A social purpose model for nursing

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Introduction

Legislative exercises such as the UK's *Commission on the Future of Nursing* document set out to define the purpose of nursing – not just what it is but what it does (DH, 2009), and identify the competencies and skills of nursing and midwifery staff for preparation of practice in the 21st Century. The commission does not exclude nurses and midwives from the task but seeks their identified observations and analysis in preparation for a modern role in leadership and healthcare. Internationally, governments have every right to know that what they are spending is in accordance with what they are getting and, consequently, the UK document is not limited to countries or either country or political whims of the day: purpose driven rationale is pervasive across continent and culture. What this paper does is take the impersonalised and bureaucratic concept embedded in most nursing documents and apply it to the working individual, personalise the process and offer a framework that allows the practicing nurse the opportunity to define their own role and purpose on an individual level. This paper concentrates on nursing, and considers the questions being asked of nurses in relation to how their current role can evolve. This means understanding where nursing is now and identifying it for a future with an autonomous and interprofessional leadership role (Davidson, 2010). Being positioned at this difficult juncture means letting go of some ideas and keeping hold of others and being critical reflectors.

The paper argues that if nursing is to be an autonomous profession (Clark, 2010) – which means a profession identifiable as nursing amongst inter-professional colleagues

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– it needs to ordinance and shape its theoretical perspective to preserve principles which enable it to justify, order, and clarify the traditional values of the nursing profession in a contemporary way without being reductive or theoretical. 21st Century nursing is hegemonic and diverse and quickly reaches the limits of language. It is argued here that an understanding of role has to come from within practice itself and is not necessarily captured by definition, partisanship or the language of the academic. The nurse's place, in a multi-professional healthcare society needs to escape the enduring trace of helpmeet without impairing the caring aspect of the role. The scope of the paper limits a detailed exploration of a range of implicit values, and examines instead the latent constructs underlying the role of the nurse as carer and critical thinker (*carer* and *critical thinker* is chosen to describe loosely the past and present nursing identity embedded in the media and still evident in current scholarly debate).

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The model that is provided is intended to equip the practising nurse with the explicit means of evaluating what they do and lets nurses constructively analyse their practice to share with others through the constructivist means of evaluation. Although nurses tacitly engage in a process of reflection at a personal level, it is often difficult to translate either the role or its purpose beyond the task at hand so that other professional's struggle to understand the explicit objectives of the role of the nurse. Constructive evaluation of experience is continuously employed as the means of assessing the nurse's professional role and practice, simply because practice determines the shape of the role (Beam et al., 2010). What this paper provides is a frame of reference for purpose of practice that is readily manageable, yet flexible enough so that without any undue violence to any one set of statements about nursing, it will translate a plurality of thought into a single plane

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of theoretical discourse. The study sets out to widen present debate so that competency standards instinctively include discussions on value structures for the future of nursing.

The theoretical and practical implications of social interaction

One way of increasing or sustaining informed knowledge of practice is to develop a means of evaluating nursing within its social context. Current reflective mechanisms, by their very nature, are a means of justifying and questioning what one does from a personal perspective, and if reflection as a technique is still left to chance and nurses are unsure about how reflection works (Shih et al., 2009) then very little corroboration will come about. Moreover, theoretical understandings of reflection do not offer much in way of assistance, instead they provide ideas that offer what seems like ambiguous theories with little applicatory relevance. In contrast, what the social model does is acknowledge the power of the caring collective in influencing care delivery from the perspective of the professional in practice. Theories in nursing are mostly felt to be relevant when they can be practised; therefore, where theories *make* a prediction, a model implies *how to get* a prediction. This being so, the following social purpose model is devised:

