

**THE WHOLE PATIENT IN PERSPECTIVE**

**A THEORETICAL INVESTIGATION OF THE OPTIONS TO  
BROADEN AND TO INTEGRATE NURSE EDUCATION**

**THESIS:  
TO FULFIL REQUIREMENTS  
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**STUDENT:** WILCO VAN DER MEER  
**SUPERVISOR:** PROFESSOR ROBIN S. DOWNIE  
PROFESSOR OF MORAL PHILOSOPHY  
DEPARTMENT OF PHILOSOPHY  
UNIVERSITY OF GLASGOW, SCOTLAND

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Wilco van der Meer

**TO ANNA**

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# **CHAPTER-1**

## CHAPTER I

### INTRODUCTION AND DIRECTIONS

#### 1-1 INTRODUCTION

In the summer of 1993 I finished a four years Bachelor of Science programme in nursing in the Netherlands. The first two years of the course were theoretically based, and in the last two years the balance shifted towards implementation of the theory into nursing practice. At the end of the course two interrelated aspects of my education concerned me. The first aspect was the narrow scientific approach and the second the potential fragmentation of nurse education. Both these aspects of nurse education have consequences for an ideal approach to the patient as an integrated whole, possessing both unique and general characteristics.

#### 1-2 THE NARROW SCIENTIFIC APPROACH

The main goal of nurse education can be described as providing educated and competent nurses. This rather vague description of what nurse education is, can be a starting point of an indepth discussion about the nature of nursing. Two important questions related to this are:

- \*what is the object of nurse education?
- \*what different kinds of understanding about the patient are relevant for the student nurse, and how can they be developed?

The first question makes us think about what nursing is, while the second question directs us to the different ways we can understand the patient. Insight into both these questions is necessary to develop a nursing curriculum.

As a base to try to answer these two questions, I want to introduce the following empirical fact:

'the responsibility of the student nurse after he has finished his degree or diploma course, is to establish and maintain an unique face-to-face nurse-patient role relationship'. The central focus-point of this 'role relationship' for the nursing discipline is 'nursing care'. Watson (1988) defines this very complex concept as:

"Caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences. All of human caring is related to intersubjective human response to health-illness, environmental-personal interactions conditions; a knowledge of the nursing care process, knowledge of one's powers and transaction limitations".  
(Watson, 1988 p-29)

Watson's broad definition of nursing care, can be used as a base to describe the purpose and the different kinds of understanding of nurse education.

In order to become a nurse, the student nurse has to obtain different kinds of understanding of the patient. In general, nurse education and practice are working with a holistic image of human beings. This means that the somatic, psychological and the social sides are equally important and cannot be seen separately. The holistic image of human beings is reflected in the current British nursing curriculum.

Project-2000, a National Board plan for the reform of basic nurse education, shows, for example, the following subject curriculum outline for the first 18 months:

- \*theory and practice of nursing;
- \*communication;
- \*social and behavioural sciences;
- \*life sciences relevant to nursing;
- \*professional, ethical and moral issues;
- \*organisational structure and processes social care provision and care systems;
- \*health promotion and health education.

These different kinds of understanding can be described as the 'tools' the nurse needs to establish and maintain the role-relationship with a patient. Most of these 'tools' are developed by means of bio-medical, social scientific, nursing scientific research etc.. It is important to look at the philosophical framework in which the scientific understanding is developed. Does this framework suits the broad definition of nursing care?

The dominating philosophical base of today's scientific thinking, was developed during the 16th and 17th centuries. This period is mostly classified as the 'period of the scientific revolution'. Important characteristics of thinking during this period are: dehumanisation of the world; power over nature; and a metaphysics of dualism. The traditional scientific approach that emerged through these ideas, can be described as: empirical, positivist and, axiomatic, focused on generalised, objective and detached explanations of our world, through deduction.

Bio-medical science, social sciences and the science of nursing, which are all important for nurse education, have been influenced by this traditional approach.

The scientific explanations for human ill-health and nursing care, taught in nurse education, are largely based on these narrow foundations. This brings us back to the roots of the first aspect of nurse education I am concerned about, namely the narrow scientific approach used to educate nurses. Further examination of the traditional approach of science will be discussed.

Scientific understanding is focused on generalised patterns of the constitution and behaviour of a human being and his environment. Another issue which has to be addressed is whether generalised insights alone are enough to provide nursing care. Griffin (1993) described two preconditions of nursing care, related to human values:

\*"respect for the person. The fundamental ethical principle requires that we treat each person as an end in themselves, and never as a means";

\*openness and receptivity. It is necessary to clear one's mind of habitual attention to self and to be more aware of another's needs and to have the willingness to consider these.

These preconditions of nursing care, direct us to a different kind of understanding of the patient, namely ‘unique’ understanding. Erich Fromm (1985) in this respect writes: “the very differences between individuals must be respected, that while it is true we are all one, it is also true that each one of us is an unique entity, is a cosmos by itself”. (Fromm, 1985 p-19) Besides a generalised understanding, the nurse needs to have an insight into the unique life-history of the patient and has to understand the patient’s unique experience of ill-health. For example, breast-cancer for one patient can have a different meaning, then for another patient in the same situation.

In contrast to generalised understanding, unique understanding reveals the individual suffering, pain, beauty etc. of a patient. The former way of understanding is produced by ‘nursing as a science’, while the latter is produced by ‘nursing as an art’. Unique understanding is in agreement with the empirical fact, introduced earlier, that the student nurse has to establish and maintain an unique nurse-patient role relationship.

Besides an unique insight into the patient, the nurse needs to have an unique personal insight into himself, since he is the ‘tool’ which provides nursing care. Personal fears or ideas about, for example, breast-cancer, can influence the role relationship either positively or negatively. Personal insight is related to Griffin’s second precondition of care. Furthermore, unique understanding gained through, for example, experience and reflection, can be used as an inductive source of scientific research. In this way, the role relationship between the patient and the nurse practitioner, becomes the central source of scientific investigation and a link can be made between ‘unique’ and ‘scientific’ understanding.

The introduction of ‘unique’ understanding alongside general understanding, brings us again to the roots of the first aspect about which I am concerned. Within the current and dominant narrow philosophical framework, there is little room to develop a value base. As described earlier, this model is based on detached, and objective explanations of man and his environment. Currently personal reflection is slowly becoming part of nurse education and practice. However due to the dominance of the traditional approach, unique understanding of the patient and the nurse himself, have been underestimated as the other central pillar. A broader philosophical foundation is needed, in which we can include the value base of nursing.

Based on Griffin’s preconditions of nursing care and the framework of unique understanding, the following important issue will be discussed: ‘Can respect for another’s individuality (i.e. the patient) be learned or is it as Socrates stated, “an instinct given by God to the virtues?”’ In other words, is it possible to build a ‘value bridge’ between the patient and the nurse.

In this thesis I hope to show that the dominant traditional approach of scientific understanding is too narrow to analyse all aspects of Watson’s definition of nursing care. Then a second step will be to look for broader foundations. Furthermore based on Griffin’s preconditions of nursing care, ‘unique understanding’ of ‘the self’ and ‘the other’ should be introduced. The ‘general-unique’ patient view can be described as the ‘whole-person’ approach. In conclusion, nurse education needs two related platforms, namely a knowledge base (general understanding) and a value base (unique understanding).

### **1-3- FRAGMENTATION AND NURSE EDUCATION**

My second concern of nurse education was its potential fragmentation. The phenomenon ‘fragmentation’ is connected with the complexity of our being and our environment. Modern Western society has recently been experiencing a wide range of technological revolutions. Related to an accumulation of ‘one dimensional knowledge’ (knowledge related to the application of mechanistic solutions), health care has started to divide into specialities. The different specialities have little knowledge of the other specialities and work largely independently. Capra (1982) pointed out that the success of the medical science has been based on detailed cellular and molecular knowledge. By concentrating on smaller and smaller parts, the patient, as a human being, and the environmental and socio-political context in which the ill-health occurs, are being ignored. Hewa and Hetherington (1994), in this respect, write: “fragmentation encourages specialists to make decisions on various health care services that do not take into account the ‘whole patient’, including her/his social, cultural, emotional and psychological characteristics”. (Hewa/Hetherington, 1994 p-182)

The nursing discipline which is strongly connected with the medical discipline, as will be described in chapter-II, has been under the influence of specialisation based on ‘one dimensional knowledge’. The nursing discipline is both concerned with ‘mechanistic’ solutions and with the total well-being of the patient. While emphasising traditional and fundamental values of nursing, the tension between ‘the total’ and ‘the parts’ is a major concern within the nursing discipline.

The importance of allowing the nursing discipline to stick to the fundamental value of the total well-being of the patient, rather than fragmenting the patient and the discipline, will be discussed.

In order to ‘hold the patient together’, nurse education has an important role. Through integrated programmes nurse educators have to ‘produce’ educated humanitarian servants dedicated to the well-being of the sick and disabled. In other words, a broad variety of subjects have to be linked, so that the student nurse obtains an integrated understanding of the nurse-patient role-relationship.

#### **1-4 AIMS, METHOD AND RELEVANCE OF THE THESIS**

The aims of the thesis are twofold, namely to obtain an insight into the narrow scientific approach and the potential fragmentation of nurse education, and to open new directions to ‘broaden’ and to ‘integrate’ nurse education. I am going to illuminate these two aims by means of philosophical research.

The relevance of the thesis is to support the ideal that a patient should be approached as an integrated whole, with both unique and general characteristics. In order to approach the patient in this way, nurse education has to be based on ‘broad’ and ‘integrated’ philosophical foundations. The reflection at student level will be ‘integrated’ and ‘broad’ educated nurses, to the point that they will see themselves as evolving ‘tools’.

## **1-5 OUTLINE (ABSTRACT) OF THE THESIS**

In chapter-II I will discuss the history of nurse education in relation to two problems, namely: the dual role of the student nurse and the development of nursing theory. Chapter-II will also explore an obstacle of change (obedience) in the light of women's development to adulthood.

Chapter-III, will give an insight into the two perspectives, general and unique, of understanding a patient, relevant to nurse education (knowledge base and value base). This chapter refers to the question: 'what different kinds of understanding of the patient are relevant for the student nurse, and how can they be developed'?

In chapter-IV I will clarify the four central concepts of the nursing discipline, namely: health, person, environment and nursing care. This chapter relates to the question: 'what is the object of nurse education'?

In chapter-V I will draw my conclusions and establish further directions to be investigated.

The thesis covers a lot of 'ground'. The relationships between the large amount of important concepts, prevails over a detailed analysis of each of the concepts. In this respect the thesis can be classified as a framework thesis. I want to invite the reader to discover the complex but beautiful country of nurse education. Afterwards the spots of personal interest can be explored individually.

\* In the thesis I have used 'he' to address the student-nurse. 'He' can be replaced with 'she'. Furthermore, the terms nurse education, nursing discipline and nursing and the terms nurse and student-nurse are compatible.

## **CHAPTER-2**

## **CHAPTER-II**

### **FROM NIGHTINGALE TO PROJECT-2000**

#### **2-1- INTRODUCTION**

Is the present a perpetual repetition of the past? Although the appearance of the matter might differ from the past, the content is the same! This kind of question and statement is obvious through the history of nurse education. The same problems and obstacles tend to appear over and over again. For example, the tension between the ‘service’ role and the ‘student’ role of the student nurse, is a problem that can be seen all through this century with no real solution, as yet, in sight.

A historical investigation can help to put current nursing problems and developments, for example project-2000, into perspective. Many people throughout this century involved in nursing and nurse education, have been trying to solve nursing problems. A relevant question is: “why has it been so difficult to accomplish structural change”? An important part of the answer, as I will discuss in this chapter, may be connected with the fact that the deep-rooted problems are not only isolated matters to nursing, but strongly connected with society.

In this chapter I will describe the history of nurse education highlighting two problems, namely: the ‘dual-role’ (student/service) of the student nurse and the development of ‘nursing theory’. The second part of this chapter describes the moral/legal concept ‘obedience’ and its role as an obstacle to change the problems.

I will illuminate the differences, in psychological development to adulthood, between women and men, with respect to obedience. This analysis is based on Gilligan's research. She revealed a 'different voice' in the moral development between men and women. Gilligan has been attacked on the sex-dichotomy she established. I will discuss the attack of Tronto, important for the nursing discipline to develop the value base.

Before the historical analysis of nurse education, it is important to describe briefly the differences between 'training' and 'education'. Downie and Charlton (1992) relate the following criteria to 'education': it is something worthwhile for its own sake; it must have a wide perspective; the persons who attended the education must get engaged in that specific field. 'Training' specifically deals with learning certain skills, for example the correct techniques to give an injection. With reference to nurse education, both aspects must be part of the curriculum. Historically however, training has dominated over education

### **2-2-1 THE DUAL-ROLE: SERVICE VERSUS EDUCATION**

Nurse training in Britain started to develop in the 1840's. The founders of nurse training in the United Kingdom are Elizabeth Fry (1840's) and Florence Nightingale (1860's). Elizabeth Fry established a community nursing service and Florence Nightingale in 1860 founded the Nightingale School at St. Thomas Hospital, called 'The Institution for the Training, Sustenance, and Protection of Nurses and Hospital Attendants'. Other nursing services were established by various religious orders.

Nurse education, until the National Health Service (N.H.S.) was established in 1948, was mainly provided by a large range of hospitals. Every hospital had its own nurse training scheme. The 'student' nurse worked in the hospitals on a probationers base, the so called 'apprenticeship system', i.e. the nurse got 'training on the job' by a qualified nurse. In the apprenticeship system the 'doing' was emphasised over the 'knowing'.

Besides an educational role, the qualified nurse had a managerial and a patient-care role. As a result of the busy agenda of the qualified nurse, time to train the 'student' nurse was limited. In fact, the hospitals needed the cheap 'student' nurse to keep the wards running. Florence Nightingale stated in a letter in 1873: "Our school is not a training school, it is taking half the hospital's work". (Allan/Jolley, 1987 p-2) It is interesting, in the sense of the history repeating itself, that Florence Nightingale wrote in the 1870's, with reference to the problems of the dual-role of the 'student' nurse: "We must begin now, all over again. If we don't we are ruined". (Allan/Jolley, 1987 p-2) Today, the same problems in nurse education are still on-going. Besides the workload, the training given by qualified nurses to student nurses appeared in some cases to be inadequate.

In the 1870's, the fight for nurse state registration began. Nurse state registration only became a reality 45 years later. In comparison, the state registration for the medical profession took only 18 years (1840-1858)! In 1919, the General Nursing Council (G.N.C.) was founded.

The G.N.C. is a statutory body established to supervise the standards in nursing. The general attitude amongst the nurse educationists was optimistic at this time. They saw great opportunities for expansion, innovation and change of the nursing curriculum, as well as the creation of standards. This optimistic attitude was reflected in the draft syllabus of 1923:

“Stimulate and foster the nurse’s powers of development; increase her capacity by a more extensive knowledge of subjects, scientific, social and practical, pertaining to her profession; to train her mind to a wider outlook than the usually obtained within four walls of an institution, bringing into line with curative measures the no less important branches of preventative work”. (Allan/Jolley, 1987 p-4)

However, these optimistic ideas crashed during its implementation of G.N.C.’s standards in nurse education. Resistance came from the ward-sisters and management. Again the dual-role of the student nurse was the main cause of the opposition. The gold-mark report (1923), written in the United States, suggested a reduction in nurse training by removal of unnecessary repetition and non-teaching time. The report also suggested college or university education for nurses. The position of the British Lancet Commission (1932) was: “It (a shorter training) would be detrimental to the hospitals who required the ‘probationers’ to give service”.

