

# **The Discipline of Nursing: Moving Forward Boldly**

Keynote Address

Peggy L. Chinn, RN, PhD, FAAN

Case Western Reserve University Frances Payne Bolton School of Nursing

“Nursing Theory: A 50 Year Perspective, Past and Future”

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## **The Discipline of Nursing: Moving Forward Boldly**

It is my deepest honor to be able to stand before you on this occasion that I believe will be as momentous as the landmark events of 50 years ago. We are indeed at a point in time when we have unprecedented choices to make. The authors of the papers published in ANS<sup>1-5</sup> are here with us today to not only discuss the important visions they have for the future, but to join with us in discussing of the possibilities inherent in their ideas, as well as how your ideas come together to form clear visions of our paths forward.

Part of the richness of our discipline is the diversity and complexity that we can and do embrace, so I believe we have many possible paths forward. However, in the second half of the 50 years since the landmark nursing theory conferences, we have begun to waiver and to doubt the value and the worth of the foundation that is reflected in the theories and philosophies created in the early years, compromising our efforts to build a strong and lasting presence in society and in healthcare. Now is the time to examine our own assumptions and actions, and resolve to chart our paths forward well-founded on a clear commitment to what we stand for as a discipline.

The three landmark conferences we are commemorating were held in 1967, 1968 and 1969 at Case Western Reserve University and the University of Colorado<sup>6-8</sup>. These are the first known conferences of this type, and they resulted in a series of articles, originally published in *Nursing Research*, and commemorated in the March 2018 issue of *Nursing Research*. Thank you to

Rita Pickler, *Nursing Research* editor, and the Lippincott publishers who have made a number of these article available at no cost on the Nursing Research website for this conference <sup>9</sup>. These 1967-68 conferences, and the published articles that came from them, have had a significant influence on the development of nursing knowledge over the past 50 years <sup>10</sup>. Their lasting influence was affirmed by the inclusion of many of these papers in the 1986 text edited by Leslie Nicoll *Perspectives on Nursing Theory* <sup>11</sup>.

The inspiration for this conference grew out of an intention to honor those upon whose shoulders we stand, to reflect on the importance of their work, and to address the growing concern that the ideals and values of our discipline have begun to fade. This concern was articulated in an article published in *Nursing Science Quarterly*” by Elizabeth Barrett, who aptly described herself in 2010 as a “quiet rebel with a pioneering spirit” <sup>12</sup>. In 2017, she posed the question “Again - what is nursing science?” <sup>13</sup>, calling for serious debate around not only this question, but also the circumstances that keep surfacing to undermine our confidence in the meaning of nursing and nursing science that has evolved over the past 2 to 3 decades. We are here at this conference to engage in that serious debate.

My perspective is grounded in what I believe to be a fact - that the focus of our discipline is clear and that it is based on a firm foundation that has been well-expressed over decades, and well documented by Marlaine Smith in her current *ANS* article <sup>2</sup>. Our dilemma has not been what is known and how we

come to know it (our epistemology) - rather our problem (or dilemma) has been how to express what we know in living/ being nursing (our ontology). Our struggle arises not simply because we are a practice discipline. I believe it also is rooted in the fact that the focus of our discipline - our epistemology - is not a “thing” - it is experience and process - or more accurately many particular manifestations of particular kinds of experiences or processes.

Consider for a moment the difference between what it means to “doctor a drink” and to “nurse a drink.” We hardly need to go into the potential explanations of the differences - I have yet to encounter a person (at least a native English speaker) who does not immediately already understand this difference, and who also immediately knows the actions associated with each of these phrases. But notice that “doctoring” involves a “thing” - an action to change the character or effect of a drink. “Nursing” on the other hand is a process that requires many different actions and that can take many forms, depending on who is doing the “nursing” and where! Nursing the drink probably involves an action (sipping the liquid) but what happens to fill the spaces between sips is the real key to understanding what this phrase means - it involves a process that makes it acceptable, in the context of drinking the liquid, to keep the same drink going over a period of time - implicitly understood to be a social context<sup>1</sup>. Note that the “in-between” actions cannot be anticipated in advance, these actions that fill in the time/space between sips

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<sup>1</sup> From Jane K. Dickinson - “I have to doctor it so I can nurse it.” I add lots of cream and sugar (so I can't taste the coffee) so I can spend time being with it - comforted by the warmth and sweetness of it. (I drink coffee very rarely as a dessert only!)

depend entirely on what is called for and what is possible in the social space where the person is sipping on the drink.

