A Dialogue on the Future of Nursing Practice

Mary Ann Lavin, ScD, RN, APRN-BC, FAAN, Geralyn A. Meyer, PhD, RN, and Peggy Ellis, PhD, RN, APRN-BC

PURPOSE. *The challenges of health care; its safety, effectiveness, and efficiency; the quality of care; and the outcomes patients experience are issues central to nursing practice. This centrality needs to be affirmed as the profession shapes its practice over the next 50 years. The purpose of this article is to initiate a dialogue on the future of nursing practice.*

METHODS. *The methods used are observation, reflection, dialogue, and proposed actions.*

FINDINGS. *The results of this process are preliminary. They suggest that the establishment of nursing hospitals is a distinct possibility.*

CONCLUSIONS. *This article concludes with a series of arguments for and against this position along with an invitation for your participation in this dialogue.*

NURSING IMPLICATIONS. *The major implications of this article are not "nursing" implications per se but client and patient implications and the future contribution of nursing to improved health and patient care.*

Search terms: *Actions and future, classification, dialogue, health problems, life processes, NANDA, nursing diagnosis, nursing hospitals, nursing practice, observation, reflection*

Mary Ann Lavin, ScD, RN, APRN-BC, FAAN, Geralyn A. Meyer, PhD, RN, and Peggy Ellis, PhD, RN, APRN-BC, are Associate Professors, Saint Louis University School of Nursing, St. Louis, MO.

> As leaders confront the issues and impending problems of today and the future, their number and complexity may overwhelm some. The individuals and organizations that will energize themselves and others to meet the challenges of health care are those who maintain quality patient care as their central priority, have a bias for action, and collaborate with other stakeholders.
>
> —K. Sanford, 2007

Introduction

There are a number of articles that have focused on nursing's agenda for the future (American Nurses Association, 2002; Henriksen, Williams, Page, & Worral, 2003; Kany, 2004), nursing education in the future (Bevill, Cleary, Lacey, & Nooney, 2007; Connors, Warren, & Weaver, 2007; Jenkins & Calzone, 2007; Livsey, Campbell, & Green, 2007), and nursing leadership in the future (Sanford, 2007; Yoder-Wise, 2007). This article focuses on the future of nursing practice.

There is no monolithic structure to dictate what nursing practice will look like in 50 years. There is a methodology, however, that invites professionals to engage in a reasoned dialogue, after reflecting on observations of current nursing practice. If the dialogue is productive, action will follow.

In retrospect, this was the method used in creating the first taxonomy of nursing diagnoses in St. Louis in 1973 (Gebbie & Lavin, 1975). It was observed that nurses were making sophisticated diagnoses, even if they did not articulate them. The First Conference provided a means of articulating and classifying them and of creating an organizational structure to move the classification forward. While the starting point for the First Conference was the observation that

nurses diagnose, the starting point for this article is the observation that nurses are indispensable providers of safe, effective, and efficient health and hospital care. The purposes of this article are to (a) reflect and dialogue on that observation, (b) articulate its implications, (c) suggest ways of strengthening the platforms that support the advancement of practice, and (d) invite others to participate in the dialogue, creating a professional ambience in which the dialogue is expanded and the proposed actions move forward.

Methods

The methods employed in this paper are inductive. This means that the dialogue is based on a bottom-up or grassroots approach in which all voices were reported. The tools used are: observation of practice, reflection, dialogue, and proposed actions.

Observation is the first tool. Each of us is capable of observing practice. For example, we observe that nurses conduct surveillance. Nurses make assessments. Nurses arrive at diagnoses. Nurses, with patients, identify goals and develop treatment plans to achieve those goals. Nurses evaluate outcomes. Nurses practice in all care settings with clients across the entire lifespan. Nurses are the only professionals who care for hospitalized clients for the entire 24 hr of a day. Nurses practice at basic and advanced levels. Observations such as these form the basis for reflection.

Reflection is a process by which the human person discovers meaning. If we are reflecting on life, then we are attempting to understand or discover its meaning. Frankel reflected on search for meaning itself, drawing on the observations he made in his own life (2000). Tolstoy (2004) reflected on the meaning of death, based on the observations made by the fictional character Ivan Illych. Ivan Illich (1976), a philosopher (and not the character in a Tolstoy novel), reflected on the meaning of medicine, based on his own observations of and the experiences of others with regard to how it is often practiced. In this article, the authors reflect on the meaning of nursing practice as observed today and use the reflections to engage in dialogue.