The Lancet Commission suggested that the ward sisters should be relieved of some of their duties to enable them to spend more time teaching nurses, and it also stated unequivocally that "nursing is essentially a craft". (Alexander, 1983 p-12)

After the Second World War, the 'war' to improve nurse education and the wish to relate better nurse education with better nursing practice, carried on. Many reports have been published. Some important dates on the nursing historical calendar are:

- \*1949: Nurses Act: area nurse training was established; finances of hospitals and training schools were separated; empowered Statutory Bodies were set up;
- \*1952: as a result of the empowering of the Statutory Bodies, a new syllabus was published with two new subjects, namely: 'Human Behaviour and Illness' and 'The Social Aspect of Disease';
- \*1953: nursing studies was established in the university of Edinburgh;
- \*1964: the Platt Committee published a report, named: 'A reform of nursing education'. Important proposals in this report were: a student status and an academic base for the first two years of nurse education; full-time work in a hospital ward during the third year of nurse education. However the response of key persons in the nursing field were: this report is 'too drastic' and 'unrealistic';

\*1969: a new syllabus was published by the G.N.C of England and Wales. They suggested: a greater integration of theory and practice by means of more ward training by student tutors. They also wanted new forms of teaching;

\*60's-70's: "the curriculum in nurse education was now being widened and deepened, but the student wastage continued to be a cause of anxiety....."; (Allan/Jolley, 1987 p-6)

\*1986: Project-2000 published.

## **2-2-2- NURSE EDUCATION AND NURSING THEORY**

An important development during the 1950's, was the development of nursing theories and research. This was also a reason for deep and difficult problems in nursing. Theoretical thinking in nursing began with Florence Nightingale in the early 20th century. The mission of nursing in those days was focused on providing care, creating a sense of well-being, providing comfort to enhance healing, and creating an healthy environment. One of the main goals of the theory of nursing for Nightingale, was to achieve nurse education.

In the 1950's nursing theory and research began to develop seriously, predominantly in the United States. Theory development is important for two different reasons. The first reason is that nursing is partly seen as an science. The belief is that an important step to develop the scientific aspects of the nursing discipline, is the "development of a theoretical foundation for the examination of practical problems through model building". (Akinsanya, 1989 p-i)

The second reason is that for a long time the nursing discipline had depended on the medical and behavioural sciences for its theoretical under-pinning. Inside the nursing discipline a desire began to develop to find a 'private' nurse identity. Issues such as 'what are the main concepts?' and 'how can we mould them into a specific nursing perspective?', began to become important in nursing. The nursing discipline tried to achieve professional 'autonomy'. By means of theory development, nurses wanted to describe, explain, predict and prescribe the 'nursing reality'. Meleis (1991) writes:

"The autonomy of a profession rests more firmly on the uniqueness of its knowledge, knowledge gathered ever so slowly through the questioning of scientific inquiry. Nursing defined by power does not necessarily beget knowledge. But knowledge most often results in the ascription of power and is accompanied by autonomy". (Meleis, 1991 p-22)

In order to build a body of knowledge, the nursing discipline adopted the traditional scientific approach. The features of this approach and whether this was the right choice, will be discussed in chapter-III.

Important questions related to the concept 'autonomy', referred to above, are: 'what is autonomy and in what context does the nursing discipline want autonomy'? For example, is complete autonomy realistic and truly desired by the nursing discipline? Health care professionals tend to work more and more in multi-disciplinary teams.

Having its own theoretical base is important as a means of defining its professional borders and communicating with other health care disciplines. But the main focus-point remains the support of the patient by a team. If care is a moral ideal, as described in Watson's definition in the introduction, "one route it might take would be to focus upon the patient rather than to concentrate on professional codes and aspirations". (Melia M. Kath, 1993 P-10) This implies that professional development based on patient care, is the central direction.

Other important reasons for theory development are:

- \* it provides a tool for practical nursing to work more efficiently and effectively. If the nurse knows what his 'domain' is, he can concentrate on this domain instead of 'running' around without knowing the limits of his responsibilities;
- \* if the nursing discipline can define what nursing is about, then the discipline has a stronger base in the fight over resource allocation. In this respect the nursing discipline has to describe its central concept 'care' as a socially relevant concept.

Nursing theory can thus be seen as an important enterprise and was, in the beginning, closely related to nurse education and curriculum development. Questions like: 'what is nursing and what do nurses do?' are important to direct what should be included and excluded in the new baccalaureate programs of nursing. Henderson stated: "these questions prompted nurses to articulate the core of nursing theory". (Meleis, 1991 p-26)

In order to establish nursing theories, nursing research started to develop. The research was parallel to nursing theory, focused on defining the nursing curricula.

As described above, in the beginning, nursing theories were not put into practice but used for education. A major problem evolved out of this process, namely an increased gap between education and practice. Graduates who finished their nursing degree experienced frustration since the nursing practitioners were not familiar with the novelty of nursing theories. The growing dichotomy caused expressions like: "Your theories are too theoretical and your research is too esoteric; what do you know about practice anyhow?" or "Stick to teaching and leave practice to us". (Meleis, 1991 p-53) Chapman (1975) stated: "while the clever doctor or lawyer is spoken of with awe, the clever nurse is usually the subject of sneers and considered to unlikely to be any good 'practically'". (Allan/Jolley, 1987 p-6).

Between 1975 and 1980, theories began to make a leap into practice and theoretical thinking in the 1980's and 1990's are characterised by philosophical questions like: 'what is the nature of nursing knowledge?', 'what is the nature of inquiry?' etc.. The following scheme outlines the basic features of initial nursing theory (Meleis, 1991 P-29):

- \* use of external paradigm to guide theory;
- \* uncertainty about discipline phenomena;
- \* discrete and independent theories;

- \* separation between research, practice and theory;
- \* search for conceptual coherence;
- \* theories used for curricula;
- \* the goal of a single paradigm prevails.

Now that I have outlined the problem of the dual-role of student nurse and the development of nursing theory from a historical point of view, I will now focus on an important antagonist to the development of nursing and nurse education, i.e. obedience.

### **2.3.1 NURSING AND THE CONCEPT ‘OBEDIENCE’**

The nursing curriculum was, until the 1950's, mostly an adjunct to the medical profession. ‘Obedience’ was an important aspect of the training. Florence Leeds writes in 1874: “a rigid obedience to order and truthfulness cannot be too strictly enforced”. (Allan/Jolley, 1987 p-2) She also stated: “In the training of our nurses we should aim to make them (women) intelligent, conscientious hand maidens to the medical staff (men). (Allan/Jolley, 1987 p-2)

‘Obedience’ in nursing can be seen as a heavy rock, dragging behind the ‘cart’ of innovation. Carter (1939) writes on this subject: “habits of discipline and unquestioning obedience must have led to an acceptance of conditions (e.g. the dual-role) which might have been improved had they been criticized”. (Allan/Jolley, 1987 p-2)

'Obedience' also slowed down the theoretical progress in the ward. Meleis (1991) writes: "Nursing education has a long history of squelching curiosity and replacing it with conformity and a non-questioning attitude". It (the hospital) managed to socialize students to roles that are not congruent with scholarship and discovery". (Meleis, 1991 p-51) Another quote directed at the same problem: "Tradition in nursing has been one of the most vigorous enemies of the graduate nurse, rejecting innovation, critical appraisal or independence of action". (Allan/Jolley, 1987 p-8). All these latter human qualities are important and necessary to develop theoretical thinking.

The concept 'obedience' can be described from two and sometimes related angles, namely as a legal or as a moral concept. From a legal point of view, it is often explained as compliance with the law. The law requires that we refrain from violating the status. Obedience in this legal framework is narrow. Davis writes: "we are only bound to comply with the letter of the law..... . If we can find loopholes in the law, we cannot be legally chastised if we choose to take advantage of them". (Singer, 1993 p-217) Furthermore, laws have to be developed by an authoritative (moral) law-giver. Important questions are: 'who is the authoritative law-giver?', and 'which laws must constrain our conduct etc.?'

Another angle is to describe the concept 'obedience' from a moral point of view. Related to morality, obedience can be seen in the ancient wisdom teaching of Hebrew. Of interest is the division between male and female morality.

The moral man was defined as: “the wise who adhered to the divine law and who were good citizens, discreet, prudent, reliable, honest and impartial in judgement”. The immoral man ignored the law and was stupid. In contrast, the moral women was defined as: “the ideal wives whose major concerns were the welfare of the family and husband and who worked diligently as home managers”. (Singer, 1993 p-37) The adventuresses women were described as ‘evil’ or immoral.

Obedience can be connected with reward and disobedience with punishment. This can be both subtle or bluntly expressed. Throughout history, there has been a shift that morality must come from a source outside of man, into a belief that the source of morality are human beings themselves. Kant for example, can be connected with the latter idea.

The concept ‘obedience’ can also be found in two important theories about the moral development of people. Kohlberg developed six stages of moral development. The first stage can be described as: “the stage of punishment. One obeys in order to avoid being punished”. (Singer, 1993 p-465) Gilligan, who established a dichotomy between the male and the female moral development, describes obedience in the second stage ‘goodness as self-sacrifice’: “this is the level of the conventional view of women as care takers and protectors. Moral judgements are derived from social norms and consensus.

Concern for others, particularly the feelings of others and the possibility of inflicting hurt, is of major concern to people (women) at this level. Goodness, equated here with self-sacrifice and the need for approval, is joined with the desire to care for others". (Larrabee Mary Jeanne, 1993 p-36)

The basis of Gilligan's moral theory of care and the criticism of her theory, which is important for the nursing discipline, will be discussed in the next paragraph.

### **2-3-2 WOMEN AND OBEDIENCE**

One can wonder if 'obedience' is simply a quality of the nursing discipline or whether more profound social phenomena have to be disentangled.

95% of nurses are women. Dechalet, Heide and Wren (1978) write: "There is little doubt that many of the issues facing nursing emanated from the feminine image of nursing and the idea of nursing as a profession for women, particularly in societies in which women are relegated to secondary class". (Meleis, 1991 p-55) Why are 'obedience' and 'submission' qualities described more to women than to men? Is this a social, cultural or psychological phenomenon?

Important in this sense is the 'care' discussion, initiated by Gilligan. Gilligan (1982) assumes, based on empirical research, that women develop an ethic of care, while men develop an ethic of justice.

Gilligan's work was a reaction to Kohlberg's hierarchically arranged stages of moral development, in which "girls generally were at lower stages than boys". (Larrabee Mary Jeanne, 1993 p-241) Gilligan was disturbed by the gender difference and revealed two 'different voices' instead of a 'weaker' female voice. Gilligan, in turn, has been attacked on the sex-dichotomy she established. Tronto (1987) argues that the ethic of care has to go beyond the gender discussion, to a broad theory of care. Her arguments are important for the nursing discipline in order to develop a nursing identity and to transcend today's problems and obstacles in nursing. The feminist discussion about an ethic of care, must be read as a prelude to develop the value base of nursing.

If we concentrate on the psychological phenomenon, different life cycle theories can be analysed. The structure of these theories are mostly based on the different phases of human development. In this respect, it is important to note that most theorists were men, who have established the male development "as the norm and female behaviour as some kind of deviation from that norm". (Gilligan, 1982 p-14) How can we describe this 'deviation'? Gilligan (1982), based on studies of Chodorow, writes: "gender identity, the unchanging core of personality formation is, with rare exception, firmly and irreversibly established for both sexes by the time a child is around three". (Gilligan, 1982 p-7) She further states that although for the first three years the primary care taker for both sexes is typically female, "the interpersonal dynamics of gender identity formation are different for boys and girls".

Female identity is related to on-going relationships because the mothers tends to see their daughters more like and continuous with themselves. The same applies for the daughters who can see themselves as alike their mothers. Identity formation for a girl circles around attachment. The opposite happens with boys, who tend to separate themselves from their mothers. "Male development entails a more emphatic individuation and a more defensive firming of experienced ego boundaries". (Gilligan, 1982 p-8)

Differences between boys and girls in the middle childhood years in relation to child games, were observed by Jean Piaget (1932). He considered child games as crucial to social development during the school years. Games are important for various reasons: children come to see themselves through another's eyes; children learn to respect rules and how they can be made and changed. Janet Lever (1976) observed the following sex differences, related to child games: boys play outdoors more than girls; boys play more in large and age-heterogeneous groups; boys play more competitive games; boy's games last longer; disputes tend to result in legal debates for boys, while girls tend to end the games. The last observation is important because it suggests that girls subordinated the continuation of the game to the continuation of the relationships. Important mechanisms in this process are-not hurting the other and self sacrifice. Brabeck (1983) writes: "infliction of hurt as the central moral concern superseding issues of fairness". (Larrabee Jeanne Mary, 1993 p-35) During puberty the described process continues.

Based on the different psychological developmental processes between boys and girls, Gilligan developed an ethic of care, related to women. Obedience appears in her model of moral development in stage-II, ‘goodness as self-sacrifice’. According to Gilligan this is only a stage in women’s moral development and they can thus grow beyond ‘obedience’. In this respect, obedience in the female dominated nursing discipline, can be related to the psychological development of women. Gilligan (1977) describes three levels and two transition periods in the ‘female’ development of an ethic of care:

First Level: Orientation to individual survival: the self is the solo object of concern. The survival of the self is of central importance;

First Transition: From selfishness to responsibility: “... a definition of the self within the attachments and connections made with others. One’s wishes and the responsibilities one has for another are viewed as defining the conflict between what one ‘would’ and ‘should’ do”; (Larrabee Jeanne Mary, 1993 p-35)

Second Level: goodness as self sacrifice: This level has been described above;

Second Transition: From goodness to truth: “a heightened sense of responsibility for the decisions accompanies the increased attention to one’s responsibility to self as well as others”; (Larrabee Jeanne Mary, 1993 p-36)

Third Level: Morality of non-violence: the conflict between responsibility and selfishness is resolved in a principle of non-violence. Care becomes the universal obligation, the self-chosen ethic that allows the assumption of responsibility for choice.

The importance of Gilligan's research is that she challenged the male dominated principle approaches and that she opened the doors to develop an 'ethic of care'. Both moral approaches will be developed in chapter-III and -IV.

### 2-3-3 GILLIGAN CRITICIZED; TO AN ETHIC OF CARE

As earlier described, Gilligan and her associates work from the hypothesis that men and women develop different moral systems. Nona Lyons, quoted by Tronto in her article 'beyond gender difference to a theory of care' writes:

"those who viewed the self as 'separated' from others and therefore 'objective' were more likely to voice a morality of justice, while those who viewed the self as 'connected' to others were more likely to express a morality of care. Since men are usually 'separated/objective' in their self/other perceptions, and women more often view themselves in terms of a 'connected' self, the difference between justice (based on principles) and care (contextual) is gender related. (Larrabee Mary Jeanne, 1993 p-242) The psychological differences are thus based on either 'connection' or 'individuation'.

Tronto (1987) is concerned about the ‘different voices’ between men and women. Two important arguments for the nursing discipline are:

- \*“the equation of ‘care’ with female is questionable;
- \*”it is likely to become trapped trying to defend women’s morality rather than looking critically at the philosophical promises and problems of an ethic of care”. (Larrabee Mary Jeanne, 1987 p-241)

Gilligan based the dichotomy of the sexes on psychological differences. But she also mentioned social causes, for example: “when women feel excluded from direct participation in society, they see themselves as subject to a consensus or judgment made by and enforced by the men on whose protection and support they depend and by whose names they are known”. (Larrabee Jeanne Mary, 1993 p-243) What are the main reasons for the split between the sexes, psychological or social?

Tronto argues that in a study that compared the cognitive moral development (abstract) between a minority and a dominant social group, the people of the latter group were ahead. In this respect, the minority groups (men and women) are like ‘Gilligan’s’ women, also classified lower in Kohlberg’s hierarchy of abstract moral thinking. Is social deprivation a reason to develop an ethic of care? Furthermore, some cultures are more based on the principles of an ethic of care than others.

African thinking in contrast to Euro-American thinking, relies on: “syncretic reasoning, intuitive, holistic, affective etc..” (Larrabee Jeanne Mary, 1993 p-244)

In conclusion, the dichotomy in moral development between men and women is questionable. Cultural or social phenomena can also be the cause for the development of an ethic of care. In that respect, obedience has to be analysed from different angles. and other strategies have to be developed to transcend ‘obedience’. More empirical research is necessary, to reveal the roots of obedience.

