The Medicalization of Nursing: The Loss of a Discipline's Unique Identity

M. Patrice McCarthy, PhD, RN, CNS
Notre Dame College, South Euclid, Ohio

Jeffrey S. Jones, DNP, RN, PMHCNS-BC, CST, LNC
Landmark Health, Hilliard, Ohio

Abstract: The authors propose that the evolution of the role development for generalist and advanced practice nursing is increasingly at odds with the contemporary scholarship of the discipline and ultimately betrays the unique identity and autonomy of the nursing profession. The development of the evidence-based practice movement in medicine and nursing is explored as the predominant theoretical framework guiding nursing practice. Professional challenges and recommendations to reclaim the unique nature of nursing are discussed with attention to the implications for the educator, clinician, and scholar.

Keywords: nursing theory; nursing education; nursing profession; advanced practice

An Identity Crisis in Nursing

A graduate student at a prominent mideastern university was enrolled in the adult nurse practitioner (NP) program. During a classroom discussion regarding appropriate interventions suited for the advanced practice nurse, the student raised a question regarding the approach to the patient and was informed by the instructor, "You now need to quit thinking like a nurse." This exchange actually happened. What was most disturbing to the student was that it ran counter to her expectation of expanding her thinking as a nurse as she was, after all, enrolled in a graduate program in *Nursing*! It created dissonance for her that was not resolved until she reengaged with nursing paradigms in her doctoral program years later. What is more disturbing is that this experience seems to be an exemplar of what is happening, curricular-wise, at both the generalist and the advanced level of nursing practice. The concern generated by this scenario includes, but extends beyond, the individual student's distress recalled years later in its retelling.

Last year in Ohio, House Bill 216 was signed into law. The original intent of this new legislation, as originally proposed, was to grant advanced practice registered nurses (APRNs) more autonomy, allowing them unencumbered ability to practice within the full scope of their role. The original incarnation was met with vigorous pushback from the Ohio Medical Association, mainly because of language that would remove the requirement of a physician collaborator. Thus, the bill that ultimately passed was a much different version of the original (Ohio Association of Advanced Practice Nurses, 2017). One of the most concerning elements was the new mandate that to be

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classified as an APRN in Ohio by 2019, you *must* obtain prescriptive authority (Ohio Board of Nursing, 2017). So, providers such as clinical nurse specialists (CNSs), who have functioned in the APRN role for decades, providing organizational consultation, staff/nursing education, quality assurance, and the development of programs to meet specific client population needs, now are at risk of losing their status if they fail to meet the prescription obligations. It is yet another example of the degree to which we have shifted away from the foundations of nursing and that the manner in which we frame nursing practice is now truly at odds with the scholarship of a discipline that emanates from a distinct body of knowledge unique to that discipline.

These two examples shed light on the challenges facing the discipline but they emanate from the same core issue. The scholarship of the discipline that grounds the work of the profession is not what is influencing the definition of its practice. Whether by faculty directive to a student or the paradigmatic framework influencing the regulation of practice, both are reflective of the hegemony of a biomedical model still shaping the preparation of its clinicians and constraining the scope and focus of the profession as it seeks to fulfill its commitment to the health of society at large.

Albert Einstein's (2006) perspectives on science, knowledge, and the imagination necessary to address societal challenges is chronicled in a collection of his lectures and letters to colleagues. His perspectives on the necessity to be open to new ways of thinking challenged his contemporaries to think broadly to advance science and a peaceful world. His reflections brought attention to the general concern of nuclear scientists in the mid-20th century regarding the power of the atom and the obligation to use its power for the benefit of humanity rather than human destruction. His perspectives drew attention to the manner of thinking and the importance of recognizing how one's frame of reference influences the ability to identify creative solutions to societal problems. He drew attention to the obligation to reflect on the level of consciousness that informs one's actions and how that shapes the potential solutions considered. His ideas hold particular relevance to the current discussion regarding the framing of nursing scholarship and its relevance to practice at the generalist and the advanced practice levels. More precisely, if we fail to remember, understand, and appreciate nursing's historical struggles for autonomy, independence, and identity as a unique and separate discipline, are we not doomed to repeat mistakes that have hindered our progress and actually betray our founder's designs?

