My Personal Philosophy of Nursing

A personal philosophy of nursing has become a critical element in my approach to developing as a professional nurse and nurse educator, promoting good patient care and quality of life, and determining my values, beliefs and future directions.

Personal Meanings within Nursing's Metaparadigm

Fawcett (1985) articulated a four-domain metaparadigm as a basis for organizing nursing knowledge and beliefs about nursing's context and content: person, environment, health, and nursing.

Person. **I view patients and students as people first and strive to encounter them in *I-Thou* relationships**—two-way relationships based in dialogue and in which I engage in encounters characterized by mutual awareness (Scott, Scott, Miller, Stange, & Crabtree, 2009). I view patients as partners in their own care, and students as partners in their own learning; I view patients and students as complex and multifaceted individuals on a life trajectory in which they are doing their best. As a nurse and as an educator, **I seek to engage in meaningful encounters and establish authentic connections** with patients and students (Johnson 2006: White 2009). I understand there to be an inherent power differential in the nurse-patient relationship, which is one reason why I prefer the term 'patient' over 'client'. I also recognize that there is a power differential in the educator-student relationship, which I seek to recognize and then minimize through transparency and shared negotiation. As a nurse educator, I approach students with the thought, "Who *are* you?" **I seek to know the student, honour the spirit of the student, and help develop the nurse from within the student**.

Health. **I endeavor to understand the patients and communities with which I work in the context of the determinants of health**, as put forth by the Public Health Agency of Canada [PHAC] (2010). As a nursing educator, I model this holistic perspective to nursing students and through a variety of teaching strategies and interactive games to assist them to engage this perspective in their own practice. I challenge my students to routinely view the patient in light of his or her life circumstances.

Environment. Nightingale (1860) said that the role of the nurse is "**to put the patient in the best condition for nature to act upon him**" (p. 70) and this statement has always resonated with me. I understand the concept of environment to comprise both internal and external components. **As a community health nurse, the concept of environment broadens to include the natural and built environments, both of which play a role in individual and population health**, as well as sociopolitical environments. Through participation in local community groups and advocacy groups, such as my neighbourhood association and activity-related advocacy groups, I seek to promote awareness and change at the population level.

Nursing. In an effort to assuage the divisiveness in the nursing world regarding the metaparadigm concepts, Thorne et al. (1998) has proposed a definition of nursing that reflects the middle ground of the debates, while permitting a range of paradigmatic and philosophical positions. They suggest, and I agree, that

> Nursing is the study of human health and illness processes. **Nursing practice is facilitating, supporting and assisting individuals, families, communities and/or societies to enhance, maintain and recover health, and to reduce and ameliorate the effects of illness**. Nursing's relational practice and science are directed toward the explicit outcome of health related quality of life within the immediate and larger environmental contexts (Thorne et al., 1998, p. 1265).

With this definition in mind, **I emphasize the notion of nursing as a practice:** a collectively performed activity of which the shared intention is to enact something of benefit. While I find the binary science-art debate about the nature of nursing to be restrictive, nursing defined as a practice, which is indeed how most individuals (including nurses) encounter it, is a unifying concept. To me, **the term *practice* denotes the need for knowledge, competence, and skill proficiency** (Bishop & Scudder, 2010), and good care is the goal of nursing practice. The abstraction *good care* is expansive but consists of actions, attitudes and relationships that foster wellbeing and dignity in all of the human dimensions (Schotsmans et al., 1998).

I perceive **nursing as a moral practice**, in that its purpose is the restoration of others, not personal gain or profit (Austin, 2011). I experience **nursing as a triune embodiment of: a caring relationship, caring behavior (which includes cognitive and affective virtues, as well as expert knowledge and skills**), **and good care** (Schotsmans et al., 1998) (Schotsmans, Gastmans et al. 1998). Nursing is inherently a 'moral' act because nurses and patients encounter each other and participate in a kind of dance of trust, vulnerability and power, and because the nurse is concerned with enhancing the life of another human being (Delmar, 2008). I find this notion both profound and humbling.

Structuring Nursing Knowledge: Paradigms and Theories

I **have always approached life, the world, and nursing through an empirical lens**. My underpinning epistemological framework is best described as **positivist with an occasional leaning towards postpositivist**. A positivist paradigm values the scientific method, empirical testing, precise instrumentation, systematic approaches, and prediction of events (Weaver & Olson, 2009). I also embrace the postpositivist notion of the "realization that reality can never by completely known and that attempts to measure it are limited to human comprehension" (Weaver & Olson, 2009, p. 251). The postpositivist view also recognizes the fallacies of verification and thus seeks only to establish probable, not universal, truths. It is more holistic than a strictly positivist view, as it permits the consideration of subjective states and multiple perspectives (Weaver & Olson, 2009).

Nursing deals a great deal with physiological and psychosocial phenomena, both of which are situated within complex humans, and so I believe nursing must straddle both empirical and interpretive paradigms to different degrees. **I personally find complex human phenomena easier to understand and treat systematically and in parts, and prefer categorical and generalizable information—so the empirical is a suitable framework for me to appreciate and understand patients and their care**. However, while empiricism is at the heart of my nursing practice, **the more I work with humans, the more complexities I see**, and I see where empiricism ends and the interpretative perspective (holism, human experience, and interpersonal encounters) must begin. Thus, I see the line between the empirical and interpretive as fluid and changing. Because I have strong empirical and postpositivist leanings, I naturally gravitate toward quantitative and mixed methods research as I add to the extant body of nursing knowledge.