Tronto believes that there is much to gain from an ethic of care, outside the gender discourse. The doctrine of care can become an important theoretical and practical framework, complementary to the abstract principle approach. We then have to analyse meta-ethical questions such as: what is the foundation of this approach?, and what are the limits of care, like the possibility of relativism? It is very important to analyse the doctrine of care in a political and social framework. For example, how do we connect ‘care’ with our educational system?

‘Care’ is the central concept in nursing. In that respect the nursing discipline is the professional embodiment of an ethic of care and must place itself in the centre of the care discussion. In this way the nursing discipline can develop its own identity, related to care and based on arguments. As a consequence ‘obedience’ can be transcended.

## **2-4 SUMMARY**

In this chapter I have discussed two problems of nurse education and one obstacle to change, i.e. obedience. I have shown that obedience can be caused by either social, cultural or psychological phenomena. Gilligan has introduced a gender discussion, while Tronto wants to go beyond the split between men and women, to a theory of care. In that respect the ethic of care may become a promising complementary framework to the principle approach, to develop the value base of nursing. The nursing discipline, as the professional embodiment of care, has to be in the centre of the care discussion. In this way the nursing discipline can develop its own identity, based on sound arguments. In chapter-III and -IV, I will attempt to reveal the promises of care.

## **CHAPTER-3**

## **CHAPTER-III**

### **TWO PERSPECTIVES TO UNDERSTAND A PATIENT**

#### **3-1 INTRODUCTION**

In chapter-I, I stated that ‘the responsibility of the student nurse after he finishes his degree or diploma course, is to establish and maintain an unique face-to-face nurse-patient role relationship’. In this chapter I want to develop in more detail how to understand a patient from two different perspectives. The different perspectives of understanding, can be imagined, for example, as maps of Scotland. In order to get a better insight into this country different maps are necessary, for example: a map which shows the different resources of the country, a map which illustrates the vegetation of the country etc.. Each map views the country from a different angle, and in the end, helps to a better understanding of the country as a whole.

Understanding the patient from different perspectives is strongly linked to the structure and the content of the nursing curriculum. In fact the main goal of nurse education is to ‘give’ the student nurse the right ‘tools’ in order to establish and maintain a nurse-patient relationship. Since nurse education has to focus on ‘transmitting’ different perspectives of understanding, it’s important to expand on the subject of understanding. In chapter IV, the insights obtained in this chapter will be used to develop the main concepts of nursing, namely: nursing care, environment, person and health.

The two perspectives, general and unique understanding, can be differentiated into five separate parts in order to understand the whole patient (Downie, 1992):

knowledge base (general/scientific understanding)

- \*scientific based bio-medical understanding;
- \*social scientific understanding (sociology, psychology etc.);
- \*scientific understanding of nursing;

value base (unique understanding)

- \*case-histories;
- \*imagining in the framework of lived-experience and reflection.

The first three ways of understanding the patient are useful to obtain generalised understanding. In other words it gives a general knowledge base to the nurse. Scientific understanding describes similarities and repetitive patterns. I have separated 'scientific understanding of nursing' from 'social scientific understanding' for, the first two reasons, described below, and from bio-medical science for the third reason:

- \*nursing is not only an art and a science but also a practical vocation. Obtaining an insight and improving the quality of nursing practice, is in fact the only legitimate reason to apply science of nursing. In other words the face-to-face role relationship between a nurse and a patient has to be the focus-point of science of nursing;
- \*although science of nursing is mainly 'borrowing' concepts from the social sciences, it tries to develop its own 'unique' direction. In fact it tries to translate sociological and psychological concepts into a nursing care perspective;

\*the nursing discipline is focused on ‘care’ while the medical discipline is focused on ‘cure’. This means that the former concentrates on the consequences of ill health, while the latter concentrates on the causes of ill-health. For example, the medical doctor is interested in the type of bacteria that causes pneumonia; whereas the nurse is interested in the consequences such as: the right position of the patient in bed, supporting problems with eating etc.. Nevertheless, a medical doctor also has care roles, just as the nurse also has cure roles (wound-care). The division is made on the criteria of role emphasis. It is important to realize, that the two domains, causes and consequences, are both connected and different. The medical and the nursing discipline are connected because the causes and the consequences of ill-health are complementary, and at the same time the nursing discipline possesses a ‘private’ area (consequences) to develop its own identity.

The scientific perspective will be developed in more detail later in this chapter (section 3.4.1).

The fourth way of understanding the patient is biographical understanding. Downie and Charlton (1992) define this kind of understanding as: “the policies, values and motivation of one person through a period of time”. (Downie, Charlton, 1992 p-94) Biographical understanding is not focused on repetitive patterns but concentrates on the unique and unrepetitive life history of a patient. As described in the chapter-I, unique and unrepetitive understanding is based on moral values.

The fifth way of understanding the patient is also focused on unique understanding. The main principles in this respect are: lived-experience(1), reflection(2) and imagining(3). The fourth and the fifth ways of understanding will be discussed in section 3-4-2. At the end of this chapter, I will integrate general and unique understanding in a hypothetical curriculum model for nurse education.

Both unique (value base) and general understanding (knowledge base), are important to understand the patient as an integrated whole. I will first discuss Western scientific thinking from a historical point of view, because scientific thinking, within a particular framework, has been very powerful in theory building since 1600. The historical overview will give us an insight into how scientific thinking has been defined through time. One must realise that the features described in this section are much more complex in reality. The development of science, must be placed in large historical/social context. The voyage through some features of scientific thinking is useful as a background to an explanation of the two perspectives of understanding the patient. I will describe some features of the so called scientific revolution through the key-words: ‘dualism’; ‘dehumanisation of nature’ and; ‘power over nature’. In the following section, I will describe the traditional image of science (positivist, empirical, axiomatic). I will then discuss criticism of the traditional image of science.

### **3-2 SCIENTIFIC THINKING AND ITS HISTORY**

In the 16th and 17th centuries, a so called scientific revolution took place. Verhoog (1980) defines the scientific revolution as: “The formulation of a new concept of nature which is embedded in a specific social-cultural matrix”. (Verhoog, 1980 p-26) In this period of enlightenment, after a religiously dominated period of thought, new important principles were established which direct developments in today’s scientific thinking.

In order to understand the new concept of nature, the distinctions between the ‘internalist’ and the ‘externalist’ schools of thought have to be described. The former school believes that “scientific ideas have a life of their own, one that is insulated,....., from the general, cultural, economic setting ..... . These influences do not determine the direction and of rate of growth of scientific thought itself”. (Verhoog, 1980 p-19) The latter school thinks that “social, economic, religious, psychological and artistic forces, all of them external to the substance of science itself, have been the true stimuli of scientific progress”. (Verhoog, 1980 p-19) The dominating internalist school defines natural sciences as: “scientific knowledge, ..... , as a collection of theories or statements which ultimately, have a life of their own, independent of the personality of the scientist and the social setting in which the scientist is doing research”. (Verhoog, 1980 p-10) Modern science is in fact an autonomous, neutral and value free island in our society.

Modern science has been occupied with finding objective and law-like knowledge. In order to reveal this kind of knowledge, it has been necessary to narrow the concept of nature. Only observable sense-data experiences, are valid, and the dominating method of research is the experimental method. Two themes are important to understand the new concept of nature, namely: 'dehumanisation of the world' and 'power over nature'.

### **3-2-1 DEHUMANISATION OF THE WORLD**

Dehumanisation of the world can be described as the removal of all subjective anthropocentric elements from our understanding of 'nature'. This aspect can be split into two topics namely:

- A-the distinction between 'primary' and 'secondary qualities';
- B-the distinction between 'res cogitas' and 'res extensa'.

The distinction between primary and secondary qualities is mostly ascribed to Locke. The primary qualities are the "truth and independent attributes of external reality, belonging to the nature as such" (for example a rock). (Verhoog, 1980 p-28) Locke describes secondary qualities as: "nothing in the objects themselves, but powers to produce various sensations in us by their primary qualities" (for example the smell or the colour of a rock). (Verhoog, 1980 p-29) In fact, the primary qualities are only those that can be measured and expressed in numbers. The secondary qualities are variable and sensible like colours, sounds and smells.

Theorists, were only interested in the ‘belongings to nature as such’ and ignored the secondary qualities. Planck (1970) writes: “True natural science strives after a constant physical world-picture, completely liberated from individuality of the creative mind. This constant is what we call ‘the real’”. (Verhoog, 1980 p-29) Only primary qualities were therefore interesting.

The dichotomy described above is based on a metaphysics of dualism (subject-object). Man as a single-subject, disconnected from his environment, was believed to be able to reveal nature’s secrets. A dualistic world-picture is also found in ‘Descartes’ ideas. He said that the exterior reality (*res extensa*), is completely detached from the interior reality of thought (*res cogitas*). An important consequence of the metaphysics of dualism for health care, is the view that “Man’s body must be considered as a machine , an automaton, not needing the soul for it’s activity”. (Verhoog, 1980 p-30) What, in fact, was created, was a mechanistic picture of ‘nature’. It was believed that the human body, for example, could be examined as a ‘machine’ made out of different parts that can be analysed, understood and controlled by man. This view also believed that to analyse the world, the research method had to be analytical, deductive and based on mathematics. Thus only in this way, could ‘real’ knowledge about the world be accumulated.

### **3-2-2 POWER OVER NATURE**

The main driving force of dehumanizing nature was the urge to find ‘truth’ and ‘law-like’ understanding of our environment, that could be used ultimately to control and predict the course of nature. Control is strongly linked with power. Nature becomes subordinate to man’s theories. In order to reveal its secrets and thus to control nature, it had to be dehumanized. Subjective human qualities such as feelings, metaphysical ideas, morality etc., were excluded from the ‘voyage’ to absolute understanding and power. The distinction between ‘objective’ and ‘subjective’ understanding, is another form of dualism.

In conclusion we can say that the changed concept of nature resulted in: a metaphysics of dualism and dehumanisation of nature, in order to get absolute power over nature. Influential philosophical schools in this century, such as the ‘positivists’ and ‘empiricists’, were strongly influenced by this concept of nature. In turn, ‘bio-medical science’ and ‘science of nursing’ were strongly influenced by ‘positivist’ and ‘empirical’ ideas.

### **3-3 THE TRADITIONAL IMAGE OF SCIENCE**

The ideas of these influential schools of philosophy, formed the basis of a traditional image of science. The three main features of the traditional image of science are: positivism, empiricism and axiomatic. (structure adapted from Verduin P., 1992 P-26) These will be discussed separately below.

### **3-3-1 POSITIVISM**

The positivist view of science can be ascribed to the ‘Vienna Circle’. This was a group of theorists in the beginning of the 20th century, that held the view that scientific rationality was the absolute norm. Scientific rationality was defined as empirical science (primary qualities) and was seen as the only valid way of gaining knowledge about the world, at the expense of all other approaches (occult, imagination, intuition etc.). Verhoog calls this approach ‘scientistic’.

As well as having a narrow idea of what should be defined as knowledge, the positivists also believed that scientific thinking (empirical) was the only and best way to solve social and human problems. The following quotation of the ‘Manifest,’ published by leading members of the ‘Vienna Circle’, showed the close relationship between scientific rationality and social matters: “..... there is an inner link between the scientific world-concept and the organization of economic and social relations, the unification of mankind and a reform of school and education”. (Verhoog, 1980 p-53) It was believed that positivist science should replace religion and metaphysics, as the basis of social organization.

### **3-3-2 EMPIRICISM**

“the givennes of observation, observations are simply there, as the empiricist tradition has it, waiting to be recorded by the classical camera obscura, the human mind”. (Verhoog, 1980 p-60)

Logical empiricism has the following beliefs (Meleis, 1991 p-82/83):

- \*statements that cannot be confirmed by sensory data and through sensory experiences are not considered theoretical statements worthy of pursuing. As a result, they are disqualified as common sense statements and are therefore nonsense. Predictive statements that have no sensory corroboration are not scientific;
- \*true statements are considered to be only those that are based on sensory-experience and known from sensory-experience;
- \*science is seen as value-free, and there is only one method of doing science, which is the scientific method;
- \*traditional metaphysics and ethical views are meaningless. These views possess “emotive” meaning and are considered as being “cognitively” meaningless;
- \*there is a split between the ‘context of discovery’ and ‘the context of justification’. The context of discovery, explains how the scientist reveals concepts and makes laws and theories etc. and the influences of psychological and social factors. The context of justification deals with logical consistency and the empirical truth. The logical empiricists deny the context of discovery;
- \*there is a belief in a unified science. The strict norms for natural science are also the rules for all other sciences, such as psychology and sociology.

### 3-3-3 AXIOMATIC

An axiom can be described as a general assumption that the scientist ‘must’ have as a base to start his/her research. It is the platform of all scientific thinking. Two important axioms in health care, related to the traditional approach of science, are

- \*ill-health is caused by a disorder;
- \*there is a split between the physical and the psychological aspects of human beings.

### 3-3-4 CRITICISM OF THE TRADITIONAL SCIENCE

In the 1960's there began a heavy attack on the traditional image of science, by critics such as Thomas Kuhn (1962) and Karl Popper (1939). The former perceived science as a revolutionary process whereby old ideas are overturned by new ideas. Science is thus, in his view, not steadily progressing and a way to accumulate knowledge. He distinguished periods of relative stability (normal science), which are dominated by one paradigm, with periods of unrest in which an alternative paradigm tries to take over the dominant paradigm, a ‘paradigm shift’. Kuhn defined the concept ‘paradigm’ as: “A collection of beliefs and presuppositions on which normal research within a particular scientific community is based”. (Verhoog, 1980 p-60) The scientists, in this context, can be described as the members of a ‘tribe’ with certain beliefs, which can be overtaken and replaced by another ‘tribe’ with other beliefs. Kuhn believed that the competition between the different paradigms was ‘irrational’ and depended on individual factors rather than on a described logic. For this reason Kuhn is often accused of or praised as being a relativist.

To avoid getting submerged in absolute relativism, Popper established the theory of falsification instead of verification. This idea is based on the principle that a theory is true until it is falsified. In this way a safety net was made.

Kuhn's (and Popper's) criticism of the traditional image of science, gave space for a more pluralised and creative approach to scientific thinking. It also created more room for ethical and social considerations on science, included in the 'context of discovery'.

### **3.4 TWO PERSPECTIVES TO UNDERSTAND THE PATIENT**

Nursing can be described as a 'science'(A), an 'art'(B) or as a 'base for social action'. Aspects of the third description was discussed in chapter-II, with reference to obedience. The first two descriptions of nursing, will be the stepping-stones to develop the two perspectives to understand the whole patient, namely:

#### **A-knowledge base (general/scientific understanding)**

This can be subdivided into three types of general understanding: bio-medical understanding; social scientific understanding and; scientific understanding of nursing

#### **B-value base (unique understanding)**

This can be further divided into: case-histories and lived-experience (versus experience), reflection and imagining.

These two perspectives of understanding the patient and their subsets therein, will be described below.

### **3-4-1 GENERAL/SCIENTIFIC UNDERSTANDING**

#### **BIO-MEDICAL UNDERSTANDING AND NURSING**

As described in chapter-II, the nursing discipline followed the medical discipline for a long time. In fact the nursing discipline was seen as an ‘adjunct’ to the medical discipline. For most of its history, medical science and practice have followed the traditional image of science, translated into the bio-medical paradigm. ‘Descartes’ ideas were very influential. The base of all bio-medical thinking is the medical diagnosis. A medical diagnosis can be defined as an ‘objective’ and ‘verifiable’ ‘signpost’ on the way to health. The assumptions behind the medical/nursing diagnosis, will be further developed in relationship with the concept ‘health’, in chapter-IV. Watson (1988) described the following features of the bio-medical paradigm:

- \***PERSPECTIVE:** objectivity, observable-measurable;
- \***DESCRIPTION:** quantitative;
- \***CONCEPTUALIZATION:** generalizable;
- \***RELATIONS:** external, often statistically inferred;
- \***COMPREHENSION:** explanation, prediction;
- \***EMPHASIS:** facts-data;
- \***USE:** technical, validation and extension of existing knowledge;
- \***STRUCTURE:** paradigm adherence.