Today, I am deliberately focusing on the signs that we do know what nursing is, and that nursing theory, conceptual and empirical frameworks, and the commitment to fully embrace our nursing traditions and values are still alive and well. Of course, not every nurse feels this level of confidence, and there are certainly many who still insist that nursing theory is hog-wash, or that nursing is really just a sub-set of medicine.

But I am not addressing those audiences today. Rather, I am addressing all of us who are gathered here today, scholars of the past, present and future who value nursing theory. I am calling on us to lead the way in declaring, with a new and invigorated level of confidence, pride and utter clarity – we KNOW what nursing is, we BELIEVE in nursing as a vital service, and we can point to a strong, vibrant and relevant body of knowledge that gives our discipline its unique focus. We do not need a “majority opinion” among all nurses (although that actually might exist despite the delusion that it does not). We DO need strong, confident voices inspiring the way forward.

There are several recent experiences that have shaped my conviction that there is ample support for the fact that we can proceed with confidence. First, I am beginning to see popular blog posts that address the importance of nursing theory. David Foley, faculty member here at Case Western, wrote a blog post for the “American Nurse Today” published on March 28, 2018 titled “Rescuing

Nursing Theory” in which he shared his experience of adopting a nursing theory every day and using it to inspire beginning students to understand the rich possibilities for their future nursing practice. There were only a couple of responses to the post, but they reflected the fact that readers were inspired by not only David’s story, but also felt affirmed in their own positive nursing theory orientations <sup>14</sup>.

Another blog post appeared on Medscape on May 17, 2018 titled “How Relevant Is Nursing Theory In 2018?” <sup>15</sup>. The author, Donna Goodman, is an acute care nurse practitioner, who is described on the blog page as follows: “With more than 30 years of experience in critical care and medical/surgical nursing, she has gained an immense amount of *insight into the human and patient experience* (repeat *insight into the human and patient experience*)– and an unrelenting passion for the practice of nursing.” In the post, she asked:

Do we need Nursing Theory? You tell me. I believe it's our heritage, our birthright, and it's our responsibility to keep it relevant.

Another example -- a few months ago I had an opportunity to speak directly with Alex Wubbles, a baccalaureate-prepared nurse who was wrongfully arrested in Utah for refusing to draw blood for the police on a comatose patient she was caring for in the ICU <sup>16,17</sup>. We were in a small group listening to her story and much of the discussion was around how complex an ICU situation is, with so much going on and so many people involved. I asked her what it is that she as a nurse brings to this kind of situation. Without a

moment's hesitation, she stated "We are the ones who know the patient." She went on to elaborate that it is the nurses who understand what the patient needs, everything that is happening with the patient, and that nurses are the ones who know the patient's and family's feelings about what is happening. She emphasized that nurses are there to protect the patient, to make sure they get what they need from whoever on the team can provide what the patient and the family need. The bottom line - Alex had no doubt as to what nursing is, or what she needed to know to practice nursing. I remind you - her first words, which I quote verbatim: "We are the ones who know the patient."

## **The ontology of it all**

So what does the literature provide that sheds light on the questions before us?

In 1995, Mary Silva, Jeanne Sorrell and Christine Sorrell<sup>18</sup> published an article in *ANS* that examined Carper's fundamental patterns of knowing, and proposed an ontological shift. They noted that the early theoretical achievements by nurse scholars provided a vital and important foundation for this shift "that moved nursing largely away from medical and other theoretical perspectives to nursing perspectives, with all their richness and diversity." (p. 2)

Silva, Sorrell and Sorrell (1995) observed that as society shifted from an interest in "knowledge" to "information," questions of meaning, purpose and being began to surface, but without the same kind of attentiveness that the

epistemologic questions had engendered. In particular, they explored the persistent collision that happens in practice when confronted with that which is inexplicable, and that which is unknowable, and explored what a shift toward ontology could mean. To me this a key point, and reveals the folly of continuing to subscribe to the myth that we do not know what nursing is.

