some form of formalized and structured nurse training.
1907	Mary Adelaide Nutting became the first nursing professor and began the first state nursing association in Maryland. At this time nursing was moving toward a more formal educational system, similar to that of the discipline of medicine. A professional organization at a state level gave recognition to nursing as a distinct discipline.
1907	Now a distinct discipline, nursing needed standards to guide practice and education. Isabel Hampton Robb wrote *Educational Standards for Nurses*.
1908	Other professional organizations grew, beginning with the National Association of Colored Graduate Nurses.
1909	The first bachelor's degree program in nursing was started at the University of Minnesota.

(Continues)

EXHIBIT 2–1 *(Continued)*

1900s–1940s	As nursing became more ensconced in university settings, nursing research was another area viewed as necessary for a well-educated nurse to study. The first research focused on nursing education.
1911	The concept of specialties within nursing began with Bellevue Hospital's midwifery program.
1912	The American Society of Superintendents of Training Schools became the National League for Nursing Education (NLNE). Also: ■ The National Organization for Public Health Nursing was founded. ■ The *Public Health Nursing* journal was started.
1917	The National League for Nursing Education identified its first *Standard Curriculum for Schools of Nursing*, a remedy for the lack of standards in nursing education.
1920	The first master's program in nursing began at Yale School of Nursing.
1922	Sigma Theta Tau International (STTI), the nursing honor society, was formed.
1923	The Goldmark Report called for nursing education to be separate from (and precede) employment; it also advocated nursing licensure and proper training for faculty at nursing institutions.
1925	Mary Breckenridge founded the Frontier Nursing Service in Kentucky. Her intent was to provide rural health care; this organization was the first to employ nurses who could also provide midwifery services.
1925	As the status of women increased, nurses were among the first women to lead the women's rights movements in the United States.
1930	A total of 41 (out of 48) states have regulatory state boards of nursing.
1900–30s	A shortage of funds put nursing education under the control of doctors and hospitals. This situation resulted from: ■ Leaders believing that the only way to change was to organize. ■ The need to provide protection for the public from poorly educated nurses. ■ A lack of sanitation. ■ Schools providing cheap services for hospitals.
1931	The Association of Collegiate Schools of Nursing is formed, eventually the Department of Baccalaureate and Higher Degrees of the NLN.
1934	New York University and the Teachers College start PhD and EdD in programs in nursing.
1940	Nursing Council on National Defense, formed after World War I (1917–1918), underwent changes during 1940.
1942	American Association of Industrial Nurses (AAIN) was founded.
1948	The Brown Report recommended that nursing education programs be housed in universities; this report also formed the basis for evaluating nursing programs.
1950	Graduate nursing education started with the clinical nurse specialist.
1954	The University of Pittsburgh started a PhD program in nursing (academic doctorate).
1956	Columbia University granted its first master's degree in nursing.
1950s–1960s	Early nursing theory was developed.
1950	The American Nurses Association (ANA) published the first edition of the *Code for Nurses*.

EXHIBIT 2–1 *(Continued)*

1952	The NLNE changed its name to the National League for Nursing (NLN).
1952	Initial publication of *Nursing Research* under the direction of the ANA.
1952	Mildred Montag started the first associate's degree nursing programs. These were designed as pilots to create a technical nurse below the level of the professional nurse, but with training beyond that of a practice nurse.
1955	American Nurses Foundation was formed to obtain funds for nursing research.
1960	The doctorate in nursing science (DNS) degree was started at Boston University (professional doctorate).
1960s	Federal monies were made available for doctoral study for nurse educators.
1963	The initial publication of the *International Journal of Nursing Studies* was available.
1964	The first nurse practitioner program was instituted by Loretta Ford at the University of Colorado.
1965	The first nursing research conference was held.
1965	The ANA made the statement that a baccalaureate degree should represent the entry level for nursing practice.
1967	The STTI launched the initial publication of *Image*.
1969	The American Association of Colleges of Nursing formed with 123 members to serve as representation for bachelor's degree and higher education nursing programs.
1970s–90s	This marked the period of development that saw the birth of most nursing theories; some of these theories were tested and expanded upon.
1973	The first nursing diagnosis conference was held.
1973	The American Academy of Nursing was formed under the aegis of ANA to recognize nursing leaders.
1973	The ANA published the first edition of *Standards of Nursing Practice*.
1978–79	Several new nursing research journals had their initial publication.
1985	The National Center for Nursing Research was established at the National Institutes of Health, later to become the National Institute of Nursing Research.
1990s	Evidence-based practice began to become a major focus.
1993	The ANA published its position statement on nursing education.
1993	The Commission on Collegiate Nursing Education was formed to accredit nursing programs, with an emphasis on bachelor's and master's degree programs.
1993	The Cochrane Collaborative was formed for systematic reviews and was named after British epidemiologist Archie Cochrane.
1996	The Joanna Briggs Institute for Evidence-Based Practice was founded in Adelaide, Australia.
1997	The National League for Nursing Accrediting Commission became a separate corporation from the NLN.
1995	The ANA published the first edition of *Nursing's Social Policy Statement*.