This kind of understanding of the human body is derived from a narrow traditional approach. It tries to clarify the physical ‘facts’ about ill-health, established between bio-medical researchers.

The traditional scientific approach, in reference to Popper's principle of falsification, is useful in this domain. For example, through cancer research on a molecular level, medical researchers can reveal important causes of the disease. Besides physical factors, psychological and social aspects can also cause physical ill-health, for example heart diseases through stress. In that sense, all parameters have to be investigated.

The nursing discipline needs the bio-medical base (which describes the causes of ill-health) to develop its own domain (the consequences of physical ill-health). In the domain of physical ill-health, the nursing discipline can also use the narrow traditional paradigm. For example, guide-lines about 'what is the best method to wash a cancer patient after operation-X', can be revealed within this approach. 'The best' in this example, is narrowed to the physical 'facts' and measurable criteria of nursing care.

Bio-medical understanding, translated into the consequences of ill-health, is relevant but does not cover the whole field of human care. Other ways to understand the patient, are developed by the social sciences.

### SOCIAL SCIENTIFIC UNDERSTANDING

Nursing is a complex activity. Nurses often have to deal with concepts that are difficult to define, measure and observe, like for example: fear, anger, pain etc.. 'Secondary qualities' like: smell, colour etc. are also important in nursing.

In order to understand these concepts, nurse education like medical education, has implemented social sciences into the curriculum.

The social sciences are an “attempt to trace the patterns or systems which shape human wants and objectives”. (Downie/Charlton, 1992 p-92) Because of the complexity of daily live, it ‘has’ to use simplified models to describe the concepts and its relationships.

The social sciences have been influenced by the traditional approach of the natural sciences. In section 3-3-2, I described the empiric belief that “the strict norms for natural science are also the rules for all other sciences like for example psychology and sociology”. The social sciences have also been pushed into a narrow empirical approach, looking for a single truth.

What are the implications following this line of thought? In order to get an insight into this question, let us examine the following ‘black and white’ research question: ‘Are cancer patients afraid before they go to the operation theatre? If the answer is yes: ‘why are they afraid’? In order to answer these questions, at least three related steps have to be taken, namely:

\*specification and specialisation of the concepts underlined. The concepts have to be defined so they can be measured through sensory observation and quantitative methods;

\*a hypothesis has to be established. For example: ‘cancer patients are afraid before they go into the operation theatre because .... (reason-x)’ ;

\*testing the hypothesis through, for example, sensory observation and quantitative methods.

The applied deductive method in order to find an objective, detached and verifiable truth, has profound consequences for the outcomes. The answer(s) are at least influenced by: A -the way the concepts are defined and converted into measurable units; B -the hypothesis, (reason-x-); C -the chosen research method. Through this method, based on the foundations of the traditional scientific approach, the social sciences try to give external and observable explanations of the research subject.

It is important to ask if this deductive method, based on the traditional approach, is applicable for the complex moral, social and psychological ‘subject’ of the social sciences. For example, can ‘afraid’ be defined in measurable terms, without losing its human ‘flavour’? Is the knowledge obtained ‘truth’ and ‘objective’? Sigmund Koch, a distinguished theoretical scholar in psychology, is clear about these questions. Related to psychology he wrote:

“Psychology cannot be a coherent science, and the end result of the enterprise has been nothing more than a proliferation of pseudo-knowledge ..... . After 100 years of experience, psychology has failed and is lost and it must be discovered anew where in it is established on a more meaningful philosophical foundation”. (Watson, 1988 p-18)

I will use this analysis of the social sciences, as a stepping-stone to discuss a more ‘meaningful’ theoretical foundation, related to the science of nursing.

### SCIENTIFIC UNDERSTANDING OF NURSING

Nursing is a practical occupation. The only reason nursing research can be applied, is because nurse-patient relationships are established and maintained. In order to gain an insight into the psychological and social aspects of the nurse-patient relationship, two theoretical foundations are possible:

- \*traditional approach of science;
- \*human scientific approach.

The question now can be asked: ‘which of the two approaches suits nursing better’? The history and the main characteristics of the traditional approach of science, have been described in the first paragraphs of this chapter. I have linked the central characteristics of this traditional approach, with bio-medical understanding and social scientific understanding. The traditional approach applied to social sciences is arbitrary. In this sense the psychologist Koch, asked for a more ‘meaningful’ philosophical foundation.

Now I will examine the broader human scientific foundation which potentially suits nursing better. Through analysing the social and psychological aspects of nursing care in the traditional framework, we only reveal the ‘manipulated’ empirical and observable ‘facts’.

In other words, "it is limited by its starting point and fundamental scientific and philosophical restrictions of human life". (Watson, 1988 p-17) Holmes (1991) wrote on this subject: "because nursing addresses such a complex network of human phenomena, simplistic notions of discoverable truth might be reasonably out of question". (Gray/Pratt, 1991 p-440)

In order to go beyond the restrictions put on human life by the traditional approach, we have to look for other directions. A perspective that accepts all dimensions of human life is the human science approach. Watson (1988) describes the following characteristics:

- \*a philosophy of human freedom, choice, responsibility;
- \*a biology and psychology of holism (non-reducible persons interconnected with others and nature);
- \*an epistemology that allows not only for empirics, but for advancement of aesthetics, ethical values, intuition, and process discovery;
- \*an ontology of time and space;
- \*a context of interhuman events, processes, and relationships;
- \*a scientific world view that is open.

Watson's definition of nursing care, the main focus-point of nursing, can be completely embedded in this approach. Watson's definition is important for the following reasons:

- \*firstly, it goes beyond the narrow scientific approach. In other words, the non-observable aspects of a nurse-patient relationship with reference to human dignity for example, are included in the definition;

\*secondly, It puts nursing into the metaphysical ideas of intersubjectivism; the human world develops itself within a dialectical relationship. In this sense, Watson goes beyond the metaphysics of dualism. This aspect of the definition reflects the idea that the centre of nursing is the nurse-patient face-to-face relationship;

\*thirdly, it acknowledges the fact that the nurse ought to have an insight into in his own ‘power’ and ‘transaction limitation’.

The human science approach and Watson's definition of nursing care, are in agreement with a feminist philosophical foundation, (i.e. lived-experience). In this sense we establish a ‘feminist human science’ related to nursing care’. This connection is important for the nursing discipline, for at least two related reasons:

**\*ideologically:** the feminist movement tries to improve the position of women in our society. Since 95% of the nurses are women, it is important for the nursing discipline to be involved in the discussions. In chapter-II, I discussed the obstacle to change in nursing, i.e. obedience. The reasons for the difficult and oppressed position of women, can either be psychologically, socially or culturally. In reference with the principles of the feminist movement, (women are oppressed; the personal is political -power and its use can be examined from the stand-point of women’s personal lives-; and consciousness raising (Gray/Pratt, 1992 p-192/3)) women (nurses) can try to improve their position in society, through for example to develop the concept ‘care’ as a socially relevant concept.

In this sense we talk about an emancipation discourse with the central concept ‘inequality’;

\*scientifically and philosophically: in order to improve, you need arguments based on an understanding of the world. What theoretical foundation has to be established to develop these arguments? The feminist movement builded their ideas for a long time on Marxist or neo-Marxist meta-theories. Stanley and Wise (1983) insist that the feminist social sciences must begin with the recognition that the personal lived-experience, underlies all behaviours. (Gray/Pratt 1992 p-194) In other words the ‘meaning’ of a complex lived-experience is the centre of investigation, instead of the observable ‘facts’.

A lived-experience is the foundation of a phenomenological philosophy. Van Manen writes: “phenomenological research is the study of the lived-experience. Its purpose is to seek a fuller understanding through description, reflection, and direct awareness of the many facets integral meanings of a phenomenon”. (Gray/Pratt, 1991 p-232) In contrast with the traditional approach, the phenomenological approach looks at the world from the view of the individual actors with complex lived-experiences. The assumption is that human-beings should be interpreted as actors with motives, intentions in a contextual and historical situation etc., and cannot be observed and understood like isolated material objects. An important criticism in this respect in reference to the traditional approach is:

"experimental research is typically isolated in a clinical laboratory, in order to 'objectivize' and 'neutralize' the outcomes ....". Furthermore: "... this denies social and contextual factors, stripping them of the very complexity that characterises the real world". (Gray/Pratt, 1992 p-197)

Furthermore, feminist ideas must be based on a metaphysics of intersubjectivism, instead of dualism (single subject). In other words, the researcher is 'in the world', and not a detached observer. The researcher and the research 'subject', are in a dialectic relationship. In that respect it denies the characteristics of the traditional approach like: impartiality, detachment, anonymity etc.. Finally, feminist research must be seen as multi-paradigm, since our world is too complex to be understood from one angle.

In conclusion, based on the human science principles and connected with a feminist foundation, i.e. lived-experience, all dimensions of the psychological and social sides of nursing care can be examined. In other words, the complex meaning of the lived-experience of the nurse and the nursed, is the starting point of an inductive investigation.

### SCIENCE OF NURSING AND SOME IMPLICATIONS FOR PRACTICE

Through an inductive method, related to the lived-experience, a body of understanding can be established. This approach can be used to integrate nursing practice, research, management, and education. It can also direct the content and structure of the nursing curriculum.

For example, the nurse practitioner can reflect on his lived-experience after the interaction with a patient. The nursing scholar can use this information to gain an insight in the centre of nursing, namely the face-to-face nurse patient relationship. In this sense unique understanding is generalized. The nurse educator can use the generalized knowledge, obtained through induction, to direct the content of the nursing curriculum. By means of this approach, based on broad theoretical foundations, the nurse-patient relationship will be the centre of understanding and the integration force at meso-level. In this respect the theory/practice gap, mentioned in chapter-II, can be transcended. Furthermore a nursing identity can be developed.

This approach contrasts with the narrow deductive scientific method, that contains the danger of segregation. A nursing scholar, for example, would develop his/her hypotheses in ‘isolation’. As a result, various units within the discipline can be established instead of one interconnected unit, centred around the nurse-patient relationship.

### **3-4-2 UNIQUE UNDERSTANDING: NURSING AS AN ART**

In the future, the student nurse will have to establish and maintain a unique face-to-face role relationship with the patient. In this respect it is important, that besides generalised understanding, the student nurse has ‘tools’ to understand the uniqueness of the patient, with whom he is interacting. Unique understanding is based on moral values, introduced in chapter-I.

Besides an unique insight into the patient, the nurse also needs to have a personal insight. The nurse is the ‘tool’ of professional nursing care and ‘private’ ideas can influence the role-relationship either positively or negatively. Two related perspectives of unique understanding are relevant, namely: case-history and imagining(3) through lived-experience(1) and reflection(2).

### CASE-HISTORY

Understanding the patient through ‘case-history’ is, in contrast to science, not focused on repetitive patterns but on the unique life-story of a patient. Downie and Charlton (1992) wrote: “historians or biographers give us understanding of human actions by telling the story, as factually accurate as possible, which enables us to understand how particular persons came to act as they did”. (Downie/Charlton,1992 p-94). It was Hippocrates who introduced the case-history, in context with ill-health. According to Hippocrates, every disease has a course, from its first intimations to its climax and thence to its fatal or happy resolution.

The case-history Hippocrates introduced, can be classified as ‘natural histories of disease’. Although described as a case-history, Oliver Sacks, a distinguished neurologist, argues that Hippocrates approach is too narrow. Sacks (1986) writes: “they convey nothing of the person, and the experiences of the person, as he faces, and struggles to survive, his disease ..... . To restore the human subject as the centre (the suffering, afflicted, fighting, human subject) we must deepen a case history to a narrative or tale”. (Sacks Oliver, 1986 P-X)

Case-histories, in agreement with the view of Hippocrates or Sacks, can be used in two ways. The first way is in connection with professional limits and responsibilities. Unique historical information is often gained at the beginning of the professional relationship in order to direct the nursing actions. The relationship between the vision of human-beings and ill-health, is important. One could, for example, decide that only reductionistic personal facts and measurable bio-medical information are relevant to case-histories. On the other hand, the nursing discipline can take a holistic approach to case-histories. In this way the nurse would obtain unique historical information about somatic, social, and psychological aspects of the patient. The content and the extent of the holistic case-history depend on:

- \*how is the nursing role defined;
- \*what kind of role relationship has been established.

The definition of the nursing role requires answers within the nursing discipline, and in relation with other health care professionals, such as role definitions. The kind of role relationship, can be assessed by means of criteria such as time. For example, the extent of historical information required from polyclinic patients can differ from long-stay patients.

The nurse can, as described above, use the case-histories to direct his actions. In this way a 'bridge' is created from the unique to general scientific patterns. The information can be used to direct 'our' scientific tools, to what is useful.

The second use of case-histories, more related to Oliver Sacks idea of case-histories, is a ‘bridge’ into the direction of the unique instead of the general. A direction without professional limitations. An example of this perspective is ‘uninterested’ listening. The nurse listens as an intrinsic and moral part of ‘care’, to the unique life story of a patient.

The distinctions between both uses of case-histories, is of course analytical. In the ‘lived’ patient-nurse relationship, both uses appear intermingled. It is important for nurse education to differentiate between the two, so that student nurses can be made conscious of both aspects.

Understanding the patient through case-history, the unique contextual and historical dimension of nursing care, has to be connected with the second aspect of unique understanding, namely lived-experience, reflection, and imagining. What does it mean for a patient to be in this particular and unique position?

#### EXPERIENCE VERSUS LIVED-EXPERIENCE (1)

As described in the section ‘traditional science’, in this view sensorial experiences and detached observations are the only valid bases to gain knowledge. This idea is based on Locke’s theory of experience. A feminist approach, derived from the phenomenological doctrine, values the lived-experience as its starting point. It is now time to look in more detail to both, experience and lived-experience.

As earlier mentioned, Locke (1690) may be considered as the founder of the empiric doctrine. Within this doctrine the view is held that all knowledge (except logic and mathematics) is derived from experience. The basic assumption of this doctrine is that the world is what it is. Human reason is an important quality to develop knowledge. According to Locke, human reason consists of two parts namely: "first, an inquiry as to what we know with certainty; second, an investigation of propositions which it wishes to accept in practice, although they have only probability". (Russell, 1993 p-587). The grounds of probability conform with our own experiences or the testimony of others people's experiences. Locke supposes that the mind is a 'white paper'. In other words, there are no inborn ideas (as argued by Plato). According to Locke, we can only think by means of ideas. Ideas are solely derived from experiences and thus none of our knowledge can antedate experience! Two sources from which these ideas are derived are: firstly, a sensation; secondly an 'internal sense', perception of the operation of our own mind. A problem with the empiric doctrine is: 'does the cause of a sensation resemble the human perception'? In other words can we conceive the world as it is?

In conclusion according to Locke, knowledge is derived from a sensation -perceiving the existence of certain objects; reason -an agreement or disagreement of two ideas- (or intuition). Before the reason can 'work', it needs experiences!

Van Manen (1984) defines the lived-experience as “ It includes all the feelings, memories and desires which are generated by the awareness of what has happened in the past, what it means at present and the future”. (Gray/Pratt, 1991, p-253) In other words it includes ‘who I am’ and ‘who you are’ as a person. The lived-experience is based on daily life experiences in all its dimensions, for example the ‘meaning’ of pain and joy from the unique person.

The lived-experience is, as described earlier, the point of connection between unique understanding and the new established theoretical foundation, i.e human science. Understanding the lived-experience should be a mayor concern of the nurse-practitioner and the nurse scientist. Furthermore, case-histories are valuable to disentangle the various aspects of the lived-experience.

Jarman and Marsden (1985) define four uses of the concept ‘lived-experience’ in nursing, namely:

- \*exposure to a particular situation, emotion or situation;
- \*time spent in nursing or particular speciality;
- \*amount of knowledge gained over a period of time;
- \*the experience of role playing.

I want to expand this list to all lived-experiences in a person’s life. Every personal experience can be useful to gain a better understanding of the patient. The latter usage, role playing, is particularly important to nurse education.