If we shift to the ontology of nursing knowledge, we see the theories that form our foundation as a ground from which to understand what is knowable, and turn to questions like “How do I find meaning in what I know?” “What meaning does the unknowable and the inexplicable have for me? For those I care for?” “Do I know what I do, and do I do what I know?” We can recognize that the “knowing” that is expressed in any theory or model is only a shadow of what is possible. If we grapple with the ontological meaning these theories have for us, and search for the meanings and realities that lie beyond their theoretical reach, then we can begin to close the gap between nursing science and art. We can recognize the significance of epistemologic knowledge, and how ontological perceptions of reality can change how nurses practice nursing.

At about the same time Pamela Reed <sup>19</sup> published an article that explored the ontology of the discipline in which she defined nursing as an inherent human process of well-being characterized by complexity and integration in human systems. She noted that the process of nursing is not focused on the reversal of a disease process, but a movement forward in the direction of well-being, regardless of the presence or absence of a disease. Further, the nursing process

(nursing in action) is a relational process characterized by participation in the movement forward process. Reed stated:

“Nursing (as practice and praxis) is a way of doing that creates good actions that facilitate well-being. Nursing (as syntax and science) is a way of knowing that creates goods in the form of knowledge. And nursing (the substance and ontology) is a way of being that creates patterns of changing complexity and integration experienced as well-being in human systems.

. . . . Ongoing philosophic dialogue about the ontology of the discipline will help ensure that nurse theorists are theorists of nursing in its fullest sense, and likewise, that nurse researchers are researchers of nursing, and nurse practitioners are practitioners of nursing (p. 79).

In her later response to a critique of her article, Reed noted that “the very name of our discipline, nursing, is unlike the names of most disciplines, which describe the study rather than the action of phenomena”<sup>20</sup>. Reed noted that perhaps it was time to re-name the discipline to a noun, rather than a verb - and noted that one possibility would be the term used by Paterson & Zderad<sup>21</sup>- “nursology”<sup>19</sup>. She suggested that the term “nursing” - the verb - be retained as an element in the metaparadigm. While renaming the discipline is not a magic wand that will fix all of our challenges, it offers real possibilities for change, and finally, 20 years later, there is a movement afoot to do exactly that!

My sense of the significance of what we can now refer to as nursing has been affirmed mightily by the experience of developing the Nursing.net website, where we actualize Paterson & Zderad's very early suggestion, and advanced by Pamela Reed and Jacqui Fawcett as well, to embrace "nursing" as the name of our discipline<sup>19,22-24</sup>. Developing the site, and witnessing the unfolding documentation of the amazing evidence of the knowledge of our discipline, I came to realize, at a deeper level than ever before, that our epistemology has a firm foundation. Like any other body of knowledge, it is forever in process, and each theory or other construction that expresses what is known, or how it comes to be known, is an important stepping stone to the next idea. Each construction deserves serious and critical examination. The very fact that these constructions exist and can now be accessed from a central location is remarkable evidence of a firm, lasting and evolving disciplinary foundation.

But realizing - in action - who we are, what we stand for, the values we believe in - these are the real challenges that remain before us. The social and political circumstances in which we put nursing into practice are not all of our own making, and place on us huge constraints that lead us to doubt who we are. Even though many (if not most) nurses recognize these constraints and attempt at many levels to change them, they are also circumstances in which we can be complicit. In essence, we are not actually asking "what is nursing?" we are still asking the question posed by Nightingale in her essay titled

“Cassandra” written before “Notes on Nursing.” Nightingale asked “Why have women passion, intellect, moral activity -- these three -- and a place in society where no one of the three can be exercised?” <sup>25(p2)</sup>. Today, I believe we are asking, essentially, “why have nurses passion, intellect, moral activity -- these three -- and so very few places (if any) in society where these three can be exercised?”