(Continues)

EXHIBIT 2–1 *(Continued)*

1999	The American Association of Colleges of Nursing (AACN) published its position statement on nursing research.
2004	The NLN established Centers for Excellence in Nursing Education to recognize exemplar schools of nursing.
2004	The AACN endorsed the development and called for pilot schools to create the Clinical Nurse Leader (CNL).
2004	The Columbia University School of Nursing offered the first doctor of nursing practice (DNP) degree.
2007	The NLN established the Academy of Nursing Education to recognize nursing education leaders.
2010	Publication of the landmark nursing education report, *Educating Nurses: A Call for Radical Transformation* (Benner, P., Sutphen, M., Leonard, V., and Day, L.)
2010	Publication of the significant Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, 2011.

Nursing Theory

A simple description of a **theory** is "words or phrases (concepts) joined together in sentences, with an overall theme, to explain, describe, or predict something" (Sullivan, 2006, p. 160). Theories help nurses understand and find meaning in nursing. Nursing has a number of theories that have been developed since Nightingale's contributions to nursing, particularly during the 1960s–1980s, and there is variation in the theories. This surge in development of nursing theories was related to the need to "justify nursing as an academic discipline"—the need to develop and describe nursing knowledge (Maas, 2006, p. 7). Some of the major theories are described in **EXHIBIT 2–2** from the perspective of how each description, beginning with Nightingale, responds to the concepts of:

- The person
- The environment
- Health
- Nursing

EXHIBIT 2–2

Overview of Major Nursing Theories and Models

Theories and Models	Person	Environment	Health	Nursing
Systematic approach to health care Florence Nightingale	Recipient of nursing care	External (temperature, bedding, ventilation) and internal (food, water, and medications)	Health is "not only to be well, but to be able to use well every power we have to use" (Nightingale, 1969, p. 24).	Alter or manage the environment to implement the natural laws of health

EXHIBIT 2–2 *(Continued)*

Theories and Models	Person	Environment	Health	Nursing
Theory of caring in nursing Jean Watson	A "unity of mind body spirit/nature" (Watson, 1996, p. 147) (human).	A "field of connectedness" at all levels (p. 147).	Harmony, wholeness, and comfort	Reciprocal transpersonal relationship in caring moments guided by curative factors
The science of unitary human beings Martha E. Rogers	An irreducible, irreversible, pandimensional, negentropic energy field identified by pattern; a unitary human being develops through three principles: helicy, resonancy, and integrality (Rogers, 1992) (human being).	An irreducible, pandimensional, negentropic energy field, identified by pattern and manifesting characteristics different from those of the parts and encompassing all that is other than any given human field (Rogers, 1992).	Health and illness area a part of a continuum (Rogers, 1970).	Seeks to promote symphonic interaction between human and environmental fields, to strengthen the integrity of the human field, and to direct and redirect patterning of the human and environmental fields for realization of maximum health potential (Rogers, 1970).
Self-care deficit nursing theory Dorothea E. Orem	A person under the care of a nurse; a total being with universal, developmental needs, and capable of self-care (patient)	Physical, chemical, biologic, and social contexts with which human beings exist, environmental components include environmental factors, environmental conditions, and developmental environment (Orem, 1985).	"A state characterized by soundness or wholeness of developed human structures and of bodily and mental functioning" (Orem, 1995, p. 101).	Therapeutic self-care designed to supplement self-care requisites. Nursing actions fall into one of three categories: wholly compensatory, partly compensatory, or supportive educative system (Orem, 1985).
The Roy adaptation model Callista Roy	"A whole with parts that function as a unity" (Roy & Andrews, 1999, p. 31).	Internal and external stimuli; "the world within and around humans as adaptive systems" (p. 51).	"A state and process of being and becoming an integrated and whole human being" (p. 54).	Manipulation of stimuli to foster successful adaptation
The Neuman systems model Betty Neuman	A composite of physiological, psychological, sociocultural, developmental, and spiritual variables in interaction with the internal and external environment; represented by central structure, lines of defense, and lines of resistance	All internal and external factors of influences surrounding the client system	A continuum of wellness to illness	Prevention as intervention; concerned with all potential stressors

(Continues)

EXHIBIT 2–2 *(Continued)*

Theories and Models	Person	Environment	Health	Nursing
Systems framework and theory of goal attainment Imogene M. King	A personal system that interacts with interpersonal and social systems (human being)	A context "within which human beings grow, develop, and perform daily activities" (King, 1981, p. 18). "The internal environment of human beings transforms energy to enable them to adjust to continuous external environmental changes" (p. 5).	"Dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living" (p. 5).	A process of human interaction; the goal of nursing is to help patients achieve their goals.
Behavioral systems model Dorothy Johnson	A biophysical being who is a behavioral system with seven subsystems of behavior (human being)	Includes internal and external environment	Efficient and effective functioning of system; behavioral system balance and stability	An external regulatory force that acts to preserve the organization and integrity of the patient's behavior at an optimal level under those conditions in which the behavior constitutes a threat to physical or social health or in which illness is found (Johnson, 1980, p. 214).
Theory of human becoming Rosemarie Parse	An open being, more than and different than the sum of parts in mutual simultaneous interchange with the environment who chooses from options and bears responsibility for choices (Parse, 1987, p. 160).	In mutual process with the person	Continuously changing process of becoming	Use of true presence to facilitate the becoming of the participant
Transcultural nursing model Madeleine Leininger	Human beings, family, group, community, or institution	"Totality of an event, situation, or experience that gives meaning to human expressions, interpretations, and social interactions in physical, ecological, sociopolitical, and/or cultural settings" (Leininger, 1991, p. 46).	"A state of well-being that is culturally defined, valued, and practiced" (Leininger, 1991, p. 46).	Activities directed toward assisting, supporting, or enabling with needs in ways that are congruent with the cultural values, beliefs, and lifeways of the recipient of care (Leininger, 1995).