## REFLECTION (2)

Reflection is important and necessary to gain an insight into a lived-experience. Boud et al (1985) defined reflection as: "The total response of a person to a situation or event: what he or she thinks, feels, does and concludes at that time and immediately thereafter". (Jarman/Marsden, 1993) Reflection in this definition is limited by the concept time. But Benner (1984) defined reflection as: "the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades differences to theory". (Jarman/Marsden, 1993) In her definition, reflection is not limited by time. In these definitions, in order to reflect, a practical situation (Benner) or an event (Bout et al) is necessary. In fact a practical experience is the centre of both definitions. A broader definition was developed by Meizerov: "Reflection (is) the act of becoming aware of a specific perception, meaning or behaviour of our own, or of habits we have of seeing or thinking". (Jarman/Marsden, 1993) In this definition reflection is seen as an 'act to become aware'. Furthermore the concept 'experience' is connected with 'meaning'. A problem with this definition is that 'experience' is defined as only seeing or thinking. I feel this should be expanded to all our lived-experiences, i.e. feelings etc., in connection with the unique person.

In order to reflect, a nurse needs to develop certain qualities, namely (Dewey 1933): “open mind, being responsible, having a whole-hearted approach in order to consider all sides of an argument, being able to consider the outcomes of actions you might wish to undertake, and taking active control over your own education and practice”. (Jarman/Marsden, 1993). To develop these aspects nurse education has an important role.

After having discussed reflection and (lived-) experience, I will now make the step to the concept ‘imagining’, as a bridge to understand and respect the individual patient.

### IMAGINING (3)

Imagining brings the self and the other together. In other words a fusion takes place between ‘the self’ and ‘the other’. Through imagining, a person can try to understand the other’s lived-experience. Theoretically this means that the self becomes the other. Although the theoretical idea of imagining is impossible since every experience has its roots in a private case or life history, the concept ‘coming together’ through nursing care, is important for the nursing discipline.

In order to fulfil care as a moral ideal and to value the patient as an unique and valuable human-being instead of an detached and ‘generalised fact machine’, the process of imagining can be an important tool. By means of an example, I want to show a way to develop this tool.

Every human being, from time to time, goes through physical pain. Physical pain can be described as a human experience. The aim of reflection is to reveal the personal and subjective meaning of this experience. Did you stop working? Did you ask for help? Did you take pain-killers? By getting an insight into these personal lived-experiences, one has private and subjective insights (related to physical pain), that can be used in the process of imagining. If ‘the other’ suffers from physical pain, the private experiences of ‘the self’ can be used to understand what it means for ‘the other’ to be in pain.

(N.B. This construction is only a hypothetical model. Further insight has to be obtained in the concepts ‘lived-experience, reflection and imagining, related to the concept ‘coming together’.)

In general terms, through personal lived-experiences and reflection, ‘the self’ has the tools to imagine what it means for ‘the other’ to be in a certain situation. In this sense we can talk about ‘moral imagining’. Understanding the meaning of a certain experience can be a ‘bridge’ to respecting the other person. Furthermore, in agreement with the idea of intersubjectivism of human science, the nurse is integrated in the nurse-patient relationship instead of being a detached ‘tool’. The latter idea, a detached tool, is based on the traditional theoretical foundations. In other words, the subjective lived-experiences of the nurse are included in the nurse-patient relationship. In this respect both preconditions of nursing care, introduced in chapter-I, respect for a person and openness and receptivity, come back.

If the hypothetical model proven to be ‘correct’, then the first possible direction of the question raised in chapter-I, ‘can respect for the individual be learned’, is established. By means of role-playing, nurse education can use this construction to reveal the personal lived-experiences of the individual student nurse. In this way, the student nurse becomes closer and more aware of his own lived-experiences, which can be useful in relationship with the patient.

Through imagining related to a lived-experience and reflection and the deepened idea of case-histories, the nurse has tools to integrate ‘the unique’ in the nurse-patient relationship, with ‘the general’.

### **3-5 THE UNIQUE AND THE GENERAL INTEGRATED**

One of the concerns I started this thesis with has been the potential fragmentation of our nurse education. By fragmentation I mean that our thinking is concentrating on smaller and smaller units, with a consequence that we lose the understanding of the whole.

Hewa and Hetherington (1994) argue that the nursing discipline is trapped between two paradigms, the mechanistic (traditional approach) and the humanitarian (human science). Their argument was that nursing from the beginning attempted to accomplish two fundamental goals, namely:

"first, for nursing to become an ancillary medical occupation, dedicated to maintaining the comfort and well-being of the sick and the disabled; second, for nurses to become obedient and disciplined assistants to physicians, and to be involved in hospital ward organisation and ward management". (Hewa/Hetherington, 1994 p-181)

The former goal can be connected with the whole human well-being approach, while the latter goal, discussed in chapter-II, is attached to the mechanistic and fragmented medical paradigm. The struggle of the nursing discipline comes down to subordination to the mechanistic paradigm or protection of the whole human well-being approach.

Important is now the 'care discussion', described in chapter-II. In order to get out of the 'trap' between the two paradigms, the nursing discipline has to grow beyond 'obedience' by means of developing the ideal of nursing care. This can be done by two means:

\*the nursing discipline has to grow from a single paradigm to a multi-paradigm perspective. For the physical aspects the traditional paradigm can be useful, while for the social and psychological aspects the human science paradigm is necessary. The information gained through scientific research, has to be integrated to a whole in daily practice!;

\*it must be connected with the medical discipline. As described in the introduction, the medical discipline is focused on the 'causes' and the nursing discipline on the 'consequences' of ill-health. In that sense they are connected.

‘Out of the trap’ must be seen as developing the domain of the ‘consequences’ of ill-health, based on the ‘causes’.

Unique understanding, as earlier described, is connected with a growing self-awareness. In that sense, this can be a starting-point to grow beyond the ‘trap’ between the two paradigms mentioned, to a perspective that supports the whole patient.

After generalised understanding and unique understanding and, ‘the trap’ that the nursing discipline is threatened to fall in (fragmentation or the whole), I will finally discuss the development of a hypothetical curriculum integration model. This model will try to integrate ‘unique’ and ‘general’ understanding.

An important means of curriculum integration in today’s nurse education, is the nursing process (assessment, goals, actions, and evaluation). The nursing process is, in itself, an empty framework to systematise, control, and predict nursing interventions. Therefore the nursing process has to be ‘filled’ with a model of nursing, like for example ‘Orem’. The fundamental base of the nursing process is the nursing diagnosis or the patient assessment. Some important characteristics of the nursing diagnosis are that it has to be: measurable, observable and verifiable. In that sense the nursing diagnosis is strongly linked with the narrow traditional approach of science.

The ideal, to be able to understand the patient as an integrated whole, can be narrowed to only generalizable and observable patterns, because of the link between the nursing process and the traditional approach.

Another hypothetical curriculum integration model is ‘linking unique and generalised understanding’. By means of connecting the main concepts of the sciences (general understanding) with the humanities (unique understanding), e.i. drama, theatre, music etc., a curriculum network could be constructed. In this way the integration force is not an external tool, like the nursing process, but the ‘tool’ that has to establish and maintain the unique face-to-face relationship, namely the student nurse. By means of this model, the ideal to understand the patient as an integrated whole, has been protected. Furthermore, unique self-development in order to understand and respect the other (imagining experience/reflection) has an established place in the nursing curriculum. The following scheme shows the steps to be taken

#### **STEP-I**

The main concepts of sciences related to the nursing reality, have to be prioritized. For example psychology (fear, anger etc.), biomedical (breath, food etc.-).

#### **STEP-II**

Educational methods have to be developed to allow the student nurse to experience the main concepts of the sciences (generalised understanding) in a personal and unique way (unique understanding of the self). At this level the humanities i.e. art, music, theatre, drama, writing etc., can be useful.

### **integration curriculum level**

as a result of step-1 and step-2 a network would be established between the sciences and the humanities. For example, during the psychology lectures general patterns about ‘fear’ will be explained, while during the drama classes the concept ‘fear’ will be related to the the students personal lived-experiences.

### **integration student level**

As a result of this method, the different concepts are analysed from two perspectives, a general perspective (knowledge base) and an unique personal perspective (value base). This idea correlates with the empirical fact that the student nurse has to establish and maintain a unique face-to-face nurse-patient role relationship.

### **3-6 SUMMARY**

I started this chapter with a historical overview of Western scientific thinking, as a background to the different ways of understanding the patient. I then discussed three kinds of scientific understanding, i.e. bio-medical, social scientific and science of nursing. Bio-medical understanding, concerned about the physical aspects of ill-health, is important for the nursing discipline as a base to develop the nursing interventions, based on the consequences of the physical sides of ill-health. In this sense the traditional scientific paradigm is useful. Besides bio-medical understanding, the nurse also needs to have an insight into the psychological and social patterns of the patient. The social sciences have been analysed in relationship to the traditional scientific approach.

The question ‘what is the correct scientific and philosophical path for the social sciences’, has been a stepping-stone to the section on ‘science of nursing’. The social and psychological sides of nursing care, have to be analysed from a broader perspective. I have introduced the principles of human sciences and connected this because of an ideological and theoretical reason, to a foundation of the feminist approach, i.e. lived-experiences. In this way the nursing discipline works with a multi-paradigm approach. Furthermore, the knowledge gained through scientific research, should be integrated to a whole in daily practice. As a practical consequence of analysing the lived-experience, the nursing discipline can build a ‘body of understanding’. This ‘body of understanding’, can be used both as an integration force between the different groups in nursing and as a signpost for nurse education. The lived-experience is the point of connection between general and the value based, unique understanding, i.e. case-histories and imagining in the framework of lived-experience and reflection. After I have discussed the ‘trap’ between the two paradigms that threatens nursing, I have integrated both perspectives, unique and general understanding, into a hypothetical curriculum model.

## **CHAPTER-4**

## **CHAPTER-IV**

### **NURSING AND ITS META-PARADIGM**

#### **4-1 INTRODUCTION**

In chapter-II, I discussed nursing from a historical point of view and in chapter-III I described five different ways of understanding a patient: bio-medical, social scientific, science of nursing, case-history and imagining (reflection/lived-experience). The next question to be answered is: ‘what are the central concepts of the nursing discipline, and how can they be developed’?

By means of developing the main concepts and its relationships, a structure or framework of the nursing discipline can be established. Schwab (1964) talked about the meanings and significances of the structure of the nursing discipline. To explain what he meant by the concept ‘structure’, he used the metaphors: ‘mapping the terrain’ followed by ‘exploring (in more detail) the land’. Petal et al (1989) defined ‘structure’ as: “the organization of concepts in relation to each other”. (Gray/Pratt, 1991 p-97) Schwab used the same kind of description, namely: “networks of conceptualization”. (Gray/Pratt, 1991 p-97) The latter makes a distinction between two interrelated terms ‘substantive structure’ and ‘syntactical structure’, in order to describe the structure of the nursing discipline. The substantive structure can be explained as the ‘themes’ or the ‘boundaries’ of nursing, while the syntactical structure is based on the way a discipline obtains its understanding about its subject, i.e. research methodologies, verification of the knowledge etc..

In order to develop a framework for the nursing discipline, Schwab (1964) suggested four organisational fields, namely: (Gray/Pratt, 1991 p-96)

1-“The Subject Matter: that which has to be investigated or worked on;

2-The Practitioners: the competencies and habits that must be acquired to carry out their work;

3-The Methods (syntax): the modes of enquiry by which the subject matter is addressed;

4-The Ends: the types of knowledge or other outcomes at which they aim”.

These interrelated fields are of extreme importance for the development of the whole nursing discipline, i.e. practice, research, management and education. The central question of nurse educators is: ‘what competencies are required to act as a professional nurse’? ‘The’ answer will direct the content and structure of the nursing curriculum. In order to answer this question, the discipline first has to define the subject-matter, the methods, and the ends. For example, if the nurse educators have an insight into the concept ‘health’, know what method(s) can be applied to obtain an understanding of health and, know the ‘nursing aims’ when a patient needs nursing care, then they can define the nursing curriculum more precisely.

A comprehensive description of the four interrelated fields is complex. One reason for the complexity is that different theoretical bases can be justified. It comes down to the fundamental question: ‘what is the nature of nursing’?

In this chapter I wish to describe the ‘subject matter’ or ‘substantive structure’ of the nursing discipline by means of the four central concepts: “health, person, environment and nursing”. (Akinsanya, 1989 p-1) The concept health will be discussed in section 4-3. The ideas of health are strongly connected with the perception of a person. In health care, Descartes vision of a person has been very influential. Descartes idea of a person in connection with the structure of the medical and nursing diagnosis, will be discussed in the section 4-2. I will also show in this chapter that a person is always directly connected to his/her environment. In order to use this concept, it has to be described in more detail in section 4-4. The central concept of nursing is care. I have described earlier, that nursing care is a ‘moral ideal’. In section 4-5, I will describe the ‘moral ideal’, related to two moral doctrines, i.e. the ‘principle approach’ and an ‘ethic of care’. In that sense, unique understanding, the value base of nursing, can be further developed.

#### **4-2 ‘DESCARTES PERSON’ AND A MEDICAL DIAGNOSIS**

In chapter III, I described the so called ‘scientific revolution’ which was formulated as a new concept of nature, embedded in a specific social-cultural matrix.

One of the most influential philosophers of this period was Rene Descartes (1596-1650). Descartes was searching for a fundamental foundation of enquiry. In order to find this foundation, he established the ‘method of doubt’. Everything that has the slightest doubt of certainty cannot be the foundation for further enquiry. Descartes found fundamental certainty in the fact that human beings themselves are engaged in thinking. This idea resulted in the famous words, ‘Cogito ergo sum’ (I think therefore I am). Descartes thought that man must be irreducible be thought and that his body was not part of the ‘quintessential me’. “Man’s body must be considered as a machine, an automon, not needing the soul for it’s activity”. (Verhoog, 1980 p-30) The Cartesian division between mind and matter had a major impact on Western thought. Heisenberg (1961) writes: “This partition has penetrated deeply into the human mind during the three centuries following Descartes and it will take a long time for it to be replaced by a really different attitude to the problem of reality”. (Gray/Pratt, 1991 p-294) The general belief was that we are isolated ‘egos’ inside our bodies.

Descartes vision of a person as two separated parts (soul and body) and the external world (environment including the human body) as a controllable machine, opened the doors to the development of modern science. Bio-medical science and more recently science of nursing, are very much influenced by the traditional image of science and Descartes metaphysics of dualism.

In the middle part of the 19th century, the bio-medical scientific knowledge and techniques (the stethoscope etc.) increased. Furthermore a medical diagnosis based on laboratory science, gained more and more weight. As a result the objective medical diagnosis, supported by an increasing amount of tools, became the rational 'court' between disease and health of the human machine. A disease, according to the idea of a controllable external world, could be objectively diagnosed.

In order to make an objective diagnosis the following steps are usually taken: (Hare/White, 1986 p-179)

- \* a (a person) exhibits observable features F..... F;
- \* so A has a condition C;
- \* but C is a disease;
- \* so A is not healthy;
- \* but T is the treatment most likely to remove C;
- \* so A ought to be given T.

This scheme is based on two assumptions, namely: (Berg, 1992 p-151)

- \*\*historical and examination data are seen as 'facts' which the physician only needs to reveal;
- \*medical criteria and disposal options are regarded as scientific fixed 'givens'".

What bio-medical researchers in fact try to establish, is a map of causal classifications and possible solutions to ill-health of the human body and mind. The physician can use this 'map' to make a diagnosis. The diagnosis serves as a 'signpost' in the process to cure the patient.

On first sight, this model looks very hopeful and powerful. By means of medical research and the medical doctor as translator into practice, it is hoped that one day we can control disease and human agony. This Cartesian bio-medical model, which views the body as an objectifiable artefact, is based on a reductionistic view of person and health.

#### 4-2-2 NURSING, PERSON AND DIAGNOSIS

Currently, the nursing discipline is trying to develop its own identity. In order to obtain more social recognition the nursing discipline adopted the structure of the causal bio-medical model, described above, to classify and control nursing care. Parker (1991) writes: "nurses to a greater or lesser extent have been forced to accommodate their understanding about caring to this meaning system" (bio-medical). (Gray/Pratt, 1991 P-302) As described in chapter-III, the nursing discipline has to concentrate on the consequences of ill-health. In this area lies the connection with the medical discipline and the 'independence' to develop an own identity.

