Change in Nursing:
The 5th International Philosophy of Nursing Conference

Hosted by The University of Leeds and Leeds Metropolitan University, September 17th-19th 2001

Conference Abstracts

'The Treachery of Post-Modernity: Into the Nihilistic Void' <u>or</u> 'The Zen of Bedmaking'.

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Having presented a brief exposé of some of the key ideas which are often referred to as 'post-modern' in approach, the presenter suggests that although some value may be gained from an appreciation of these notions, on deeper analysis there is little which may be described as truly 'constructive' thinking. The whole notion of post-modernity, it is argued, is treacherous, in that it leads the reader into a 'nihilistic void' from which it suggest few means of escape. It is destructive and reactionary, rather than constructive and progressive.

If this thesis is correct, the presenter argues that this has major implications for the status of nursing knowledge, which it is argued, has claimed some legitimacy through borrowing from post-modern narratives and themes.

Instead of continually emphasising the subjectivism which makes up much of the nurse's universe, nursing scholars could find new and constructive ways to discuss the activity of nursing which transcends the subject/object dichotomy. This requirement is made all the more urgent at a time when the evidence-based practice movement threatens to undermine much of the intrinsic value of nursing in the name of performitivity!

A distinctive, yet unhelpful moralism has grown up to further strengthen a working culture that values the objectification, and subsequent manipulation of clinical variables. Arguments about the usefulness of hard and soft data have their origins more in the political realm than in that of the philosophy of science or epistemology.

<u>If nursing practice is to be progressive rather than merely reactionary, territorial or defensive, it must indeed ask questions about its 'identity' (group consciousness) as a social construct, but it also needs to examine its 'ontology' at the level of transpersonal caring/healing. By moving beyond the insecurity which stems from a failure to reconcile 'it'</u>

(objectivism) with 'I' (subjectivism) the activity of nursing can be revealed in all its 'impotent' glory. To emancipate itself from a dominant power, nursing must not only point to the pragmatic and philosophical limitations of that power's dominant paradigm, it must also suggest an alternative which is preferential to it.

Most importantly I ask whether we need to transcend our limiting concerns with the rational mind in order to reframe our practice within a new (yet ancient) 'grand narrative': a 'Zen of caring'? The work of Jean Watson is considered in this light.

What do parents value?
A qualitative study of parents' participation in life-and-death decisions concerning their premature children

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The aim of this paper is to generate knowledge about parents' participation in life-and-death decisions concerning their very premature and/or critically ill infants in hospital neonatal units. It asks what are parents' attitudes towards their involvement in such decision-making? This project is the third phase of a larger study entitled "Ethical decisions in neonatal units, in whose best interest?" The focus of the first phase was on how nurses and physicians experience these difficult ethical decisions. The second phase of the study focused on how parents, having been part of such ethical decision-making, experience life with a severely disabled child.

A descriptive study design was chosen using in-depth interviews. During 1997/2000, 20 qualitative interviews with 35 parents of 26 children were carried out. 10 of the infants died 16 were alive at the time of the interview. The qualitative, comparative method (Grounded theory) has been used in the analysis of the data. The analysis was carried out continuously and in parallel with data collection

The findings seem to indicate that parents agree that parents should not have the final word in decisions concerning their infants' future life or death. Such a responsibility would put too heavy burden on parents who lack the medical knowledge and the professional experience needed to make such a decision, and would be likely to lead to their experiencing strong feelings of guilt. However, it may be argued that parents should be well informed and listened to during the whole decision-making process. The parents' primary concern was how nurses and physicians communicate with parents who are experiencing a

crisis, and how this serious information is presented. In this paper these findings will be discussed against previous research and the ethics of the Danish theologian and philosopher K.E. Løgstrup.

Key Words ethics, life-and death decisions,Løgstrup, parents, premature infants, neonatal medicine

Problematising representational and presentational modalities in the discourse of nursing.

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It is becoming increasingly difficult within present healthcare paradigms, to combine the best of health science scholarship with the realities of nursing practice. While health science scholarship provides direction and insight into healthcare and patient situations at a theoretical level, these theoretical principles are often difficult to implement in clinical settings that tend to be organized in contexts of abstractive, and increasingly economic, health science models of care.