EXHIBIT 2–2 *(Continued)*

Theories and Models	Person	Environment	Health	Nursing
Interpersonal relations model Hildegard Peplau	"Encompasses the patient (one who has problems for which expert nursing services are needed or sought) and the nurse (a professional with particular expertise)" (Peplau, 1952, p. 14).	Includes culture as important to the development of personality	"Implies forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal, and community living" (Peplau, 1952, p. 12).	The therapeutic, interpersonal process between the nurse and the patient

Sources: Johnson, D. (1980). The behavioral systems model for nursing. In J. Riehl & C. Roy (Eds.), *Conceptual models for nursing practice* (2nd ed., pp. 207–216). New York, NY: Appleton-Century-Crofts; King, I. M. (1981). *A theory of nursing: Systems, concepts, process*. New York, NY: Wiley; Leininger, M. M. (1991). *Culture care diversity and universality: A theory of nursing*. New York, NY: National League for Nursing; Leininger, M. M. (1995). Transcultural nursing perspectives: Basic concepts, principles, and culture care incidents. In M. M. Leininger (Ed.), *Transcultural nursing: Concepts, theories, research, and practices* (2nd ed., pp. 57–92). New York, NY: McGraw-Hill; Nightingale, F. (1969). *Notes on nursing: What it is and what it is not*. New York, NY: Dover; Orem, D. (1985). *Nursing: Concepts of practice* (3rd ed.). St. Louis, MO: Mosby; Orem, D. (1995). *Nursing: Concepts of practice* (5th ed.). St. Louis, MO: Mosby; Parse, R. R. (1987). *Nursing science: Major paradigms, theories, and critiques*. Philadelphia, PA: Saunders; Peplau, H. (1952). *Interpersonal relations in nursing*. New York, NY: G. P. Putnam's Sons; Rogers, M. E. (1970). *An introduction to the theoretical basis of nursing*. Philadelphia, PA: Davis; Rogers, M. E. (1992). Nursing science and the space age. *Nursing Science Quarterly, 5*, 27–34; Roy, C., & Andrews, H. A. (1999). *The Roy adaptation model*. New York, NY: Appleton-Lange; Watson, J. (1996). Watson's philosophy and theory of human caring in nursing. In J. P. Riehl-Sisca (Ed.), *Conceptual models for nursing practice* (pp. 219–235). Norwalk, CT: Appleton & Lange, as cited in K. Masters (2005), *Role development in professional nursing practice*. Sudbury, MA: Jones and Bartlett.

Since the late 1990s, there continues to be less emphasis placed on nursing theory in nursing education. This change has been controversial. Theories may be used to provide frameworks for research studies and to test their applicability. In addition, practice may be guided by one of the nursing theories. In hospitals and other healthcare organizations, the nursing department may identify a specific theory on which the staff bases its mission. In these organizations, it is usually easy to see how the designated theory is present in the official documents about the department, but it is not always so easy to see how the theory impacts the day-to-day practice of nurses in the organization. It is important to remember that theories do not tell nurses what they must do or how they must do something; rather, they are guides—abstract guides. **FIGURE 2–1** describes the relationship between theory, research, and practice.

Most of the nursing theories were developed in the 1970s–1990s, so what might some of the issues of future theories be? In 1992, the following were predicted as possible areas to be included in nursing theories (Meleis, 1992):

1. The human science underlying the discipline that "is predicated on understanding the meanings of daily lived experiences as they are perceived by the members or the participants of the science" (p. 112).

Knowledge Development in a Practice Discipline

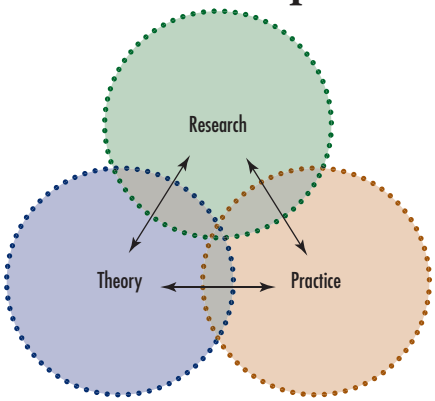

FIGURE 2–1 Relationship Theory, Research, Practice
Source: Masters, K. (2005). *Role development in professional nursing practice*. Sudbury, MA: Jones and Bartlett.

2. The increased emphasis on the practice orientation, or actual, rather than "ought-to-be," practice.
3. The mission of nursing to develop theories to empower nurses, the discipline, and clients (patients).
4. "Acceptance of the fact that women may have different strategies and approaches to knowledge development than men" (p. 113).
5. Nursing's attempt to "understand consumers' experiences for the purpose of empowering them to receive optimum care and to maintain optimum health" (p. 114).
6. "The effort to broaden nursing's perspective, which includes efforts to understand the practice of nursing in third world countries" (p. 114).