An ‘empty’ framework is the nursing process, i.e. assessment, goals, interventions and, evaluation, which will make nursing a systematic and goal-orientated practice. Like the medical discipline, the starting-point for all nursing interventions is the nursing diagnosis. The medical discipline makes a diagnoses related to the ‘causes’ and the nursing discipline related to the ‘consequences’ of ill-health! A good analogy to describe a nursing diagnosis is ‘the captain of a ship’.

Recently, nursing researchers have started to develop standard diagnoses, which can be applied as an ‘objective’ starting point for the nursing process. In the development of nursing standards, it is important that the concepts used, are defined as unambiguously as possible. For this reason, a special nursing language or terminology, like in the medical discipline, should be developed. For the sake of continuity and clarity of nursing care, all nursing practitioners should adhere to the prescribed definition. By means of this diagnostic framework, the rational nursing ‘court’ between care or non-care has been established. Two potential dangers of an ‘unambiguous’ nursing care diagnosis, are: ‘transformation’ and ‘ignoring’.

TRANSFORMATION: In order to make a nursing diagnosis, the nurse has to observe and listen to the patient. The patient will express him or herself in their own daily-used language. This language is very much connected with the daily-life experiences of that person. Transformation takes place during the interaction between the nurse and the patient. Two different linguistic realities, the ‘unambiguous’ and the ‘daily-life’, will interact.

In order to establish an unambiguous nursing diagnosis, daily-life speech has to be transformed into a professional speech. Wittchenstein describes the different linguistic realities as different 'language games'.

IGNORING: a possible danger is that an unambiguous language will be connected with only the observable features (empiricism) of the human body. In other words the nursing discipline will only focus on the philosophical foundation of the bio-medical paradigm. This means that if certain health complaints of a patient are not observable, this will be classified in the grey zone of 'vague' complaints. This grey zone occurs even more apparently if one works with a holistic model, as the nursing discipline does, instead of a reductionistic model. Because of the holistic approach, nurses intervene a lot in the grey zone of vagueness. For example, to diagnose decubitus clear, is fairly easy. It is more difficult to diagnose fear, anger, sadness etc. unambiguously. A possible solution to this 'problem' is to focus on the verifiable aspects of patients care, and to ignore the undefinable aspects.

'Transformation' and 'ignoring' are in contradiction with the features of the human science approach, developed in chapter-III. Transformation is in contradiction because the human science approach is based on understanding the 'lived-experience' and 'knowing from within' etc.. Ignoring contradicts predominantly with the acceptance of the human science view of the complexity of the world.

In fact to follow a strict line between what we can unambiguously can diagnose, and what we cannot, could lead to a narrow model of nursing care which contradicts the ideal of 'care for the whole patient'.

The idea of developing an objective and unambiguous diagnosis relates to a specific vision of health. The medical discipline and also the nursing discipline prescribe, through the use of observable classifications, what is health and what is non-health. The foundation of this idea was established by Descartes, earlier described. This brings us to an important question: 'is the division between health and non-health as obvious as supposed'? In order to obtain insight in this question we have to examine to concept health in more detail.

#### **4-3-1 HEALTH FROM A NEGATIVE ANGLE**

Health can be defined as 'the absence of ill-disease'. (Downie/Charlton, 1992 p-33) Downie and Charlton talk in this sense of negative health. Negative health refers to disease, illness, injury, disability or handicap singly or in various combinations and experienced over a long or a short period of time. (Downie et al, 1990 p-10) All five concepts are very complex, but the relevance of clarification is obvious. For example, a handicapped person will have different demands of care than a 'temporarily' diseased person. I will focus on only two concepts, namely 'disease' and 'illness' in relationship to health.

The concept ‘disease’ is a more technical term than ‘illness’. As Downie (1990) wrote: “to call certain features a disease a person has to suffer from medically defined conditions which are identifiable as similar to that suffered from by others. (Downie, 1990 p-11) Illness on the other hand is a more subjective concept. A distinction can be made between ‘being-ill’ and ‘feeling-ill’. Criteria for being-ill are that the person himself is aware of certain symptoms (pain etc.) and that the symptoms be can observed by others. In this sense ‘being-ill’ can be the ‘bridge’ to ‘disease’. ‘Feeling-ill’ is a more private experience. For example somebody can feel tired all the time, but the tiredness is difficult to detect by others.

The aspect both concepts, disease and illness, have in common is ‘disorder’. The difference between disease and illness is made on a distinction between an ‘objective’ disorder and a ‘subjective’ disorder. The former is prescriptive and the latter is evaluative.

White and Hare argue the strict dichotomy between an ‘objective’ disease and an ‘evaluative’ illness. They conclude in the Journal of Medical Ethics, that an ‘objective’ disease like a subjective illness, is also evaluative. The central concern in their article was: ‘On what base can we define the concept disease?’ They built their argument on a descriptive definition of health by Professor Boorse: (Hare/White, 1986 p-176)

"An organism is healthy at any moment in proportion as it is not diseased; and a disease is a type of internal state of the organism which:

- I) interferes with the performance of some natural function -i.e., some species-typical contribution to survival and reproduction- characteristic of the organism's age; and
- II) is not simply in the nature of the species, i.e. is either atypical of the species or, if typical, mainly due to environmental causes".

Illness on the other hand was defined in evaluative terms:

"A disease is an illness only if it is serious enough to be incapacitating, and therefore is:

- I) undesirable for its bearer;
- II) a title to special treatment;
- III) a valid excuse for normally criticizable behaviour".

Hare and White criticised the descriptive definition of Boorse with the following comments. First they wondered, what is 'internal'? For example, some conditions of the skin are classified as a disease, while others, for example a dog bite, are not? What is the reason for this distinction, i.e. visibility, size? Further problems appear if we analyse the aspect 'disease interferes with the natural function, connected with survival and reproduction'. For example, some natural functions, like the growing of hair, do not contribute to survival or reproduction. In that sense, baldness, caused by a physical condition, is not classified as a disease.

The last two questions they raise are, ‘what is species atypical and what are environmental causes’? For example, “there is said to be a tribe in South-America in which the disease of dyschromic spirochetosis, marked by coloured spots on the skin, is so prevalent that it is accepted as normal, and those without the spots are regarded as pathological and excluded from marriage”. (Hare/White, 1986 p-175) Furthermore, the aspect ‘environmental causes’ is also problematic. Hare/White write: “it is hard to say what is or is not due to environmental causes”. Strangely enough malaria is classified as a disease and being hanged, which can also be caused by the environment, is not.

Hare and White conclude that the descriptive classified term ‘disease’ is in fact also an evaluative term. They write: “there seems, then, to be missing from Boore’s definition of ‘disease’ as cited, and thus of ‘healthy’, an element which he does include in his definition of illness: the evaluative element”. He concludes that “we seem to classify conditions as diseases if and only if they are bad things for the patient”. (Hare/White, 1986 p-178) Bad is a normative or evaluative word.

The first value judgement to an ‘objective’ diagnosis, is made in the third line of Hare’s and White’s five steps model, earlier described: “but C is a disease”. A judgment of ‘disease’ or ‘health’ made on criteria like disorder, unwanted state or abnormal is primarily a human constructed classification. In this respect multi-cultural research could reveal several explanations for a similar set of symptoms.

Furthermore, Downie (1994) writes that the construction of the diagnosis in daily practice, is not only based on rational scientific knowledge. Other, non-scientific factors such as time, resources etc., do also influence the medical judgements. Downie claims that the medical (nursing care) choices and objectives "are made in a social context". (Downie, 1994 p-35)

If working with a 'negative' concept of health, one has to realise that the line drawn between health and non-health is an artificial line. In fact objective is not as objective as we thought it would be. This conclusion is important because the nursing discipline tries, as described before, to adopt the same structure as the medical discipline to establish a diagnosis, related to the consequences of ill-health. In other words, it gives the nursing discipline no legitimate reason to build on only the so called 'objective' aspects of care.

This statement is based on three related arguments, namely a conceptual, practical and a moral argument. I have established the conceptual argument, through discussing the descriptive definition of disease by Professor Boorse. I concluded that the descriptive definition is in fact an evaluative definition. The moral argument is based on the conceptual argument. Since the line between health and disease is connected with the normative term 'bad', one can wonder who decides what is bad for the patient? Who is going to draw the line between what is bad or what is not bad for the patient. Is it the nurse, the patient, or both?

It is Important this question is applied within the framework of nursing responsibilities. For example, performing an appendix operation goes beyond the professional framework of a nurse.

If the nursing diagnosis, based on the traditional paradigm, is to serve as the starting point of all nursing interventions, ‘vague’ complaints can be 'ignored'. In other words, it is the nurse who decides which complaints get nursing support and which do not. The line drawn by the ‘objective’ diagnosis, to decide bad or not bad, is due to the evaluative character of disease and health, a power division.

Kant’s important moral principle: treat the patient always as an end and never as a means, becomes relevant. The nurse cannot ‘ignore’ the patient in order to establish his ‘closed’ diagnosis. The patient in this sense is used as a means to serve the nursing diagnosis. Furthermore, it is Important to view the patient as the central factor. A central factor for whom there is no distinction between vague and objective, since he/she experiences both aspects as an integrated whole.

In conclusion, the concepts disease/health are evaluative concepts. The evaluative character of the concepts is in contradiction with the foundations of the medical paradigm, connected with the traditional approach of science. In this framework, based on objective criteria, disease and health can be clearly distinguished. As a result of the evaluative character of health and disease, ignoring ‘vague’ complains does not have a legitimate base and the value-judgement ‘bad for the patient’ has to be made as much as possible, in a intersubjective or cooperative perspective.

If thus working with a nursing diagnosis two aspects have to be taken in account

- \* the potential danger of ‘ignoring’ and ‘transformation’;
- \* the evaluative character of ‘disease’ and ‘health’ and as a result of this the intersubjective/cooperative character of both concepts.

#### 4.3.2 POSITIVE HEALTH

Besides viewing health from a ‘negative’ point of view, its positive dimensions can also be examined. A positive definition of health was adapted by the WHO (World Health Organisation) in 1946:

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”.

Downie et al (1990) wrote that the elements of positive health are ‘well-being’ and (fitness). I will focus on well-being. They distinguished subjective well-being from true well-being. Subjective well-being has hedonistic tendencies. It can be seen as “no more than people’s subjective estimations of mood or level of happiness on a given occasion”. (Downie et al, 1990 p-18) They continue that the influences of subjective well-being can be detrimental to an individual and or society. For example, the widespread administration of heroin to the public to enhance the subjective well-being, cannot reasonably be supported. True well-being is linked with the idea of the 'good-life', what implies acquiring life-skills and empowering the patient, in a holistic way. The central question to gain an insight into true well-being is: ‘what activities make human life flourishing’?

Before answering this question, I want to concentrate on ‘values’ and ‘attitudes’, because these are important in the model of negative (and positive health).

### VALUES AND ATTITUDES

The model of true positive health is more obviously connected with values, than the model of negative health. The former health model is through its concepts like ‘flourishing’, ‘empowering’, ‘good life’, directly connected with value judgements. The latter health model tries to justify health care assessments on an objective and rational basis, beyond value judgements. Deeper examination, reveals the connections with health value judgements. Western health care professionals, mostly work with a negative concept of health.

A person’s values can be described as the things he “values for its own sake”. (Downie et al, 1990 p-130) In this sense, valuing is related to preference and choice. An example of this comparative view is that some people value a low stress job more than a stressful career, since the latter can negatively influence the persons health. ‘Value for its own sake’ can be divided in two parts, namely: ‘liking values’ and ‘moral values’. Liking values have a personal quality while moral values have an interpersonal quality. Downie et al (1990) wrote: “people with a particular moral value will judge others as well as themselves in terms of it”. (Downie et al, 1990 p-131) What both distinct types of values have in common, is the influential relationship with one’s attitudes. Moral values as well as liking values are subsets of attitudes.

Downie et al (1990) describe Ribeaux and Poppleton's (1978) definition of an attitude: "an attitude is a learned predisposition to think, feel and act in a particular way towards a given object or class of objects". (Downie et al, 1990 p-100) A learned predisposition can be differentiated into consciously and sub-consciously learned. In order to understand someone's attitude three components have to be analysed, namely:

\*cognitive component: An individual's belief about the object or attitude;

\*affective component: feelings, and emotions;

\*behavioural component: verbal/non-verbal, actions.

Roediger et al (1984) emphasized other descriptions of an attitude, such as: "relatively stable" and "tendency to respond consistently". The former aspect implies that an attitude can be changeable while the latter aspect implies that a person does not always reacts according his attitude.

Attitudes and values are related in that "values are preferences that both express attitudes and effect attitudes". (Downie et al, 1990 p-131) The three components of an attitude (think, feel and act) also appear in values: "values are expressed in behaviour, and through preferences based on beliefs about objects, persons, or situations, and are accompanied by feelings of approval and disapproval." (Downie, 1990 p-131)

## MORAL VALUES AND THE 'FACTS OF HUMAN NATURE'

In order to apply the model of positive health one must ask: 'what are the component values of a flourishing human life and society'. Some people would argue that this question can not be answered, since the value components are entirely personal.

This relativistic point of view can be disentangled through the idea of 'continuance of society'. In order to continue human existence, mankind needs to cooperate in a constructive way. 'Cooperation in a constructive way' asks for general moral values or principles of humanity. The principles can be deduced from the 'facts' of human nature, the so-called 'consensus model':

- \* the vulnerable nature of human-beings;
- \* human-beings are not self-sufficient;
- \* limited knowledge of human-beings;
- \* limited power of human-beings;
- \* limited goodness of human-beings;
- \* limited resources.

From these natural 'facts' we can derive the following duty based moral principles of social well-being, in order to continue human existence and to establish preconditions for a flourishing society and human life: non-maleficence (to do not harm other people); benevolence (to help people wherever necessary); justice (to treat people fairly or equally before the law) and; utility (to create the best possible consequences for the majority).

Besides social values there are also rights based, individual moral principles. These values are derived from the ‘umbrella’ principle autonomy. The moral values, needed to establish a flourishing individual human life are: self-determination (the option to formulate and carry out one's own plans or policies); self-governing (ability to be detached in order to take account of the needs of others as well of one's own); sense of responsibility (people are responsible for their actions unless its beyond their control) and; self-development (the option to develop one's own capacity to a full extent). Although the emphasis is on the individual side, these moral values also have an intersubjective dimension, for example, responsibility.

### MORAL VALUES AND NURSING

The values derived from the ‘facts of human nature’ for continuation of human existence and creation of preconditions for a flourishing society and individual life, are important to the nursing discipline. Two important reasons why positive health has to be embraced by the nursing discipline are:

\*The social values will link people. In other words it is a cooperation or model, based on human values. The relevance of a cooperation model becomes obvious if we realise that the centre of the nursing discipline is the face-to-face nurse-patient role relationship;

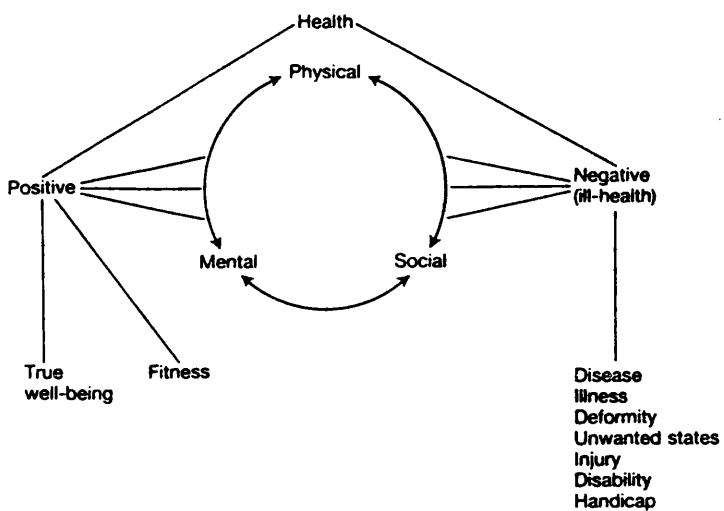
\*The social and personal values, deduced from natural ‘facts’, can be used as a value framework of nursing care.