To problematise this a bit, models and theories that aim to represent practice inevitably negate practice. Representational forms that pre-select a framework to stand for nursing, often misrepresent, misunderstand the actual practices of nursing. Even theoretical knowledge that is generated by qualitative methodologies often fails to present the experiences of patients as they occur in life or the subtle but complex practices required of nurse professionals.

Citing the findings from my hermeneutic-phenomenological study, *Nursing and its Practices*, I will problematise how the knowledge base of nursing expresses an ongoing tension between representational and presentational forms. I will aim to show that the more the knowledge base tips towards representational forms, the more it tends to lose contact with what is present in lived practice. I will suggest that the representational forms, in which nursing knowledge is cast, resemble envelopes - theory, research, and models of practice are the envelopes that contain the literate traditions that make up theoretical nursing. The problem is that some envelopes are nearly empty and others contain little of the lived meaning that still relates to the experiential reality of the recipients of the envelopes. There is little osmosis/diffusion among them. With the content of the paper I hope to contribute to a better balance between the intellectualised forms of knowledge and the forms of knowledge that may lie more at the very heart of nursing as expressed in its practices.

Advocacy and moral sensing

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The moral metaphor of advocacy is frequently used in the discussion of the development of nurses' professional practice. Patient advocacy is a corner stone in ANA and UKCC code of ethics. The literature however, illustrates a variety of interpretations. Advocacy is there described as acts of pleading or arguing in favour of patients' rights, a cause or a professional value. Advocacy as a good professional practice means proper function of the nurse. Advocacy as a professionalisation strategy promotes the profession's best interests and status. Advocacy has also been used as a metaphor for conflict between nurses and physicians in connection to mal-practice and whistleblowing. Conceptual clarity about of how nurses view their advocacy role and the circumstances under which they exercise the role is important to avoid confusion surrounding the many models of advocacy. This paper concentrates on advocacy in relation to the unique nature of the nurse/patient relationship. In close relationships it is a matter of personal attitudes, values and degree and not of fiduciary principle which contain many difficulties. Emphasis on nurse characteristic seems therefore to be central such as nurses' personal virtues or skills to be able to advocate in patients' best interests and not the professions'.

"ALL CHANGE!":
NURSING IN THE CLOUDS OF THE KNOWLEDGE ECONOMY

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"Knowledge and information today is being produced
like cars and steel were produced a hundred years ago."

This paper explores the increasingly complex relation between nursing, discourse and society with specific regard to changes in the treatment of knowledge and what is now commonly referred to as the knowledge economy. The paper begins with an overview of the main elements of a knowledge economy, including the changing culture of knowledge and its concomitant emergence in the discourse of nursing policy directives. It is argued that nursing education and practice is now permeated with various strands of this discourse, yet, to date, with little critical analysis of its values or indeed its ultimate purpose. To inform the analysis form a philosophical perspective, the paper introduces Michel Foucault's concept of ethics as a relationship that one has with one's self (*rapport a soi*). In filtering the implications of a knowledge economy through Foucault's notion of *rapport a soi*, I develop the idea that nurses and nurse educators are now being asked to carry out a work on themselves that is presented as a moral code. Two questions are asked. First: in the changing context of a knowledge economy, what does it mean to carry out a work on one's self? Second: what are the potential relations between such a work and concomitant changes in our professional identity and subjectivity?

Nursing- what becomes integral to the whole?

Sarah Fogarty

In this paper I am proposing examining the current changes in the whole Health Care Systems in the UK, which in turn affect the contextual environment for Nursing linking this to the development of the clinical governance strategy that is underpinning the changes. I propose that this term is more than words but develops historical philosophies merging with current thinking to synthesis a pathway through to enhancing the value of nursing and care that can be dynamic, fluid and responsive to the needs of people in society.

The evolving process of designing services with the patient/client as the focus, concentrates people to examine their practice in a reflective manner: this development needs to be encouraged, space and time devoted to creating responsive thought and action, as this is an opportunity to develop people. I would like to examine further the links between Heidegger's position on 'being' and Levinas stance on care.

The developments in the UK health system I believe could offer potential for developing 'humanness' in caring if the perspectives on caring at all levels are listened too in an open and responsive manner. The integration of nursing and the wider aspects of clinical governance, I believe can produce a positive paradigm shift towards holistic care.

Sarah Fogarty
April 2001

***Development of a problem based learning approach to the teaching of
ethics with pre-qualification nursing students.***

Change is the only true constant.