The recent trend in nursing curricula, in both undergraduate- and graduate-level programs, has been to focus almost exclusively on practice based from a scientific/fact or evidence-based paradigm with little consideration of a postmodern perspective reflected in curricular guidelines (Smith & McCarthy, 2010). The hegemonic stance of this paradigm gives primacy to objectivity, a hierarchy of evidence, and quantitatively derived findings based on statistical probability as a foundation for prediction (Holmes, Perron, & O'Bryne, 2005). Although qualitatively derived findings are cursorily included, the gold standard of clinical trials precludes any serious consideration of scholarship derived from alternate paradigmatic perspectives. More importantly, with regard to nursing practice, the definition of a proposed curricular structure distances the practitioner from the relational dynamic with a patient, which counters what actually constitutes the historical premise of the discipline. Indeed, the relational dynamic in nursing has eroded to the extent that even in psychiatric units, the one place one would assume practice was still based on interpersonal models, fewer than 4% of psychiatric patients report any regular contact with nursing staff (Shatell, 2007). In exploring how nursing may have arrived at this juncture, we must first acknowledge the evidence-based practice movement, which some have described as an oppressive system that is insufficient to the breadth of the discipline (Cody & Mitchell, 2002).

The Evidence-Based Movement

Several decades ago a movement known as evidence-based medicine (EBM) began receiving some notoriety. The notion was that practice based on fact and statistics was better than practice based on intuition. While many lauded this trend as the new gold standard for practice, others in the medical field cautiously urged a more balanced approach and suggested a blending of intuitive and EBM practices. Loewy (2007) argued retrospectively that EBM has actually become a "straightjacket for reason," one that dissuades

the user of intuitive and creative reasoning by reducing practice to the memorization of algorithms and protocols.

Now evidence-based practice (EBP) has become the gold standard in nursing. Although Carper (1978) defined four ways of nurses' knowing—empirical, ethical, personal, and esthetic—only empirical knowing is now given primacy, and the other modes of inquiry leading to practice are given only passing reference in nursing curricula. Emphasis on the nurse, generalist or advance practice, arriving at treatment strategies based on self-understanding and their relationship with (and in context with) the patient is now all but forgotten. The nurse–patient relationship as a model for practice is now deemed less than desirable and the scholarship that supports it marginalized from mainstream nursing (Cody & Mitchell, 2002). Education in nursing in most institutions has now been structured almost solely around standards and protocols. Some recent research on this trend suggests that placing such emphasis on this mode of practice results in an extinguishing of intuitive decision making and critical thinking skills (Slemon, 2018). The epistemology necessary to address the complexities and contextual factors inherent in nursing practice is not supported from a rigid reliance on the nature of knowledge derived from the significance testing of this paradigm of research (Ou, Hall, & Thorne, 2017; Pesut & Johnson, 2008).

The Joint Commission has endorsed organizations to move toward EBP. The Institute of Medicine (IOM) as well as others herald EBP as the key essential skill for healthcare providers. Yet, a recent study examining why nurses are having trouble incorporating this mind-set revealed that *time* was the biggest barrier (Brown, Wickline, Ecoff, & Glaser, 2009). The recommendation by these authors was that nurses should somehow spend less time at the bedside in order to be able to think in a fashion consistent with EBP. If EBP has not been successfully translated to the bedside in guiding nursing practice, then what has? What is absent from these endorsements is that all knowledge is theory-laden, acknowledged or not, and that the evidence-based movement is itself a theoretical framework. However, it is one that delimits the breadth of other theoretical considerations, specifically nursing theory that has been derived from diverse paradigmatic assumptions. Each theory is grounded in unique ontological and epistemological assumptions.

Utilization of Nursing Theory

Beginning in the late 1950s with Hildegard Peplau, nursing was introduced to its first conceptual model of practice (Peplau, 1991). The next several decades were alive with a flourish of activity around the development of ways and means to theorize about and describe nursing. Translating some of these theories into practice has always been a problem. Indeed, some recent studies on exactly who is using nursing theory indicate that while nurse scholars are publishing research using theoretical underpinnings, they aren't always using nursing theory but rather borrowed theories (Bond et al., 2011).