A practical example of the positive health model related to nursing is: ‘a patient who suffered from a stroke needs, especially directly after the event, support with daily care activities like: washing, eating etc. (benevolence). At the same time if the patient shows an increasing capacity of self-care (autonomy) this should be supported as well’.

#### 4-3-3 INTEGRATION: NEGATIVE HEALTH AND POSITIVE HEALTH

Both health models, negative and positive, have to be placed in an intersubjective framework. The negative model because of the evaluative character of ‘disease’ and ‘health’, and the positive model to create a ‘flourishing’ and ‘continual’ society and personal well-being. The model of negative health, mostly connected only with the philosophical foundations of the medical paradigm, can be useful to establish a standard diagnosis. In this sense the scope has to be broadened from a single paradigm to a multi-paradigm approach. The physical consequences of ill-health can be investigated in the traditional scientific framework, while the psychological and the social aspects have to be placed in a human science framework. The standard diagnosis provides only ‘signposts’ and must be translated into an unique perspective in daily practice. Unique understanding is the value base of nursing. In chapter-III, I described two ways of unique understanding, i.e. case-history and imagining (lived-experience/reflection). The five moral principles, connected with positive health, should be seen as a way to construct a value base for nursing. In this way negative health is connected with general understanding and positive health with unique understanding.

Both health models can be connected as follows: (adapted from Downie, 1990 P-24 )



#### 4-4 THE NURSING ENVIRONMENT

The environment as a central concept of the nursing domain, was already recognised by Florence Nightingale. Optimum health, in her vision, was related to an optimum environment. Nightingale focused on both the suffering and the discomfort caused by the environment and the actions of the nurses on that environment. Because of the close connection of the nursing discipline with the medical profession, nursing followed the bio-medical model for a long time. It is important to note that the 'context' (environment) of a health disorder was not taken into account.

The only possible connection with the outside world was established on a controllable micro-organic level. The idea was that the situation of ill-health could be cured in isolation.

Besides the micro-organic aspects of the environment, other aspects also influence our health condition. The social factors, for example, became obvious after a recent research revealed a growing gap between the health condition of the poor and the rich in Britain. Multiple environmental factors influence our health situation. More contemporary nursing theorists, like Rogers, re-introduced the environmental concept in the field of nursing

The concept environment has been defined by Kim (1983) as: "that which is external to the person, and which has an impact on the existence of the person". (Akinsanya, 1989 p-8) Kim distinguished three environmental aspects, namely: spatial, temporal and qualitative.

The spatial aspect was conceptualised as concentric circles. The patient is placed in the centre of the circles. By means of this model, the proximity of environmental elements to the person can be indicated. Two features of the temporal aspect can be distinguished, namely duration (intermittently or continuously) and manner (regularly or randomly). The qualitative environmental aspect can be differentiated into three subdivisions, i.e. physical, social and symbolic. The physical part can be described as the biotic and abiotic elements in a patient's environment.

The social element is the interactions of the patient with individuals and groups. The last element, the symbolic, can be divided into three parts, namely: ideational (values, beliefs and knowledge); normative (values, rules etc.) and; institutional (organisation etc.).

The environmental elements, spatial, temporal and, qualitative integrated, makes a very complex field of interrelated concepts. This model directs the nursing profession to an ontology of time and space in relation to the qualitative aspects of the nursing environment.

#### **4-5 NURSING-CARE**

“The only true standard of greatness of any civilization is our sense of social and moral responsibility in translating wealth to human values and achieving our full potential as a caring society”

-The Right Honourable Norman Kirk-

It's now time to make the 'leap' to the 'heart' of the nursing profession, namely 'nursing care'. Watson writes: "Caring is the essence of nursing and the most central and unifying focus for nursing practice. (Watson, 1988, P-33) In chapter-I, I described care as a moral ideal. The two focus-points of this paragraph are: the role relationship between a nurse and a patient and the 'moral ideal' care.

#### **4-5-1 ROLE-RELATIONSHIPS**

The term ‘role’ in role-relationships can be explained in different ways. The first way is as a class concept. In this way it’s used to label a group of individuals in order to describe properties they have in common, for example, nurses or doctors. The second way to describe the term ‘role’ gets closer to the original meaning, namely ‘a part in a play’. In this way the term role is connected with certain expectations that the society (audience in a theatre) has about a person when he or she acts in a certain way. As a waiter for example, you are expected to serve the food and drinks, to do this in a nice way and to have knowledge about the different types of food. A waiter is not expected to give a lecture on the role of a nurse. This is the role of a nurse lecturer when he/she lectures on nursing care. The third way to explain the term ‘role’ is connected with the idea of ‘playing a role’, namely ‘projecting an image’. Downie (1971) describes ‘projecting an image’ as: “self-consciously to adopt a style of behaviour and hope to be identified with this style”. (Downie, 1971 p-122) The style of behaviour can be made up in many ways. One way is the image of an ‘ideal’ nurse. The fourth option of describing the concept role is in terms of ‘rights and duties’, i.e. rules. In order to get a better insight into this description, biological analogies (functional explanations) are better than dramatic analogies. The functional biological explanation is based on three assumptions (Downie 1971):

\*the object of study is a unitary system;

\*the unitary system is composed of elements;

\*in order to maintain the whole, the different elements are connected by means of causal factors.

If we apply these assumptions to nursing, we can say that the object of study is nursing, the different elements are the different nursing roles (manager, researcher, educator, care taker) and the causal factors are the connecting aspects between the different roles. In order to describe the first assumption, 'the object of study is a unitary system', it is necessary to define its boundaries. Where do the responsibilities of a nurse start and where do they end?

Another important aspect of the term 'role' is the relationship between 'being a person' or 'moral agent' and 'having a role'. One theory is that being a person and having a role are two distinguished roles. The strongest argument against this theory is that if a moral agent is a specific role then this role can be rejected, like all other roles. The fact is that the role of moral agent can not be rejected. This argument is based on two premises (Downie, 1971):

\*all roles can be rejected;

\*a man cannot choose not to be a moral agent.

The consequence of these premises is that a nurse, besides having a role, is also a person. Downie (1971) writes: "The morality of the action is never wholly reducible to the rights and duties of the role; there is always an irreducibly personal element in any moral action and a person cannot completely transfer the moral responsibility for what he does to his role". (Downie, 1971 p-133)

This aspect of a role is very important in nursing practice and deserves a lot of attention in nurse education. If I care, what are my role characteristics and what are my personal characteristics? How can I find the balance between too-personal and too-impersonal? This aspect about the term ‘role’, brings us back to unique understanding through experience/reflection and imagining. A potential danger of the ‘whole person approach’ and the integration of the nurse into the role-relationship, is that the nurse could become too-personally involved.

#### **4-5-2 CARING AND TWO MORAL MODELS**

One can question why it is important to look at different ethical models when examining caring as a part of nurse education. Is it not correct that we only need these models in particular situations, like: euthanasia, abortion etc.. I believe, nurses certainly need a theoretical signpost for a particular situation, but not only just then.

In chapter one, I defined care as a ‘moral ideal’, that can be described as respect for the person as a contextual and unique being. Every nursing intervention ought to be directed at this ideal. For example, a technical skill like giving an injection, has a moral component in the sense of respect for the contextual being. Nursing care thus always has a moral component simply because of its human intersubjective character.

## AN ETHIC BASED ON PRINCIPLES

Earlier I talked about the principles of a flourishing society and human life related to positive health, namely: beneficence and non-maleficence, justice, utility and autonomy. The principles should be seen in the light of a deductive ethical approach. Murray (1987) describes the deductive procedure as “a moral judgement made by a progression from moral theory, through intermediate principles, maxims or rules, finally to the judgement itself”. (Murray, 1987 p-637) The moral theory can be connected with several doctrines, like the utilitarian or the deontological. I would like to concentrate on the intermediate level, the principles of bio-ethics.

The question can be raised if the deductive ethical method, through principles or maxims, can give enough guidance in daily nursing practice. Murray (1987) mentioned the following criticism. First, it is too abstract to apply in daily practice. The general assumption is that principles can be applied mechanically and insensitively without looking at the particular case. Secondly, connected with the first complaint is that it is very hard to apply in a plural setting. The basic claim in the deductive approach is that the principles are universal. Thirdly, it is ahistorical. In other words, the principles are placed out of the framework of time. Fourthly, the various principles can contradict, like beneficence and autonomy. One positive aspect of the deductive ethical method, is that clear rules and duties can be established.

## AN ETHIC BASED ON CARE

In order to overcome the problems mentioned by Murray, another ethical approach, beside the principle view described above, is necessary.

The focus-point of the ethic of care is a particular situation, that exists for example between a nurse and a patient. Within the role relationship between these two people, all decisions are made. Alderson (1991) writes: "They are helped (the patients) by the ability of people to engage with one another in such a way that the needs and feelings of others come to be experienced and taken on as part of the self. (These) experiences structure moral feelings. Understanding the dynamics of human relationships then becomes central to moral understanding. The ethic of care is seeing the world compromised in relationships rather than in people alone, a world that coheres through human connection rather than through a system of rules". (Alderson, 1991 p-20) The ethic of care is contextual or narrative rather than formal or abstract. It is important to focus on the uniqueness of people in the context of time and space. This approach considers everyday life and its problems, uses common language and allows people to work together towards solutions. The essence is thinking/feeling knowledge. In this sense moral imagining, described in chapter-III, is an important concept.

## THE PRINCIPLES AND CARE ETHIC INTEGRATED

Two positions can now be taken. The first is to reject the deductive principles approach completely. The second is to use both positions as complementary models. The latter choice is more promising. Autonomy for example, is a worthwhile principle which has to be respected by the nurse. But the principle of autonomy, generalised within a framework of 'rules' and 'duties', is not sufficient. Autonomy can be seen as a general base, but the fine tuning has to be established 'around the bed'. Brabeck writes: as both approaches are taken together "the moral person is seen as one whose moral choices reflect reasoned and deliberate judgements that ensure justice be accorded to each person while maintaining a passionate concern for the well-being and care of each individual". (Larrabee Mary Jeanne, 1993 p-48). In other words, the 'ethic of care' and the 'ethics of justice' should be integrated in one person.

In conclusion, the value base of nursing is connected with two complementary frameworks, namely a rule and duty based 'principle approach' and an 'ethic of care', which can be connected with moral imagining and case-histories. In reference with these frameworks (value base) and the knowledge base (nursing as a science), the discussion about what is nursing care, can start. In this sense I refer back to chapter-II, in which Tronto asked for a broad discussion of care.

#### 4-5-3 CARE MORE DEFINED

Jeffrey Blustein (1991) differentiates four uses of the concept care:

\*to care for: i.e. liking, having affection, being attracted, being pleased. example: 'I care for my wife';

\*to have care of: i.e. charged with the responsibility for supervising, managing, providing for, attending to the needs of, or performing services. example: 'the nurse cares for our bodily needs'. In this case the nurse cares of a person without being attracted etc. to that person';

\*to care about: i.e. to be invested in it; example: 'The dedicated nurse cares about high quality care';

\*to care that: this propositional and has a situation as its object; example: 'certainly, I care that there are so many homeless'.

The two uses of the concept 'care' that can be applied most to nursing practice are: 'to have care for' and 'to care about'. 'To care for' doesn't suit the nursing profession since the nurse-patient relationship is a role-relationship. Characteristics like being attracted and having affection, do not fit within the perspective of a role relationship. It is like the care of the parents for their child. 'To care that' doesn't fit nursing because of its propositional character.

'To care for' does fit with nursing since the nurse tries, within the framework of his responsibilities, to attend to the needs of the patient.

Some nurses might say that ‘caring for’ is the only use of the concept care. In this situation, the nurse views the patient as a collection of needs which he has to support, for example, helping the patient to go to the toilet. Although the patients needs are the base of nurse interventions, attending these needs alone is not enough. The danger exists that the nursing discipline can get trapped in a mechanistic model. The patient is then the total of its needs. In order to perform nurse interventions in a human way, nurses have to be invested in their patient. In this way the value base of nursing, besides the knowledge base, comes back again.

To be invested can be described as: “S cares about X” that is S wants to do something that will benefit X, or will be welcomed by X, or that will enhance him/her in some way, or keep him/her from being harmed or damaged, and so on” (Blustein, 1991 p-28). Two bio-ethical principles can be detected, namely: beneficence and non-maleficence. In short, every nurse intervention (to have care for) has a moral component (to care about).

If we focus further on ‘caring about’ we can detect different subdivisions. For example, the difference between ‘positive care about’ and ‘negative care about’. The difference can best be explained by means of the concept ‘interest’. In order to care, a nurse needs to have and take an interest in the patient; I make a situation my active concern.

This means that the nurse gains if the situation of the patient improves or at least is stabilised on a favourable level and the nurse loses if the situation of the patient deteriorates (positive care about). With ‘negative care about’, the nurse gains if the situation deteriorates and loses if the situation improves! It looks quite obvious that ‘positive care about’ is the type of care that nurses should be interested in, since we must assume that they want to improve the patient’s situation.

‘Positive’ and ‘negative care about’ can further examined in the context of ‘an end in itself or a means’. Let us consider ‘positive care about’, since this is most related to the nurse-patient relationship. Approached as an end in itself, the nurse is interested only in the benefit to the patient and not his own advantage. This purely altruistic and disinterested approach doesn’t exist. Even a nun who dedicates her life to God, has private reasons to worship God, for example, going to heaven. Nursing as a ‘means’ is related to a promotion of self-regarding interest. For example, ‘I am a nurse because I just want to earn money’ or ‘I just want to perform high quality care since that satisfies me’. Which one is better is difficult to say. The former and latter direction can turn out in maleficence, for example, not enough or too much care. It is important to recognize both extremes. Each nurse has to discover his own balance.

In order to test if a nurse is really caring about his patients, Blustein (1991) describes a method by Annette Baier. “A reliable sign of real caring is the intolerance of ignorance about the current state of ‘what’ we care about”. (Blustein, 1991 p-32)

For example, if a patient lies in bed in his/her own urine and the nurse doesn't change this situation while informed, we can assume that the nurse does not care about the patient's condition.

Finally we come to a very difficult point, namely how can we judge what is good and what is bad care. Blustein (1991) names two criteria:

\*if the values of care are not in line with my own values. for example assistance with euthanasia;

\*over-value or undervalue. For example, a nurse can care so much about the patient that the patient doesn't have any scope for expression etc.. In this sense there is a tension between the principles of beneficence and autonomy.

#### **4-6 SUMMARY**

Nursing care takes place in an environment of time, space and quality. Disease and health can be viewed from a negative and a positive perspective. The former model is focused on the absence of disease, while the latter is connected with true-well being. Negative health is based on the philosophical foundations of the medical paradigm. This means that disease and health are viewed as prescriptive concepts and, as a result, an unambiguous diagnosis can be made. This idea is very much connected with Descartes idea of a person.

Deeper investigation reveals the evaluative character of the concepts. This results in the moral question: 'who decides what is a bad situation for the patient'. Because of the evaluative character of disease and health, a cooperative framework between the nurse and the patient is necessary. The development of a standard diagnosis is still useful. But the scope has to be broadened from a single paradigm to a multi-paradigm perspective (The physical aspects of nursing care within the traditional approach and the social and psychological aspects should be connected with the human science paradigm and the lived-experience). In this way general understanding and the concept 'negative health' are connected (knowledge base). Furthermore, two potential dangers of a diagnosis are 'ignoring' and 'transformation'. Negative health has to be connected with positive health. Positive health is connected with five moral principles, based on right and duties. Together with the contextual ethic of care, they can form the theoretical value base of nursing care. In reference with the ethic of care, case-histories and moral imagining, developed in chapter-III, are relevant. In this way positive health is connected with unique understanding. Nursing care can be defined in two ways, namely: to have care of (needs) and to care about (to be invested in). In this way the concepts reflects both the knowledge base and the value base of nursing.