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The development of, and our growing dependence upon, medical technology in
the last handful of decades has increasingly set us apart from nature and has
forced us to re-examine the concepts of 'health' and 'illness' upon which the
provision of healthcare is traditionally based. Changes in the nursing and
medical professions, the redefinition of the role of practitioners, and the
development of a 'consumer' culture within the NHS have, at the same time,
greatly increased client expectations of care.

When we consider these changes within the context of ever decreasing
healthcare resources it seems inevitable that situations in which moral decisions,
dilemmas or conflicts challenge healthcare providers will become increasingly
complex.

While it has long been recognised that, in order to provide nursing students with
the 'conceptual equipment' (Edwards, 1996) required to deal with the complex
moral situations they will encounter in healthcare settings, we must develop their
knowledge of moral philosophy and develop their ethical decision making skills.
The increased complexity of these situations demands that we reconsider and
restructure our approach to teaching ethics to pre-qualification students.

This paper deals with the development of a comprehensive programme of ethics
founded upon problem based learning at The Robert Gordon University in
Aberdeen designed to develop students moral decision making skills, their ability
to identify morally significant elements in complex ethical situations and facilitate
their moral development and qualification as ethically aware practitioners.

Edwards, S. (1996) Nursing Ethics: a principle-based approach. London:
Macmillian

"THE CHICKEN, THE EGG AND THE PARROT", a story otherwise known as

DO YOU NEED A DEGREE TO GIVE A BEDPAN?
(with apologies to Jane Salvage)

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As long ago as 1991, Christine Hancock, the then general secretary of the Royal College of Nursing warned delegates that:

"If qualified nurses are content to delegate the *heart* of their role to others, (my italics) they should not be surprised if they are supplanted in the workforce"

(Hancock 1991)

As a registered general nurse by background and senior university lecturer by profession, I am interested in an apparent perception by *some* pre-registration nursing diploma and degree students in relation to the delivery of *essential* nursing skills (formally known as *basic* and sometimes identified as *menial*).This is that while so-called technical nursing skills eg drug administration or catheterisation for example, require delivery by expert, skilled professional practitioners, that the essential skills of maintaining hygiene or perhaps pressure sore prevention, may appropriately be performed by individuals *not* academically educated to the same level.

A first issue for discussion might be how far conference delegates are in agreement with this original idea as expressed by Salvage (2001)

Secondly, given that our current pre-registration student nurses and post-registration staff are the future change agents of professional practice, how realistic is it, in the current political and economic climate for nursing, to expose them to a value system, or philosophy which might drive forward this concept that the sum totality of nursing care, practices and procedures would be delivered by expert, skilled professional practitioners?
An opposing view might see it as a recipe for discouragement and/or demoralisation in the context of the contemporary reality of British health care. This is arguably a most unwanted outcome, given the current drain of qualified British nurses from the workforce (Rcn Congress 2001) with all its attendant consequences.

A third issue then for nurses educators, would be the question of what stage in the curriculum is it most useful to introduce issues of power relationships in the health care professions and society.

Many students entering the profession both at degree and diploma level are understandably at a beginning stage of requirement to learn the "tools of the trade". They may consequently be either unable or unwilling to consider the broader picture.

A consequent issue for nurse teachers is that by the time students are sufficiently skilled enough to be inclined to consider it, then *socialisation* into the so-called "real world" of nursing may have submerged or suffocated any feeling or motivation to develop a philosophical ideal for practice

Which comes first then, the chicken or the egg? And how does the parrot fit in?

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The spirit, the body and nursing: *feminist explorations of the concept of spirit in current nursing research advocating that nurses should give specific spiritual care*

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A growing body of nursing literature recommends that nurses are taught to practise not only physical, socio-cultural and religious care, but also specific spiritual care. Although a definition of spirit remains unclear, it is generally agreed to be that which gives individuals meaning, purpose and fulfilment and which transcends physical, psychological and cultural experiences of bodily life (Ross, 1997). Wider literature demonstrates, however, that individual meaning is embodied in the material body through the senses (Jackson 1995; Greenfield 2000). This raises questions about whether the spirit is different from, or integral with, other bodily experiences. Concept analysis of spirit in nursing literature similarly suggests lack of clarity about separate existence of 'spirit' (Golberg 1997)

If nurses are to practise spiritual care, this arguably presents a major change to traditional nursing which focuses on caring for the physical, emotional and social needs of people. It seems that the literature suggesting that nurses should give specific spiritual care to enable people to have meaning may be a problem of a body/spirit split. In this paper therefore a key theme of spirituality as oppressive of the physical body, woman and nursing is explored from the perspective of feminist philosophical theology (Hampson 1996).

