

“Nursing Philosophy”

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The nursing metaparadigm is a complex and evolving philosophy of what the core tenants of nursing are, and what it means to be a nurse in any given epoch. Florence Nightengale is often credited as being the godmother of nursing who first laid out specific principles regarding how a nurse is defined, the roles they fulfill, and the expectations or obligations that come with wearing the label of “nurse”. More recently, in the late 20th century, Ann Mary Fawcett was credited with establishing the four main components of the modern nursing metaparadigm. These were considered: Person, Environment, Health, and Nursing. In her book “Contemporary Nursing Knowledge: Analysis and Evaluation of Nursing Models and Theories: 2nd Edition” - Nursing Researcher Jacqueline Fawcett (no relation to Ann Mary Fawcett) further explored these four components.

Person (sometimes labeled simply as “Human Beings” in some texts), the first label, was the patient themselves from a micro view. This can include all the intrinsic factors associated with your patient – their biology, genetics, and past medical history. A person in the more macro sense, however, could encompass everything from the family unit to a whole neighborhood, or even the whole community at large. Fawcett also elaborated that this could be more than just the passive recipient/patients, but also the active members within said community and the role they play to help reinforce health and wellness within their population. Even those outside of the professional healthcare provider role- everyone can have positive and negative impacts upon the wellness of others.

It was this inclusive and expansive definition of Person that transitions nicely into discussing Environment, as the role community plays in healthcare bridges the intrinsic of the patient with the extrinsic factors outside of the patient. Environment, as a component of the nursing metaparadigm concerns itself with such things as where you live, the climate there, the

people and culture. It also considers what an individual's access to healthcare and quality food/water are like, as these have a significant impact on a given individual's wellness. It is the compilation of all these aforementioned data points that brings us to "Health" as the 3rd category of Fawcett's view of the nursing metaparadigm. Here, Health is viewed as the overall condition of a given subject and runs the full spectrum of ranges of well and unwell being. This can be viewed as a scale from the worst of illness all the way to the peak of healthy condition and includes everything in between. Health is a paradigm in constant flux – as it may be preventative in nature, care-centric during illness, or rehabilitative after-the-fact.

This then is where Nursing comes in as the final element of the paradigm. Consider how nursing interfaces with these elements. The entirety of the ADPIE nursing process can be reviewed here – Assessment of the client, Diagnosis of condition(s), Planning of care, Implementation (of outcomes and goals), and Modification (of those goals). These are just the broad strokes of how nursing itself demonstrates its significant interactions with the not only the patient, but the environment, and health/wellness; as well as defines itself within the broader context of the nursing metaparadigm.

Taken together, the sum of these parts would suggest that a nurse is an individual who makes an impact on the health and wellness of others, their communities, and the environment in which they inhabit by utilizing a reasoned and scientifically comprehensive approach to addressing the ailing aspects identified within. A large charge, to be sure, but one that it would seem is patent with almost anyone who takes up the mantle of the title of nurse. What it means to be a nurse is so much more than just a bulleted list of tent-pole edicts erecting a metaparadigm, however. Many nurses, nursing students, and honestly even non nurses would argue that what it means most to be a nurse is to be someone who cares and wants to make the world a better place.

So much so that it, more than any other component, is intrinsic and inseparable to the identity of the nurse. Cingel & Brouwer found that:

Novice and student nurses often start their professional career with one's own motivational values often reported in terms of wanting to help, wanting to be of significance, to do something for others who are ill or otherwise in trouble. In short: most nurses make their career choice out of compassion and strive to put this in practice. They see themselves as a helping, kind and understanding person. Novice nurses and student nurses even perceive such features as the core of their profession to such an extent that if they cannot put this into practice, they consider leaving the profession. (p. 4)

Indeed, the aspiration to make a difference, when confounded by limitations imposed by corporate governing bodies, particularly during trying times, has been the root cause of many in healthcare's early departure from the clinical field – nursing, or otherwise.

Similarly, my view of Nursing personally is probably less defined by a structured theory of nursing, and rather is more loosely associated with the personal feelings I hold growing up idealistic about trying to help and do well unto others. A view which has evolved through raw experience, and at times violently by the same “when-the-rubber-meets-the-road” realities endured in the raw clinical world that we alluded to earlier. During my career I have witnessed a truth that we all seem to share an origin story of trying to do something “good” and “right” with our lives and work. People who work in patient care may come in all shapes/sizes/and differing personalities, but underneath the superficial variances there remains that shared genesis of a starry-eyed hopeful trying to make a positive impact. Which is something I feel defines what it

means to be not only a nurse, but any healthcare provider broadly. A desire to insert yourself as a stopgap against death, harm, disability, and entropy – and make the world a better place.

Nowadays my current values and beliefs about going into nursing stem from an existing career in healthcare that took me to some fantastic places and care settings. They were formed by helping people at their worst and seeing how much a comprehensive and supportive approach could maximize a patient's recovery and limit permanent impairment(s). To make a real and measurable impact on the quality of life someone would have after their time rehabilitating with my unit was very fulfilling. To understand my thoughts now though, you must take these ingredients, marinate them in the best and worst experiences I've had- and throw them into a blender called Covid19. During my time frontline during the pandemic, I saw profound failures by hospital administration. I saw clinical staff flee in droves. I saw those who remained through it become broken-down, but I marveled at them for their dedication to stay in the fight. All of this has had a dramatic reshaping of my sentiments toward the healthcare apparatus from what it was before. Note that I am not a cynic, but I am far more pragmatic than I once was.