Dialogue involves interpreting meaning. Meaning is multifaceted. There is no one meaning that encompasses all other meanings. Meaning is often more complex than an either/or proposition or dialectically opposed positions, although positing a thesis and an antithesis, if not stalled in the process, is likely to lead to a synthesis of thought. As a method of intellectual reasoning, dialogue is intended to uncover various aspects or representations of truth and multiple pathways to truth, leading to "ah-ha" experiences. In developing this dialogue, the authors conversed among themselves after the primary author provided her observations and reflections. The assumptions that undergirded their dialogue were:

1. Contributions to dialogue flow from reasoned reflections on the observations of current nursing practice.
2. Dialogue is not a debate but a conversation.
3. Different perspectives are encouraged.
4. Even diametrically opposed views contribute depth to dialogue.
5. No one nurse or group of nurses possesses the entire truth about nursing practice, its meaning, or its future.
6. Expect that dialogue will open your mind to new perspectives.
7. Dialogue is a fluid, dynamic process and not a rigid one.
8. Prejudgment or hasty judgment short-circuits the insights attained by an open mind.

Dialogue leads to action. Dialogue about the future of nursing practice leads to actions that assume an expanding scope of professional nursing practice. "Scope of practice" refers to practice boundaries. Technology and advances in education expand practice boundaries. The scope of nursing practice certainly changed in the last 50 years and will continue to change over the next 50 years.

Results

The results do *not* represent a prediction of the future. The results do represent the results of observations, reflections on those observations, a dialogue, and proposed actions that address what the nursing profession is capable of creating in the next 50 years, given the need for improved patient safety and healthcare system effectiveness and efficiency, current nursing competencies, and levels of nursing practice. The results are presented in two main formats. Table 1 presents results categorized as: observations, reflections, dialogue, and proposed actions. A text format is used to describe currently available platforms that require strengthening to support the actions proposed. Platforms are supporting structures. If there are to be nursing hospitals, then platforms need to be in place to support such structures. Examples of these platforms follow.

Post-DNP Clinical Nursing Specialties and Subspecialties

Examples of specialty practice in nursing include wound care, pain management, therapeutic management, risk reduction, injury prevention, and self-care. It is difficult to conceive of a nursing hospital without these specialties in place. While the concepts are basic to nursing practice at all educational levels, in a manner analogous to the way in which respiratory or cardiology content is basic to all nursing practice, the depth of knowledge and skill required to be called a "specialist" in these fields requires post-DNP preparation.

Nursing Economics, Departments or Centers of Nursing Economics, and Nursing Economics Consulting Firms

Contexts for the study of the economic influence of nursing diagnoses on patient outcomes are several (Lavin et al., 2004). Within the clinical context, the assumption is that correctly diagnosing the client and selecting safe and effective interventions help achieve desired patient care outcomes. The measurement of nursing-sensitive patient outcomes is of importance not only clinically but also economically. Complications cost money; complications averted save money. The extent to which nurses are averting complications represents one set of economically important variables.

The ability to diagnose and treat adequately is also influenced by working conditions and related variables. In one study, comprehensively defined working conditions of nurses were inversely related to infection rates: the better the working condition, the lower the infection rates (Stone et al., 2007). These finding have economic implications and such studies are indispensable to the advance of nursing practice. Yet, the authors conclude that nursing trails behind other health professionals in the economic analysis of practice (Stone, Bakken, Curran, & Walker, 2002; Stone, Curran, & Bakken, 2002). Steps forward include the formation of departments or centers of nursing and health economics and the establishment of nursing economics consulting firms.

Nursing Epidemiology

Nursing epidemiology is the study of the distribution and determinants of responses to health problems/life processes and the application of this study to their control. This definition is an adaptation of and consistent with Last's (2001) definition of epidemiology, which is the study of "the distribution and determinants of health-related states or events in specific populations, and the application of this study to the control of health problems."

Today, nursing is experiencing a resurgence of interest in epidemiology as a tool of nursing science and practice. On the one hand, this resurgence is long overdue, given the example set by Florence Nightingale. On the other hand, it is most timely, given the potential for the profession to establish nursing

Table 1. Observations, Reflections, Dialogue, and Proposed Actions Regarding the Formation of Nursing Hospitals