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Thinking about Change.

Beginning by offering a conceptual analysis of change - a statement of what change of any kind is - the paper sets out to examine possible ways of understanding a very common and important variety of change that may be called 'evolutionary'. These changes include anything from the production of a clay pot on a potter's wheel to the emergence of a system of management, or from the effects of an analgesic drug to the development of a new programme of care. As few philosophers have discussed such topics, theories are borrowed from the philosophy of science which attempt to explain the development and rationality of science. The ideas of Karl Popper and Thomas Kuhn are discussed and criticised, before turning to evolutionary theories: Darwinian and Lamarckian. The paper ends by offering a model which, it is hoped, may help in thinking about a wide range of changes.

Attraction, satiation and fatigue: collected views on paradigms

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This workshop offers the opportunity to examine and discuss the responses to an Internet survey inquiring into the influence that the acceptance (or indeed rejection) of a particular paradigm or set of paradigms has on the work of individuals. The meaning of 'paradigm' in nursing seems related to, but not wholly derived from, the ideas proposed by Thomas Kuhn (1962 & 1970) in 'The Structure of Scientific Revolutions'. While the usage of the term in a nursing context often seems to convey 'the intellectual standards and practices of a scientific community' and 'shared metaphysical and philosophical assumptions' (Williams and May 1996), the central idea of a single dominant paradigm as the hallmark of a mature science clearly does not resonate with the multi-paradigm environment of present-day nursing.

It must be admitted that the notion of 'paradigm' lacks clarity. Margaret Masterman (1970) found that Kuhn was working with 21 senses of 'paradigm', and reduced these to three groups: metaphysical, sociological, and construct paradigms. Kuhn himself attempted to draw attention to the potential for ambiguity, distinguishing between 'the entire constellation of beliefs, values, techniques, and so on shared by the members of a given community and 'one sort of element in that constellation, the concrete puzzle-solutions which, employed as models or examples, can replace explicit rules as a basis for the solution of the remaining puzzles of normal science' (1970 p. 175). In a nursing context, 'paradigms' can be taken to refer to philosophies, conceptual models or theories of nursing (Alligood and Choi 1998 pp. 56-7). For this reason, no definition of paradigm was offered to respondents in the Internet survey, and it would seem appropriate to use the opportunity to investigate the range of meanings that are in current use.

Respondents have been sought from the Jiscmail discussion list 'nurse-philosophy' as well as from delegates at the conference. The questionnaire is software-based to offer ease of completion and enable rapid collation of the data. The software provides intuitive visual display of the results of the questionnaire and 'live' analysis during the workshop is possible using a variety of ways of grouping the data. It is hoped that a range of views will emerge, and since participants at the workshop will have had the opportunity to contribute to the outcome of the exercise, a lively and insightful discussion should ensue.

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Towards An Educational Philosophy

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Towards An Educational Philosophy: creating a mutually supportive and respectful climate between midwives, midwifery lecturers and student midwives.

The move of midwifery education into universities has resulted in students working in separate sites of education and practice, which prioritise differing values and philosophies. This separation has tended to have a polarising effect upon the values and commitments of teachers and clinicians involved in education. It has also created complex issues for student socialisation. There is clearly a need to forge a common educational philosophy based upon but not bounded by the realities of clinical practice.

A recent major reorganisation in the provision of maternity unit facilities in Sheffield has created an opportunity for four midwifery lecturers, linked to the clinical area, to re-establish, and re-create some of the traditional ways in which our educational obligations to both students and clinicians are met. The four lecturers are working for half a day per week as midwives, so that through shared clinical endeavours, bridges can be built and a common educational philosophy emerge.

Each lecturer is linked to a designated team, providing continuity for the clinicians. The students allocated to each team become the personal students of the link lecturer, remaining with that team throughout their programme. This eases channels of communication supporting the link between education and practice, and facilitating ongoing learning.