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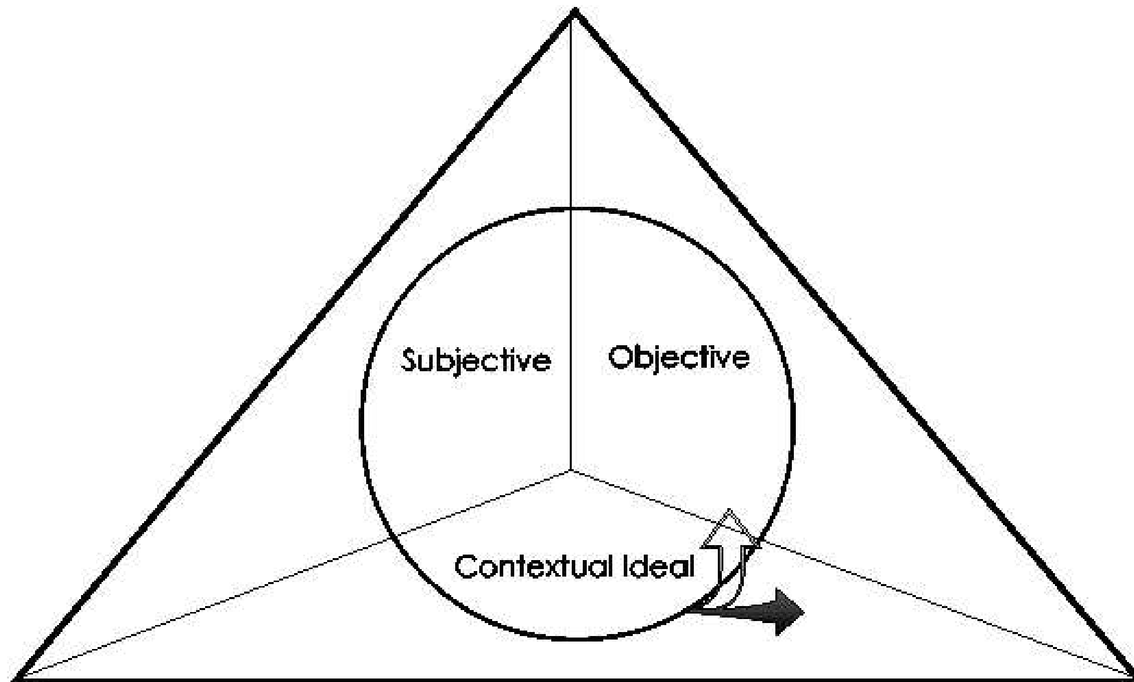

Figure 1 SOCIAL purpose model

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It is a very achievable and clear model constructed to offer the nurse a visual and practical applicatory tool. Its simpleness lies in its economy, with three planes to enable the user to reflect on the purposefulness of practice.

An explanation of the SOCIAL purpose model

The subjective quarter signifies the nurse, the objective quarter indicates theory, and the contextual ideal represents the spatial arena in which the nurse works. It must be stressed, however, that ideal is not used as a term to indicate a composite situation. Rather, it is employed to problematise the notion of context itself. For example, students complain that in the classroom ideal situations are presented as examples of nursing that do not bare any relation to the real-world they encounter once they arrive in practice. Therefore, the "contextual-ideal" addresses this to include the frequent degrees of

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working within a hectic and variable situation; to prompt safe practice against the given situation.

To use the example of the perceived theory / practice divide in nursing, the Objective is what is learnt in higher education so exemplars in the classroom are accepted. The subjective element (perhaps for the mentor or tutor in practice) is how information is interpreted in practice – tempered by the given situation and demands of the day – so although there are many things nurses would all like to do for their patient, they are de-prioritised by the needs of the collective (for example skill mix, shift patterns or staff quotas). The social purpose model can help explain why things are done some of the time but not necessarily all of the time; because of that it acknowledges that nursing practice is not consistent – it is subject to the social interplay and variables on an hour-to-hour basis. For example, the constraints of skill mix might fully enhance the management skill and approach of the most creative or most influential member of the caring collective at that time (not necessarily the most senior person present), so that the student learns different skills from the team at different times. This means that different aspects of the nursing experience emerge to be seen and named through the use of this model even though a particular scenario may not be ideal to the student. There is a daily agenda that has to be fulfilled for the work to be done, continuously influencing the timing, direction and quality of intervention in the needs of patients and their families. The two separate social arenas that nurses are placed in are delineated, on the one hand with an idealistic view of what should occur – when in the classroom – and a pragmatic view of what should happen – when at the bedside.