These potential characteristics of nursing are somewhat different from past theories. Consumerism is highlighted through better understanding consumers/patients and empowering them. Empowering nurses is also emphasized. The suggestion that female nurses and male nurses might approach care issues differently has not really been addressed. The sixth characteristic listed is highly relevant today with the increase in globalization. Developed and developing countries can share information via the Internet in a matter of seconds. There are fewer boundaries than ever before; better communication and information exchange is possible. A need certainly exists because the nursing issues and care problems are often the same or very similar worldwide. A global effort to solve these problems on a worldwide scale is absolutely necessary. Take, for example, issues such as infectious diseases, which, because of the ease of travel, can quickly spread from one part of the world to another in which the disease is relatively unknown. In conclusion, it is not really clear what role nursing theories might play and how theories might change, although theory development is not active today.

Nursing Research

Nursing research is "systematic inquiry that uses disciplined methods to answer questions and solve problems" (Polit & Beck, 2010, p. 4). The major purpose of doing research is to expand nursing knowledge to improve patient care and outcomes. It helps to explain and predict care that nurses provide. There are two major types of research: basic and applied. Basic research is conducted to gain knowledge for knowledge's sake; however, basic research results may then be used in applied or clinical research.

Nursing has not connected research with practice as much as it should. This type of approach separates the practitioner from the research process too much. Nursing needs to know more about "whether and how nurses produce knowledge in their practice" (Reed, 2006, p. 36). Nursing, and all health care, needs to be patient centered (IOM, 2003), and research should not be an exception. This does not mean that there is no need for research in administration/management and in education, because there are critical needs in these areas, but it does mean that nursing needs to gain more knowledge about the nursing process with patients as the

center. Because of these issues, EBP has become more central in practice.

The research process is similar to the nursing process in that there is a need to identify a problem using data, determine goals, describe what will be done, and then assess results. Research and evidence-based practice are discussed more in Chapter 11.

Professional Literature

Professional literature is an important part of nursing scholarship, but it is important to remember that "because of the changing health care environment and the proliferation of knowledge in health care and nursing, much of the knowledge acquired in your nursing education program may be out of date 5 years after you graduate" (Zerwekh & Claborn, 2006, p. 197). This literature is found in textbooks and in professional journals. The literature provides a repository of nursing knowledge that is accessible to nursing students and nurses. It is important that nurses keep up with the literature in their specialty areas, given the increased emphasis on EBP. There is increased access of journals through the Internet, and this is a positive change because it makes knowledge more accessible when it is needed.

Textbooks typically are a few years behind current information because of the length of the publication schedule. Although this is improving, it still takes significantly longer to publish a textbook than a journal. It is also more expensive to publish a book, so new editions do not come out annually. The content found in textbooks provides the background information and detail on particular topics. A textbook is peer reviewed when content is shared with experts on the topic for feedback to the author(s). Today, many textbook publishers offer companion websites to provide additional material and, in some cases, more updated content or references. More and more publishers are publishing textbooks in e-book format; some offer both hardcopy and e-books, and others offer only e-books. This change might reduce the delay in getting textbooks published and provide a method for updating content quickly.

Content in journals is typically more current than that in textbooks and usually focuses on a very specific topic in less depth than a textbook. Journals with higher quality articles are peer reviewed. This means that several nurses who have expertise in the manuscript's topic review submitted manuscripts. A consensus is then reached with the editor regarding whether to publish the manuscript. Online access to journal articles has increased accessibility to nurses. Nursing professional organizations often publish journals.

In 2010, there were 190 nursing journals in continual print, and 15 of them focus on research (University of Adelaide Library Guides, 2010). Any nurse with expertise in an area can submit for publication. The profession needs more nurses publishing, particularly in journals. **EXHIBIT 2–3** identifies examples of nursing journals.

EXHIBIT 2–3

Examples of Nursing Journals

- *American Journal of Nursing*
- *American Nursing Today*
- *Emergency Room Nursing*
- *Home Healthcare Nurse*
- *Journal of Cardiovascular Nursing*
- *Journal of Nursing Administration*
- *Journal of Nursing Care Quality*
- *Journal of Nursing Informatics*
- *Journal of Nursing Scholarship*
- *Journal of Pediatric Nursing*
- *Journal of Perinatal and Neonatal Nursing*
- *Journal of Professional Nursing*
- *Journal of Psychiatric Nursing*
- *Nursing Management*
- *Nursing Outlook*
- *Nursing Research*
- *Nursing 2011*
- *Oncology Nursing*
- *Online Journal of Nursing*
- *World Views of Evidence-Based Nursing*

New Modalities of Scholarship

Scholarship, as noted previously, includes publications, copyrights, licenses, patents, or products for sale. Nursing is expanding into a number of new modalities that can be considered scholarship. Many of these modalities relate to web-based learning—including course development and learning activities, and products such as case software for simulation experiences—and involve other technology, such as personal digital assistants and podcasting. Most of these new modalities relate to teaching and learning in academic programs, though many have expanded into staff development and continuing education. In developing these modalities, nurses are creating innovative teaching methods, developing programs and learning outcomes, improving professional development, and applying technical skills. When interprofessional approaches are used, integrative scholarship occurs. The Sigma Theta Tau International course on EBP described in **BOX 2–1** uses the Web to provide broader access to this critical content.