Contradiction, 'the dynamo of change'

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This paper explores aspects of contradiction as the 'dynamo of change' from the critical realist perspective of Roy Bhasker. Initially the paper acknowledges the problem that the concept of contradiction poses for nursing as a personal, social and professional activity before exploring forms of contradiction and the limits of its powers. The main section outlines seven common philosophic errors that may be held with regard to the concept of contradiction and these are then used as the bases to argue for a critical realist perspective on dialectic. The critical realist holds that dialectic, or conflicts in communication, can be viewed as the logical key to change. That conflict prefigures change. From this it is argued that dialectic is actively employed as a means to remove contradictions, and so constraints to human flourishing, with the goal of universal human freedom. In conclusion, the critical realist stance is linked to nursing and found to be congruent with its broad means and ends in that it could be said that the nurse aims to relieve patient distress in order that they may flourish. In this sense then contradiction could be argued to be the key to effective caring.

Benner's remnants
Culture, tradition and everyday understanding

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In commenting on a study of people with asthma, conducted by herself and three colleagues (Benner *et al*., 1994), Professor Benner has made the following observation:

> "The intent and outcome of the chapter, based on the study, is not to provide a faithful rendering of either Descartes' or Kant's philosophy. Instead, the participants' interviews point to remnants of these thinkers' influence in everyday understandings about responsibility and control related to chronic illness…" *(Benner, 2000, p. 1300)*

This paper will discuss the idea that 'remnants' of Cartesian and Kantian thinking somehow find their way into the 'everyday understandings' of Californians with asthma. It is by no means obvious, of course, how this is supposed to happen – how the concept of autonomy, for example, manages to get from the *Critique of Practical Reason* into the head of a person with chronic illness in San Francisco. Certainly, Professor Benner offers us no clues as to what sort of mechanism is involved; and, to that extent, the claim that 'remnants' of Kant's thinking exert this kind of influence is highly speculative. In the absence of a convincing narrative - showing how such remnants shape the experience of people who may not have even heard of Kant, and who are likely to be less than familiar with his metaphysical and ethical writings - it is best to remain sceptical.

It is clear, however, that this picture of 'thinking remnants' seeping down into the everyday understandings of asthmatics is based on Professor Benner's quasi-Heideggerian ontology. In particular, it presupposes the view that everyday understandings are 'made available' by a particular culture to which the person concerned belongs, and that this culture is the medium (like an ether) through which features of a specific tradition are 'inherited'.

I will argue that this view is incoherent. There is, in this sense, no such thing as a culture. Indeed, there is nothing at all that can do the work which Professor Benner would like 'culture' to do (and Heidegger not only refuses to adopt the concept himself, he explicitly warns against it). Consequently, it is a mistake to suppose that everyday understandings can be 'inherited' from a tradition, or that

features of that tradition can be 'read off' from the interview transcripts of people who are unfamiliar with it.

This conclusion has certain implications for research practice in nursing, and these will be briefly reviewed.

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Re-Imagining a Moral Climate for Nursing Practice

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Challenges to nurses' ability to practice according to the ethical standards of their profession are not a new phenomenon. However, over the past decade the challenges for nurses practicing in Western industrialized countries have been escalated by a burgeoning biotechnology, a socio-culturally diverse population, shifting political ideologies, and widespread cost constraint. Thus, a growing body of international research is warning that nurses have become increasingly constrained in the enactment of their moral agency because of situational constraints in the sociopolitical context of their work. And a newly emerging body of international research is linking the deteriorating quality of nurses' work environments to adverse outcomes for clients.

In this paper, the author will draw on the results of a recent Canadian multi-site qualitative research study describing nurses' experiences of their ethical practice. The author will argue that the quality of nurses' work environments is affected by the moral climate of those environments, not just structural and human resources. Secondly, she will argue that we need to re-imagine a moral climate for nursing practice. On the basis of the research results, the author will suggest that re-imagining a moral climate for nursing practice requires that we attend to the meaning that nurses find in their day to day practice worlds. And it requires that we find strategies to foster nurses' active participation in making decisions about their conditions of work.

Discipline, Punishment and the Construction of Competence in Nursing

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Ensuring practitioner competence in a time of dramatic change is one of the major challenges facing the nursing profession today. There is little question that this is indeed a laudable goal and literature is replete with descriptions of various means to attain this end. Yet only rarely have the philosophical assumptions underlying the notion of competence, and its ongoing maintenance, been examined. What are the social, economic, and political conditions that lend credence to this notion and function to sustain it?