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In attempting to resolve problematic situations of this kind relating to ideal scenarios for the student, we cannot calculate the efficiency of different possibilities towards the derived end and this is because nursing is based on a social exchange. A hospital is a particular social reality that nurses and patients enter into; the parameters of behaviour, social cues and so on defined by the existing members of that collective. Students enter that collective as aspirant members and quickly assimilate within the social hierarchy. That process of assimilation, affiliation and acceptance leads onto role emergence and role definition that identifies nursing's progression for a purposeful future. The model recognises that as a collective, nursing has been around for a very long time (as an existing body of nurses be they conceived via traditional or 'new' perspectives) against the backdrop of patient need which has likewise always been there. However, if nursing is to reflect on its past to name its future, what reflective processes is it using? What is given scant attention by existing reflective mechanisms is the influence of social interplay on day-to-day practice. Consequently, the same scenario the student is taught in the classroom (such as temperature taking) is subject to the workload in practice of who is there at any given time and the degree of patient wellness. If the existing nursing fraternity is to identify a future for nursing, it needs to be mindful of the messy arenas in practice – sometimes overlooked by the nursing academics writing for the profession.

Even as a general range of application, the model helps us to go beyond an empirical definition of nursing role and purpose. Any government document such as the *Commission on the Future of Nursing* is an attempt to atomise nursing into a recipe of constituent parts, the sum of which will never equal the whole because the power of the working collective is not acknowledged as a force that shapes who nurses are and what

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they do. The fundamental flaw with reflective models, be it Gibbs (1988), Kolb (1984), Schon (1987), or Johns (2000) is that they are all introverted in nature and there is no explicit acknowledgement by them that social interplay is a major contributing influence on the reflective process when if you view nursing as a social enterprise, this is at the core of nursing.

The "contextual ideal" should prompt reflection so that nurses question their own expectations as well as standard practical and theoretical goals, and reflect on their practice in relation to the context in which they are placed. Contextual ideal is never limiting because if, and when, the ideal is reached reflection must be made to determine if the ideal is too low or how a better evidence-base might be achieved. In relation to the three dimensions, the subjective plane represents a creative and innovative dimension of personal inquiry. The second segment represents the nurse's personal inference with a theoretical and knowledgeable baseline, resulting in the transformation from theory to practice; and the third segment represents the generalisation and shared agreement for that practice. The model advocates a process of combination in which the nurse implements all three dimensions and works at the interface of personal, theoretical, and contextual nursing. The Social Purpose model also acts as a defence against 'one dimensionalism' (traditionally isolated professionals) so that in practice the nurse works, for most of the time, in all three dimensions with others in a social context. Otherwise, the following scenario might develop, where, if the nurse is wholly subjective, there will be less evidence-based practice and more nursing individualism. If the nurse works solely in the theoretical dimension then self-reflection might not be utilised sufficiently. If the nurse works only in the contextual ideal then the patient is

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being overlooked and the nurse becomes task orientated. If the social purpose model is accepted, an understanding takes place in which ideal practices shift with time, experience and external changes.

The most important feature of the social purpose model however, is its three sided shape to include the notion of three dimensions – that which exists in time is organised by context, and context shapes perspective. This means that all parts of the model are related to perspective; with the most important point being that subjective, objective, and contextual perspectives depend on how good the nurse's individual analysis is. Hence, structured self-examination within a shifting social milieu is a primary nursing skill that can be a shared practice in action.