Multiple Nursing Roles and Leadership

Nurses use knowledge and caring as they provide care to patients; however, there are other aspects of nursing that are important. Nurses hold multiple roles, sometimes at the same time. As nurses function in these roles, they need to demonstrate leadership.

Key Nursing Roles

Before discussing nursing **roles**, it is important to discuss some terminology related to roles. A role can vary depending on the context. Role means the expected and actual behaviors that one would associate with a position such as a nurse, teacher, pharmacist, and so on. Connected to role is **status**, which is a position in a social structure, with rights and obligations—for example, a nurse manager. As a person takes on a new role, the person experiences **role transition**. Nursing students are in role transition as they gradually learn the nursing roles. All nursing roles are important in patient care, and typically

BOX 2–1

Example of a Continuing Education Program Promoting Clinical Scholars at the Bedside

Sigma Theta Tau International offers a continuing education course for nurses, Clinical Scholars at the Bedside, which focuses on evidence-based practice. Content includes the following modules:

- Clinical Scholars at the Bedside: An EBP Mentorship Model for How Nurses Work Today
- Origins and Aspirations: Conceiving the Clinical Scholar Model
- Observation: Conceptualizing a Researchable Clinical Issue
- Analysis: What's All the Speak About Critique?
- Synthesis and Evaluation: The Clinical Scholar Model in Practice
- Critiquing Clinical Guidelines
- Creating the Clinical Scholar Student: Collaboration Between Education and Practice
- Curiosity and Reflective Thinking: Renewal of the Spirit
- Dear Diary: Rewards and Challenges of Applying Evidence

Source: Sigma Theta Tau International. Continuing Education Program Promoting Clinical Scholars at the Bedside. Retrieved from http://www.nursingknowledge.org/Portal/main.aspx?PageID=36&SKU=67128&WT.mc_id=&WT.desvid=954750955

these roles are interconnected in practice. Students learn about the roles and what is necessary to be competent to meet role expectations, and **identity** also is involved. "Identity is foundational to professional nursing practice. Identity in nursing can be defined as the development within nurses of an internal representation of people–environment interactions in the exploration of human responses to actual or potential health problems. Professional identity is foundational to the assumption of various nursing roles" (Cook, Gilmer, & Bess, 2003, p. 311).

Nursing is a complex profession and involves multiple types of consumers of nursing care (e.g., individuals, families, communities, and populations), multiple types of problems (e.g., physical, emotional, sociological, economical, and educational), and multiple settings (e.g., hospitals, clinics, communities, and schools), and specialties within each of these. Some roles do not focus so much on direct patient care, such as teaching, administration, and research roles. Different levels of knowledge, caring, and education may be required for different roles. There are many nursing roles, and all of them require leadership. The key roles found in nursing are discussed in the following sections.

Provider of Care

The **provider of care** role is probably what students think nursing is all about, and this is the role typically seen in the hospital setting and the role that most people think of when they think of a nurse. Caring is attached most to this role, but knowledge is critical to providing safe, quality care. When the nurse is described, it is often the caring that is emphasized with less emphasis on the knowledge and expertise that is required, and more emphasis on the emotional side of caring. This perspective is not indicative of what really happens, because nurses need to use knowledge and be competent, as was discussed earlier in this chapter. Providing care has moved far beyond the hospital, with nurses providing care in clinics, schools, the community, homes, industry, and at many more sites.

Educator

Nurses spend a lot of time teaching—teaching patients, families, communities, and populations. Nurses as **educators** focus on health promotion and prevention and helping the patient (individuals, families, communities, and populations) cope with illness and injury. Teaching needs to be planned and based on needs, and nurses must know about teaching principles and methods. Some nurses teach other nurses and healthcare providers in healthcare settings, which is called staff development or staff education. Other nurses teach in nursing schools. Nursing education is now considered to be a type of nursing specialty/advanced practice.

Counselor

A nurse may act as a **counselor**, providing advice and counseling to patients, families, communities, and populations. This is often done in conjunction with other roles.

Manager

Nurses act as managers daily in their positions even if they do not have a formal management position. Management is the process of getting something done efficiently and effectively through and with other people. Nurses might do this by ensuring that a patient's needs are addressed. For example, he or she may ensure that the patient receives needed laboratory work or a rehabilitation session. The nurse plans who will give care (and when and how), evaluates outcomes, and so forth. Managing care involves critical thinking, clinical reasoning and judgment, planning, decision making, delegating, collaborating, coordinating, communicating, working with interprofessional teams, and leadership. Much of this will be discussed in later chapters, particularly Chapter 15.

Researcher

Only a small percentage of nurses are actual nurse **researchers**; however, nurses participate in research in other ways. The most critical is by using EBP or evidence-based management (EBM), which is dis-

cussed in more detail in Chapter 11 as one of the five core healthcare professional competencies. Some nurses now hold positions in research studies that may or may not be nursing research studies. These nurses assist in data collection and even manage data collection projects.

Collaborator

Every nurse is a collaborator. "**Collaboration** [boldface added] is a cooperative effort that focuses on a win-win strategy. Collaboration depends on each individual recognizing the perspective of others who are involved and eventually reach a consensus of common goal(s)" (Finkelman, 2012, p. 353). A nurse collaborates with other healthcare providers, members of the community, government agencies, and many more. Teamwork is a critical component of daily nursing practice.