We all participate, often unknowingly, in sustaining and co-opting the circumstances that cloud our focus. A few weeks after we launched [nursology.net](http://nursology.net), I wrote a blog addressing the persistent “cultural noise pollution” inherent in messages that we do not really have a focus, that nursing theory is irrelevant to practice <sup>26</sup>. These messages serve only to detract from the reality that we do have a disciplinary focus, that we have a lively community of scholars developing very relevant nursing theories. So the first challenge we face, I believe, is developing a keen awareness of ways in which this message is sustained, forming ways to turn these messages around, and becoming involved in creating situations in which our gaze is clearly focused on the practice of nursing to the fullest.

So I now turn to examining fundamental evidence of our disciplinary focus inherent in common definitions of nursing that frame our epistemologic landscape, and that also frame our ontology -- the being/doing of nursing. Each of these definitions point to two elements that are essential to the focus

of the discipline, and that define the parameters of what it means to nurse, the characteristics of nursing practice -- our ontology. These elements are:

- knowledge of the nature of the human health experience, and
- knowledge of nursing healing practices - practices that engage in the human health experience (not disease or other circumstantial condition)

<sup>27</sup>. This essential element reflects Reed's recent claim that "Nurse practice actions and interactions with patients are *constitutive*, not contextual components of theory development" <sup>5(p25)</sup>

Each of the common definitions of nursing that I examine here embrace both of these elements.

### **Affirming what is known - definitions**

From a theoretical perspective, a definition only points to the crucial characteristics that can be widely accepted as the nature of a phenomenon - a thing. There has been a long-standing opinion that we need a single definition of "nursing," that everyone agrees is "the correct definition." This is a specious claim - there are no two dictionaries that contain exact same definitions of most terms, and a serious explorer of word meaning knows to consult several dictionaries to get a full picture of the crucial characteristics of a term. The opinion that we need one single definition of nursing is often justified by pointing to the belief that in other disciplines there is a generally accepted definition that gives other disciplines their defining focus. I agree that other disciplines have a "name" that is generally understood as an

appropriate “label” that identifies the discipline, just as each of our names (seen on our name tags here) identify or “label” who we are. But I am not convinced other disciplines can claim to have a single definition that covers all of the nooks and crannies of their field, just as our names do not give a clue as to who we are – the persons we come to know.

In my view, the establishment of “nursology” as a label for our discipline is a step forward in addressing the “verb/noun” issues, distancing our discipline from common associations of the verb “nursing” that have some conceptual links, but little or nothing to do with the nature of the discipline of nursing.

But given a identifying label, varying definitions serve any discipline well – they represent and embrace diversity in the field that accommodates a wide range of possibilities, that point to variations among particular global contexts or changes over time, that express subtle nuances and points of view, and that leave open space for innovation and creativity. Having said that, common threads among varying definitions do serve to provide the cohesiveness that makes it possible to say “this is nursing,” or “this is not nursing.” Or, likewise, “this is nursology,” or “this is not nursology.”

I am starting with examples of definitions from the mid to late 1900s to show that all along, when we have been decrying our lack of focus, we actually have had common understandings of what nursing is, and more importantly, varied and fluid statements that reflect the time in which they were used, and the purposes for which they were created.

## Early Definitions

In Nancy Roper's 1976 *Journal of Advanced Nursing* article titled "A Model for Nursing and Nursology," she reported the development of a model intended to address the changes in hospitals between 1940 and 1970 in Scotland that resulted in lack of clarity around the question "What is nursing." <sup>28</sup>. The definition she derived from the model is (edited for pronouns):

" . . . nursing is helping a person towards [their] personal independent pole of the continuum of each activity of daily living; helping [them] to remain there; helping [them] to cope with any movement towards the dependent pole or poles; in some instances encouraging [them] to move towards the dependent pole or poles, and because [people are] finite, helping [them] to die with dignity. (p. 224)