I ultimately believe that good nursing requires a pragmatic approach, with unity in what matters most (patient care) but diversity by which paradigm that is achieved. Such an approach acknowledges **the complexity of human experiences of health and illness** and suggests the **need to work within a range of knowledge forms and paradigms, making the best informed decision** on which there is consensus at the time (Stajduhar, Balneaves, & Thorne, 2001).

Knowledge Base for Nursing Practice. As a clinician, I believe that my **practice is concerned with health, illness and healing**, and I therefore draw on an empirical body of nursing knowledge and what is often considered 'borrowed' knowledge. Borrowed knowledge, which originates in disciplines other than nursing, is concerned with anatomical, physiological, pathophysiological, pharmaceutical, sociological, psychological, epidemiological and educational processes. Because I view nursing primarily as a practice, I am not bothered by the use of borrowed knowledge, but am concerned that instead, they are implemented well and in a way that is uniquely nursing. That said, I believe nursing needs to continue to develop its own body of knowledge that is "distinguishable from, complementary to, and in some respects conflicting with, other disciplines" (Northrup et al., 2009, p. 86).

Ways of Knowing in Nursing. There are four fundamental patterns of knowing in nursing: empirical knowing, ethical knowing, personal knowing, and aesthetic knowing (Carper, 2009). White (2009) has added sociopolitical knowing as a fifth pattern. **My nursing practice, both in the clinical and education arenas, is primarily driven by empirical ways of knowing**. Because of this preference, I am suspicious of interventions that lack objective and measurable evidence. Ethical knowing is concerned with beliefs and

values, goals of practice, moral obligations, and ethical practice. **The values I espouse in my nursing practice can be found in the Canadian Nurses' Association's Code of Ethics** (Canadian Nurses Association, 2008). I endeavor to express these values consistently in my relationships with patients, students, colleagues, families, groups, populations, and communities.

For me, personal knowing comes from the awareness of self, the embodiment of personal values, and the culmination of personal experience. To increase personal knowing I engage in reflective practice, in which I examine my own practice and interpersonal relationships in order to enhance practice. **I endeavor to be authentic with my patients and my students**. The evidence for me is in the narratives I hear from both patients and students and how I see them react to our interactions.

Aesthetic knowing enables me to pursue possibilities as I think creatively; it also contributes to my own personal style of nursing and educating. I believe it is this pattern of knowing that contributes to the **transformative** experience many students have in my classes and clinical groups. Aesthetic knowing can also be applied to conceptual knowledge. As a clinician and as an educator, I recognize patterns and make abstractions based on my observations. Through a process of reflection, this contributes to the development of theoretical notions (Schultz & Meleis, 2009).

As a nurse working with marginalized populations, and as a student advocate, **sociopolitical knowing helps me recognize oppressive structures that affect the health of individuals and communities**. As well, my practice as a nurse and as an educator occur as part of a larger system which I seek to both understand and challenge as an outworking of my social justice imperative. In my clinical teaching I demonstrate and provide opportunities for students to explore sociopolitical structures and to examine how power imbalances impact health.

Theories that Inform My Nursing Knowledge and Practice

Interestingly, it was grand nursing theory that initially drew me to the nursing profession. **The grand theory with which I am presently working closely is the Neuman Systems Model of Nursing (NSM)**. Widely accepted for use with individuals, groups, and communities, the NSM "provides a comprehensive, flexible, wholistic, and systems-based perspective for nursing" (Neuman, 1996, p. 67). **The middle range theory which resonates with me is Pender's Health Promotion Model (HPM)**. The HPM provides a guide for exploring the complex biopsychosocial processes, factors and relationships that motivate individuals to engage in a health promoting lifestyle (Srof & Velsor-Friedrich, 2006). This theory appeals to me as a community health nurse because it segues easily with the **Population Health Promotion model** (Public Health Agency of Canada, 2001). I rely on both of these theories to help students help individuals, groups and communities gain greater control over their health.

My Contributions to Developing Nursing Knowledge

As a nurse scholar I want to remain in touch with practice, so that I can help strengthen the link between research and practice. It is easy to become "removed from the real world of nursing" (Wuest, 2006, p. 91). Wuest (2006) states that "the approaches to nursing theory [developed by the elite] reflect the dominant culture rather than the lived experience of nurses at the bedside" (p. 93). This type of research also runs the risk of lacking clinical impact. **As a researcher I would like to meet the needs of nursing practice and education by using real situations as the catalyst for the development of nursing knowledge**. I enjoy pursuing problems that are important to nurses, patients, and nursing students. I would like to promote the opening of spaces for theory development through pragmatic inquiry (Doane & Varcoe, 2009) and engage staff nurses and students in this process.

Conclusion

As a new scholar, I am excited about my future in knowledge development. Through articulating my philosophy of nursing I have become more confident about my beliefs and values about nursing's metaparadigm, nursing as a practice, nursing knowledge, and where nursing knowledge needs to go. I have renewed affinities for nursing theories and possess the language to articulate why I love them and how I use them. I have regained a sense of passion for nursing knowledge and nursing practice, and for the reciprocal relationship that entwines the two.

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