## **CHAPTER-5**

## **CHAPTER-V**

### **SYNOPSIS, CONCLUSIONS AND DIRECTIONS**

#### **5-1 SYNOPSIS**

##### **5-1-1 INTRODUCTION**

This thesis has been written because of two related concerns that I have about the current nurse education curriculum, i.e. the rather narrow scientific approach and the potential fragmentation. The aims of the thesis have been twofold, namely to obtain an insight into both concerns and to open new directions, to 'broaden' and to 'integrate' nurse education. Connected with the goals, I have discussed two aspects of the nursing curriculum, namely the various ways to understand a patient and the central concepts of the nursing discipline. A base to start the thesis was the empirical fact: 'the responsibility of the student nurse after he has finished his degree or diploma course, is to establish and maintain an unique face-to-face nurse-patient role relationship'. The consequences of this thesis is hopefully to open the way for a ideal means of approaching the patient, i.e. as an integrated whole with unique and general characteristics.

##### **5-2-1 'THE VOYAGE'**

I started the 'voyage' by describing nurse education from a historical perspective. In this way todays problems in nurse education, can be contextualized. I have linked the historical picture of nurse education with two current problems, the dual role of the student nurse and the development of nursing theory, and one obstacle to change the problems, i.e. obedience.

Obedience is a moral and/or legal concept. I have discussed this concept in the light of the moral development of boys and girls to adulthood. This is important as 95% of nurses are women. Carol Gilligan introduced the theory that women follow another path than men in their moral development to adulthood. Women's moral development is based on 'connection' and 'care', while men's moral development is based on 'individuation' and 'rules'. As a result of her research, she says that women are different in their moral reasoning and judgements instead of weaker than the male norm. Through empirical research, Gilligan developed different stages of female moral development. Obedience, self-sacrifice and avoiding hurt, all potential obstacles to changing nurse education, are only a phase of development in this model.

However, Tronto (1987) advocates that the 'ethic of care' should be discussed beyond the gender lines. Tronto found evidence that an 'ethic of care' can also be connected with social or cultural phenomena, as well as psychological. Furthermore, the ethic of care can be made complementary to the principle approach. In this sense it is more important to look at the promises and the problems of an ethic of care, beyond the gender lines. The nursing discipline, as the professional embodiment of care, has to take a central role in the care discussion.

I described five ways to understand the patient. Besides insight in the patient, the nurse needs to have a personal insight since he is the ‘tool to provide nursing care. Understanding the patient can be divided into two complementary parts, namely general understanding (knowledge base) and unique understanding (value base).

GENERAL UNDERSTANDING: As a background to the different ways to understand a patient, I have discussed the main lines of the scientific revolution, i.e. dehumanisation of nature, power over nature and a metaphysics of dualism (single-subject). Scientific thinking has been influenced deeply by the new world picture. The main features of traditional scientific thinking can be described as empiric, positivist and axiomatic, focused on general, objective, law-like and detached explanations, obtained through deduction. In turn, three kinds of general understanding, relevant to nursing, i.e. bio-medical science, social sciences and science of nursing, have been influenced by the narrow standard approach.

Bio-medical explanations, obtained in the narrow framework through deduction, are important for the nursing discipline. The medical discipline is concentrated on the causes of physical ill-health, while the nursing discipline is focused on the consequences. In this way, the nursing discipline is both connected with the medical discipline and has an own domain to develop its identity. In the physical domain, the traditional approach and methods are useful to develop general patterns.

Bio-medical understanding as a base to develop the consequences of physical ill-health, does not cover all aspects of the ‘whole person approach’ in nursing.

The social sciences are focused on the social and psychological aspects of human-beings. Like bio-medical science the social sciences have been influenced by the narrow standard approach of science, focusing on single explanations. If the social sciences follow this path, then the results of the research will be influenced in at least three ways, namely: A-how are the concepts defined and converted into measurable units; B-the hypothesis; C-the research method. This thesis has tried to show that, the complex psychological and social aspects of men cannot be revealed by the standard approach, but require a more ‘meaningful’ approach. I have used the analyses of the social sciences connected with the standard approach and the question about its direction, as a stepping-stone to discuss a more ‘meaningful’ theoretical foundation related to the science of nursing.

The centre of nursing is the unique face-to-face nurse-patient role relationship. Gaining an insight into the very complex psychological and social aspects of the role relationship, is an important aspect of the science of nursing. I have looked at the two theoretical paths that the nursing discipline could follow, the narrow scientific standard image related to ‘law-like explanations’ or a broader approach related to ‘meaning’ and ‘understanding’. Which path is chosen is dependent on the ‘object’ of research. As described above, the central focus-point of nursing is to provide nursing care within a role relationship.

To analyse the social and psychological aspects of nursing care by means of the standard approach, means that we only reveal the empirical ‘facts’. In other words “it’s limited by its starting point and fundamental scientific and philosophical restrictions of human life”. (Watson, 1988 p-17) In order to go beyond these restrictions of human life, I introduced a **broader** framework, namely the human science approach. I connected this paradigm with a feminist theoretical concept, i.e. lived-experience. Besides being important for theoretical reasons, the connection between nursing and feminism is also important for ideological reasons. In this framework, which accepts all dimensions of our human existence, I’ve embedded the definition of nursing care as a ‘moral ideal’.

According to Hetherington and Hawe, the nursing discipline is trapped between two paradigms, namely the mechanistic (traditional approach) and the humanitarian paradigm (human science approach). The former is connected with a fragmented vision of human-beings, while the latter is connected with the ‘whole’. In order to get out from this trap, the care discussion, claimed by Tronto, is important. Moving beyond the ‘trap’ has to be understood in two ways. Firstly, a multi-paradigm approach should be used instead of a single-paradigm approach (the physical aspects of nursing care can be investigated in the traditional paradigm, and the social and psychological aspects in the human science paradigm connected with the lived-experience) and secondly, it should be connected with the medical discipline but be concentrated on the consequences of physical ill-health.

**UNIQUE UNDERSTANDING:** Nursing care takes place within a unique face-to-face nurse-patient role relationship. Besides a generalised understanding of the patient, the nurse needs to have an insight in the unique aspects of the patient. To see the patient as an individual, is based on moral values. There are two distinct ways of unique understanding, namely case-history and imagining through lived-experience and reflection. By means of case-history, the patient's situation of ill-health can be contextualized. The case-history can be used to analyse the lived-experience. Imagining connected with the lived-experience and reflection is important for the four reasons given and explained below:

**A**-it introduces the moral component in the nurse-patient role relationship.

Every human relationship has a moral component. Because the narrow scientific approach dominates, this aspect can be underestimated. Through unique understanding, which is based on respect for the individual, the moral component can be re-emphasised;

**B**-it helps to build a hypothetical 'value bridge' between the patient and the nurse.

I described 'respect for the person' as one of the preconditions of nursing care. 'Can respect for another person be learned or is this 'an instinct given by God to the virtues'. I described a hypothetical model through which respect for the other person can be learned.

Through personal lived-experiences and reflection, nurses have a tool to imagine what it means for the patient to be in a particular kind of situation. More insights have to be obtained in this model; C-it establishes a source of understanding for nursing science to investigate the psychological and social aspects of the lived-experiences of nurse-patient relationship.

Through lived-experiences and reflection, a source of information can be established. Consequently, a **connection** can be made between unique understanding and general understanding. The centre of investigation is the personal lived-experience. Subsequently, the different groups involved in nursing can be integrated in the following way: firstly, the source of information is the face-to-face nurse patient role relationship; secondly, the nursing scholar can use the information to gain an insight in the nursing care process; and thirdly, this information can be used in nurse education;

D-It can help to establish a hypothetical curriculum framework in which general and unique understanding has been linked.

Through concept linking between the sciences (general understanding) and the humanities (unique understanding), I have tried to link both kinds of understanding. In this way an **integrated** curriculum can be constructed. The integration force is the student nurse. This is in line with the central place of the nurse, namely the unique face-to-face role relationship.

Furthermore, if self-awareness through experience/reflection and imagining becomes an integrated part of nurse education, this model could be a stepping stone to grow beyond obedience. This model should be developed further for nurse education.

I discussed the main concepts of nursing, namely: health, person, environment and nursing care. Nursing care takes place in an environment of time, space and quality. Disease and health can be viewed from a negative and a positive perspective. The former is focused on the absence of disease while the latter is connected with true well-being. Negative health is based on the philosophical foundations of the medical paradigm. This means that disease and health are viewed as prescriptive concepts and, as a result, an unambiguous diagnosis can be made. This idea is very much connected with Descartes idea of a person. Deeper investigation reveals the evaluative character of the concepts. Because of the evaluative character of disease and health, an cooperative framework between the nurse and the patient is necessary to decide what is good/bad for the patient. The development of standard diagnosis are still useful, But the scope has to be broadened from a single paradigm to a multi-paradigm approach. In this way general understanding and the concept 'negative health' are linked. Furthermore, two potential dangers of a diagnosis, 'ignoring' and 'transformation', are highlighted. Negative health has to be connected with 'positive health'. Positive health is linked with five moral principles, based on rights and duties. Together with the contextual ethic of care, in which case-histories and imagining are important, these principles can form the theoretical value base of nursing care.

In this way positive health is connected with the concept unique understanding. Nursing care can be defined in two ways, namely: 'to have care of', which reflects the knowledge base, and 'to care about', which reflects the value base.

### **5-2-2 CONCLUSIONS**

The two concerns I started the thesis with, are interwoven into the text in the following ways:

#### **BROADENING:**

- \*In order to broaden nurse education in the area of general understanding, it should move from a single paradigm to a multi-paradigm approach;
- \*unique understanding (value base) must be linked to general understanding (knowledge base);
- \*positive health is linked to negative health;
- \*the idea of an environment should be broadened from bio-organic to include time, space and quality.

#### **INTEGRATION:**

- \*A hypothetical model of concept linking has been constructed in this thesis. This model can be developed as a curriculum integration force;

\*through unique understanding as a source of information, general social/psychological understanding and unique understanding can be linked together. In this way the different groups in nursing (practitioners, researchers, management and educationist) would come together.

The proposals for broadening and integrating nurse education, mentioned above, will have consequences for the ideal to view the patient as an integrated whole, with unique and general characteristics.

### **5-2-3 DIRECTIONS**

This thesis has been written primarily as a framework thesis. It has been my policy to let the relationships between a large number of different concepts prevail over a detailed analysis. Now, the individual concepts should be expanded and developed in detail. In this way, the framework can be converted into a more 'precise' overview.

A second direction is the development of the hypothetical models related to nurse education, namely:

\*the 'value bridge' model;

\*curriculum integration model.

## REFERENCES

Akinsanya, J. A.

Recent advances in nursing; theories and models of nursing.

Singapore, 1989.

Alderson, Priscilla

Abstract bio-ethics ignores human emotions.

Bull. Med. Eth., may 1991, p.13-21.

Alexander, Margaret F.

Learning to nurse; integrating theory and practice.

Edinburgh, 1983.

Allan, J. and Jolley, M.

The Curriculum in Nursing Education.

London, 1989.

Allen, Charlotte

Nurse, heal thyself.

Nursing Times, August (18-24) 1993, p. 24.

Beattie, Allan

Preparation for practice; curriculum co-ordination.

N.B.S., no.5 1991.

Berg, Marc

The construction of medical disposals; medical sociology and medical problem solving in clinical practice.

Sociology of Health and Illness, no.2 1989, p. 151-180.

Blustein, Jeffrey

Care and Commitment; taking the personal point of view.

Oxford, 1991.

Clark, Janice B.

Ethical issues in health education.

British Journal of Nursing, no.10 1993, p. 533-538.

Couts, Jorman Jacqui

Using reflection and experience in nurse education.

British Journal of Nursing, no.1 1993, p. 77-80.

Dancy Jonathan and Sosa Ernest  
A companion to epistemology.  
Oxford, 1993.

Descartes, Rene  
Discourse on method and the meditations -Penguin edition-  
Middlesex, 1968.

Downie, R. S.  
Roles and Values; an introduction to social ethics.  
London, 1977.

Downie, R. S. and Telfer, Elizabeth  
Respect for persons; a philosophical analysis of the moral, political,  
and religious idea of the supreme worth of the individual.  
London, 1969.

Downie, R. S. and Charlton Bruce  
The making of a doctor; medical education in theory and practice.  
Oxford, 1992.

Downie, R.S. et .al.  
Health promotion; models and values.  
Oxford, 1990.

Downie, R. S.  
Healthy Respect.  
Oxford, 1994

Frankene, K. William  
Ethics.  
London, 1973.

Fromm, Ehrich  
The art of loving.  
London, 1985.

Gallagher, Ursula  
Teaching and learning nursing ethics.  
Worcester, 1991.

Gilbert, Paul  
Human relationships.  
Cambridge, 1991.

Gilligan, Carol  
In a different voice; psychological theory and women's development.  
London, 1982.

Gray, Genevieve and Pratt, Rosalie  
Towards a discipline of nursing.  
Singapore, 1991.

Griffin, Anna  
Holism in nursing; its meaning and value.  
British Journal of Nursing, no.6 1993, p. 310-312.

Hare, R.M.  
Health.  
Journal of Medical Ethics, no.12 1986, p.174-181.

Hewa, Soma and Hetherington, W. Robert  
Specialists without spirit; crisis in the nursing profession.  
Journal of Medical Ethics, no.4 december 1990, p. 179-184.

Holloway, David and Race, Angela J.  
Developing a rational for research based practice; some considerations for nurse teachers.  
Nurse Education Today, no.13 1993, p. 77-80.

Jarman and Marsden  
using reflection and experience in nurse education.  
British Journal of Nursing, no.1 1993, p. 77-80.

Jones, Elizabeth  
In the hall of mirrors.  
Nursing Times, december (8-14) 1993, p. 637-644.

Larrabee, Mary Jeanne  
An ethic of care; feminist and interdisciplinary perspectives.  
Newyork/London, 1993.

Leiniger, Madeleine M.  
Qualitative research methods in nursing.  
London, 1985.

Mason, Susan A.  
Employing quantitative and qualitative methods in one study.  
British Journal of Nursing, no.17 1993, p. 869-872.

Mc Kenna, Gilean  
Caring is the essence of nursing practice.  
British Journal of Nursing, no.1 1993, p. 72-75.

Melia, M. Keith  
The task of nursing ethics.  
Journal of Medical Ethics, no.1 march 1994, p. 7-11.

Meleis, I. Afaf  
Theoretical nursing; development and progress.  
Philadelphia, 1991.

Mori, Maurizio  
The philosophical basis of medical ethics.  
Soc. Sci. Med., no.6 1987, p. 637-644.

Murray, Thomas H.  
Medical ethics; moral philosophy and moral tradition.  
Soc. Sci. Med., no.6 1987, p. 637-644.

N.B.S.  
Nursing education; preparation for practice.  
N.B.S., july 1992.

O' Neil, Gnora  
Introducing ethics; some current position.  
Bull. Med. Eth., november 1991, p. 18-21.

Quinn, Francis. M.  
The principles and practice of nurse education.  
Bury St. Edmonds, 1980.

Russel, Bertrand  
History of western philosophy.  
London, 1993.

Sacks, Oliver  
The man who mistook his wife for a hat.  
London, 1986.

Singer, Peter.  
A companion to ethics.  
Oxford, 1993.

Spouse, Jenny  
An ethos for learning.  
Middlesex, 1990.

Toon, Peter D.  
After bio-ethics and towards virtue.  
Journal of Medical Ethics, no.12 march 1993, p. 17-18.

Verduin, Pieter  
The rationality of the (para) medical treatment of somatizing patients in the perspective of the theory of communicative action.  
Amsterdam, 1992.

Verhoog, Hendrik  
Science and the social responsibility of natural scientists; a meta-scientific analysis of recent literature about the role of natural science in society.  
Leiden, 1980.

Watson, Jeanne  
nursing, human science and human care; a theory of nursing  
Newyork, 1988.