Change Agent (Intrapreneur)

It is difficult to perform any of the nursing roles without engaging in change. This change may be found in how care is provided, where care is provided and when, to whom care is provided, and why. Change is normal today. The healthcare delivery system experiences constant change. Nurses deal with it wherever they work, but they may also initiate change for improvement. When a nurse is a **change agent** within the organization where he or she works, the nurse is an **intrapreneur**. This requires risk and the ability to see change in a positive light. An example of a nurse acting as a change agent would be a nurse who sees the value in extending visiting hours in the intensive care unit. The nurse reviews the literature on this topic to support EBP interventions and then approaches management with the suggestion about making a change. The nurse then works with the interprofessional team to plan, implement, and evaluate this change to assess the outcomes.

Entrepreneur

The **entrepreneur** role is not as common as other roles, but it is increasing. The entrepreneur works to make changes in a broader sense. Some examples are nurses who are healthcare consultants and legal nurse consultants, and nurses who establish businesses related to health care, such as a staffing agency, a business to develop a healthcare product, healthcare media business, or collaboration with technology such as engineering.

Patient Advocate

Nurses serve as the patient and family **advocate**. The nurse may advocate on behalf of an individual, a family, a community, or a population. In this role, the nurse is a change agent and a risk taker. The nurse speaks for the patient but does not take away the patient's independence. A nurse caring for a patient in the hospital might advocate with the physician to alter care in order to allow a dying patient to spend more time with family. A nurse might advocate for better health coverage by writing to the local congressman or attending a meeting about care in the community. Additional information about advocacy is included in Chapters 6 and 9.

Summary Points: Roles and What Is Required

To meet the demands of these multiple roles, nurses need to be prepared and competent. Prerequisites and the nursing curriculum, through content, simulation laboratory experiences, and clinical experiences help students to transition to these roles. The prerequisites provide content and experiences related to biological sciences, English and writing, sociology, government, languages, psychology, and mathematics and statistics. In nursing, course content relates to the care of a variety of patients in the hospital, in homes, and in communities; planning and implementing care; communication and interpersonal relationships; culture; teaching; community health; epidemiology; issues related to safe, quality care; research and EBP; health policy; and leadership and management.As discussed earlier in this chapter, this content relates to the required knowledge base. When students transition to the work setting as registered nurses, they should be competent as beginning nurses; however, the transi-

tion is often difficult. **Reality shock** may occur. This is a shocklike reaction that occurs when a new nurse is confronted with the realities of the healthcare setting and nursing, which are typically very different from what the nurse has experienced in school (Kramer, 1985). Knowledge and competency are important, but new nurses also need to build self-confidence, and they need time to adjust to the differences. Some schools of nursing, in collaboration with hospitals, now offer internship/externship and residency programs for new graduates to decrease the reality shock (see Chapter 14). The major nursing roles that students learn about in their nursing programs are important in practice, but it is also important for students to learn about being an employee, working with and in teams, communicating in real situations, and functioning in complex organizations.

More nurses work in hospitals, particularly new graduates, than in other healthcare settings, although the number of nurses working in hospitals is decreasing. Hospital care has changed since 1996, with sicker patients in the hospital for shorter periods and with greater use of complex technology. The healthcare delivery system is discussed in more detail in Chapter 6. These changes have an impact on what is expected of nurses: competencies.

Nursing standards, nurse practice acts, professional ethics, and the nursing process influence nursing roles. Health policy also has an impact on roles; for example, legislation and changes in state practice guidelines were required before the advanced practice nurse could have prescriptive authority (ability to prescribe medications). This type of change in role requires a major advocacy effort from nurses and nursing organizations.

Conclusion

This chapter has highlighted the definitions of nursing, description of nursing roles, the changing skills sets needed by nurses, transformational leadership, and ties to patient safety, ways of knowing, and the need for a movement toward nurses as knowledge workers.

Chapter Highlights

1. The definition of nursing is variable.
2. The need to define nursing relates to the ability to describe what nursing is and what it does.
3. Caring and knowledge are critical components of the nursing profession.
4. Competency is defined by and related to the new skills that nurses need to function in today's healthcare environment.
5. The movement toward preparing nurses as knowledge workers is discussed.

DISCUSSION QUESTIONS

1. Discuss the relationship between knowledge and caring in nursing.
2. How might knowing the definition of nursing impact how you practice?
3. What does *knowledge worker* mean?
4. What are the characteristics of a transformational leader?
5. What are the characteristics of a nurse manager?
6. Describe the nurse's role in today's healthcare system.
7. Why are competencies important?
8. Discuss the role of critical thinking in nursing education and why there is little agreement about what constitutes critical thinking. What is the importance of clinical reasoning and judgment? Identify examples from your practice thus far that apply to critical thinking and clinical reasoning and judgment.

6. The key roles of the nurse are care provider, educator, manager, advocate, counselor, researcher, collaborator, change agent (intrapreneur), and entrepreneur.