This definition echoes the definition of nursing that dominated my own undergraduate nursing education at the University of Hawaii in the early 1960s - the well-known Virginia Henderson definition, which is "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery or to peaceful death, that [they] would perform unaided if [they] had the necessary strength, will or knowledge" <sup>29</sup>. Notice - these long-standing definitions point to the two essential elements that I have suggested characterize nursing knowledge as ontology - 1) knowledge of the human health experience (specifically in these definitions the activities of daily living in the face of a health challenge), and 2)

knowledge of nursing healing practices (ways to help sustain ADLs in the face of health challenges)

### **ANA and ICN definitions**

In the ANA Scope of Practice, the definition of nursing has evolved, appropriately. Like the Roper definition, the ANA definition has been influenced by changes in the healthcare system. The current “Scope of Practice” definition is: “Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; facilitation of healing; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, groups, communities, and populations.”<sup>30</sup>. I actually recall when “diagnosis” was added to the Scope of Practice definition, prompted in part by the work of the Nursing Diagnosis conferences in which a number of our early thought-leaders participated.

On the ANA website, there is this additional explanation, primarily aimed to help the public understand nursing:

“21st Century nursing is the glue that holds a patient’s health care journey together. Across the entire patient experience, and wherever there is someone in need of care, nurses work tirelessly to identify and protect the needs of the individual”.<sup>31</sup>

The International Council of Nurses (ICN) which reaches a global constituency, draws on the ANA definition, but adds a dimension that

explicitly includes nursing's obligation to shape public policy as a nursing healing practice aimed at the health of populations:

“the phenomena of particular concern to nurses are individual, family, and group "responses to actual or potential health problems" (ANA, 1980, P.9). These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population.”<sup>32</sup>

### **Definitions foundational to, and derived from nursing theory**

In 1991, Newman, Sime & Corcoran-Perry published a landmark article that addressed the need to have a clear, concise statement that specifies the area of study of the discipline. The definition they proposed is now well-known - nursing is the study of “caring in the human health experience”<sup>33(p3)</sup>. In this succinct statement, the two essential elements I have identified are clear - nursing requires knowledge of the human health experience, and nursing healing practices are caring practices. About 15 years later, Newman, along with Marlaine Smith, Margaret Dexheimer Pharris and Dorothy Jones revisited the challenges related to this focus, and stated in their closing paragraph:

“Nurses are thirsting for a meaningful practice, one that is based on nursing values and knowledge, one that is relationship centered, enabling the expression of the depth of our mission. . . . What is

missing in healthcare is what nursing can provide when practiced from a disciplinary perspective.” <sup>34</sup>(pE25)

In essence, this affirms the focus of the discipline and points to the problem I believe is the ontological heart of the matter - few, if any, places in society where nurses can exercise their passion, intellect and moral activity.

There are two more definitions that shed light on how various definitions serve to point to a common purpose, while at the same time pointing the way to embrace diversity. In 2008 Danny Willis, Pamela Grace and Callista Roy proposed a central unifying focus of the discipline: facilitating humanization, meaning, choice, quality of life, and healing in living and dying <sup>35</sup>(ppE32-E33). Similarly, Barbara Jacobs defined the very essence and the “end” of nursing as human flourishing, nurtured in an intersubjective relationship <sup>36</sup>. I view these rich defining statements not as a replacement of other definitions, but as definitions that bring new insights and possibilities to the forefront, particularly for the purpose of envisioning the ontologic nature of nursing. These conceptualizations carry significant ethical and moral imperatives that are not so evident in other statements. They still point to the human health experience, and bring forth images of nursing healing practices. They do not contradict the other definitions - they amplify and open windows of possibility.

As scholars and thought-leaders, we are not called on to “choose” one definition or the other - we are called on to recognize the common elements in these focus statements, to challenge ourselves and our colleagues and students to come to appreciate the richness inherent in different expressions of our common disciplinary identity.

All of these definitions point to significant theoretical achievements that go far beyond the definitions alone. They are significant in that they express common threads that make nursing what it is, and that serve to appreciate, anew, the vast volume of theoretical and philosophical foundation of our discipline. It is time to recognize the fundamental ontologic commitment inherent in all of these definitions - they require - demand - that nurses know the patient in their own very particular context.