Observations	Advanced practice nurses are currently providing high-quality patient care within hospital and primary care settings (Cowan et al., 2006; Larrabee, Ferri, & Haring, 1997; Mundinger et al., 2000; Nash, Zachariah, Nitschmann, & Psencik, 2007; Rideout, 2007; Verger, Marcoux, Madden, Bojko, & Barnsteiner, 2005). Nurses, whether basic or advanced, practice within all healthcare settings: community health, public health, home health, hospitals, and skilled nursing facilities and nursing homes. Whether basic or advanced, nurses address human responses to health problems or life processes. These responses are essential for the promotion of wellness and, when impaired, are responsible for suboptimal wellness states or exacerbation of disease. The major reason for admitting a patient to any hospital is for 24-hr professional nursing surveillance, care, and the additional technology that hospitals provide. A significant proportion of the variance in hospital outcomes is attributable to health problems/life process diagnoses present on admission, and this variance is distinct from the variance in hospital outcomes attributable to disease diagnoses (Welton & Halloran, 1999, 2005). More studies related to nursing diagnoses and their related outcomes as well as the newer studies of the association between nursing intensity to outcomes are needed (Welton, Halloran, & Zone-Smith, 2006; Welton, Unruh, & Halloran, 2006). The current system of health care is complicated and costly and services lack continuity.
Reflection	Reflection on the meaning and value of the term "nursing diagnosis" is important. Overuse of the term "nursing diagnoses" clouds or obscures the subject matter of the diagnosis, i.e., human responses to health problems or life processes (NANDA International, 2007, p. 332). It is the latter, the diagnosis and treatment of *the human response of the client*, that is the foci of nursing, not simply the act of diagnosing. Furthermore, the phrase "treatment of human responses to health problems or life processes" is of utmost value in the establishment of nursing hospitals. To understand why requires an exploration of the meaning and use of the terms "allopathic medicine" and "osteopathy." There are hospitals in which the majority of those who direct care practice allopathic medicine, where allopathic refers to a system of medicine that fights disease through drugs and surgery. There are hospitals in which the majority of those who direct care practice osteopathy, where osteopathy refers to a system of medicine that focuses on structural integrity and the manipulation of the bodily structure, supplemented by drugs and surgery. There are no hospitals in which the majority of those who direct care practice advanced nursing, where advanced nursing practice is a system of care that diagnoses and treats human responses/life processes, supplemented by drug and related therapies. The *raison d'être* for the establishment of nursing hospitals is to diagnose and treat acute and chronic responses to health problems/life process responses and, in so doing, study-related morbidity, comorbidity, mortality rates, quality of life, and other health outcomes with the intent of improving the quality and safety of hospital care and its cost-effectiveness and efficiency. This model is built on that established by Florence Nightingale, who said that the Crimean soldiers were not dying of their wounds but of conditions, such as cold, hunger, lack of hygiene, insufficient shelter. She treated these conditions and collected evidence to support her hypotheses (Lavin, Avant, Craft-Rosenberg, Herdman, & Gebbie, 2004). Today, patients are dying of chronic illnesses, such as hypertension, diabetes, and chronic obstructive pulmonary disease, because of the ineffective therapeutic management of these conditions, deficient self-care, and preventable physiological responses (hypoglycemia, hyperglycemia, and the like).

Table 1. *Continued*

Reasoned dialogue	Why aren't there nursing hospitals where advanced practice nurses admit all patients and are primarily responsible for the management of the patients, and where professional nurses provide all care, assisted by licensed practical nurses and certified nursing assistants? In such a system: 1. The patient or family would be the center of care—recognizing that the patient or family is the one primarily responsible for managing the health problems and life processes on a day-to-day basis. 2. Nursing, medical, and other healthcare specialists would be available for consult and interprofessional teamwork purposes. 3. Research would be directed toward the study of human responses to health problems or life processes, testing the safety and effectiveness of patient care interventions/treatments and interprofessional team effectiveness, evaluating patient care outcomes, and the conduct of cost, benefit, and efficiency studies. 4. Health problems/life process response *diagnoses* would be coded for tracking, epidemiological research, and reimbursement purposes in a manner analogous to the coding of disease diagnoses. 5. *Procedure* codes, for example, the ABC codes, would be used for to reimburse treatment of health problems/life processes in a manner analogous to the way current procedural terminology (CPT) codes are used for reimbursing the treatment of disease. To provide an integrated system of nursing care that is complementary to and not competing with medical care requires: 1. Complementary or tiered architectural structures, or 2. Adapting current facilities so that the majority of primary care providers, who admit and treat their patients in the hospital, are nurse practitioners. In either approach, the nursing hospital would serve as a hub of care within a healthcare system that provides a continuum of team services that integrate and bridge patient care within all settings: 1. Nursing care stations delivering basic and advanced nursing practice within public housing residences, neighborhoods, schools, and public health departments where mental health, physical therapy, occupational therapy, language and speech development, and social work services are integrated into care. 2. Primary healthcare offices, where integrated mental health, physical health, and dental health services are provided 3. Assisted living facilities 4. Urgent care facilities 5. Skilled nursing facilities 6. Nursing homes The Urgent Care Departments will operate parallel to Emergency Departments. The former will be nurse practitioner managed and the latter physician managed. Admission of an Urgent Care patient to the medical hospital would require approval by an Emergency Department physician. Admission of an Emergency Department patient to the nursing hospital would require approval of an Urgent Care nurse practitioner. Urgent Care and Emergency Department nurse practitioners and physicians may admit directly and respectively to the nursing hospital and medical hospital. Triage nurses (not admitting clerks) will serve as the first person seen by any patient who walks into an Urgent Care or Emergency Department. Within a nursing hospital, professional nurses (basic and advanced) would be the leading professional providers of services. Ownership of the system could follow a number of nonprofit or private ownership options—the significant factor being that advance practice nurses lead, manage, direct, and are accountable for all clinical services.
Proposed actions	Begin dialogue and action among nursing professionals now. Your contributions to the dialogue are important. See Appendix A. Build/strengthen the platforms of practice.