Much of the criticism of nursing theory stems from the difficulty of testing them. Some seem to pass rigorous muster; others do not and are categorized as philosophical musings or dismissed as frameworks defined in the interest of curricular development. In the face of inconsistent applicability of nursing theory and the EBM movement in medicine, EBP found its entree into nursing practice to fill the void. The questions the nursing profession should be asking are, Should EBP drive the entire model of nursing practice? Are there not many situations that nurses encounter on a daily basis that speak to the utilization of a humanistic intuition? Is not the recognition of a patient's distress and the desire to provide comfort, as Travelbee (1971) described, the very foundation of nursing practice? Can we not agree with the findings of Attree (2001) that the most valued activities of nurses are those born out of compassion and empathy?

Caring science and its foundation of respect for the integrity of the person in dynamic relationship with the nurse casts a uniquely nursing framework for practice (Ray, 2016). Yet, it is difficult to find EBP protocols for these said skills, and so instead of educating undergraduates around nursing theoretical concepts to help guide the intuitive self in the purveyance of care derived from compassion and empathy, future nurses are taught to think about every task they perform as being driven by EBP and time management. Again, as with medicine, some watchers of this unfolding have called for a tempered, measured, combined approach to nursing education where nursing theory and EBP are taught in concert (McCrae, 2012). Some suggest a return to a theoretical paradigm guiding nursing practice that utilizes core concepts of relationship-based care blended with a caring,

ethical practice is the way forward in the development of nursing knowledge (Hoeck & Delmar, 2018).

When every action is derived from a truncated framework, nurses in practice are positioned in an ethical stance of impersonal detachment, denying their own and their patients' personhood. This instrumental framework fosters the moral distress evident in the life experience of practicing nurses. Practice from a theoretical framework grounded in the ethic of the discipline informs the practice of nursing and gives the practitioner an established framework for a moral voice and enhances the moral agency of the practitioner (Barlem, Lunardi, Lunardi, Tomaschewski-Barlem, & Silveira, 2013; Burston & Tuckett, 2012; Rathert, May, & Chung, 2016). Further arguments supporting the need to reembrace nursing models (conceptual) as a framework for practice have been discussed. Models in particular could be a manner to develop, describe, and preserve knowledge that is unique to nursing (Bender, 2018).

The obligation to attend to the theoretical grounding of the discipline as the framework for nursing curricula, practice, and research is championed by numerous scholars of the discipline (Barrett, 2017; Newman, Smith, Pharris, & Jones, 2008). Willis, Grace, and Roy (2008) provide substantial analysis of the scholarship of the discipline and identify five key areas that articulate the unique dimensions of the nursing discipline: facilitating humanization, meaning, choice, quality of life, and healing in living and dying. The authors claim these topics as a means to articulate the unique manner in which nursing attends to the care of patients and to foster the clear articulation of nursing perspectives.

Humanization captures the relational dynamic that defines the experience of self and other in the unitary human-natural world. As practiced by nurses, it is an "open-minded, caring, intentional, thoughtful, and responsible unconditional acceptance and awareness of human beings as they are" (Willis et al., 2008, p. E33). It encompasses the breadth of the caring ethic of the discipline and the scholarship derived from nursing as a human science and a caring science. Meaning is "a human's arrived-at understanding of life experiences that comes from processing those experiences" (Willis et al., 2008, p. E34). Nurses facilitate this facet of the human experience in three modes: by attending to recipients of nursing care and making sense of their health concerns, by constructing meaning within the larger sociocultural and political arena, and by reflecting on nursing ways of knowing and a relational use of self to form effective healing relationships. Choice is "the human potential for making personally derived decisions . . . and involves both the nurse and the recipient of care making sense of the recipient's life experience envisioning quality of life, and health and healing concerns" (Willis et al, 2008, p. E35). Despite the breadth and depth of scholarship that has emerged over the past 50 years, nursing continues to "be confounded by the perceived need to give priority to objective data, and to plan virtually all programs of education, research and service accordingly" (Cody & Mitchell, 2002, p. 11). The propensity to maintain allegiance to a dominant paradigm, that is, EBP, thwarts the effective use of all ways of knowing and undermines the full expression of the discipline.