I highlight all this to say that my values and beliefs, in terms of how I suspect they will impact my nursing practice, center around a theory of the case that where nursing (and clinical care of all kinds) can improve the most is along the fault lines upon where it interfaces with the corporate level. I have strong feelings about advocating (see also: demanding) that more financial resources be moved from board-level to direct clinical application – Facility improvement, maintenance/procurement of equipment, and staff support related aspects. I have bitter memories of major city hospitals touting record profits in the same breath that they pleaded for us to work harder and risk our physical/mental health more and more to offset losses related to covid expenditures. Making the case that they were doing great financially, and owed it to the

clinical staff, but they couldn't provide us with anything we needed and required us to throw ourselves harder into the gears of a pandemic to stem their rising once-in-a-generation costs due to poor planning/preparation/response on their part. All the while we ran out of both supplies and staff and watched them make decisions that strained common sense and usually had a locus of reasoning in the mighty dollar. It offended my every fiber.

As such, I believe my personal nursing philosophy centers around: better staffing ratios, no equipment shortages, better staff reimbursement and retention efforts, more PTO to deal with the mental load of the work we do, Etc. I am very pro-union. I have seen the entire hospital mechanism fundamentally break down due to the strain and burden placed on staff while CEO's collected obscene salaries and raises (that they put in the PAPER for crying out loud!). The greatest catharsis I've had in the years since was watching the CEO, COO, and CFO all terminated within the next two years. Heads did roll in the end, but it did little to assuage folks like those I knew who worked in our PCU, in one case who received a \$0.01 raise during 2020 – worth less than the paper they printed her raise notice on. True story(s).

But I did not, and do not, want to remain bitter or scarred by these grievances. Which is why I am already well on my way through my objectives in a pre-existing plan to achieve my personal 2030 goals- You see, my wife and I were both living a good life and working as frontline healthcare employees in one of the 40 largest cities in America when we had our world rocked by a tidal wave of misery and suffering from Covid, with front row seats to the horror show. I had already been struggling with questions about when and whether to start a family or motivate my career further, and whether I was doing enough with my time on this earth in the subsequent years after I lost my only sibling. It was in the nexus of these events and considerations, and against the backdrop of the uncertainty of the political and economic

landscape, that my wife and I made a pact to keep a light burning in the darkness. We would do it all, everything else be damned. No goal in this plan we had would be dropped, and we would make it all happen in a handful of years. We would throw ourselves wholly into the belief that the world would figure its crap out, and we would keep extra busy in the meantime, so that on the other side of the insanity we would be on top of it all – a complete life Renaissance and paradigm shift. Bet it all on our optimism and drive to realign our stars. This was our gamble.

Where do I consider myself in the year 2030 then? Thoroughly settled back into my Rockies, and on top of a summit both physical and metaphorical in my life. Having put everything on the line with no promises of success other than the ones my wife and I made to one another when the shit hit the fan (*Pardon mon français*). I foresee my second child already born and now older than my son is presently. We will be fully moved into our new home, having been back for a couple years already at least. The most likely scenario is I will be in Denver, working in a regional hospital for an ortho unit, with my BSN and an ortho certification (+ potentially a charge nurse role?). I imagine I will be beginning to establish a trajectory from clinical work to something less physically demanding, having more than served my time (and body) to patient care by then- but still working with the area hospitals and utilizing the combination of my academia and clinical experience to its fullest.

Calling back to my view/beliefs relating to healthcare and my personal sacrifices, it's hard to say what I will be doing next after 2030. I find myself increasingly in a liminal space between wanting to execute on those feelings the pandemic left me with, and much like my wife's trajectory – pursue avenues by which I can supplant the incompetence I witnessed with an experienced and coherent approach by getting involved in more executive level decision making to prevent what I saw as either ignorant leadership or willful negligence from ever happening on

my watch again. Or, alternatively, be a tired old man and find comfort outside of clinical work and take solace in the family and life I worked so hard during these years to build. As an example of this - I've spent some time researching the lucrative potential to be involved in the growing impact of technology in medicine. Borrowing from experience refining Epic with therapy teams as the department super-user for Epic EMR's, and merging it with my transition into a nursing career, I am eyeballing work in a hybrid employment roll that allows me flexibility as I work in clinical documentation to assist our physicians and clinical staff on their documentation/record keeping and improving how they and Epic interface to improve efficiency, accuracy, and thoroughness.

The question of where I will be by 2030 hits very different for me than it probably does for some students, because while we are all in the same box right now on our journey at Lakeview, my journey has had a very specific vision and timeline and has demanded significant skin in the game. But my peers and I share this uphill climb through one of the most transformative endeavors of our lives. I learned a long time ago that the key to summiting is to simply keep putting one foot in front of the other, complain as little as possible, and don't forget to enjoy the views along the way.

References:

Cingel, M. van der, & Brouwer, J. (2021, January 15). What makes a nurse today? A debate on the nursing professional identity and its need for change.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/nup.12343>

Fawcett, J. (2005). *visibilityLook Insidedescription1 Contemporary Nursing Knowledge: Analysis and Evaluation of Nursing Models and Theories 2nd Edition.*

<https://www.fadavis.com/product/nursing-research-theory-contemporary-nursing-knowledge-fawcett>. https://resources.fadavis.com/1194/documents/1_2042_618.pdf