hospitals. Examples of current epidemiological studies in nursing include:

1. Prevalence studies of urinary incontinence in young female athletes (Carls, 2007) and nursing home clients (Boyington et al., 2007), postnatal perineal morbidity (Herron-Marx, Williams, & Hicks, in press; Williams, Herron-Marx, & Hicks, in press; Williams, Herron-Marx, & Knibb, 2007), and delayed vomiting in children receiving chemotherapy (Robinson & Carr, 2007).
2. Longitudinal studies of the association between birthweight and neonatal morbidities on school-age outcomes (McGrath & Sullivan, 2002, 2003; McGrath et al., 2005), perinatal loss and treatment appraisal and coping in subsequent pregnancy (Cote-Arsenault, 2007), hypothalamic–pituitary–adrenal dysregulation in postpartum depression (Jolley, Elmore, Barnard, & Carr, 2007), and stressors and coping strategies in women following cancer therapy (Lauver, Connelly-Nelson, & Vang, 2007).
3. Randomized controlled trials studying the effectiveness and safety of sucrose in relieving procedure-associated pain in term and preterm neonates (Gibbins et al., 2002), a birth center versus standard maternity care (Morano, Cerutti, & Mistrangelo, 2007; Waldenström & Nilsson, 1994, 1997; Waldenström, Nilsson, & Winbladh, 1997), and continuous display of cerebral perfusion pressure on traumatic brain injury outcomes (Kirkness, Burr, Cain, Newell, & Mitchell, 2006).

Healthcare Policy and Legislation

The establishment of nursing hospitals will result in changes in health policy and healthcare legislation and vice versa. To support these efforts, nurses need to use decision analysis methods and other analytical tools to engage proactively in policy-making and governmental activities. This recommendation is consistent with an earlier finding that nurses in policy-making positions need to increase their contact with nursing researchers and scholars (Gebbie, Wakefield, & Kerfoot, 2000). Steps forward include the appointment of qualified nurses as faculty in schools of government within universities and the establishment of analytically oriented departments of health policy and law within schools of nursing.

Expanded Use of Evidence-Based Classifications and Related Informatics

An evidence-based classification is not simply a terminology or a vocabulary. It is a classification of diagnoses that possesses tested definitions, etiologies, and signs and symptoms. Furthermore, there must be a growing body of evidence that:

- Valid and reliable clinical assessments are being made.
- Sensitive and specific diagnostic tests are available or in the development stage.
- Treatments/interventions are safe and effective.

Advances in this field signify advances in the science and practice of nursing. Crucial to success will be the concerted efforts and contributions made by advanced practice nurses, nurse researchers, and informaticists.

Philanthropic, Grant, Business, and Other Stakeholders

Capital will be needed to establish nursing hospitals. Sources for capital include philanthropists, foundations, businesses, and other stakeholders (major nursing, informatics, medical, health professional, and healthcare administration organizations). Those who control capital are interested in outcomes. Unwavering focus on diagnostic-specific patient outcomes that impact patient satisfaction, length of hospital stay, morbidity, comorbidity, and mortality rates will be mandatory. Pilot programs will be needed to show that (a) nursing hospitals improve the delivery of safe, effective, and efficient patient care to a population with increasingly complex health problems and scarce resources; and (b)

the inclusion of nursing hospitals within health centers strengthens the provision of state-of-the-art care.

Globalization

Just as midwifery or birthing centers are available in many but not all countries throughout the world, it is anticipated that nursing hospitals will become available in many but perhaps not all countries within the next 50 years. It may be that nursing hospitals will be especially important in the therapeutic management of emerging infections in developing countries, assuming that a cadre of professional nurses, in the tradition of Florence Nightingale, would be willing to establish them.