In this paper, the notion of competence in nursing will be examined in light of the work of Foucault and his thoughts related to discipline and punishment. Whereas discipline and punishment are for the most part viewed as negative, it will be argued that these forces are inherent in, and essential to, sustaining current constructions of competence in nursing at the level of the individual nurse as well as within the profession.

The Impact of the Internet on the relationship between the health practitioner and the patient.

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The Internet is a powerful agent for change and one that could prove invaluable in health care. In today's rapidly changing world of new and emerging technologies, delivering global communication and e-commerce to an ever increasing number of people in our society, the Internet is increasingly playing a major role in the patient and health practitioner relationship. The Internet is rapidly becoming a third party between the health practitioner and the patient. The World Wide Web, E-mail and Discussion groups have dramatically increased the quantity of medical and health information available to patients, who in turn vary greatly in their understanding of that newly discovered information.

The Internet seems attractive to patients requiring information because it is so accessible and user friendly. To patients the Internet speeds up the flow of information and answers questions they feel are not answered by the health practitioner. The Internet allows patients to have access to information, which they would not always receive from the health practitioner. Due to the tremendous amounts of information available over the Internet patients feel that they know more about their illness. Due to the Internet the relationship between the patient and health practitioner has inevitably changed, as more and more patients use the Internet to gain a greater understanding of their illness.

As the Internet is international and individual users (recipients or providers) can not be traced, reliability of the information available over the Internet is questionable. Also opinions offered, claims made or material supplied over the Internet all pose ethical and epistemological questions. In this paper I will deal with two key issues--the impact on the epistemological relationship between the clinician and the patient and the implications of the variation in the quality of information on the ethics of informed decision making.

The More Things Change ….

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Change is part of the (post)modern condition. Three aspects distinguish the modern experience of change: i) the accelerating pace; ii) the increasing volume; and iii) the blurring of boundaries between changes. By comparison previous decades appear as periods of relative stability

Nursing conceived as a social practice has a tradition of adaptation and survival in the face of change. Indeed, even during those periods generally considered to be without change this tradition can be identified.

It is posited that two virtues are necessary if nurses are to continue to deal with change: the virtue of adaptability and the virtue of open-mindedness. These two virtues are identified within the nursing traditions and it is argued that nursing has been most successful where these virtues have been demonstrated in the right measure.

The two virtues are set to become increasingly important if, as seems likely, the tendencies of the modern experience of change continue unabated. This paper will set out to consider the nature of these two virtues and to make some tentative suggestions about their relative importance in the history of change in nursing.

Johns' Structured Model of Reflection as a Basis for Change - Some Philosophical Observations

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The Reflective Practice movement is influential in the UK, with a growing literature that includes accounts of the incorporation of reflection into pre- and post-registration curricula. The objective of the reflective process is learning about oneself and one's practice, so that practice may become more effective. That is to say, reflection is intended to lead to change.

Chris Johns has been an influential author in the UK literature. Johns has published widely, is frequently quoted, and has for some years organised a conference on the subject. Johns' Model of Structured Reflection (currently in its 10th version) has been widely adopted by educationalists, practitioners and students as the basis for reflective analysis of critical incidents and thus as an instrument through which to change practice. By Johns' account, reflection should lead to a process of personal deconstruction and reconstruction, as a result of which one may become a certain (different) sort of person.

This paper will offer a critique of the theoretical basis of Johns' Model of Structured Reflection and will indicate certain difficulties and inconsistencies within the model. It will be suggested that, while Johns' model may be a pragmatically useful tool, it lacks theoretical and philosophical rigour and coherence.

'Being critical' as a philosophical aproach to managing change in clinical practice – a return to Benner

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Currently, nurse practitioners in all fields of professional clinical practice are being urged to reinforce a critical attitude to their work in the light of change and increasing professional accountability. Underpinning this is the assumption that practitioners are cognisant of the nature of critical thinking in practice. However, some important questions need to be asked. What does 'being critical' mean? Why is it important for clinical practice? What strategies are available for achieving it? This paper will explore Benner's (1999) notion that 'being critical' is about a 'thinking–in-action' and 'reasoning-in-transition' approach to managing change in clinical practice.

Benner (1999) believes that 'thinking' conveys the innotiative and productive nature of the clinician's active thinking in ongoing situations. But how can this be achieved? Benner (1999) points to the use of clinical narrative reflection as a means of developing critical thinking skills and expert clinical judgement. Narratives can demonstrate the ways in which ethical, clinical, and scientific reasoning are linked in practice. At the same time, they open up the possibility of demonstrating clinical inquiry in practice and importantly, provide the basis for managing, and effecting change.