Yearnings for More Autonomy and Changes in Advanced Practice

The APRN movement has not been immune to the aforementioned curricular trend. As originally conceived by Hildegard Peplau at Rutgers University in the mid-1950s, the psychiatric CNS was the first advanced practice role to emerge (Hanrahan, Delaney, & Stuart, 2012). These providers were masters-prepared nurse clinicians who performed several duties in state psychiatric hospitals including but not limited to psychotherapy (both group and individual), program and milieu management, and hospital consultation. The role of the CNS expanded to become understood as an APRN who functions within three spheres of influence. These spheres are client, nursing, and systems. Thus the APRN who is a CNS would be educated to provide expert services in a specialty area to an organization/hospital/system through consultation and organizational and program development; to the nursing staff through mentorship, staff development, clinical supervision and research; and directly to a client population through case management and direct intervention. The CNS uses organizational and systems theory, and in mental health, interpersonal theory, as undergirding to support practice. What are now known as EBP protocols were developed from research and integrated into the service sector and provided to nurses as a means to improve practice and client outcomes. Other nursing specialty areas adopted the role of the psychiatric CNS as a model

of advanced practice, including pediatrics, maternal/child, and medical–surgical, and geriatric specialties, to name a few.

The NP movement was born out of the need for physician services in rural areas. Loretta Ford, RN, and Henry Silver, MD, started the first NP program in 1965 at the University of Colorado. The NP role has clearly now evolved to practice predominantly from an EBP/medical model of care. The NP role was originally viewed as a means for nurses to provide care and support for those living with chronic illness based on attention to the patient's lived experience and careful attention to empowering patients through an emphasis on patient education. The advent of the CNS and the NP establishing themselves in healthcare became a rallying cry for advanced practice. Advanced practice was then seen as a foundation for an advanced level of practice and a more autonomous framework for nursing care with unique patient populations, yet with a distinct identity from medicine. The pediatric NP movement in the 1970s explicitly argued, however, that they saw their role as collaborators with medicine, not separate (D'Antonio & Fairman, 2004). The role of the NP has now become dominated by the medical model that frames the attention to the diagnosis and treatment of acute medical conditions. With this shift in focus of advanced practice identity, many CNS programs are closing, and fewer and fewer nurses are choosing the CNS route to expand their education, as the inferred message both now in academe and with the lay public is that the definition of an APRN is a nurse who diagnoses and prescribes medications and functions in the direct care role predominately as a physician extender. The perception that CNSs is not true APRNs unless they prescribe has emerged, and in Ohio has become a reality.

Theorizing Unique Perspectives

Beginning with Florence Nightingale, professional nursing practice became a structured discipline organized around a body of knowledge devoted to caring, health, illness prevention, attention to the environmental influence on health, support for the natural healing capacity of the person, and holism (Nightingale, 1992). The intent was to be separate from medicine, which was and is focused on illness identification and treatment. A review of nursing educational texts between 1907 and 1969 reveals that nurses were educated in the practical over the theoretical, with medicine heavily influencing the curricula (Walker & Holmes, 2008). Yet, there were glimmers of hope on the horizon regarding defining a practice that represented true autonomy from medicine.

As previously mentioned, Carper's (1978) seminal work identified nurses' four ways of knowing (empiric, ethics, personal, and esthetic patterns) and exemplified the balanced convergence of using facts (empiric), morality (ethics), self-understanding (personal), and immediacy (aesthetics) in order to practice nursing (Carper, 1978). More specifically, the corollary of nursing practice was proposed to be the result of the understanding of the self within the context of the relationship with the patient, guided by moral constructs toward interventions, suited to the significance of the current need, with respect to scientific predictions. For many this was the gestalt that perfectly and finally defined who we were as nurses. Yet, there was interest in doing more and expanding the APRN role that was seen as a way toward further delineation of nursing practice rather than overlapping with other disciplines. The development of the human science tradition and its philosophical underpinnings followed in the wake of Carper's contributions and further refined nursing's unique perspective and its role in preserving human dignity and freedom in the human health experience (Cody & Mitchell, 2002). The continued dialogue between diverse theoretical traditions signified the maturity of the scholarship that informed nursing's perspectives (Cowling, Smith, & Watson, 2008; Newman, Smith, Pharris, & Jones 2008).