### **Challenge of escape from the handmaiden role**

So now let us turn to examine the challenges we face in exercising our intellect, passion and moral activity. In Barrett’s 2017 article addressing the question “Again - what is nursing science,” she posed this possibility:

Isn’t it time to stop tiptoeing through the tulips and start recognizing we are in a patch of thorny rose bushes? If we can remove the thorns, beautiful roses of different colors will safely remain, yet all will be roses. The revolutionary creators of the nursing theory movement did not tiptoe. They marched! When we have the courage to do what we need to do, and we do it, the rest will, most likely, take care of itself. <sup>13(p132)</sup>.

So now, I invite you to consider these “thorny bushes.” In my assessment, these are circumstances that have left severe gashes on the “skin” that provides protection for the integrity of our professional ontologic integrity. Once we recognize these circumstances for what they are, we can begin to heal the wounds and actualize our ontology.

First, the current imperative to engage in interdisciplinary research, education, etc. is a laudable urge -- but there are credible questions to ask about how this is playing out in real time <sup>37</sup>. It is time to acknowledge that we, as nurses, have long been the ones advocating for interdisciplinary teams <sup>10</sup>. I do not know of any nurses who advocate a “silo” for nursing. But all too often, the inter- or multi-disciplinary context creates an opportunity for certain disciplines to achieve their own interests and exploit the talents of others, rather than a context in which all disciplinary perspectives are exercised equally. As Marlaine Smith stated in her current ANS article: “A deeper and more textured understanding of a phenomenon, the human response to it, and the ways it might be addressed, can only be gained if each discipline comes to the table with its own unique perspective intact.” <sup>2(p2)</sup>

The fact is that we, as nurses, have not been the problem standing in the way of interdisciplinary teamwork, we have in fact raced to embrace the “new” interdisciplinary bandwagon <sup>38,39</sup>. As Thompson and Schwartz-Barcott explicated recently, nurse scientists are well equipped to be a knowledge broker translating science into practice and policy <sup>40</sup>. But interdisciplinary

teamwork has all too often betrayed us and we have all too often remained silent and vulnerable to being co-opted. We get into situations, in practice, education and research, where we find ourselves erased, serving the interests of other disciplines (sometimes not even realizing it), with our own interests as nurses ignored or placed at the bottom of the barrel <sup>41</sup>. In some instances, nurses walk into the “interdisciplinary team” without a clear sense of what they might contribute as a nurse. We in essence all too often become the handmaiden. When, for example, a research team objectives turn out to be clearly those of another discipline, with no consideration of the perspective that nursing might offer, we become handmaidens to another discipline’s objectives. We develop interdisciplinary educational projects that place students in these contexts before they are clear about the contributions they can make as nurses and with little, sometimes no content related to nursing interests. As compelling or interesting or important a team’s objectives are, and no matter how closely those objectives might be situated with our own, when our interests are not part of the team objectives, then we are serving their interests, not ours.

Let me be clear - when this happens, it is not of our own making although we all too often willingly participate, and if we do recognize the problem blame ourselves for not being more assertive, or we withdraw, or fade into the background. We have a responsibility to take a close look at what it is, in interdisciplinary contexts, that really happens to our focus, and create

possibilities for exercising our nursology sensibilities - our own ontology. Indeed, there are interdisciplinary “tables” where we do not belong - and the right thing to do is to create a different table!

One “side” note to this thorny bush - the current move to call everyone by one term - “healthcare provider.” As physician author Victoria Sweet noted in her book “Slow Medicine” there is now no nursing, and no medicine - only “healthcare,” governed by the electronic medical (health) record <sup>42</sup>. I concur with this observation but will add that clearly, the dominant framework for this new form of healthcare is that of medicine, and nursing struggles, having very few of our disciplinary concepts built into the electronic systems that now govern action. Many electronic record systems have had a nurse involved in its development, and yet the systems focus on tasks and medical diagnoses - not the human experience and nursing perspectives intended to move toward health and wellbeing - even when they are called “electronic health records.”