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                    Milton Keynes Open University

Contemporary inquiry into nursing theory echo's historical debates

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Questions of stability and change are some of the oldest questions in philosophy. Plato's considerations led him to introduce the unchanging perfections, Ideals, in which changeable being participates. Knowledge of these Ideals was accessible only through the intellect withdrawing from the world of images "sights and sounds" into the verbal world of thought. Aristotle rejected this postulation of perfections because it requires that terms like The Good have univocal meaning arguing instead that there are stable universals present in all things of the same kind. These universals are forms that can be grasped by the intellect transcending sensible particulars in its abstraction of concepts. These concepts are the building blocks of knowledge and language. The 12th Century denial of the existence of extramental universals gave rise to Nominalism, which holds that the world is composed of unique particulars. The human intellect collects and names particulars that appear to us to be similar. In this way humans participate in the creation of order in their world. What is known is from experience as organized and universalized by the intellect. This lecture will turn from a discussion of these historical origins of idealism, realism and nominalism to current efforts to understand theory and knowledge development in Nursing.

A New Human Life: An Aristotelian discussion of Substantial Change

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An explanation of change was one of the ancient philosophical quests. This lecture will provide an Aristotelian explanation of change including changes in quality (alteration), quantity (augmentation and diminishment), local motion, and coming into and going out of existence (substantial change). Changes in health would be alteration. Significantly, an understanding of natural substance and substantial change would argue that a new life is present when there is an internal principle of activity and rest. Contemporary science tells us that maternal mRNA controls early nuclear development and cleavage of the zygote. Following two cleavages, at the four-cell stage, the chromosomal DNA (human embryonic genome) becomes activated in one of the daughter cells. This cell forms the inner cell mass from which the body of the fetus is formed. After genome activation, 52 hours after the sperm contacts the ovum, the mRNA dissolves leaving the nuclear DNA in control of all subsequent development. This, then, would be the moment when a new human life begins. Subsequent grown and development reflects changes in quantity and quality but there is no difference in kind.

Perception and imagination in generating change through reflective practice.

Brandon Williams and Liz Walker

University of Central Lancashire

This paper describes the process of facilitating groups of registered nurses to generate change in themselves and their practice through guided reflection. The concept of perception is explored in respect of individual interpretations of personal experiences where perception becomes reality for that individual. Such perception is subject to bias and without supported guidance in the reflective process inappropriate conclusions are easily generated. Through facilitating group deconstruction of the perceived experience the individual is able to identify the elements of bias emerging and subsequently reaches valid conclusions by reconstructing the experience with reduced elements of subjectivity which are more appropriate to personal and practice development.

Within the reconstruction process, imagination is stimulated by steering individuals within the group towards visualising outcomes of planned actions. Use of imagination allows internal acting out of events and the identification of consequences of following a particular course of action. This process enables generation of appropriate change to take place through development of insight and deeper awareness of influences on personal change. Through appropriate change in personal approaches the ensuing changes generated in practice will take place through considered strategies, which will enhance nursing and care provision.

Pieces of Time

Valerie Young

University of Luton

This presentation explores my interpretation of a narrative study of sixteen qualified nurses working in different National Health Service Trusts in the Home Counties of England. My intention was to gather descriptions and analyses of how nurses negotiate inter-professional relationships in managing critical incidents at work. The qualitative approach used in the interviews was that of phenomenological – hermeneutics influenced by Ricoeur (1976, 1984). The themes or narrative strands that underpinned analysis and interpretation were those of Time and artistry.

Time and its significance to caring and nurses' availability to care was the core theme or narrative thread that was woven through all narratives. Nurses concerns were analysed to reveal the complexities of an ethic of care. Narrative problems and dilemmas around time enhanced or inhibited care. These involved: time dissonance/harmony; life lime/career time; time as arbitrator; time as mender, healer, creator; time past, making memories, remembering mis-remembering and imagining.

Though the metaphor of craft emerged during the research process the final metaphor 'patchwork quilt' both describes nurses' lifeworlds and is created from the actual words of the co-participants. Their words which included 'intricate motif', 'mending', 'unravelling', 'framing', 'admired their handiwork', 'pattern', 'thread', 'creative' contributed subtle nuances at the level of interpretation carrying the project beyond the confines of these stories.