Current Reflections

The need to revisit the role of theory as a defining element of the discipline will be essential if the transformation of curricula recommended by the Carnegie report is to be realized. These recommendations will require dramatic shifts in nurse faculty thinking about the scholarship of the discipline and its essential role in the educational process in nursing (Benner, Sutphen, Leonard, & Day, 2010). These recommendations include the following shifts in focus: (a) from decontextualized knowledge to teaching for a sense of salience, situated cognition, and action; (b) from a sharp separation of classroom and clinical teaching to integrative teaching in all settings; (c) from an emphasis on critical thinking to clinical reasoning and multiple ways of thinking that include critical

thinking; and (d) from an emphasis on the socialization of role-taking to an emphasis on formation of the whole person as professional. Inherent in each of these recommendations is the need to be fluent in articulating the philosophical assumptions of a theoretical perspective and its role in situating the nurse as a moral agent in professional practice.

Understanding the direct link between how you think about something and the actions you take is vital to professional practice. Theory informs our way of thinking and is a reflection of the ethical orientation of the discipline. "Theories provide opportunities for reflective practice and they serve as practical and rational guides for transforming reality in a chosen way" (Cody & Mitchell, 2002, p. 7). Our reluctance to embrace nursing theory as the framework for practice undermines the merit of the argument that we are a distinct discipline. Rather than the technological skill set often taught as the foundations of practice, should not the foundations of the discipline—its philosophical, ethical, and theoretical groundings—as the framework for practice, ultimately informing the actions of the nurse, be the primary orientation? The less conscious we are of these foundations, the more instrumental and the less articulate we are about the unique role we play in society as advocates for health.

In closing we present another true exemplar. A recent doctoral candidate at yet another prominent mideastern university was studying nurse's affinity with nursing identity and adherence to nursing theory–driven practice. She interviewed a cohort of graduating senior BSN students regarding role identification and ability to define nursing. Most (over 90%) were able to do so in some explicit manner. She interviewed the same cohort 1 year after graduation. The results were stunning. Only 5% still identified any remnants of nursing paradigms as guiding their practice. The other 95% now identified with a medical model and saw their practice as being driven by medical protocols. For them, nursing no longer had a distinct identity or occupied any autonomous domain.

Recommendations for Reversing This Trend

We propose the following:

1. Recognize that if we fail to appreciate our nursing history, we are doomed to repeat it. Nursing curricula should include a review of the evolution of the discipline in contemporary society, respectful of the structural and political forces and the ideology that shaped and influenced the discipline.
2. Curricula should be predicated on nurses' multiple ways of knowing that prepare students for the intuitive dimensions of practice grounded in the ethics of the discipline and an understanding of nursing as a relational narrative that evolves out of the ethical stance of the nurse (Gadow, 1999).
3. Beyond a nursing introductory theory course, midrange and major theoretical perspectives should be developed as strands to form the foundations of practice throughout the entire curricula.
4. Diverse paradigmatic perspectives should shape the discussion about the multidimensionality of nursing practice in a postmodern world.
5. Role model and promote professional development that emphasizes the interpersonal dynamics of nursing as integral to its practice and its inherently personal challenges.
6. Promote a model of professional practice that recognizes that personal and professional development work hand in hand as a means to move beyond the technical role that implements the medical regimen and requires an attention to the breadth of human experience.

Those of us who teach and those of us who practice have a unique obligation to our students, both undergraduate and APRN, and the society that we all serve. Preparing future scholars and clinicians to meet the needs of an evolving society requires that we equip them with the ability to discern the complexity of the world they encounter from a uniquely nursing paradigm. Drawing from its humanitarian origins, the wisdom of nursing is a voice sorely needed in a society who seeks to build for the future. Future graduates will be ill-equipped without attention to the full breadth of the discipline's scholarship as a basis for practice and for engaging in a meaningful way in the larger sociopolitical context that shapes our world. As educators, we need to understand that our students will learn what we value enough to teach. As clinicians, we need to understand that our patients and the society we serve will be the beneficiaries of practice derived from the scholarship of our discipline. As scholars, we need to understand that the future of our discipline will be defined by the

breadth and depth of the philosophical underpinnings that define our scholarship. Our discipline and its professional practice will be defined by what we value and what we advocate for.

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Correspondence regarding this article should be directed to M. Patrice McCarthy, PhD, RN, CNS, Notre Dame College, South Euclid, Ohio. E-mail: mpmccarthy@ndc.edu