Linking to the Internet

- National Institutes of Health
  http://www.nih.gov
- National Institute of Nursing Research
  http://www.ninr.nih.gov/
- American Nurses Association
  http://www.nursingworld.org
- North American Nursing Diagnosis International (NANDA)
  http://www.nanda.org
- Nursing Interventions Classification (NIC)
  http://www.nursing.uiowa.edu/excellence/nursing_knowledge/clinical_effectiveness/nic.htm
- Nursing-Sensitive Outcomes Classification (NOC)
  http://www.nursing.uiowa.edu/excellence/nursing_knowledge/clinical_effectiveness/nocpubs.htm
- Omaha Nursing Classification System for Community Health
  http://www.himss.org/content/files/ImplementationNursingTerminologyCommunity.pdf

CRITICAL THINKING ACTIVITIES

1. Based on what you have learned about critical thinking, assess your own ability to use critical thinking. Write down your strengths and limitations regarding using critical thinking. Determine several strategies that you might use to improve your critical thinking. Write down these strategies and track your improvement over the semester. Use the critical thinking web link to guide you in this activity.
2. Review the descriptions of the nursing theories found in Exhibit 2–2. Compare and contrast the theories in relationship to views of person, environment, health, and nursing. Identify two similarities and dissimilarities in the theories. Select a theory that you feel represents your view of nursing at this time. Why did you select this theory?
3. Caring is a concept central to nursing. Review the description of the nursing theories found in Exhibit 2–2. Identify which theories emphasize caring, and describe how this is demonstrated in the theory.
4. Go to the National Institute of Nursing Research website (http://www.ninr.nih.gov/AboutNINR/) and click Mission & Strategic Plan. Explore the Ongoing Research Interests section. What are some of the interests? Do any of them intrigue you? If so, why? Now, on the Mission & Strategic Plan page, click Nursing Research—Making a Difference. What can you learn about past and current nursing research? Did you think of these areas of study as part of nursing before this course? Why or why not? What impressed you about the research? Do you think these results are practice oriented?
5. What does *caring* mean to you? How does your view of caring compare with what you have learned in this chapter?
6. Do you think nursing scholarship is important? Provide your rationale for your response.
7. Select one of the major nursing roles and describe it and why you would want to function in this role.
8. Interview a staff nurse, nurse manager, and educator and ask for their definition of nursing. Compare your answers. Why do you believe there are differences?
9. Ask a patient to describe the role of a nurse; then compare it with your view of nursing. Is it similar or different, and why?

Case Study

An Historical Event to Demonstrate the Importance of the Art and Science of Nursing, Nursing Roles, and Leadership

The following case is a summary of a change in healthcare delivery that impacted nurses. After reading the case, respond to the questions.

In the 1960s, something significant began to happen in hospital care and, ultimately, in the nursing profession. But first, let's go back to the 1950s for some background information. There was increasing interest in coronary care during this time, particularly for acute myocardial infarctions. It is important to remember that changes in health care are certainly influenced by changes in science and technology, but incidents and situations within the country as a whole also drive change and policy decisions. This situation was no exception. Presidents Eisenhower and Johnson both had acute myocardial infarctions, which received a lot of press coverage. The mortality rate from acute myocardial infarctions was high. There were also significant new advances in care monitoring and interventions: cardiac catheterization, cardiac pacemakers, continuous monitoring of cardiac electrical activity, portable cardiac defibrillators, and external pacemakers. This really was an incredible list to come onto the scene at the same time.

Now, what was happening with nursing in the 1950s regarding the care of cardiac patients? Even with advances, nurses were providing traditional care, and the boundaries between physicians and nurses were very clear.

Physicians

Examined the patient
Took the electrocardiogram
Drew blood for lab work
Diagnosed cardiac arrhythmias
Determined interventions

Nurses

Made the patient comfortable
Took care of the patient's belongings
Answered the family's questions
Took vital signs (blood pressure, pulse, and respirations)
Made observations and documented them

In the 1960s, change began to happen. Bethany Hospital in Kansas City had a physician, Dr. Hughes Day, who had an interest in cardiac care. The hospital redesigned its units, moving away from open wards to private and semiprivate rooms. This was nice for the patients, but it made it difficult for nurses to observe patients. (This is a good example of how environment and space impact care.) Day established a code blue to provide response to patients having critical cardiac episodes. This was a great idea but often came too late for many patients who were not observed early enough. He then instituted monitoring of patients with cardiac problems who were unstable. Another good idea, but what would happen if there was a problem? Who would intervene, and how? Day would often be called, even at home at night, but how could he get to the hospital in time in such a critical situation? Nurses had no training or experience with the monitoring equipment or in recognizing arrhythmias, or knowledge about what to do if there were problems. Day (1972) was beginning to see that his ideas needed revision.

At the same time that Day was exploring cardiac care, Dr. L. Meltzer was involved in similar activity at the Presbyterian Hospital in Philadelphia. Each did not know of the work that the other was doing. Meltzer went about the problem a little differently. He knew that a separate unit was needed for cardiac patients, but he was less sure about how to design it and how it would function. Meltzer approached the Division of Nursing, U.S. Public Health Services, for a grant to study the problem. He wanted to establish a two-bed cardiac care unit (CCU). His research question was *will nurse monitoring and intervention reduce the high incidence of arrhythmic deaths from acute myocardial infarctions*? At this time, and good for nursing, Faye Abdella, PhD, RN, was leading the Division of Nursing. She really liked the study proposal but felt that there was something important

(Continues)

Case Study *(Continued)*

missing. To receive the grant, Meltzer needed to have a nurse lead the project. Meltzer proceeded to look for that nurse. He turned to the University of Pennsylvania and asked the dean of nursing for a recommendation. Rose Pinneo, MSN, RN, a nurse who had just completed her master's degree and had experience in cardiac care, was selected. Meltzer and Pinneo became a team. Pinneo liked research and wanted to do this kind of work. By chance, she had her opportunity. What she did not know was that this study and its results would have a major impact on the nursing profession and all cardiac health care.