I submit that one dynamic that plays out when our disciplinary focus is erased or compromised is internalized nursogyny<sup>2</sup>. This is the knee-jerk reaction to discount, even disparage our own nursing sensibility, the worth of our own values, to buy the myth that nursing is “less than.” It is a socially inherited sense that comes in part from the historical trauma of nurses’ exploitation as students and even further back to the killing of women as

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<sup>2</sup> This term is problematic based on the root meanings of “nurso” and gyny,” neither of which point to the underlying problem of internalized hatred. Nonetheless, even in consultation with several of my “word geek” colleagues, we cannot come up yet with a good alternative!

healers. Like internalized misogyny, homophobia, racism and other socially constructed prisons that exist only in stereotypes and prejudices embedded in societal norms, nursogyny is alive and well. I am here to tell you that dealing with each one of these internalized prisons is something I know all too well - as a lesbian with mixed-race children and grandchildren, a woman who was taught as a child that the white men's protestant religion was the only truth and taught in my undergraduate program to yield my chair at the "nurses station" to any physician who entered, to never cite a nursing source because it was "secondary." This is not an easy struggle. It is humiliating to admit, even to oneself, that we are struggling to gain our own voice in a situation that is stacked against us. It is far easier to ignore it, go on about our business, and try to play along and get done whatever we can accomplish.

But there is no shame - there is only freedom and liberation - in coming to terms with what we have inherited from our historical trauma, as nurses with a history of being exploited as unpaid workers, and as women healers who have been killed because of their gifts of healing. When we manage to acknowledge, and then to overcome whatever seeds of nursogyny prevent us from bringing our strong nursing voice to the table, or changing the table to one where our voice is equal to that of others, then we can break out. Like the character Sophia in "The Color Purple" who finally declared at the dinner table with her family when she was out of prison, "Sophia's back!" -- we can declare with

confidence that the voice of nursing is alive and well .. we will not be silenced ...  
we are here with a vital perspective that without us, will be missing.

## **The Things We Worship**

I now turn to another thorny bush – the things we worship. There are certain trends that come along that are well-intended and sometimes even necessary and highly desirable, but that become objects of worship – to the detriment of the integrity of our discipline. This tendency is not unique to nursing, but it has been a significant part of our history, as nurses have struggled to gain recognition in the halls of academe and status in the structures of the healthcare system.

One of these trends is the sacred cow of funding. This trend may be necessary, but it is not sufficient. Of course, funding is a good thing, and we should pursue it diligently for those projects for which there is funding. But this becomes a detriment when the only projects that we pursue, and those that we celebrate publicly, are those that are “fundable.” Then, we become susceptible once again to forces whose values and priorities are not our own. We sacrifice pursuing the study of certain phenomena that are central to our discipline because they are “not fundable.” Pamela Grace, Danny Willis, Callista Roy and Dottie Jones noted that the focus on research that is “fundable” has led to the development of only certain types of knowledge, detouring us away from our own disciplinary focus <sup>43</sup>

So what are we to do to support work that is not “fundable”? Or work that does not require funding? The first thing is to establish firmly in our collective consciousness that our work is to be fundamentally driven by our own values and perspectives. From that place of clarity, the pragmatic answers will flow.

Related to funding is the recent trend toward very fundable omics, big data, symptom science, precision medicine. There is not time here to explore this bandwagon in depth, but it raises important questions about the possibility that this trend is leading down a path of “empirics gone wild”<sup>44</sup> with a nod in the direction of Carper’s patterns of knowing to justify jumping on this bandwagon. Starkweather and colleagues’<sup>39</sup> provide a starting place for this discussion in their work that places the epistemologic dimensions of biobehavioral symptom science within the context of nursing’s patterns of knowing. This, and the other articles in the current issue of the *Journal of Nursing Scholarship* that focus on biobehavioral science provide an important focus for serious discussion related to the ontology of our discipline.

One other important trend that to me, is particularly emblematic of the hazards of things we worship - the “evidence” bandwagon. Like funding, omics or big data, there is not a thing wrong with evidence, but when it becomes an object of worship, particularly when the definition of what counts as “evidence” is not of our own making, then we are in trouble. We emphasize the epistemology or what we “know” (or think we know) and fail to seriously consider the meaning of our being, the expression of what we know in practice.