Interprofessional Teamwork

Hospitals that focus on the treatment of acute and chronic health problems/life processes cannot function optimally without integrated, interprofessional teamwork from the outset. Nursing hospitals will promote and optimize state-of-the-art interprofessional team care.

Nursing Education

The establishment of nursing hospitals depends on and even mandates multiple entry and exit educational points for the professional nurse, simply because patients require many and varied levels of care. Fortunately, multiple levels of education and the availability of career ladders are distinguishing characteristics of professional nursing. At the same time, methods of educating larger numbers of nurses in the face of an aging nursing faculty must be addressed by innovative and sound educational methodologies.

Conclusions

The most apparent conclusion of this article is that 50 years from now the scope of nursing practice will have expanded and nursing hospitals are likely to exist. However, there are several other conclusions that readers may draw, regarding the depth of the dialogue and proposed actions, reactions to the changes discussed, fear of change, the value of the dialogue to nursing, and value of discerning the future. In addition, readers are invited to participate in the dialogue (see Appendix A).

Depth of the Dialogue and Proposed Actions

Some readers may view this dialogue as simplistic. Others may view it as grandiose and unrealistic. Still, others may view it as lacking a research foundation. Some may view the idea of a nursing hospital as a logical consequence of advanced nursing practice. At its most basic level, this article is a first attempt at a valuable dialogue within NANDA International about the future of nursing practice and the continued development and classification of human responses to health problems or life processes.

Reactions to Change

Reactions to this article and to change will vary. Early adopters will welcome this dialogue and begin to think of ways of developing nursing hospitals or strengthening one of its platforms. Some will assume a "wait-and-see" approach. Late adopters will react with "Nursing hospitals will never happen." Actually, all responses to this dialogue are good. Positive reactions provide energy to move forward. "Wait-and-see" approaches insure that caution is taken. Negative reactions highlight the nature of obstacles that lie in the way.

Fear of Reaction From Others

Change is associated with fear. One fear may be that others might see nursing hospitals as competitive with rather than complementary to existing hospitals or interprofessional teamwork. It is not as if nursing

practice is going to advance alone and other professions remain static. Advances in the clinical practice of nursing are associated with advances in medicine and other health professional sciences. All health professions advance together.

The foundation of dialogue is reason, respect, and the sharing and exchange of ideas—not dominance or competition. A dialogue on the ways in which nursing hospitals would improve the safety and effectiveness of patient care is no more competitive than Florence Nightingale sharing her observations with British surgeons that wounds were not causing death, but lack of food, hygiene, and warmth. The objective was then and is now to improve patient care.

Other ways of addressing fear are to reiterate the premises underlying the establishment of nursing hospitals. Ineffective responses to health problems or life processes are causing healthcare and disease management to deteriorate in many. The treatment of such is the focus of nursing. The expected outcomes are an improvement in patient and health outcomes, patient safety, effectiveness, and efficiency of care. The establishment of nursing hospitals complements and does not compete with other hospitals within a health center.

Effective interprofessional teams recognize the contribution of each healthcare profession to improved patient care. This recognition and respect is at the heart of interprofessional dialogue and practice. Nursing's contribution is to advance the treatment of responses to health problems and life processes and improve the health and quality of care delivered to clients and patients in all settings, even futuristic nursing hospitals.

Value of the Dialogue to Nursing

Some may conclude that this article has only limited value because responses to health problems and life processes are not the "whole" of nursing. While nursing diagnoses are not the "whole" of nursing, this article concludes that their treatment is the focus of nursing practice in a manner analogous to disease being the focus of allopathic medicine and structural integrity being the focus of osteopathic medicine.

Value of Discerning the Future

Nurses must develop a plan for their future, or the future of nursing will be determined without their input. Even if the plan seems to reach beyond the possible, dreams are necessary.

> There is nothing like dream to create the future.
> Utopia to-day, flesh and blood tomorrow.
> —Victor Hugo (1862/1987)

Author contact: lavinma@slu.e

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Appendix A

Participation in Dialogue Form
To contribute to the dialogue, briefly complete and send a form like the enclosed to:

M. A. Lavin, ScD, RN, FAAN
Saint Louis University School of Nursing
3525 Caroline Mall
St. Louis, MO 63104
lavinma@slu.edu

A representative number will be posted on the member's only section of the NANDA International Web site (www.nanda.org).

Dialogue Table

Observations
Reflections
Dialogue
Proposed actions