Dr. Zoll, who worked with Meltzer, recognized the major issue: Nurses had no training in what would be required of them in the CCU. This represented a major shift in what nurses usually did. If this was not changed, no study could be conducted based on the research question that they had proposed. Notably, Meltzer proposed a new role for nurses in the CCU:

- The nurse has specific skills in monitoring patients using the new equipment.
- Registered nurses (RNs) would provide all the care. Up until this time, the typical care organization was a team of licensed practical nurses and aides, who provided most of the direct care, led by an RN (team nursing). This had to change in the CCU staffing.
- RNs would interpret heart rhythms using continuous-monitoring electrocardiogram data.
- RNs would initiate emergency interventions when needed.
- The RN, not the doctor of medicine, is central to CCU care 24 hours a day, 7 days a week.

There were questions as to whether RNs could be trained for this new role, but Meltzer had no doubt that they could be.

Based on Meltzer's plan and the new role, Pinneo needed to find the nurses for the units. She wanted nurses who were ready for a challenge and who were willing to learn the new knowledge and skills needed to collect data. Collecting data would be time consuming, plus the nurses had to provide care in a very new role. The first step after finding the nurses was training. This, too, was unique. It was interprofessional, and it took place in the clinical setting, the CCU. Clinical conferences were held to discuss patients and their care once the unit opened.

The nurses found that they were providing care for highly complex problems. They were assessing and diagnosing, intervening, and having to help patients with their psychological responses to having had an acute myocardial infarction. Clearly, knowledge and caring were important, but added to this was curing. With the interventions that nurses initiated, they were saving lives. Standing orders telling nurses what to do in certain situations based on data they collected were developed by Meltzer and used. House staff, physicians in training, began to turn to the nurses to learn because the CCU nurses had experience with these patients. Meltzer called his approach the scientific team approach. In 1972, he wrote, "Until World War II even the recording of blood pressure was considered outside the nursing sphere and was the responsibility of a physician. As late as 1962, when coronary care was introduced, most hospitals did not permit their nursing staff to perform venipunctures or to start intravenous infusions. That nurses could interpret the electrocardiograms and defibrillate patients indeed represented a radical change for all concerned" (Meltzer, Pinneo, & Kitchell, 1972, p. 8).

What were the results of this study? Nurses could learn what was necessary to function in the new role. Nurses who worked in CCU gained autonomy, but now the boundaries between physicians and nurses were less clear, and this began to spill over into other areas of nursing. There is no doubt that nursing began to change. CCUs opened across the country. They also had an impact on other types of intensive care.

Case Study *(Continued)*

Case Questions

If you do not know any terms in this case, look them up in a medical dictionary.

1. Based on this case, discuss the implications of the art and science of nursing.
2. What were the differences in how Dr. Day and Dr. Meltzer handled their interests in changing cardiac care?
3. Who led this initiative? Why is this significant?
4. Compare and contrast the changes in nursing roles before the Melzer and Day studies. What was the role supported by their work?
5. What about this case is unique and unexpected?
6. What does this case tell you about the value of research?

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Words of Wisdom

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Hospice nursing is different from any other type of nursing. Some feel that it is a ministry. The focus is on providing holistic care for the patient diagnosed with terminal disease and the family. Hospice and palliative care nurses care for patients who have incurable disease. The hospice nurse manages symptoms to allow the patient the highest quality of life possible while moving along life's continuum toward death. Hospice and palliative care nursing is a growing specialty, and it will continue to grow as the population ages and as individuals cope with chronic disease. Hospice and palliative care nurses deliver care based on principles identified by Florence Nightingale: caring, comfort, compassion, dignity, and quality.

As a hospice inpatient care center nurse, I care for my patients using the aforementioned principles. Besides using my technical nursing skills, I am able to spend time with them doing the little things that make them more comfortable—whether it is holding their hand, giving a massage, sharing a snack, reminiscing about their lives, alleviating the burden of care from the family, praying, or just providing a caring presence. Depending on the situation, I may prepare my "angels in waiting" to return home with family, to a level of long-term care, or to the hereafter. I feel totally blessed and privileged to minister, to alleviate suffering, to facilitate bereavement, and to prepare for transition from life to death.

- International Classification for Nursing Practice
  http://www.icn.ch/pillarsprograms/about-icnpr
- Our Concept of Critical Thinking
  http://www.criticalthinking.org/aboutCT/ourConceptCT.cfm
- Defining Critical Thinking
  http://www.criticalthinking.org/aboutCT/definingCT.cfm
- Sigma Theta Tau International: Nursing Knowledge International
  http://www.nursingknowledge.org/Portal/main.aspx?PageID=32
- Nursing Theory Information
  http://www.sandiego.edu/academics/nursing/theory/CINAHL/allen.html

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