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Atkins and Murphy published their work at the same time as 'New Nursing' was conceptualised in 1993. In a literature review they identified a model of the reflective process and the skills required to be an effective practitioner. The first stage of their model is an experience of discomfort or surprise, which prompts an act of reflection. The second stage is the critical analysis of the initiated feelings or knowledge about the situation. The third stage is the development of a new perspective on the situation. This process is similar to Kolb and Fry's (1975) experiential learning cycle used extensively in adult education over thirty years ago. Yet, today in many schools of nursing, students are still asked to use these dated models as frameworks for reflection. If Atkins' and Murphy's conceptual framework is outlined against the social purpose model above, the divergent ways in which the designs work can be applied to 21st Century nursing:

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Subjective → **O**bjective → **C**ontextual **I**deal

(S.O.C.I.A.L Purpose Model)

Discomfort / → Critical analysis → Development

of a

Surprise of feelings → new perspective

(Atkins & Murphy, 1993)

Atkins' and Murphy's series of relationships concentrate predominantly on individual and highly conceptual terms such as feelings, and renders problematic conceptual ideas from the outset it also creates a theory-practice divide between discomfort and critical awareness. The model presupposes a level of awareness (or unawareness) from the start or presupposes the nurse has time and the facilities to access analysis. For instance, it may well be that the nurse does not utilise an effective reflective process and so little or no surprise in an event is registered. Moreover, critical analysis is based upon feelings with no allusion to a theoretical foundation, which suggests that development of a new perspective without reference to context places too much emphasis on the nurse and fosters individualism and introspection. Whereas, it ought to be accepted that concepts are most effective when they are placed in context and measured against a theoretical rule and baseline.

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A Subjective, Objective, and Contextual Ideal becomes a **S.O.C.I.A.L** practice, offering a scale of flexibility that includes an implicit social inference. Theorists have already outlined that context is left out of discussions on isolated incidental analysis because in the social world there are hectic variables that are impossible to control. Contextual problems require solutions geared to the precise situation rather than solutions that are general and context free. Therefore, variables are easier to leave out. However, it is suggested here that there are few more hectic areas of practice than those encountered by nurses and it is impossible to envision the future of nursing without acknowledging it.

This model then acknowledges the importance of the social context in which practice and reflection is done. More importantly, as this paper shows there are frameworks of role that are defined by attributes, traits, tasks and views of nursing that have been in existence for many years, but whatever decade, patients will always need care, comfort, help with mobility, hygiene and so on – whether its rubbing goose-fat on a 19th Century school boy's chest or transfusing stem cells, the essential needs of patients never change, but the bureaucratic means by which nursing is evaluated and defined does change. The question is, how does the new achieve the positive subversion of the old? In answer, there is still a need to establish greater comprehensive models of context. Nursing today is a social practice that aims towards greater care and justice for the patient while working autonomously and inter-professionally. Yet there is still evidence that the 'caring profession' is losing some of its traditional identity and if nursing is to maintain its professional standing then traditional concepts can no longer be passed down by word of mouth, but need to be captured in the social envronment where practice in all its messy social milieu can be named.

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Conclusion

Many of us long-serving healthcare employees know that nurses can talk about the future of nursing *ad infinitum*, and in similar quantities reminiscence upon the past, but it is of little value if the profession does not strive to name its practice. How this is achieved is difficult given that nursing is so diverse but defined by bureaucratic documentation. This paper could have offered a slicker account of an envisioned hypothetical future, instead it attempts, in an admittedly limited manner, to find the means in which student nurses might be able to name their practice and draw together the classroom ideal and the real-world practice arena. Perhaps the most important conclusion to be drawn from this paper is that to extend a value structure for pragmatic purposes, value needs to be defined in relation to the social context within which it is practised. Therefore, theory and experiential evaluation inform action as a working adjunct to governmental documentation, taking it from the desktop to the bedside.

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