Sally Thorne and Richard Sawatzky <sup>45</sup> published what I believe to be one of the most significant articles of this decade, titled “Particularizing the General,” in which they examined the challenges of “evidence” in nursing. Their analysis is based on the premise that the focus of the discipline is rightfully on human health and illness experiences, and that the fundamental obligation of nursing is to respond to each individual’s experience in ways that the particular situation calls for. (Recall the words of Alex Wubbels “We are the ones who know the patient.”) Thorne and Sawatzky explained as follows:

Reviewing both serious and casual uses of the idea of evidence in nursing scholarly literature, we detect significant problems with conceptual inconsistencies regarding the meaning of evidence and how the notion of evidence relates to nursing. Concurrently, we observe that as the evidence based practice imperative increasingly directs the gaze of the practitioner toward [probabilities derived from] populations and systems of care, the discourse around patients as unique and distinct individuals seems to be losing ground as the epistemological foundation for a uniquely “nursing” angle of vision. <sup>45(p5)</sup>

Here they are referring to the “gold standard” of statistical evidence that is based on statistical probabilities derived from population samples. A nursing focus on the health of groups and populations is different from the statistical meaning. As with individuals, a nursing focus on groups is distinguished by the fundamental value of responding to the specific, particular situation of that

group or population. Thorne and Sawatzky navigate through the diverse forms of “knowledge” or “knowing” that have been acknowledged as essential to the practice of nursing, and present what I believe to be a foundation upon which nursing can evolve our own understanding and credible foundation for making sound clinical judgements in nursing. In conclusion to their article, they stated:

Our disciplinary credibility in a context of increasingly vigilant accountability depends upon our collective skill at interpreting and explaining the sources of knowledge upon which we rely and the manner in which we translate those knowledge sources into action. Unless nursing is prepared to abandon its unique contribution to the particular, it will continue to need strength in disciplinary theorizing and philosophizing to steer its way through the landmines of an evidence-based practice agenda that inevitably privileges the general.

45(p17)

It is time to recognize the nature of the “thorny bushes” that form the context in which our discipline is situated. They are not “bad” things that need to be eradicated - they are circumstances that will continue to form the context of what we know as “healthcare.” Rather, it is time to recognize that our own disciplinary perspective can all too easily get lost unless we ourselves recognize, value and strengthen our ontology.

## Conclusion

In conclusion – here are my invitations to you:

- Join with others here today in declaring a firm conviction that we indeed have a clear focus, a clear purpose. This does not mean that nursing is static, nor does it mean we all see our focus in the same way. Rather, it means that however we conceptualize it, our focus is on the experience of health (not a thing) and that our purpose is to bring the healing wisdom of nursology to that experience.
- I invite us all to call forth generosity of spirit toward one another, to reach for Margaret Newman’s fullest expression of “health as expanding consciousness” which is love, emerging from the experience of “knowing with” one another <sup>46(p66)</sup>. When we love our discipline, when we are present together in “knowing with” and love one another, when we honor our diversity and support one another in facing our own nursogyny, when we turn away from conditions that undermine our strength, we will find the confidence to overcome obstacles to living/being nursology. For those obstacles that cannot be overcome, together we can create alternatives as yet unimagined.
- I invite us all to come together as thought leaders in the discipline, and lead the way to turn away from the illusion that we are still wandering in a forest without a focus. We can engage with those who claim we have no focus to open the way toward appreciation of what we know. We can

engage with “Alex Wubbels” all over the world who have a clear and unwavering vision of nursing in action. We can overcome the thorny bushes that poke away at our clarity and cause us to doubt ourselves.

- I invite us all to stand up and be counted as advocates of nursing knowledge and what that means in practice; to privilege our own values, to dignify the foundations of our discipline; to never be silent in the face of forces that push us away from our nursing focus.
- Let us join Elizabeth Barrett and become quiet – sometimes even not-so-quiet – rebels with pioneering spirits!

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